The Role of US Mayors and Health Commissioners in Combatting Health Disparities

See also Purtle et al., p. 634.

In this issue of *AJPH*, Purtle et al. (p. 634) found that 42% of mayors and 61.1% of health commissioners "strongly agreed" that health disparities existed in their cities. Furthermore, the authors noted that "liberal" respondents were more likely than "conservative" respondents to strongly agree that health disparities existed, were avoidable, and were unfair, for reasons independent of the belief that city policies could affect disparities. The authors argue that most mayors and some health commissioners are unaware of the extent to which city policies can significantly affect health disparities. They also conclude that political ideology is strongly associated with respondents' opinions about health disparities.

HEALTH DISPARITIES

Confusion over survey terminology may explain the low percentage of respondents who noted that disparities were related to city policies. Given the framing of the questions, the language employed, and their sequence in the survey, it is not surprising that more health commissioners than mayors believed that city policies could affect health disparities. For example, participants rated the extent to which factors like health insurance, stress, housing quality, education, and other social determinants of health influenced health disparities. Health commissioners regularly wrestle with these factors as they pertain to health outcomes, in ways that mayors may not. Furthermore, participants were asked about the "avoidability of health disparities" and the "fairness of health disparities" immediately prior to questions about the role of city policies in addressing those disparities. The survey sequence may have primed respondents—in particular those with a public health background—to perceive health disparities within the framework of existing inequalities (i.e., as an inevitability, possibly existing in a realm separate from state intervention) rather than as an issue to be addressed through policy.

Contrary to the authors' conclusions, the findings suggest that survey respondents understand social determinants of health. In particular, many respondents saw a correlation between poverty and health; far fewer saw one between genetics and health. For example, 67.7% of mayors and 82.7% of health commissioners identified income as having a strong impact on health disparities. Moreover, 95% of mayors and 97.3% of health commissioners noted that they "agreed" or "strongly agreed" that socially advantaged groups were healthier than disadvantaged groups in their city.

IMPACT

The authors noted that fewer than one third (30.2%) of mayors believed that city policies would have "little" or "no impact" on health disparities. These respondents might have answered differently if health disparities were clearly defined in the context of social determinants of health. In addition, the respondents were not given an opportunity to expand on other policy concerns that may take precedence when determining city priorities. Local government leaders face competing priorities and limited budgets. Instead of surveying political identities (which were not defined) or geographic location, the authors could have documented the urgency of other policy priorities (e.g., violence reduction, economic revitalization, and employment) and the impact of budget constraints or municipal structures on agenda setting. Mayors are faced with a myriad of challenges unique to their localities. Those with competing priorities and severe budgetary constraints may view reducing health disparities as less critical than other issues, may not see the connection between those other issues and health, or may believe in improving health but not in prioritizing health equity. Moreover, respondents from localities with small health departments or weak municipal governments may want to address health disparities but answered the survey questions with their funding and structural limitations in mind.

TIE ISSUES BACK TO HEALTH

To explain correlations between political ideology and opinions on health disparities, the authors point to news consumption along partisan lines. They posit that liberal news outlets devote greater coverage to stories about health disparities than conservative outlets do. They further argue that although information about health disparities may reach conservative policymakers, such information is rejected because it reflects "liberal values . . . inconsistent with their conservative worldview." In our view, biased media coverage is not the principal challenge; rather, it is the difficulty of making the case for public health. It is incumbent upon not only health commissioners but also leaders in academia and civil society to explicitly draw the connection between health and other priorities for elected officials. If a mayor campaigned on

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This editorial was accepted February 10, 2018.

doi: 10.2105/AJPH.2018.304377

education, housing, employment, and safety, all these issues can and should be tied back to health.

Fortunately, there are national- and local-level movements actively working to achieve connections between public health and other priorities. The US Department of Health and Human Service's Public Health 3.0 initiative calls on city health officials to convene stakeholders and community partners to address the social determinants of health.[1] The Baltimore City Health Department (BCHD), in Baltimore, Maryland, has taken on this challenge in the form of Healthy Baltimore 2020, a cross-sectoral, strategic, citywide blueprint not only to improve health but specifically to cut disparities by half over the next ten years.[2]

HEALTHY BALTIMORE 2020

Specific initiatives as part of Healthy Baltimore 2020 include B'More for Healthy Babies, a partnership of over 150 public and private partners that have together reduced infant mortality by nearly 40% since 2009.[3] Understanding the importance of health to education, BCHD convened nonprofit, academic, and local businesses to start Vision for Baltimore, which aims to conduct vision screenings and supply all Baltimore City Public School students, kindergarten through grade 8, with glasses, free of charge. Since the program started in 2016, more than 2000 students have received glasses.[4] BCHD's opioid response makes the connection between overdose and other social issues such as housing, public safety, reentry, and employment. Additionally, a standing order for Naloxone was issued in 2015. Not only has this effort resulted in the lives of more than 1700 Baltimoreans being saved, but Baltimore has also piloted Law Enforcement Assisted Diversion, where low-level drug offenders are offered treatment instead of incarceration.[5] Baltimore is about to start a Stabilization Center offering round-the-clock "urgent care" for addiction and mental health disorders, where patients are connected not only to behavioral health support but also to needed social services.[5] Baltimore was also selected as one of the Center for Medicaid and Medicare Innovation "Accountable Health Community" demonstration sites. Work is ongoing to connect hospital patients' medical needs with social resources in the city, part of a broader effort to improve health and combat disparities.[6]

UNDERSTANDING GOOD GOVERNANCE

In our view, the authors missed an opportunity to explore how government can promote health and the social citizenship rights that flow from it. Health enables citizens to engage more fully as members of a polity. Enhancing our understanding of good governance—outside the confines of party identification—can provide insight into how city-level interventions aimed at addressing health disparities can also improve employment outcomes, housing access, neighborhood safety, and numerous other social outcomes. We hope the authors can frame future studies in a way that helps stakeholders from all sectors be better advocates for public health. AJPH

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How Medicaid Can Strengthen the National Response to the Opioid Epidemic

See also Sharp et al., p. 642.

In the wake of a recent US Senate hearing in which Medicaid expansion was blamed for fueling the opioid crisis,[1] the study by Sharp et al. in this issue of *AJPH* (p. 642) is a welcome indication that Medicaid can in fact contribute to resolving the most destructive epidemic that the United States has faced in decades. But to maximize Medicaid's potential to respond to the opioid crisis, the program must be substantially strengthened.

Providing individuals any form of health insurance carries both risks and benefits regarding opioids. The chief risks are that they will be prescribed an opioid inappropriately and become dependent on it or game the health care system to obtain prescription opioids for diversion and sale, thus becoming a vector for misuse by others. The chief benefits are that individuals can receive quality health care for an existing opioid use disorder as well as for other conditions that increase the risk of developing

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This editorial was accepted February 15, 2018.
doi: 10.2105/AJPH.2018.304393