government agencies less willing to take steps to protect public health, particularly when those steps might appear to undermine the commercial interests of industry partners. As a result, public health agencies collaborating with industry may undermine their public health mission and purpose, and in turn, erode their integrity.

SHARED RESPONSIBILITY AND PARTNERSHIP

I remain unconvinced that one can find a theoretical defense for public–private partnerships in Iris Marion Young's notion of "shared responsibility."[7] Young does not dismiss "backward-looking responsibility." On the contrary, she argues that we should hold corporations to account when they continue to engage in harmful practices, and that we should hold governments to account when they fail to enforce regulations designed to prevent such practices. Young's claim is that we should supplement this approach with forward-looking shared responsibility in the case of *individuals* who can *only* solve a problem of structural injustice by joining with others in collective action. But corporations are not individuals, and they could take steps unilaterally to address the health impacts of their own products.

Any multinational food and beverage corporation could cease promoting products such as sugar-sweetened beverages and energy-dense foods that exacerbate obesity. As an alternative, it could increase the prices of unhealthier products. Notably, a company could *only* take such a step unilaterally. If multinationals agreed with each other to increase prices, such collusive practices would violate European competition law and US antitrust law. In this example, collective action is not the only solution; on the contrary, it is one of the few prohibited solutions!

GOVERNMENTS AS GUARDIANS OF PUBLIC HEALTH

Corporations are often reluctant to change behavior unilaterally, for fear of losing market share. By effectively regulating industry, government agencies eliminate this concern, while discharging their responsibility to protect and promote public health. Some legislative bodies have passed soda taxes or are considering them to reduce consumption and generate revenue. Legislatures could also explore direct taxes on the manufacturers of high-calorie, low-nutrient products.

Governments, not corporations, are the guardians of public health. If sharing responsibility with the food industry means recognizing that corporations can and should improve their products and practices to prevent or reduce harm to health, few would disagree with the claim. But it does not follow that governments should collaborate with industry to protect and promote public health.

If public health agencies need to pool resources and expertise, they should build relations with other institutions that have a similar mission and purpose. This might involve horizontal collaborations with public health agencies in other jurisdictions, and vertical collaborations among local, state, and federal agencies.

In her work on shared responsibility, Young recognizes the importance of addressing conflicts of interest, and the need for the relevant actors to "struggl[e] with one another," and "call one another to account for what they are doing or not doing."[7(p130)] It is time for public health agencies and regulators to "struggle" a little more with corporations, creating structural incentives for healthier and more responsible industry practices, and calling companies to account when they fail to comply. AJPH

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Choosing Health Equity: Investing in Optimal and Equitable Health for All

Follow-up on: Barthold D, Nandi A, Mendoza Rodríguez JM, Heymann J. Analyzing whether countries are equally efficient at improving longevity for men and women. Am J Public Health. *2014;104(11): 2163–2169.*

Health equity is a choice. Worldwide, humanity is consciously choosing to make progress toward health equity. The World Health Organization has reported more than a 50% reduction in under-five child mortality since the year 2000. The *Lancet* Commission's Global Health 2035 report asserted that, with strategic investments, nearly all countries could achieve "a grand convergence in health within a generation," reducing maternal–child deaths in high-mortality countries to the levels of the best-performing middle-income nations by 2035.[1] The World Health Organization has similarly endorsed the Sustainable Development Goal of eliminating preventable

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deaths of infants and children under age five years.

WHAT IS A STRATEGIC INVESTMENT?

Spending money does not automatically buy better health outcomes. In an *American Journal of Public Health* report published in 2014, Barthold et al. found "robust differences" among Organization for Economic Co-operation and Development (OECD) nations from 1991 to 2007 in the *efficiency* of their health spending, as measured by life-expectancy improvements achieved for each one percent increase in annual health care expenditures.[2] The United States ranked poorly in these international comparisons, ranking number one in per capita health expenditures, but 19th among OECD nations in the translation of spending into increased life expectancy. The human return on US health dollars invested was only one fifth to one sixth that of Germany and Switzerland.

A most basic choice is total spending. Budhdeo et al. showed that a one percent decrease in health care spending in European Union countries was associated with short- and long-term increases in mortality across a wide range of age–gender groups.[3] How the money is spent also matters. Among OECD nations, greater public-sector spending had far greater impact on survival than total spending, and up to a certain level, public-sector government spending was significantly more efficient.[4]

The United States continues to be the outlier in these international comparisons. The moral choice to favor health care provider autonomy and free market economics over the collective good provides an ongoing demonstration of the US capacity to achieve market fragmentation and collective *inefficiency* in spending. A related outcome is the persistence of gaping inequalities in health care access and health outcomes, which exact not only a human cost, but also a significant and avoidable economic burden.

ELIMINATING HEALTH DISPARITIES

Eliminating health disparities and making progress toward health equity comes down to a series of choices. Expanding Medicaid and providing health insurance subsidies in the Affordable Care Act were small steps toward the progressive universalism that is necessary but not sufficient for ensuring population health. Repealing only those portions of the Affordable Care Act preferentially supporting the poor while maintaining only the provisions supported by families already able to purchase health insurance for themselves and their families will be a decision to move away from health equity, a choice violating the moral principles of justice and nonmaleficence.

Even so, we can choose to make progress on racial/ethnic disparities in health outcomes. Fuchs recently documented mounting evidence of Black gains in life expectancy, and even greater gains among lower-income segments of the Black population.[5] More than a decade ago, under the intellectual and moral leadership of David Satcher and Robert Levine, our team at the National Center for Primary Care at Morehouse School of Medicine dared to imagine, "What if we were equal?"[6] We demonstrated that although Black–White disparity rate ratios had changed little over the decades from 1960 to 2000, the 40-year flatline was actually the average of significant reductions in Black–White disparities for women and increasing disparities for men. The choices we made as a nation mattered. Black women's income as a percentage of White women's increased significantly, even as antipoverty programs explicitly favoring women and children (the Special Supplemental Nutrition Program for Women, Infants, and Children; Medicaid; family planning; etc.) were being implemented. Black–White disparities for women declined. At the same time, our nation chose to systematically exclude men from these same programs, and to disproportionately incarcerate Black men, exacerbating male Black–White mortality disparities.

Research on local-area variation in disparities shows that some communities are moving toward more optimal and equitable health outcomes without necessarily making conscious choices to pursue health equity or even being aware of their own progress. We have documented US counties that have moved from high levels of racial disparity to near equality in measures ranging from infant mortality to breast and colorectal cancer mortality across the entire population, as well as significant county-level variation in racial disparities in the low-income Medicaid population for conditions ranging from asthma to HIV.

At the root of health disparities are social determinants. When policy decisions and systems combine to increase inequalities in income, wealth, and opportunity, they represent an explicit choice to move away from health equity. Even so, social determinants are not entirely deterministic, and demographics are not destiny. Levine et al. found 66 counties in the United States with lower Black male mortality rates than the US average White male mortality rate, with no significant difference in Black–White poverty rate ratio or residential segregation index.[7] Perhaps we can find replicable paths to health equity by learning from these positive outlier communities that have succeeded in making a way out of no way. The road out may not be the same as the road in.

PROMOTING INTEGRATION

It will not be easy. There are highly complex, bidirectional associations among upstream, midstream, and downstream factors driving disparities. No single intervention will produce health equity. We must consciously connect our efforts across sectors to achieve collective impact. We must become a cohesive and effective movement, promoting integration and managing the in-betweens of all sectors. Medical care. Public health. Community leadership development. Income equality. Economic development. Wealth equality. Educational equity. Behavioral health. Resiliency. Social cohesiveness. *All of the above*. Many communities have individuals or agencies working in each of these areas, but let us ask—whose full-time job is it to build the coalitions, to maximize collaboration, to deepen partnerships, to measure collective impact, and to create structures for mutual accountability on the specific objective of health

equity? Who is actively measuring and reporting explicitly on progress toward equality of health outcomes and social determinants repeatedly in real time, to energize rapid cycle improvement across entire communities and nations?

Global health research and US health equity research alike suggest that population health and economic efficiency are not incompatible. They are mutually reinforcing. We can choose both health equity and economic efficiency by demanding the most effective human return on investment (whether measured as improved survival, or decreased suffering, or best possible health) for the greatest number of people—in other words, committing to spend every dollar efficiently to achieve optimal and equitable health outcomes *for all*. Other nations are achieving much higher economic efficiencies and much better health outcomes by using public-sector investments for the collective good.

So let us choose to spend our money wisely. Let us demand the greatest human return on investment for every dollar we spend. Let us pursue optimal and equitable health outcomes for all with precise economic efficiency.

We can achieve health equity—if we choose to. AJPH

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A Public Health of Consequence: Review of the March 2017 Issue of *AJPH*

As the country settles into life under a new presidential administration, it seems that the work of public health is becoming more important than ever. President Trump's choices for cabinet secretaries suggest that this administration is intent on following through on campaign promises to reverse federal regulation of a range of sectors, to lower taxes on higher earners—widening income gaps—and to disinvest in efforts to promote healthier environments.

We argued in last month's editorial that this stands to worsen overall population health and widen gaps between health haves and health have-nots. Although Republican efforts to repeal and replace the Affordable Care Act are, justifiably, attracting substantial media attention, we suggest that the changes to the social, economic, and political structures that shape our health may have an equally important impact on the health of the US population in coming years. This issue of *AJPH* presents us with five articles that make the case empirically and conceptually about the importance of the range of foundational factors necessary for the creation of healthier populations.

THE FOUNDATIONS OF POPULATION HEALTH

We start with a comment about the article by Bullinger et al.,[1] who investigated the effect of minimum wage laws on adolescent birth rates in the United States. They found that a one dollar increase in minimum wages was associated with a two percent reduction in adolescent birth rates. Bullinger et al. conclude that increasing the minimum wage by one dollar would likely result in roughly 5000 fewer adolescent births annually. It is abundantly clear that adolescent births result in delayed social, economic, and educational achievements for adolescent mothers and that these delays are a challenge for the children whose mothers have such disadvantages (http://urbn.is/2i25Gez).

This article, therefore, adds to the large and growing body of evidence that raising the minimum wage can have a broad and substantial impact on population health.[2] Although it is always difficult to project what might happen in the converse situation (i.e., a widening income gap), it does seem plausible that widening income gaps will, in turn, chip away at the social structures that help prevent adolescent pregnancies.

HOW NO ONE PROGRAM IS ENOUGH

Building on this, we turn to the work of Conrad et al.[3] This article compellingly makes the point that no one effort ultimately changes the health of populations and that improving the health of disadvantaged groups will take effort at multiple levels. Conrad et al.

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