
EDITORIAL POSTLUDE

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The Public as the Problem for Public Health

The enigma of public health is that while corporate marketing tools are blamed for many problems, those same tools seem impotent in correcting them. People are fat and they remain fat even in the face of efforts to restrict the marketing of carbonated soft drinks, fast food and candy. Despite restrictions on cigarette sales to young people under 18 years, a national ban on television advertising and decades of antismoking campaigns, significant numbers of people still smoke. The realization is that decisions are personal and that success rates will never be as complete as the national eradication of smallpox, because with education for public health as with other forms of education, many people just do not want to think about it.

When I traveled into Florida on my motorcycle, many riders in the group were quick to pull over and take off their helmets as soon as they crossed the border into the state that does not require their usage. As I stood in the roadside rest area with two people who were commenting on how those riders are reckless and “crazy,” I could not help but notice they were both chain smoking the entire time. But then, many people might have had the experience of attending a funeral of someone who died from cancer where the deceased’s offspring would be seen going through a few cigarettes at every opportunity.

Instead of merely listing the societal issues of obesity, nutrition, cigarettes or other ways the people increase their risks of health problems, the possible solutions—and limitations of any persuasive efforts—might better be understood by starting with the differing perspectives of medical people and patients toward possible treatments. Someone goes to the doctor with an ache or pain or perceived illness and wants to feel better.

To start with a medical perspective, making what is admittedly a gross over simplification, in very broad terms therapies can fit into three categories:

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1. A curative, meaning a cure that makes the underlying cause for a consumer-perceived problem go away, such as an antibiotic that is given to kill a bacterial infection.
2. A treatment that holds a disease process at bay, which to the patient might be an apparent cure because it suppresses a cause to a degree that it is no longer a problem while the drug is in use, such as HIV/AIDS drugs or chemotherapy for cancer.¹ The patient may not be “cured” but the disease process does not get worse.
3. A symptomatic treatment, or what a lay person could think of as a symptom suppressor, a drug that addresses the symptoms only and not the disease, such as antihistamines or pain killers.

As noted, this is a gross simplification, and any biological researcher or medical professional would note the caveat that there is a lot of crossover between these as a drug that may function as one in some patients may actually function differently in another group of patients. When you get into the biochemical level, sometimes the lines get very blurry. However, the difficult realization for assessments of public health strategies is that to the typical consumer, all three of these situations are the same. Once they feel better, they consider themselves cured.

Many patients stop using prescribed drugs as soon as they are feeling better, a broad problem that results in many relapses or subsequent infections that then resist the first treatment. And so it goes with seemingly self-destructive unhealthy behaviors. The motorcycle riders do not consider the possible head-impacting severe accidents they never experienced and the cigarette smokers feel fine.

Not so long ago, the mass media one Fall conveyed a sense of near panic of a possible pandemic of swine flu. In some communities the problems were widespread, and the personal stories shown on television news focused on the young, healthy people who were devastated by the illness. On my own campus, the provost directed faculty to provide written contingency plans that would be implemented if the course instructor became ill for an extended period or if an excessive number of students were unable to attend class. Yet even at the height of the public concern, and after months of widely available inexpensive vaccinations, few students took advantage of the preventive measures.

The mystery remains why this educated community evinced a preference for higher risk behavior or at least not take simple steps to reduce

1. Those taking a medical perspective do not use the word “cure” for cancer.

risks beyond use of now-ubiquitous antibiotic hand sanitizers or coughing into their elbows.

It is not an unrelated issue that people still overeat unhealthy foods, do not exercise, consume tobacco and do not check themselves for early signs of various forms of cancer. Just reading food labels can be a useful tool in an effort to lose weight (Mandal 2010), but the pattern remains for many people to engage in what public health professionals must consider as self-destructive behavior (Bone, France and Aikin 2009). For people studying these issues, it is one thing to list a string of data that a public problem exists—people smoke, people are fat, women do not do breast self-examinations—but getting changes to the situation requires a conceptual starting point for research that is stronger than just ripping statements of the problem from news headlines (also see Rotfeld and Taylor 2009).

Cancer might have killed the parent, but the smoking young adult feels okay. Unhealthy food tastes good. And there is an adrenaline rush to the wind in your hair while cruising on a motorcycle.

Public policy efforts to combat public health problems start with efforts to make basic information available for consumers, healthy information. Sometimes it is just trying different mass marketing tools and seeing what works (e.g. Lowrey, Sabbane and Chebat 2009; Smith and Stutts 2006). Another pragmatic application would involve an assessment of perspective behind the creation of public policy rules and the actual use of the resulting tools by consumers (e.g. France and Bone 2005). And both yield the realization that reactions of various members of the public are more nuanced, more individual, more personal (e.g. Bates et al. 2009; Tangari et al. 2010) and not necessarily what the people creating or sponsoring the mass communications messages might desire (Wolburg 2006).

The bottom line problem falls in part to the intrinsic difficulty of consumer education itself, or of education in general: people do not want to think about it. Feeling good, or not feeling bad, is good enough.

So the studies that start with the number of people who are fat, die from cancer or do unhealthy things could be missing the point. No program can save everyone.

Informed people can still make bad decisions that are not in their best interests. For public policy, the need is to base information programs on how people would or could actually use the information instead of what someone wants to say. For education, the need is to assess how or why some people might learn to change their behaviors and health perspectives in a positive fashion. But in all efforts, the most realistic goals would be to have a positive impact on some people, sometimes, in

some situations. Even in the best-planned, most persuasive and carefully targeted public health efforts, many people will still be choosing to do unhealthy things.

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