

R E P O R T S

124th ANNUAL MEETING and EXPOSITION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION New York, USA, 17–21 November, 1996

Between 17–21 November, 1996, New York became the city to host the participants of the 124th Annual Meeting and Exposition of the American Public Health Association. This year's leading theme was **"Empowering the Disadvantaged. Social Justice in Public Health"**. The Meeting was attended by over 5,000 specialists representing nearly 75 public health disciplines who deliberated on the most actual public health problems. Presiding the Meeting, *K.S. McCarter*, Acting Executive Director of the American Public Health Association in her opening speech highlighted the overall value of this year's theme and stressed the need for collaboration of all policy makers, local, state and national officials and public health representatives to ensure that social policies indeed empower the disadvantaged and diminish the existing health problems.

A broad spectrum of public health issues included in the program of the Meeting was discussed every day during general, panel, poster and roundtable sessions – about nine hundred and fifty in total. The main subjects of the Meeting were presented during sessions on: alcohol, tobacco and other drugs – 54 sessions; American Public Health Association – 28 sessions; cancer – 19 sessions; cardiovascular disease – 4 sessions; children – 27 sessions; community health planning – 42 sessions; disabilities – 18 sessions; environmental health – 36 sessions; epidemiology – 35 sessions; food and nutrition – 20 sessions; gerontological health and Alzheimer's disease – 28 sessions; health administration – 40 sessions; HIV/AIDS – 69 sessions; homelessness – 8 sessions; injury control – 27 sessions; infectious diseases – 7 sessions; international health – 41 sessions; lead – 15 sessions; managed care – 35 sessions; maternal and child health – 53 sessions; medical care – 50 sessions; mental health – 35 sessions; occupational health and safety – 32 sessions; oral health – 11 sessions; population and family planning – 50 sessions; public health education – 45 sessions; public health nursing – 31 sessions; sexually transmitted diseases – 15 sessions; statistics – 16 sessions; radiological health – 5 sessions; tuberculosis – 14 sessions; violence and violence prevention programs – 25 sessions; women's health – 37 sessions; vision care – 5 sessions.

Some special sessions were organized on: abortion – 4 sessions; advocacy – 3 sessions; accreditation – 2 sessions; African Americans – 16 sessions; American Indian, Alaska Native and Native Hawaiian – 12 sessions; Asians – 12 sessions; bioethics – 10 sessions; breastfeeding – 1 session; chiropractic – 4 sessions; cryptosporidiosis – 3 sessions; gays and lesbians – 8 sessions; reproductive health – 3 sessions; school health – 17 sessions.

The Opening General Session which followed the Governing Council Meeting and APHA Film Festival started with APHA President's *ER. Brown* Presidential Address. Dr Brown who is also a professor in the School of Public Health at UCLA and the Director of the UCLA Center for Health Policy Research entitled his speech "Leadership to Meet the Challenges to the Public's Health", and introduced the auditorium to the most important issues of his presidency. He presented the common struggles which are faced by the public health professionals trying to improve the effectiveness of national legislature, form public health coalitions and educate elected state and local officials about the importance of public health. He also appealed for more extensive support of lately introduced advocacy program which describes more comprehensive approach to advocacy through extensive training of members throughout the country in specific advocacy techniques to become more effective advocates of public health. In his opinion it is the only way to effectively mobilize the public health community to help protect the public's health against a seemingly hostile Congress which during the last year nearly deregulated and eviscerated environmental and workers' health protections and destroyed the safety net programmes that have sustained the most vulnerable members of society. Following Dr Brown's lecture was this year President — elect's session planned and presided over by APHA President — elect *BS. Levy*. Dr Levy who is a consultant in Occupational and Environmental Health and an Adjunct Professor of Community Health at Tufts University School of Medicine in Boston, in his speech on "Future of Public Health" focused on current and expected future trends in public health. According to Dr Levy trends range from managed care to information and communication technologies to reductions in government funding and many of them present serious challenges and sometimes even dangers to public health but still some reveal great opportunities to improve the health of the public and enable public health professionals to become more effective in their work. Nowadays, it is a time of great transition in public health and other health related fields in the United States and throughout the world. These changes have to be assessed and the public health's commitment to social justice has to be renewed.

During one of the special sessions chaired by *M. Hargraves*, Assistant Professor, Department of Obstetrics and Gynecology, University of Texas, Galveston, targets in achieving social justice in health care were described. Findings presented in this special session revealed striking evidence that 1) minority populations differ among themselves as well as with the majority population with respect to access to health care, utilization of services, and satisfaction with their experiences and 2) as ever greater numbers of vulnerable populations enter managed care, the importance grows of assuring social justice for vulnerable populations within the health care system. The achievement of these goals is enhanced by data specific to vulnerable populations, such as provided by the Commonwealth Fund Minority Health Survey. In the future, health status information systems tied to health care systems must be significantly modified to collect socioeconomic data, cultural factors, health practices, and racial discrimination indicators that shape the daily realities and experiences of minority groups. Cultural differences elucidated by this survey appear to act as mediators of health status, and must be identified by ongoing data systems and incorporated into interventions that include mental and emotional well-being as well as socioeconomic justice.

Another special session presided by *H. O'Leary*, U.S. Secretary of Energy, was devoted to President Clinton's Advisory Committee on Human Radiation Experiments. From the 1940s through the 1970s the U.S. government conducted secret experiments on American citizens to determine the effects of radiation on human body. Information on these tests was withheld from the subjects and from the American public until 1993. "While these experiments caused a tremendous harm and suffering to the individuals involved and their families the greatest harm has been the legacy of distrust the experiments created" said the Secretary of Energy and announced that the U.S. government has reached a settlement in 12 cases involving American citizens who were subjected to these secret experiments.

Occupational Health and Safety, Epidemiology and International Public Health sessions revealed many existing problems. Some of them are presented below.

OCCUPATIONAL HEALTH AND SAFETY

During the session devoted to occupational health and safety *A. LaMontagne*, Harvard School of Public Health, Boston, MA analyzed the results of introducing in 1984 the OSHA's ethylene oxide standard. The Occupational Safety and Health Administration (OSHA) promulgated a full health standard for ethylene oxide (EtO) in 1981 on the basis of its genotoxic and other hazards. The scientist presented an overview of the successes as well as shortcomings of this standard as it had been applied in the healthcare industry, where the vast majority of potentially exposed workers are found. Based on an evaluation of the implementation of the OSHA's EtO standard in Massachusetts hospitals, conducted by the author of this study as well as on studies conducted by other investigators, the successes of the standard are as follows: (1) most hospitals are aware of the standard and have implemented worker health and safety training, exposure monitoring, medical surveillance (where indicated), and other prevention and control measures, (2) worker breathing zone of EtO exposures have decreased logarithmically since promulgation of the standard, (3) OSHA citation activity in hospitals is correlated with improved implementation of the EtO standard's exposure monitoring requirements, (4) the EtO standard spurred the development of new engineering controls for EtO sterilizers that have been associated with decreased worker exposure levels and (5) the costs of complying with OSHA's 1 ppm Permissible Exposure Limit have turned out to be only half of what was originally anticipated in the OSHA's 1981 Regulatory Impact Analysis. On the other hand, the training that is still being implemented is typically brief, infrequent and passive in nature, accidental exposures that escape current exposure monitoring strategies, continue to occur widely and — potential links between EtO exposure, allergic sensitization and asthma suggest that efforts to further reduce exposures are warranted. It is concluded that, the EtO Standard provided an example of OSHA regulation resulting in increased hazard awareness, new control technologies and reduced worker exposures.

Evaluation of the OSHA lead standard in construction works was the main subject of the session chaired by *RJ. Roscoe*, NIOSH, Department of Health and Human Services, Cincinnati, OH. On August 2, 1993, an OSHA interim final rule (1926.62) went into effect adding employee protection requirements for construction workers exposed to lead. Among other provisions, this rule: (1) reduced the

permissible exposure limit for lead for construction workers from $200 \mu\text{g}/\text{m}^3$ as an 8-hour time weighted average to $50 \mu\text{g}/\text{m}^3$, (2) established $30 \mu\text{g}/\text{m}^3$ as the action level at which employers must initiate certain compliance activities, including blood lead testing and, (3) required medical removal for employees whose blood lead levels exceeded $50 \mu\text{g}/\text{dL}$. In an effort to help evaluate the effectiveness of this rule, NIOSH's Adult Blood Lead Epidemiology and Surveillance (ABLES) programme provided funding to 6 states to collect blood lead levels for construction workers in the year immediately preceding and the year immediately following implementation.

In addition to the above mentioned topics a proposition of permissible exposure limit (PEL) for perchloroethylene was described during the session chaired by *LD. Schuman*, OSHA, Washington, DC. Perchloroethylene (tetrachloroethylene) is widely used as a solvent in the dry cleaning industry and in industrial degreasing operations. The OSHA's current permissible exposure limits (PEL) for perchloroethylene are 100 ppm as an 8-hour TWA, 200 ppm as a short term exposure limit not to be exceeded for more than five minutes in any three-hour period, and 300 ppm as a ceiling. On the basis of the chemical's carcinogenic effects, the Agency has established a PEL of 25 ppm TWA in 1989 as part of the Air Contaminants Final Rule. However, in 1992, the United States Circuit Court of Appeals vacated this rule. The OSHA intends to publish a proposal to update PELs for approximately 20 substances, including perchloroethylene. Epidemiological and animal studies have demonstrated that perchloroethylene is a carcinogen. The OSHA will evaluate the health evidence for this substance, conduct a quantitative risk assessment and propose a PEL that will substantially reduce the significant risk presented by exposure to this substance at the current PEL.

The question of the relationship between carpal tunnel syndrome, gender and occupation was discussed by *LA. Peipins*, NIOSH, Cincinnati, OH. The incidence of carpal tunnel syndrome (CTS), a nerve entrapment disorder of the median nerve at the wrist, has increased over the past decade. Occupational factors associated with CTS include forceful, repetitive hand motions, vibration and awkward postures. While CTS is more common among women than men, few studies have examined gender differences within occupations. Using the Bureau of Labor Statistics' 1992 Annual Survey of Occupational Injuries and Illnesses and the 1992 Current Population Survey, incidence rates of CTS for men and women for major occupational categories were calculated. Of primary interest were differences between men and women in those occupations where (1) the number of women predominate, (2) women and men are equally represented, and (3) men predominate. Women and men made up 68.5% and 30.8% respectively of the CTS cases involving days away from work. The highest rate of CTS for women occurred among machine operators (31.4/10,000 workers) and the highest rate for men occurred among fabricators and assemblers (30.0/10,000 workers). The lowest rate for women was found among professional workers, (0.53/10,000 workers) and the lowest rate for men was found among executives and managers, (0.15/10,000 workers). In each of the major occupational categories, the rates for women exceeded those for men. The ratio of female to male rates ranged from 1.65 (administrative/clerical workers) to 11.27 (executives and managers).

Safety and health surveillance for workers exposed to inorganic arsenic and its compounds were discussed by *L. Murthy* and *R. Mullan*, NIOSH, Cincinnati, OH. Inorganic arsenic (IA) and its compounds have caused various occupational diseases. Exposure of workers to IA in smelting operations has been shown to cause lung cancer, an Occupational Sentinel Health Event. Lung cancer was also caused among copper, smelter and roaster workers exposed to IA. Arsenic exposure during arsenical ore smelting and in electrolytic processes caused non-autoimmune hemolytic anaemia as well as acute or chronic renal failure. Use of IA in pesticides, pigments, and pharmaceuticals caused agranulocytosis or neutropenia as well as inflammatory and toxic neuropathy. Medical tests recommended by the NIOSH in the 1970s for worker exposure to IA included chest roentgenograms, sputum cytology, and pulmonary function tests. Analysis of urine, hair or nails was also recommended every 50 days until exposure ceased. Recent recommendations for screening workers include: urinalysis (general), urinalysis at the end of workweek, biologic tissue and biopsy, and nerve conduction studies. Depending upon the level of exposure of the agent, specific symptoms, eg, cough, dyspnea, chest pain, giddiness, headache, may occur. Diagnosis may not be accurate, and medical services afforded to worker may thus be inappropriate. This signals the necessity of practicing physicians, both on-site and off-site, to be trained in occupational medicine.

The inclusion of low income workers and workers of color in occupational asthma surveillance and epidemiological research was described by *G. Friedman-Jimenez* and *R. de la Hoz*, Bellevue/NY Occupational and Environmental Medicine Clinic, New York, NY. According to their study the burden of occupational disease and injury is probably substantial among low income workers and workers of color. Due to a variety of difficulties in studying these groups, they have remained underrepresented in the occupational epidemiology literature. Three approaches to improving inclusion of these groups are underway: 1) outreach to primary care physicians to facilitate recognition and appropriate clinical, public health and research follow-up of patients with possible work-related asthma, 2) medical-facility-based surveillance and epidemiological studies, 3) hazard surveillance studies targeting industries which employ many low income workers. A surveillance analysis of data on 741 women asthmatics in the Bellevue Asthma Clinic found that 24% of those with adult onset of asthma but only 8% of those with childhood onset of asthma had worked as garment workers, suggesting the possibility of occupational or work-aggravated asthma in garment workers. A subsequent analysis of data from the NIOSH's National Occupational Exposure Survey found that, the apparel industry had the largest number of total potential exposures to a list of probable asthma causing agents, and the third largest number of workers potentially exposed to these agents. These surveillance findings are being followed up with an epidemiological study of asthma and occupation. It is concluded that the combination of physician-based medical surveillance and targeted hazard surveillance may be an effective approach to identifying high risk low income worker populations.

JA. Merchant, University of Iowa, Institute for Rural and Environmental Health, has introduced the auditorium to the Worksafe Iowa Occupational Medicine Associates Network. The Worksafe Iowa Occupational Medicine Associates Net-

work is a university-community-based occupational medicine clinic network that provides comprehensive health care to employers across the state of Iowa. This unique network was made possible by a grant from the W. K. Kellogg Foundation. The network was formed in 1989 with the selection of five community-based clinics; additional four clinics were added within the next two years to expand services to the entire state. An experienced team of health and safety professionals at the University of Iowa, consisting of occupational medicine physicians, industrial hygienists, ergonomists, physical therapists, chemists, toxicologist information specialists, educators and industrial engineers provide technical assistance to the Associates. These clinics have continued to develop strong programmes to provide quality health care and prevention programmes that will meet the unique needs of local employers. The Associates have defined catchment areas and also work in cooperation with one another to provide care for workers' compensation for state employees. This programme has shown a reduction in health care cost and lost time. A drug and alcohol testing programme was implemented for multiple site companies in the state and has provided employers easy access to these testing services.

The effect on employers' satisfaction of a managed health care delivery system for treating work-related injuries was described by *KB. Kyes*, University of Washington, Seattle, WA. Dr Kyes stressed that the Washington State is conducting an innovative demonstration to determine the effects on workers' compensation costs and patients outcomes of providing medical care for injured workers through managed care. This study, part of a larger evaluation, was designed to determine employers' satisfaction with managed care arrangements. Workers in the treatment condition were allowed to self-refer to specialists, including chiropractors, but only to specialists in their assigned managed care network. Workers in the control condition used the current fee-for-service system. Employers who had had a worker injured on the job were interviewed by telephone 3 to 9 months after the injury occurred. A survey developed specifically for this project queried employers about their satisfaction with the medical care received by their workers, time loss issues, work modifications, and administrative management of claims. Preliminary results suggest that employers in the managed care and fee-for-service conditions were equally satisfied with the treatment and handling of their workers' injuries. However, employers from the managed care condition were more satisfied with the timing of treatment for those injuries.

G. Sorensen, Director, Community Based Research Center, Boston, MA, devoted his presentation to the Wellworks Program. It's subject is to integrate health protection and health promotion among blue collar workers. Worksite health promotion has been least successful with this group of workers. He presented a rationale for the integration of health protection, a major worker concern, and health promotion in worksite cancer prevention programmes and described the Wellworks Program, a study of 24 worksites randomly assigned to intervention or control conditions. In this project a random sample of employees from each worksite was surveyed at baseline and follow-up. Baseline data revealed that workers reporting exposures to hazardous job conditions were significantly more likely to be smokers than unexposed workers. Smokers exposed to job risks were also more likely to be thinking of quitting or taking action to quit (odds ratio = 2.17). Among

exposed workers, concern about their job exposures was associated with intentions to decrease fat intake ($OR = 1.43$) and to increase fruit and vegetable intake ($OR = 1.96$). The final results indicate that the six-month quit rate in the intervention worksites was 17.3%, compared to 12.7% in the control sites. Changes were also noted for dietary outcomes. Although blue collar workers were less likely to participate in health promotion activities, a significant association was observed between participation in nutrition- and job exposure-related educational activities. These findings suggest that participation in programmes to reduce occupational hazards may stimulate blue collar workers' participation in health promotion activities. The Wellworks study compared a combined health promotion/health protection package to nonintervention controls. A follow-up study is comparing an integrated health promotion/health protection intervention to a health promotion only intervention, thus providing a full test of this model.

EPIDEMIOLOGY

During session devoted to epidemiological studies problem of asthma morbidity and mortality was raised. *R. Ward*, University of Medicine and Dentistry, New Jersey presented an overview of the epidemiology of asthma. According to his survey over the last decade the United States has experienced a dramatic increase in asthma related morbidity and mortality. The incidence of asthma shows a strong association with low socioeconomic status and the concentration of the greatest numbers of asthmatics in the inner city. Dr Ward stressed that it has been estimated that the annual direct and indirect cost of asthma in the United States is approximately 6.2 billion dollars. The majority of direct expenses (56%) arose from ER treatment and hospitalizations. In response to this growing problem, the national health objectives, Healthy People 2000, set the goals of decreasing the morbidity and hospitalization rates associated with asthma through improved patient education and self-management skills.

Epidemiology of asthma was also discussed by *M. McDermott*, Cook County Hospital, Chicago, IL, who presented the results of a very interesting project analyzing a comparison between Emergency Diagnostic and Treatment Unit and inpatient care in the treatment of asthma. Emergency Diagnostic and Treatment Units (EDTU) provide an alternative to hospitalization for reversible diseases such as asthma that fail Emergency Department therapy. The objective of the study was to evaluate medical benefits, cost-effectiveness, patient satisfaction, and quality of life of an EDTU for acute asthma compared to inpatient ward care. A prospective, randomized clinical trial performed at two urban public hospitals enrolled acute asthmatics, aged 18–55, not meeting discharge criteria after 3 hours of Emergency Department (ED) therapy. Patients were treated with inhaled adrenergic agonists and steroids in an EDTU up to 9 hours after randomization or with routine therapy on a hospital ward. They were followed for 8 weeks. Measured outcomes included discharge rate from the EDTU, length of stay, relapse rates, days missed from work/school, days incapacitated during waking hours, symptom free days, nocturnal awakenings, direct medical costs, patient satisfaction, and quality of life. The study enrolled 222 acute asthmatics. Sixty percent of patients treated in the EDTU were discharged. There were no differences during the 8 week follow up period in relapse

rates or in any other morbidities between the EDTU and hospitalized groups. On the other hand, there were significant differences in length of stay, patients' satisfaction, and quality of life favoring the EDTU. The average cost per patient in the EDTU arm was \$1,044.46 compared to \$1,909.07 for the admission arm. Therefore the scientist concluded that treatment of selected asthmatics in an EDTU results in safe discharge of most such patients and suggested that quality gains and cost-efficiencies can be made by introducing such units.

During another session methodological issues of a surveillance programme of cardiovascular risk factors in the general urban population were described by A. Morabia, Department of Epidemiology, Geneva University Hospital, Geneva, CH. Surveillance of risk factors is a way to assess the short term impact of public health strategies. In a surveillance program developed in the general, urban population of adults aged 35 to 74 years, information was collected on cardiovascular risk factors. Age and sex specific percentiles 10, 50 and 90 with their precision were preferred to the classical mean and standard deviation to describe the two first year results. Two methods to compute confidence intervals (CI) for percentiles were chosen; one parametric used when the studied risk factor had a gaussian distribution, the other non-parametric for non-gaussian continuous distribution. Median plas-matic cholesterol reached a peak in men at the age of 55–64 years (5.7 mmol/L) but it increased in women until the age of 65–74 years (5.9 mmol/L). In both genders, systolic blood pressure increased strongly with age while diastolic blood pressure increased slightly. Median daily caloric intake of men declined from 2,390 at the age of 35–44 years to 2,169 at the age of 65–74 years, while in women it remained stable at about 1,900 kcal. The relative intake of saturated fat declined modestly with age from 14% to 13% in both males and females. Median BMI (Body Mass Index) increased with age in women with a peak of 23.6 kg/m² occurring at the age of 65–74 years while in men BMI reached a peak during their fifties (25.1 kg/m²). As the speaker has noticed the presentation of the results as percentiles has several advantages: they are valid for any continuous distribution gaussian and not gaussian, they facilitate time trend monitoring and international comparison, independently of the shape of the distributions and they allow the clinician to identify his patients as typical or not compared with their age and sex specific peers.

Y. Huang, USC School of Public Health, Columbia, SC, presented a prospective study of physical fitness and general health in men and women. This study prospectively examined physical fitness and general health in 6,051 men and 1,694 women (average age 46 years, range 30–87) who were followed for two and more years. Participants received a medical examination and maximal treadmill test during 1971–1988, and provided information on general health in a 1990 mailed survey. Baseline physical fitness was categorized based upon quintiles of sex-age-specific treadmill time. General health was assessed by numbers of medical treatments, nights of hospitalization, days restricted to bed, and days with restricted daily activities in the 12 months prior to the 1990 survey. In total 3,785 participants reported medical treatments, 601 reported hospital stays, 2,020 were restricted to bed and 3,845 reported restricted daily activities for at least one day. Compared to individuals with higher fitness, individuals with the lowest fitness had a higher percentage of hospitalization (12% vs. 8%), medical treatments (55% vs. 49%) being

restricted to bed (37% vs. 25%), and having restricted daily activities (55% vs. 49%). Compared to individuals with the lowest category of fitness, for each higher fitness category, the adjusted relative risk (adjusted for age, sex, length of follow-up, cigarette smoking, hypertension, body mass index, cardiovascular disease, cancer, musculoskeletal disorders, diabetes, other disease, and psychological disorders at baseline) was 0.93 ($p < 0.05$) for hospitalization, 0.90 ($p < 0.01$) for medical treatments, 0.88 ($p < 0.01$) for restriction to bed, and 0.94 ($p < 0.01$) for restriction of daily activities. The results of the study clearly indicate that individuals with higher physical fitness maintained or improved general health and reduced the utilization of medical care over an average follow-up of 7.8 years.

During a session devoted to mammography *IT. Gram*, University of Tromsø, Norway, *E. Funkhouser*, University of Alabama at Birmingham and *L. Tabar*, Falun Central Hospital in Sweden dealt with studies on life style factors in relation to mammographic pattern. The relationship between mammographic patterns and cigarette smoking, alcohol drinking and physical activity was examined in 3,640 Norwegian women, aged 40–56 years, participating in the Third Tromsø study. Epidemiological data were obtained from questionnaires. The questions elicited information on smoking history, alcohol consumption as well as the level, frequency, and duration of physical activity. The mammograms were categorized into five groups. This categorization was based on anatomic-mammographic correlations, following three dimensional (thick slice technique) histopathologic-mammographic comparisons, rather than simple pattern reading. Patterns 1–3 were combined into a low-risk group and patterns 4 and 5 into a high-risk group for analysis. Odds ratios (ORs), adjusted for age, menopausal status, and parity and their 95% confidence intervals (CI) were estimated using logistic regression. Women who were never smokers were 20% less likely to have a high-risk mammographic pattern compared with those who were ever smokers (OR = 0.8, 95%, CI 0.7–1.0). Women drinking alcohol more than once a week were 30% more likely to have a high-risk pattern compared with non-drinkers (OR = 1.3; 95%, CI 0.8–2.1). Women with a physical activity enough to become sweaty for more than two hours per week were 20% less likely to have a high-risk mammographic pattern compared with those who were inactive (OR = 0.8; 95% CI 0.6–1.1). These findings indicate that life style factors like smoking, alcohol consumption and level of physical activity may influence the mammographic parenchymal pattern among perimenopausal women.

Another interesting study devoted to mammography was presented by *E. Frazier*, Center of Disease Control, Atlanta, GA. She concentrated on a study identifying women who were not having mammograms between 1990 and 1994. Although clinical trials have shown that mammography is an effective screening tool for breast cancer, many women are still not having them. The American Cancer Society recommends that asymptomatic women aged 50 and older should have a yearly mammogram and every 1–2 years for women aged 40–49.

Dr Frazier and her colleagues examined the percentage of women aged 40 years and older, who said they had never had a mammogram for each of the years, 1990 to 1994 using the Behavioral Risk Factor Surveillance System. They found that the percentage of women who never had a mammogram decreased from 31.3% in 1990 to 19.8% in 1994. Although the rates of mammography non-use decreased, there

were still disparities among many subgroups in 1994. Hispanic women (25%) were most likely to report that they never had a mammogram, compared to other women (African American — 21%; White — 19%). Women who had no health care coverage were 2.4 times more likely than women who had health care coverage to report never having had a mammogram (41% vs. 17%). Women who never had a clinical breast examination (CBE) were 3.3 times more likely than those who ever had one to report non-use of mammography (53% vs. 16%). Those most likely to report that they never had a mammogram were older ($> = 70$), Hispanic, of lower income and educational levels, and women who lacked health care coverage. Therefore it is suggested that additional efforts are needed to encourage and facilitate mammography use in disadvantaged women. Strategies, including physician and patient education are highlighted to increase the use of mammography as a screening tool.

A question of what is the role of race/ethnicity in epidemiological studies was raised by *T.A. LaVeist*, Johns Hopkins University. In any epidemiological study, it is almost routine to specify the age, gender, and ethnic group or race of a person. Such classification has been traditional in health statistics since many diseases differ markedly in frequency and/or severity in different racial groups, and statistics by race are helpful for identifying health problems. But, the classification and recording of data by ethnic group or race present conceptual and practical difficulties. In addition, medicine and epidemiology have lagged behind the social sciences in acknowledging that race is a proxy for specific historical experiences and a powerful marker of current social and economic conditions that determine exposure to pathogenic factors. Any racial differences in health, may be due to biological, cultural, socioeconomic, political, historical and legal factors as well as the effects of racism and discrimination which operate through health practices, psychosocial stress, environmental stress, psychosocial resources and medical care.

INTERNATIONAL PUBLIC HEALTH

During a session devoted to international public health a very interesting study concerning the publication of health articles on developing countries in three health journals from 1975 to 1994 was presented by *S. Nandy*, Mankato State University, Mankato, MN. This study analyzed the extent to which health articles on developing countries were published in three selected health journals: **American Journal of Public Health, Promotion and Education** (formerly known as *International Journal of Health Education, and Hygiene*), and **World Health** between 1975 and 1994. The research method was content analysis. All articles on developing countries from these three journals were selected as sample articles. and were examined in terms of frequency, theme, social issue, religion and sociocultural value, indigenous health care system, health education and family planning. The results indicate that the coverage of health articles on developing countries, generally was minimal, considering total number of articles published. The reported coverage revealed that some indicators such as social change and technology increased over time. However, some categories like indigenous health care system, family planning, infant and children's health, and health education did not get enough attention.



A session devoted to public health in industrialised nations was chaired by *S. Griffiths*, Director, Public Health Oxfordshire Health Authority, Oxford, UK. Dr Griffiths stressed that prior to the introduction in the U.K. the purchaser/provider split in the early 1990s, the practice of public health was described as the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society. The definition still stands but the context within which public health physicians work has changed and continues to do so. The separation of the provision of care from the health authorities in which the majority of public health physicians work has meant the creation of new ways of working — particularly in contracting process which determines the allocation of resources to secondary care. He also noticed that current governmental policy initiatives in the areas of clinical effectiveness and development of a primary care led NHS have increased the demand for public health skills both within the hospital sector and within primary care.

The closing general session presided by *ER. Brown* was devoted to presentation of the 1996 Jay Drotman Memorial Award to *L. Kantor*, Director, Planning and Special Project, SIECUS, N.Y. The session was attended by *D. Shalala*, U.S. Secretary of Health and Human Services who spoke about future directions in Public Health. After her speech Dr Brown turned over the presidency to *BS. Levy*, President-elect.

The next 125th Annual Meeting of American Public Health Association will be held on 9–13 November, 1997 in Indianapolis, IN. The theme for the meeting is “Communicating Public Health”.

J.A. Indulski

