

The NHPI National Health Interview Survey used many of these techniques. The study's strategy for community engagement, in particular, seems exemplary to me, a model for similar efforts in the future. Key features included finding out what data the NHPI community would most value, creating culturally tailored outreach materials (e.g., the study brochure), providing training to the interviewers to foster cultural sensitivity, designing the outreach effort with input from community members, and recruiting support from community leaders. Because of federal restrictions, they were unable to employ two other methods that are often used with hard-to-survey populations. They could not hire NHPI interviews or offer respondent incentives.

Whatever they did, it worked. The response rate (conditional on completion of the ACS) was 78.6%. Moreover, the researchers' evaluation of the quality of the data they collected indicated that the data quality was very high; they compared various estimates from their survey with benchmarks from the ACS and from the National Health Interview Survey and show that their estimates are consistently close to the benchmarks. This is another feature of their study that I regard as exemplary.

UNFAVORABLE SURVEY CLIMATE

This is an important study and it shows that, even in today's


unfavorable survey climate, it is still possible to mount an excellent survey. I applaud the authors for their efforts. Still, I would argue that if we are ever to reverse the growing difficulties that surveys face in this country, it will take a sustained federal effort to publicize the surveys, such as the ACS and National Health Interview Survey, that form the backbone of the federal statistical system and that are an irreplaceable component of the data infrastructure of the United States. We simply cannot let response rates continue to fall. **AJPH**

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CONFLICTS OF INTEREST

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 See also Anderson et al., p. 1396, Carter et al., p. 1413, and Zewde et al., p. 1379.

Public health practice builds on what we know from the population health sciences to improve health and reduce or eliminate disease. There are abundant rewards in population health science and public health practice, but the privilege of being part of an enterprise that aspires to generate good health for millions of people—whole populations—must be one of the most compelling aspects of the work. We create the evidence base that can change and inform policy—policy that creates changes that affect many. Creating opportunities for exercise will provide that opportunity for

whole cities; changing the age at which cigarettes can be purchased means that a whole generation of future adults will smoke less, improving the health of whole countries. Striving for evidence-based policies informs many of the decisions we make in our science and practice. It pushes us to think about what matters most, for example, focusing on ubiquitous forces¹ that influence the health of many in populations and communicating the importance of population health science to change the public conversation.²

And yet, the goal of making population health improvement central to our mission is balanced

by other principles that also should inform the work of public health. Central to these is a concern with social justice. In many ways social justice is at the heart of the work of public health. Health is socially patterned and population health is interlinked, influenced by shared circumstances, by transmission of behaviors and of pathogens, suggesting that the health of one is inextricable from the health of all. Therefore, we simply cannot do our work in public health

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without paying attention to the underlying structures that shape that health and the principles of social and economic justice that structure a world that affects the health of all.

This concern with the foundational principles of public health has implications for, and brings nuance to, what might otherwise be a utilitarian approach to public health—the promotion of the health of as many as possible over and above all other considerations.

THE CENTRAL ROLE OF SOCIAL JUSTICE

We have written previously about one implication of this

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thinking, namely, the centrality of health equity³ to the work of public health. It is foundational to public health to aspire to a world where there are few health have-nots. This means that public health must balance the need for efficiency in the practice of population health with the importance of equity, recognizing that the two may sometimes be in conflict. Our values inform how we strike that balance, bringing to the fore the need for complexity and nuance in the work of public health.

Another corollary of our social justice foundations must be a commitment to the health of marginalized populations, bringing attention to, and investing effort in, improving the health of these groups. There can surely be no social justice if particular groups, made vulnerable by circumstances of birth or happenstance in the course of life, are left to fend for themselves without a concerted effort by those responsible for our collective health—those of us in public health—to level the health playing field, to dedicate the resources needed to improve the health of the most vulnerable. This commitment is reflected in many public health mission statements, which often feature a focus on population health with particular attention to the health of vulnerable groups. And yet, such statements perhaps hide the nuance that that commitment entails.

For marginalized populations are often invisible to the public eye. They are often a small percentage of the population, and attention to their needs is, almost definitionally, at odds with our core interest in the health of whole populations. Insofar as we have limited resources—time, energy, money—to carry out the mission of public health, effort spent on the few will inevitably take away from efforts spent on

the many. This suggests that public health practice that is aware of its mission, and attuned to its foundational values, must have the sophistication to grapple with these sometimes conflicting aspects of our mission.

GIVING VOICE TO VULNERABLE POPULATIONS

A first step in our efforts to promote the health of vulnerable populations is bearing witness to the challenges these groups face, using the tools at our disposal to give voice to groups that frequently have few outlets to do so themselves. It is heartening that three articles in this issue of *AJPH* do just that, making visible the challenges of groups that are often invisible.

Anderson et al. (p. 1396) tackle a foundational challenge to making the invisible visible—counting what is hard to see and document. They focus on persons who have been victims of human trafficking. The prevalence of human trafficking at a population level is not high. In the United States it is estimated that there are fewer than 8500 persons who are victims of human trafficking.⁴ And yet it is hard to think of a more terrifying violation of the core tenets of social justice than the owning of a human by another, removing individual autonomy and creating conditions that directly harm physical and mental health. Anderson et al. estimate the amount of human trafficking in Ohio and correctly note, “This study highlights the important of moving toward the use of epidemiological approaches to measure the prevalence of human trafficking” (p. 1396). We could not agree more.

Carter et al. (p. 1413) focus on transgender veterans. The transgender population has long been marginalized and discriminated against across countries and contexts. In the current US context, we have seen hostility to transgender populations by the executive branch of government and a rollback of hard-won rights in many workplaces and states. A precise estimate of the prevalence and health burden of transgender, gay, lesbian, bisexual, or queer individuals is difficult because the US Census and many other official surveys do not officially ask about sexual orientation and gender identity. Carter et al. were able to use administrative data to show that transgender veterans had nearly three times the prevalence of housing instability than cisgender veterans, a difference that persists when controlling for sociodemographic covariates.

Zewde et al. (p. 1379) shed light on yet another population often at the margins—those who are evicted from their home, living in unstable housing. We have seen a recent, welcome surge in attention to this group nationally,⁵ but we have had relatively little discussion of the role of eviction in shaping health and, conversely, how much health drives unstable housing. We do know that, nationally, health is the leading cause of bankruptcy for individuals.⁶ Zewde et al. use a unique national representative administrative data set to show that medical expansion under the Affordable Care Act is associated with lowering eviction numbers, rates, and filing, providing evidence for how an approach to generate good health, via increasing health coverage, can limit the increasing marginalization caused by the unstable housing of groups that are already living on the financial edge.

STRIKING A BALANCE

Persons who are ensnared in human trafficking, who are transgender, who are marginally housed are relatively small groups, often invisible to the public eye. Despite that, and perhaps because of that, they represent the core mission of public health. Generating the evidence that can be used to improve the health of these populations is an important step forward. Public health practice that can thoughtfully grapple with the needs of these few, while also paying attention to the foundational forces that influence the health of the many, is a worthy enterprise indeed. *AJPH*

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