

KHN's 'What the Health?'

Episode Title: The Future of Public Health

Episode Number: 212

Published: Sept. 9, 2021

Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this special episode on the future of public health on Thursday, Aug. 26. As always, news happens fast and things might have changed by the time you hear this. So here we go. Today, we are joined via videoconference by Joanne Kenen, of Politico.

Joanne Kenen: Hi, everybody.

Rovner: And my KHN colleague Lauren Weber.

Lauren Weber: Hi, everyone.

Rovner: We're going to switch things up this week, as we usually do with our single-topic episodes. First, we will hear from our expert on the subject, Brown University School of Public Health Dean Ashish Jha, who will give us the broad overview. Then we'll come back and the panel will discuss what could happen next. So, without further ado, here's my interview with Ashish Jha.

Rovner: We are pleased to welcome back to the podcast Ashish Jha, whose voice you almost certainly recognize from radio or TV as one of the nation's leading experts on the covid-19 pandemic. But his day job is as dean of the School of Public Health at Brown University. And I couldn't think of anyone better to lead us through this background discussion. Ashish, thank you for joining us again.

Ashish Jha: Oh, it's my pleasure. Thanks for having me back.

Rovner: So, covid has brought public health to the fore, but lots of people still don't know what it is. So I want to start there. What is public health, and what role does it play in the nation's broader health care system?

Jha: Yeah, it's a great question. So, public health — a simple way to think about it is, you know, if you walk into a doctor's office, the physician sort of sees you as their patient, rightly so, and thinks about what can they do to improve whatever medical problem you have. Public health practitioners often say our patient is the population, that we look at a community, a neighborhood, a society, and think about the health of that community and ask the question: How do we address the diseases affecting that community? How do we improve the health of that community? And if you think about

the things that drive health in the community, yeah, it certainly is health care. It's an important part of it. But it's so much more. It's the environment. It's the housing. It's the quality and the quantity of food people have access to. So, all these other things that go into what we often talk about as, you know, the social determinants of health, that really ends up playing into the public health lens in terms of thinking about the health of a people.

Rovner: And there are lots of different kinds of public health professionals, right?

Jha: Absolutely. And public health is multidisciplinary at its heart. So, you can imagine that if you're going to go into public health, you may be somebody who's an epidemiologist or a biostatistician who crunches numbers to think about populations. You may be a behavioral scientist who thinks about how do you change people's behavior around food or exercise. You may be a policy person who says, you know — as opposed to just tinkering on, like, what does the doctor do with the patient? — How do I change the way the health care system is structured so that we get better health outcomes? That's a classic public health approach.

Rovner: And then there are sort of the more nitty-gritty community health workers. They're also part of public health, right?

Jha: Oh, absolutely. Once you get outside of the academia, yeah. Like, public health practitioners range from, you know, your public health department directors that we've all gotten to know because they've been on the front end of the covid fight, but community health workers, people who work — and, you know, and there is a little bit of a debate in the public health field of, like, how expansive do we want to be? I mean, do you think about people who really focus on education? Well, education is a major determinant of health. So, are those people doing public health? On one hand, I'd argue, yes. Another hand, sometimes you do have to create artificial boundaries. And some people who are, you know, sort of the, are you a lumpers or splitters? And if you're a lumpers, you pull all those people in and say they're all doing public health. And if you're a splitters, you say education's a little outside. I don't know. I'm more of a lumpers. So I'm fine.

Rovner: So, what's the public's biggest misunderstanding about public health?

Jha: Well, there's a bunch. I mean, I think one of the things people have struggled with on public health is there's this idea — I mean, “public.” The word “public,” often people think about as government. Right? And so then they think of public health as in the realm of the government. And of course, the government has a very large role to play in public health, but so does the private sector. And the private sector plays a very big role from the tools that it creates for enabling public health to most people interact with private health care delivery system. So there's a large role for the private sector in public health, and that feels funny to people. And most people, I think, don't think much about public health. And certainly before a pandemic they didn't. But, you know, we often talk about this in the sense of, you know, if you open up your tap and you get water that's clean and not going to make you sick, that's public health. And I'm glad you

didn't think about it. I'm glad you can assume that the water that comes out of your tap is going to be safe and healthy for you to drink. So, a lot of the work that happens in public health happens in the background in ways that people don't notice. And I see that as a good thing. Of course, it has some problems, like, then we can take it for granted and then we underfund it until there's a crisis. And then we think: Oh, my God, why have we been underfunding public health?

Rovner: I want to go back to, sort of, “lumper/splitter.” I, you know, a lot of people think, who actually have a vague understanding of public health, think about it in its most traditional sense: providing vaccines and other preventive health measures, ensuring proper sanitation and, as you said, untainted food and water. More recently, public health has come to encompass things like health equity and climate change and gun violence. Is public health trying to take on too many issues, do you think?

Jha: No. I think what is happening is public health is developing a lens in — and not developing, but really understanding that these things — so let's say climate change, for instance. Climate change can have a profound effect on people's health. It's probably the biggest health risk over the next decade, two decades. That's really hard if you think about this as a clinician. That doesn't quite make sense. But as a public health practitioner, that makes a ton of sense. Gun violence, obviously, a huge problem in our country and we can see it as one individual shooting at a time. Or we can take a public health lens and say, well, yeah, there's probably some structural things that we can do. So, the cure is, as we make progress, public health is going to shift its focus. As we make progress on sanitation — thankfully, sanitation is reasonably good in America — it makes sense to then tackle the things that are causing major health problems. And they do move away from sanitation and more into gun violence, climate change and issues of health equity, which, of course, have been with us since the beginning of our country.

Rovner: Yes, I know. I keep hearing that your ZIP code is as important as your, sort of, personal medical numbers, your blood pressure.

Jha: Absolutely. And this is, you know, there's work that goes back to [University College London professor] Michael Marmot, who did some really nice work in London. There's a very famous map of how the tube [subway] stop, and the community that lives around that tube stop — and he basically looked at life expectancy, and you can go kind of three stops down on the Metro and you get a 15-year difference in life expectancy. The kinds of differences we see between, you know, high-income and low-income countries, all within the city of London. People have done that for Boston. You can do that for every city in America. It does turn out that where you're born ends up having this very profound effect on your life expectancy and your well-being. And if you think about it, it makes sense, right? Because if where you're born affects the environment and the quality of the air you breathe, the quality of the food you get access to, the education that you will have access to, the health care you will have access to. As a country that believes deeply in meritocracy and giving people an equal chance, that's deeply wrong. Like, we don't want a child's ZIP code to determine his or her long-term well-being and outcomes. So that's something that we really need to address, and that's a classic public health problem.

Rovner: How worried are you about the politicization of public health? I am old enough to remember that right after 9/11 and the anthrax attacks, that beefing up the nation's public health infrastructure was completely bipartisan. And we saw a little bit of that last year, at least in Congress, with money for the pandemic. But we've seen sort of since then this enormous split even in communities and, you know, frontal attacks on public health workers.

Jha: Yeah, it is worrisome. And I always begin by asking the question: What else can we in the public health community be doing better and differently? First, I think public health has a problem, which is how it communicates and how it communicates to the broader American people. And I will tell you that if I want to begin at home and say "Where are we falling down on the job in the public health community?" I will say part of it is we do not have enough conservative voices within public health. You know, a survey a few years ago at the Harvard School of Public Health, where I was, of donations, I think in the 2012 election, 100% of all staff faculty donations went to Democrats. This is a problem. You actually do not want institutions where nobody who is right of center ever steps foot. Because what happens is you lose perspective on people's lives and their values and what matters to them. And that, I think, has really hurt the public health community. And so that's something we need to fix ourselves. Now, beyond that, I don't think that's the biggest and only problem. I think there has been a politicization for political goals and political gain. I think it started under the Trump administration, but it has continued. And it's a huge problem. Now, I think when I talk to, I speak to Republican members of Congress, I speak to Republican governors, they get it. Like, they can't actually go around undermining their own public health agencies. They know that the people that will be harmed will be their citizens. So I'm hopeful that the investments that are necessary in public health will happen broadly across the country. But the public discussion around public health has been far too polarizing, and I think it's a huge problem.

Rovner: How worried are you about, sort of, the individual practitioner level? I mean, we've seen people being threatened, you know, their children being threatened, being fired for telling the truth, being publicly pilloried. Are you worried that students won't want to go into public health anymore? I mean, it's never fun, but now it's not fun and dangerous.

Jha: Right. Yeah, well, it's an interesting question, right? Because public health schools have seen about a 25% increase in applications this year. Brown's public health [school] saw [over] a 110% increase in applications. So people are voting with their feet, and they do want to go into public health. The demonization of these public health officials has been horrible and completely unacceptable. I think it has happened in part of a broader context of what's happening with misinformation and disinformation in our society, right? Where there are these very well-organized disinformation campaigns and people genuinely believe that the virus is a hoax or that these vaccines are killing hundreds of thousands of people. And if you genuinely believe those things, then it makes sense that the anger you feel at public health officials. But unfortunately, I don't think that anger begins or ends with public health. We're seeing this across the political

conversation. So we've got to address the root cause. We've also got to protect our public health workers, who are not our most powerful and well-paid members of society. They're really doing God's work, and we've got to do a better job as a society.

Rovner: I spent a lot of time talking to college students and grad students and talked to a lot of public health students. And in sort of the early 2000s, I would go around the room and everybody wanted to go into global health. They wanted to do public health, but they wanted to do it in other countries. Do you think the pandemic is going to change that? Not for pandemic reasons, but do you think it's going to be more sort of sexy to try to work in the United States on our own problems?

Jha: Absolutely. And I don't know if it's sexy or just realizing that, my God, we have a lot of work to do in this country. Our public health response has been, you know, pretty abysmal, and abysmal in ways that I'm not sure that many of us could so easily predict. You know, what's interesting, Julie, is that if you go back to two years ago and you looked at, for instance, the global pandemic monitoring board or the global security index created by [Johns] Hopkins, even reports that I was involved in, we often described America as the country best prepared to handle a pandemic. Boy, that turned out to be wrong. Like, I mean, it's embarrassing how wrong that was. But it's worth asking the question, why was that so wrong? And it was wrong because we misunderstood what really drives public health. It isn't just laboratory capacity, which is, of course, is important. It is about social cohesion. It is about communication. It is about behavior change and how you get people to understand the moment we are in. We did a terrible job of that. And I think it opens up a huge opportunity, not just for traditional public health students, but a new group of public health students and public health practitioners who are going to be much more comfortable engaging in those issues.

Rovner: Which brings us, of course, to the question of funding. Funding for public health has been on a roller coaster. There's a big infusion of funds when public health is top of mind and then it dwindles. We saw that with the Affordable Care Act; the public health funding in there has been raided repeatedly for other things that seemed more pressing at the time. How important is a steady stream of funding to keep our sort of public health infrastructure viable?

Jha: Yeah. A few years ago, after the Ebola outbreak in West Africa, a group of us were talking about how we think about public health funding and the phrase — and I don't remember who said it first, but I think it captures it perfectly — that we've all used since then is “from panic to neglect.” Right? Like, you panic and you throw billions of dollars and then you're like, oh, it's fine. Well, public health what? Like, it's all good until the next crisis.

Rovner: And we threw all that money at it.

Jha: Yeah. Exactly.

Rovner: What'd we do with that money?

Jha: And so a steady stream of funding is incredibly important. There's one more important nuanced issue that you actually raise that I think is worth understanding. Most Americans, and I don't blame them for this, don't differentiate between health care and public health. They just think about health. And so then, when people like me say we're not spending enough money on public health, they're like, buddy, \$4 trillion. Like, how much more of the economy do you want? And part of it is the mix between health care and public health. And we have got to get better at that. And we definitely have to have a larger chunk of the \$4 trillion pie. I don't think we can expect the U.S. taxpayer and our country to just continue to expand that spending. I think some of it has to come from efficiencies in the health care system. And we've got to find ways of spending less on health care and having more money available for public health. And it does ...and you're right. What happens is you build these public health trust funds and then they get raided because people need MRIs and people need CT scans. And then you're like, oh, yeah. And that money is just sitting there. So we have to also have a different way of spending that money during, quote-unquote, peacetime so that we have a public health workforce that's effective and ready to go when the next crisis hits.

Rovner: If you could change one thing, right now, what would it be?

Jha: I would have a lot more people outside of public health engaged with public health. I think one of the things that struck me in this pandemic was that a lot of the mistakes that happened, is that the public health community didn't engage enough with sociologists and economists and other experts, and when you have major crises, you really need people from a broad swath of society involved in the decision-making. So that's something, again, as I said, I always begin with what can we do differently and what can we do better? Because it's important to start there as opposed to blaming others. Obviously, from the outside what I would argue is absolutely essential is a commitment from both state and federal government for long-term funding and support and steady funding and support for public health.

Rovner: Anything I didn't ask that you feel like people need to understand about public health?

Jha: You know, it's as I said in the beginning: It sits there in the backdrop. It shows up actually all the time in our lives. And I think the other thing that we all need to do a better job of — and certainly those of us in the public health community need to do a better job — is helping people connect the dots between the broad range of things that are happening in our society and the way that they are affecting our health. That is the job of public health. And I think for the next generation of public health leaders, it's going to be about connecting climate change to public health, connecting racism to public health, getting people to understand that these things that we care about, we don't care about them in isolation. We care about them because they really end up harming the health of people.

Rovner: That's great. Ashish Jha, thank you so much for doing this.

Jha: It was my pleasure. Thank you for having me back.

Rovner: OK, we are back with much to chew over. Lauren, you've spent a lot of the past year on a project looking at the impact of the covid pandemic on public health. And to paraphrase the meme of the week, public health workers are not doing all right, are they?

Weber: They are not doing all right, Julie. I mean, here's the deal. Look, let's take a few steps back. We have lost 38,000 public health workers since the Great Recession. You know, state public health budgets have been cut by about 16% from around 2008 to 2019. Local public health budgets have been cut by 18%. Your public health worker has been operating on low pay and facts. And that was all before the pandemic began. And so, when the pandemic hit, they were very ill equipped to really step into that breach.

Rovner: Joanne, you probably remember the way I did how much money was kind of thrown at public health after 9/11 and the anthrax attack.

Kenen: It was interesting, because the country has never really wanted to invest in public health. Public health's burden, or its curse, is that when it works, you don't see it. When it works, it prevents something from happening or it prevents a small problem from becoming a big problem. And because its successes are basically invisible, lawmakers looked at it and said, "We don't need that. Why spend any money on it?" So after 9/11 and anthrax, a lot of money did go into public health, but it was actually under the rubric of bioterror defense, or just biodefense, and everything they did, and it was a bipartisan effort between Sen. [Edward] Kennedy and Sen. [Bill] Frist were those sort of go-to people on that. A ton of money got sent to public health, because anything you do for bioterror, for monitoring new, weird things, is the same thing you do for a new weird non-attack — I mean, nature attacking us, which is what a virus is.

Rovner: Which has turned out to be a lot more common in recent years.

Kenen: Right. And so there's a lot more of that than people realize. They just don't become as bad as this one did. So from like 2002 or so until 2008, 2009, there was a lot of money. And then it was, you know, the Great Recession, as Julie just noted, belt-tightening. You know, they cut back and they never rebuilt. And in fact, in the big stimulus bill under [President Barack] Obama, do you remember that there was pandemic flu money in there? And I think it was [Sen.] Susan Collins who insisted on it being cut. I may be remembering that wrong. I'm pretty sure it was her. So everything we had done right for a few years, we undid and left ourselves really vulnerable.

Rovner: Well, there's a huge part of public health money in the Affordable Care Act. And pretty much every year for the three or four years following, Congress went and raided that. It's like, well, what do we need all this money for? We need it for emergency X or emergency Y that had nothing to do with public health. And then — surprise! A pandemic comes along, and we look around like, what happened to all of the money that we gave you?

Weber: And it's crazy because even now, I mean, they allocated all this money for public health preparedness and even now they're even talking about drawing back some of this money. It's being talked about that some of the [\$]30 billion or so that was allocated is going to get clawed back very shortly from now. It's considered a public health slush fund of sorts. And we all sit around and wonder why the pandemic has gone so poorly.

Kenen: And it's not just like spending more money on what we used to do. It's also rethinking public health. And Laura and I have both written about this, as have pretty much all the people who appear on this podcast. How do you rethink public health for the 21st century? How do you [re]think public health to deal with equity? How do you link public health? How do you de-silo it so it's integrated into our health care system, integrated with primary care? How do you deal with climate change, which Ashish just mentioned as well? How do you deal with equity in public health? [garbled] We just need to think of public health as part of health care or health care as part of public health. And, you know, take this opportunity not just to put money into it, but to modernize and change our thought process.

Rovner: Once upon a time, Republicans were all about public health and research, and it was the Republicans with Newt Gingrich who led the effort to double funding for the National Institutes of Health. And yet I feel like in the last decade in particular we've seen, you know, this bashing of government and this bashing of science. And I feel like one of the reasons that people have gone after public health in this pandemic is because they've met at that sort of nexus of "we don't trust you because you're science, and because you're government." Is there some way to restore the public faith in the people who do mostly keep us pretty safe every day? I mean, as Joanne said, it's the stuff that you don't see that we take for granted. You know, other infectious diseases, lead poisoning, clean water, clean air — cleanish water and clean air — and, you know, non-tainted food. How do we get that back?

Weber: You know, I'll just say she's kind of touched on this. I mean, if you look at the public health profession, it's typically called a very liberal profession. So I do think there is some argument to adding more conservative voices back into public health and getting them to be better public health advocates. But at the end of the day, I mean, if you look at President Donald Trump, I mean, back when the Ebola crisis happened, long before he was president, he came after public health and science on that front. He very aggressively tweeted about not bringing folks back with Ebola to be treated on our shores and so on. And, you know, you saw some of that anti-science rhetoric continued throughout his presidency. I mean, when the man recovered from covid, he ripped off his mask on the balcony. I mean, so I think, you know, we have a long way to go before you have a united country on public health, because it has been so intermingled with a political poison to a sense, and that has trickled down to public health practitioners. I mean, something we've reported with our KHN-AP "Underfunded and Under Threat" project is that over 250 local and state public health officials have [been] fired, resigned or retired during the pandemic. That is the largest loss of public health leadership our country has ever seen. And it leaves a gap of about 1 in 6 Americans have lost their local public health leader during the pandemic. And as you said, these are the folks

keeping your water clean. They're protecting you from TB; they're protecting you from meningitis — and we're losing them in droves.

Rovner: Joanne, is there some way to sort of regain this trust?

Kenen: Well, I mean, I think that the politicization that we saw prior to the pandemic — I mean, remember “Sharpiegate” and, you know, the attack on the National Weather Service. And I think the attack on climate science has really undermined the credibility of health and science in general. But it predated the Trump administration. It was magnified and exacerbated under the Trump administration. But this erosion of faith in science was part of a larger erosion in faith of expertise. And it's not even just in the United States, you know; it's actually global. You know, it sort of comes in waves throughout our history. Right? There have been these sort of anti-expert, anti-elite, anti-egghead, anti-knowledge at times. So it has come in waves. It's never coincided with an epidemic, pandemic of this proportion. So I think it comes to a larger lack of trust in institutions. And I don't have the answers for that. I think it's a sort of societywide problem that part of our tribalism and part of our political divisions that are impeding our recovery from the pandemic as well. The fact that someone like Tony Fauci gets death threats and has become this political symbol when for many years he was really a trusted voice. I mean, we've been hearing he has a unique ability to communicate and we've been hearing him from the AIDS crisis on.

Rovner: And when Ronald ... when there were Republicans who were president, I mean, that he was George H.W. Bush's hero in a presidential debate.

Kenen: For part of the country he's now this manifestation of evil. And he had been a bipartisan hero. And he's been, the man is 80 years old, or just about. He's been a voice of clarity for decades. And I think he's sort of the story of what's happened to Tony Fauci is sort of the story of what's happened to public health or health writ large.

Weber: And I'll just add to that. I mean, Tony Fauci has gotten a lot of death threats. Tony Fauci also has a Secret Service detail. And a lot of these local and state public health officials do not. And they are getting death threats by mail, by phone, in person, you know — aggressive, so on, and, you know, the trickle down from the federal attitude of national politics to the state and local level, you've seen armed protesters show up at public health officials' homes, and it really has changed the dynamics of public health during the pandemic.

Rovner: Yeah, I mean, it's one thing to go protest the president or to even go protest on Capitol Hill. But, you know, there was that terrifying video of the public health director in Idaho who, you know, there were people outside her house and her kids were home alone. It's not things that I remember having seen before in 35 years of covering public health. I mean, which sort of, I guess, raises the question, is public health trying to do too much? Should public health — maybe not — you know, wade into gun violence and climate change? On the other hand, those are things that certainly threaten the health of our citizens. I mean, where is the sort of balance here going forward?

Kenen: Well, I mean, I think there are questions about health care in general, like there's been a lot of talk about equity. There's been a lot of talk about social determinants of health. I mean, where is it the health care systems or the health systems or the public health system to deal with issues like food security and housing, you know, transportation — all these issues that affect our health and affect our access to health care? And yet, obviously, you know, the health care system or the public health department isn't going to rent every person an apartment or buy everybody's groceries. So there's this, you know, where do we de-silo and create partnerships? What is the health care system? What is the public health care system? What are other social services? But right now, it's so fragmented that no one's doing it, or no one's doing it adequately. So it's not that, you know — Ashish's phrase was the lumpers — you know, put everything in public health. But some of that has to be in the public health basket and some of it has to be public health extending a hand and coordinating with other sectors to achieve social programming that makes us healthier and might ultimately lower the cost of health care or at least contain the growth if we are not doing so many damaging things.

Weber: Yeah, and just to add on to that: The way that many public health officials have explained their job to me during the pandemic is that they're the people that keep you from getting to the ventilator. They want you to not even make it to the hospital. They want to keep you from getting covid altogether. And that's a huge cost saved for every — I believe it was the United Airlines CEO who said that for every covid patient, they're seeing about \$50,000 worth of cost. So if you're a public health person and you are keeping that person from the ventilator, that's a heck of a lot of savings. But that becomes very difficult in the pandemic to see where those lines get blurred. Because if you're trying to keep someone who's homeless from the pandemic or someone who works a low-wage job, who continues to have to go into the office and mask mandates may or may not be allowed in your town, city or state, you know, these are the quandaries that these public health workers are now facing. And add to that kind of the question about blurred lines.

Rovner: Well, if we weren't in the middle of a pandemic, I would say, "Go out and hug a public health worker." But since we are, I'll say, "Go out and thank a public health worker." Ladies, you have given us plenty to think about. That is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review; that helps other people find us too. Special thanks, as always, to our ace producer, Francis Ying, who still manages to make us all sound good. Also, as always, you can email us your comments or questions. We're at whatthehealth.org, all one word, at KFF.org, or you can tweet me: I'm @jrovner. Joanne?

Kenen: I'm @JoanneKenen.

Rovner: Lauren.

Weber: I'm @LaurenWeberHP.

Rovner: We will be back in your feed next week. In the meantime, be healthy.