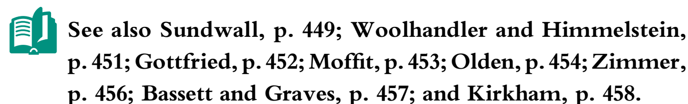
The Public Health Dialogue



See also Sundwall, p. 449; Woolhandler and Himmelstein, p. 451; Gottfried, p. 452; Moffit, p. 453; Olden, p. 454; Zimmer, p. 456; Bassett and Graves, p. 457; and Kirkham, p. 458.

"Changing our future together" is the theme of this 2018 National Public Health Week (#NPHW). In a polarized country, "together" is especially of importance. Against the powerful divisive rhetoric at work, together means rallying all the voices and opinions of those who care about the health of the public. *AJPH* has therefore assembled a set of points–counterpoints to *foster* a dialogue among experts sharing common concerns but with vastly different opinions about key issues that will shape public health in the coming years: advocacy, the environment, health insurance, and racism. These exchanges *promote* a dialogue but are not a real dialogue yet, as the shorter counterpoints were written in response to the longer points, but the authors of the points did not have the opportunity to revise their text on the basis of the counterpoints. A truer dialogue may have resulted in more convergence on some points and greater divergence on some others. This is a rough snapshot of opinions in presence.

PUBLIC HEALTH ADVOCACY

David N. Sundwall (p. 449), who was director of the health staff of the US Senate Labor and Human Resources Committee under Orrin Hatch (R, UT), wonders how we should go about advocating public health in these difficult times. He draws from his own experience "time-proven" principles, which include being evidence-based, not judging the Surgeon General by partisan affiliation, building bridges with unlikely allies (e.g., when the liberal Children's Defense Fund worked with a conservative Southern Baptist Coalition organization to reauthorize the Maternal and Child Health Care Block Grant), considering changing the rules—not the laws, and identifying which elected officials and their staffs are willing to seek compromise in public health funding and regulations.

Stephanie Woolhandler and David Himmelstein (p. 451), who have been unpaid advisors to the Bernie Sanders 2016 presidential campaign, agree that honest, open-minded, optimistic, and inclusive advocacy is important, but argue that defense positioning alone will not suffice against an authoritarian, antihealth administration. A fuller response includes joining with others to organize for health-improving reforms, protesting against harmful initiatives, voting, and contributing money. The aim of all this is to build a new-New Deal encompassing single-payer insurance, housing millions of homeless persons in vacant housing units, feeding millions of food-insecure individuals with existing harvests, improving schools and mass transit, and diverting funds from prisons, police, and defense to achieve that aim.

ENVIRONMENTAL PROTECTION

For Ken Olden (p. 454), formerly with the National Institute of Environmental Health Sciences and the Environmental Protection Agency (EPA), farmers, coal miners, and blue-collar workers do not support the EPA because it has not been able to explain its continued importance and role in protecting human health and the environment after having dramatically reduced visible forms of pollution. If the EPA does not convince us why its regulations are just as important today as they were in the 1970s, it only appears as a threat to the survival of economic sectors who depend on coal, oil, and manual or manufacturing labor. It should have been an EPA mission to play a leadership role in promoting dialogue to facilitate a socially responsible transition for the most polluting industries. Unfortunately, it did not. Now, funding and workforce reductions will devastate the agency's capacities.

Former congressman Dick Zimmer (R, NJ; p. 456) agrees with Olden that the EPA is a victim of its own success and that the EPA's regulations should better regulate nonpoint source pollution and new global economic realities. But Zimmer does not believe that the EPA will fall victim to budget cuts as nearly all proposed cuts have been rejected by the Appropriations Committees of both houses of Congress. He does not perceive the business community as being recalcitrant toward the EPA. The problem is leadership: Scott Pruitt, EPA director, fervent opponent of federal environmental regulations as Oklahoma Attorney General, "is not the man for this job," says Zimmer.

SINGLE PAYER

Richard Gottfried (D, NY; p. 452), chair of the New York State Assembly Committee on Health and sponsor of the New York Health Act (A. 4738/S. 4840), a single-payer plan, argues that New York could be the first state to adopt this "improved Medicare for all." The bill, which would cover every New Yorker without deductibles, copays, or

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restricted provider networks, has passed the Democratic-controlled Assembly three years in a row and is one vote short of a majority in the Republican-led Senate. Gottfried also explains that the New York bill has integrated the causes of the setbacks that single-payer plans have met in Vermont, Colorado, and California.

Bob Moffit (p. 453), from the conservative Heritage Foundation, disagrees that badly designed tax rates, inferior public relations, or insufficient campaign spending caused the single-payer plan collapses in Vermont, Colorado, and California. Citizens in those three states were concerned by increasing taxes, costs outrunning projected revenues, and losses of private health plans, including their employer coverage.

Gottfried and Moffit, however, are both in favor of states being free to experiment with health policy. According to Gottfried, "The states have always been 'the laboratories of democracy' and New York has led on many issues that once seemed out of reach."(p453) Moffit says, "If 'Blue' states like New York wish to enact a 'single payer' system, they are free to do so. If Congress liberalizes current law, 'Red' states should also be able to experiment in health policy. One caveat should apply to both: federal taxpayers should not be forced to bail out failure."(p454)

INSTITUTIONAL RACISM

Mary Bassett, Health Commissioner, and Jasmine Graves (p. 457), both from the New York City Department of Health, assert that all US state and nonstate institutions have public health policies and practices that discriminate on the basis of race. This institutional racism draws upon racist theories claiming some biological or behavioral inferiority of non-Whites. Racist institutions characteristically vituperate people, not policy. Acknowledging the impact of racism on health is a necessary step toward an antiracist practice of public health.

Pete Kirkham (p. 458), former executive director of the National Republican Congressional Committee, agrees that institutions, programs, and outcomes reflect the racial bias existing in our society, but cautions that it cannot be that all US public institutions and government programs are racist. The full story must include adequacy aspects related to financial, professional, economical, procedural, and competency factors. A nuanced approach to bias is more likely to bring people together to enact durable and effective solutions.

THE PUBLIC HEALTH DIALOGUE

This set of points and counterpoints has begun a public health dialogue among experts with contrasting opinions on important issues that are rarely discussed directly between opposing sides. The authors are highly qualified to address the issue(s) they agreed to discuss. Their opinions are shared by millions of people and will be considered by millions of people. These opinions are not entirely reconcilable, but the dialogue enriches our vision of the diversity of contemporary opinion and helps us understand where more research is needed. Some topics, such as racism (covered in this issue), gun control, reproductive rights, and sexual identity and orientation (my attempts to cover these questions have not been successful yet), are very sensitive; dialoguing about them is courageous.

Most readers will side with one or the other author, and counterarguments about facts or ideas will come to mind. Let us explore these divergences on the basis of evidence and history. If any ideas or statements sound inaccurate, the role of the *Journal* is to show it in substantial research articles, commentaries, and analytic essays. AJPH

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Probing Beyond Individual Factors to Understand Influenza and Pneumococcal Vaccine Uptake

See also Hughes et al., p. 517.

In a spring 2017 lecture at the University of Maryland, Anthony Fauci, director of the National Institutes of Health's National Institute of Allergy and Infectious Diseases, described pandemic influenza as what keeps him awake at night. Today, the possibility of a novel influenza virus with a high attack rate remains one of public health's greatest concerns.

Even without a pandemic, Iuliano et al. recently estimated that influenza kills 291 000 to 646 000 people globally in a year.[1] In the United States, during an average flu season, the Centers for Disease Control and Prevention estimates the disease burden to range between 9.2 and 60.8 million cases annually, with between 140 000 and 710 000 adults hospitalized with influenza-related complications (http://bit.ly/2hr9YbP). Influenza-related mortality is responsible for 12 000 to 56 000 deaths per year, the majority (64%) among adults aged 65 years and older, with higher age-adjusted influenza mortality rates for African Americans than for Whites.[2] Although the Advisory Committee on

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