2020

The Public Health Dialogue, 2020 (Editor's Choice)

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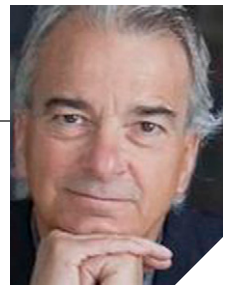

The Public Health Dialogue, 2020

This "public health dialogue" features points and counterpoints on questions shared by millions of people to be addressed in front of millions of people but rarely discussed directly among public health actors with divergent political views. The dialogue enriches our understanding of how populations think. It helps everyone to be more effective. Check them out.

STRUCTURAL RACISM

Samorani and Blount (p. 440) identify a racial bias in computer algorithms that help clinics to overbook the medical appointments of patients having traits associated with no-shows. Thus, patients of color have to wait longer to be provided care. Rodenberg (p. 441) argues that the unaddressed causes of no-show (e.g., lack of transportation or inefficient scheduling), rather than racism, are the culprit.

PRIVATE SECTOR

Relying on examples of successful private–public partnerships in consumer, community, employee, and environmental health, Kassler (p. 443) argues that business needs to be seen as a true collaborator rather than just a financier. Greenberg (p. 445) counterargues that many corporations, as in the automobile, airline and hotel industries, cause widespread harms to the environment and their consumers.

SINGLE PAYER

For Himmelstein and Woolhandler (p. 447) health professionals should be guided by the evidence favoring single-payer systems over their alternatives, rather than by hypothetical political feasibility. Sundwall (p. 448) says the goal should be single payer plus universal access to basic care for all, which, together, can be attained only by consensus on incremental policies.

ADVERSE CHILDHOOD EXPERIENCES

Atchison (p. 450) presents the Iowan experience of adverse childhood experiences and their clinical–community partnerships as a model for a US health care system relying on prevention and population health. For Kaplan (p. 451) the clinical–community partnerships comprise mostly microlevel interventions, which need to be coordinated with the macro and meso levels to effectively address social determinants of health.

HOSPITALS

Fine (p. 453) feels that to address the social determinants of health, primary health care is a cheaper and safer alternative to the trillion dollars a year spent on hospital care. Gabow (p. 454), conversely, believes that despite their cost, hospitals are safety net institutions with a unique public health value but are insufficiently integrated with the social care system.

POLICE VIOLENCE

Rodenberg (p. 456) asserts that police violence is a mutual problem of the community and the police, as are public health and safety, and not an issue of inherent bad faith and racism. Gilbert (p. 457) states that violence affects primarily Black and Brown residents and that minimizing police violence with impunity is needed to end the persistent public health crisis.

MATERNAL MORTALITY

According to former Representative Gingrey (R, GA; p. 462), extending Medicaid coverage to women one year (instead of 60 days) after delivery can reverse the rise in mostly preventable maternal deaths. For Mullen, (p. 464), greater system accountability for quality prenatal and interconception services, standardized maternity care, chronic disease management and addressing racism is essential.

NATURE'S RIGHTS

Chilton and Jones (p. 459) claim that the public whose health needs to be protected comprises lakes, oceans, rivers, trees, and millions of species, including humans. Ishay (p. 460) avers that the rights of nature (i.e., sustainable ecosystems, clean air and water) should not be isolated and/or opposed to, but viewed as essential for the universal human rights to life, health, sustainable economic development, and civil rights.

These are convincing testimonies that divergences in opinions and values may not always be obstacles for action. We should not shy away from exposing them. All people contributing to *AJPH* agree that divergences should be overcome using empirical and historical sciences. Publishing such evidence is precisely the mission of *AJPH*.

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14 Years Ago

Designing Healthier Communities: National Public Health Week 2006

Imagine having the opportunity to redesign your own community. What would you change? How would you plan development so that achieving optimum health would be a priority? Would roads dominate your transportation options? Would housing be closer to jobs, grocery stores, and retail outlets? Would you preserve more park or farmland? These considerations are paramount to developing communities that can sustain good health. . . . The good news is that while we created today's built environments, we are capable of creating healthier ones. Many communities are beginning to do just that, banding together to create more livable communities with town centers, better public transit, and more bicycle paths, sidewalks, and parks.

From AJPH, *April 2006*, p. 592.

99 Years Ago

National Health Council Launches An Early Health Week

[The] National Health Council has inaugurated plans for a health week. . . . This plan is for each community to organize its own committee for this health week, drawing upon the established health and welfare agencies for its health committee members. . . . The activities . . . which have been proposed include . . . special reference to such local problems as water supply, sewage disposal, milk and food control, tuberculosis, venereal diseases, and other problems that may be of special significance to that particular community. . . . The value of talking health, thinking health, advertising health, urging health, writing health, and pleading for health can result in only one thing—practicing health by the communities.

From AJPH, *November 1921*, pp. 1006–1007, passim.