document eligibility for coverage and subsidies, compare and select health plans, and complete and submit the application. The importance of one-on-one assistance, particularly for underserved communities, is a best practice for successful outreach and enrollment.[5]

Whether they provide direct enrollment assistance services, HIV service provider organizations are trusted community providers. The central role of case management in Ryan White HIV/AIDS Program model of service delivery means that case managers are able to build long-term, trusting relationships with clients. Many effective organizations are training case managers to talk with clients about the benefits of health coverage, as well as allaying clients' fears and concerns about getting covered. Clients may be distrustful of the health care system, or may not feel they need to enroll, particularly because these individuals may have limited past experience with health insurance. Case managers can also provide a warm handoff to an enrollment assister where needed and work with clients on an ongoing basis to ensure that they are retained in health coverage, that their coverage is affordable, and that there are no gaps in access to critical HIV medications.

Lesbian, Gay, Bisexual, and Transgender Health

Another example of the versatility of CHWs includes their role as LGBT community guides who help to identify hard to reach members for both research and intervention purposes. Transgender individuals were recruited to help conduct some of the first focus groups on the health care needs of transgender persons.[6] The transgender guides were trained in focus group facilitation, helped recruit focus group participants and cofacilitated the focus groups that identify health needs, as well as health care access barriers and facilitators. The transgender community supported the activity because members of their own community helped to develop and implement the qualitative study.

In North Carolina, Rhodes et al., developed an intervention to promote sexual health for Latino men who have sex with men. The intervention includes four modules to train Latino men who have sex with men to serve as lay health advisors known as *Navegantes*. The modules blend behavioral theory, lived experiences and cultural values of immigrant Latino MSM to maximize positive outcomes.[7]

MOUNTING EVIDENCE

The evidence is slowly but steadily mounting demonstrating the effectiveness of CHWs in improving both public health research and intervention by ensuring that both are more closely aligned with the values and practices of the communities in which these activities occur. The range of public health areas where CHWs can make a difference is likely as diverse as public health itself. AJPH

Stewart Landers, JD, MCP
Mira Levinson, MPH

CONTRIBUTORS

M. Levinson wrote the initial draft and the section on community health workers and HIV. S. Landers revised the introduction, refined the discussion of the accompanying articles, added the section on community health workers and lesbian, gay, bisexual, and transgender health and edited the entire editorial.

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A Public Health of Consequence: Review of the April 2016 Issue of AJPH

This month we start coupling this column with an editorial invited to complement the articles about which we are commenting. We intend the invited editorials to cover particular areas of concern around thinking of a public health of consequence, engaging around areas that we observe emerging from articles submitted to *AJPH* that aspire to inform our scholarship around a public health of consequence. This month's opinion editorial in the section Public Health of Consequence[1] introduces the notion of population health science as a discipline, arguing that such a discipline draws from a range of existing disciplines—from the social sciences to the natural sciences. The goal of population health science, as suggested in the editorial, would be

> the study of the conditions that shape distributions of health within and across populations, and of the mechanisms through which these conditions manifest as the health of individuals.[1(pXX)]

This then sets up the discipline well to be a foundational discipline that aspires to a public health of consequence—the subject of this series of editorials. In particular, Keyes and Galea[1] suggest that some of the principles of such a discipline

ABOUT THE AUTHORS

Sandro Galea is Dean and Professor, School of Public Health, Boston University, Boston, MA. Roger Vaughan is an AJPH editor, and is also the Vice Dean and Professor of Biostatistics, Mailman School of Public Health, Columbia University, New York, NY.

Correspondence should be sent to Roger Vaughan, Vice Dean and Professor of Biostatistics, Mailman School of Public Health, Columbia University, 722 West 168th Street, New York, NY 10032 (e-mail: roger.vaughan@columbia.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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(informed, as noted in the editorial, by the work of Geoffrey Rose), including that causes of such distributions of health between populations may be distinct from causes of health within populations, and that ubiquitous causes can exert a powerful impact on disease incidence but remain unseen without examining cross-population variation, represent foundational directions for a public health of consequence.

Several of the articles in this issue of *AJPH* well illustrate these points. The article by Hatch et al.[2] explores an issue that has been at the forefront of the health debate in this country over the past seven years and has been a constantly highlighted issue in this column—insurance coverage. Hatch et al. illustrate how those individuals who maintained insurance coverage through Oregon's Medicaid expansion had long-term utilization of community health centers compared with those who had discontinuous coverage who had no comparable long-term utilization. Health insurance coverage is a classic example of a ubiquitous cause that can have a powerful impact on population health. In many ways, health insurance aims to provide a "health floor," an opportunity for those insured to have access to clinical care through the health system. As has been amply argued in previous articles, clinical care is just one, relatively small, piece of the production of population health.[3] It is, however, an important piece and one with resonance for all individuals who experience immediate health threats and benefit therefore from access to health system resources. Therefore, the provision of health insurance ubiquitously levels the health playing field, providing an opportunity for all individuals to receive clinical care when needed, and for the overall improvement of population health. Their elegantly simple visual presentation of the effect that insurance has on primary care utilization over time by group, presented in their Figure 1,[2(pXX)] is more powerful than any table of regression coefficients. This simple demonstration of the efficacy of insurance coverage toward use of services in the article by Hatch et al. is even more sobering when we remember that 22 states have not accepted Medicaid expansion as part of the Affordable Care Act, leaving 4.3 million Americans unnecessarily uninsured.

This point is further underlined in the article by Nuñez et al.,[4] who demonstrate the effectiveness of universal health coverage programs *Plan Nacer* and *Programa Sumar* in Argentina. This article impressively demonstrates that the prevalence of stunting and underweight decreased 45% and 38%, respectively, among children enrolled in the programs. Childhood stunting and underweight have long-arc implications for children throughout the life course. The demonstration that health insurance coverage is associated with a life course determinant that can influence trajectories of health and well-being over time is an elegant demonstration of the importance of high prevalence, ubiquitous determinants of health—like in this case, insurance coverage—and the role that they play in improving the health of populations.

The importance of upstream determinants that are ubiquitous and have widespread effects on populations is also demonstrated in the article by Jin et al.,[5] who show that in cities in California and Massachusetts with tobacco-free pharmacy laws there is a 40% to 200% reduction in tobacco retailer density over time, suggesting a positive diffusion, perhaps the generation of a social consensus around tobacco leading to fewer tobacco retailers. The association between retailer density and tobacco consumption is well established,[6] suggesting that the implementation of tobacco-free pharmacy laws can have positive health consequences well beyond the direct and intended influence of such efforts that change the underlying structural environment.

We comment, in conclusion, on one more article in this vein that sounds, however, perhaps a cautionary note. Esser et al. studied alcohol interventions sponsored by the alcohol industry that aim to reduce drunk driving.[7] Conducting a systematic analysis of the contents of 266 initiatives, they found that only a tiny fraction of these interventions were based on documented efficacy, suggesting that a substantial proportion of these interventions may well be futile. An engaged public health that aims to improve the conditions that create the health of populations must, by definition, engage all sectors—including public and private partners—to achieve its goals. However, the article by Esser et al. is a good reminder that engaging in such partnerships must not jeopardize foundational focus on implementing effective interventions that indeed achieve their stated goal of improving the health of populations. AJPH

Sandro Galea, MD, DrPH
Roger Vaughan, DrPH, MS

CONTRIBUTORS

Both authors contributed equally to this editorial.

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