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THE ECONOMY AND HEALTH: CHALLENGES AND OPPORTUNITIES
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>> DEAN GALEA: Good afternoon, good evening, good morning, everybody. My name is Sandro Galea, and I have the privilege of serving as Dean of the Boston University School of Public Health. Welcome to today's Public Health Conversation, the first of the new year.

These events are meant as spaces for the free speech, open debate, and generative ideas that shape a healthier world. Guided by expert speakers, we aim to sharpen our thinking about what matters most for health.

Thank you for joining us for today's conversation. In particular, thank you to the Dean's Office and our communications team, without whose efforts these conversations would not take place.

Health is inextricable from the economic forces that shape our lives. Our health is supported by assets like good food, safe homes, neighborhoods and quality education. Our access to these assets is fundamentally, a matter of money, of economic policy. Today we will discuss how we can engage with economic policy to create a healthier world. I very much look forward to learning from all our speakers as the conversation unfolds.

I am pleased to introduce today's moderator Stefanie Ilgenfritz. Stefanie Ilgenfritz is Coverage Chief, Health and Science, and Editorial Director of the Future of Everything for

the Wall Street Journal. She leads a prize winning team of reporters and editors who cover the hospitals, health insurance, pharmaceutical and medical device industries, as well as medicine and science.

Stefanie, thank you for joining us. Over to you.

>> STEFANIE ILGENFRITZ: Thank you, Dean Galea, for that introduction. I am really happy to be here with everybody today.

To get us started, I'll introduce our speakers for the program.

First we will have Dr. Brittany Brown-Podgorski, Assistant Professor of Health Policy and Management in the Graduate School of Public Health at the University of Pittsburgh. Dr. Brown-Podgorski's research examines the policy environment as a social determinant of health and health disparities. She is interested in how state social, economic and health policies influence cardiovascular risk, outcomes and disparities among low income and minoritized populations.

After that we will turn to Mark Duggan, Trione Director of the Stanford Institute for Economic Policy Research and The Wayne and Jodi Cooperman Professor of Economics at Stanford University. Professor Duggan's research focuses on the health care sector and on the effects of government expenditure programs such as Social Security, Medicare, and Medicaid on the behavior of individuals and firms. He is also a Research Associate at the National Bureau of Economic Research and serves on the Editorial Board of the Journal of Policy Analysis and Management.

And then we will hear from Rourke O'Brien, a professor of sociology and Director of Undergraduate Studies at Yale University. His research focuses on the causes and consequences of social and economic inequalities with substantive interest in taxation, household finance, and population health.

And then finally we will hear from Kosali Simon, Distinguished Professor, Herman B. Wells endowed Professor and O'Neill Chair at Indian university's Paul H. O'Neill School of Public and environmental affairs. Dr. Simon is a nationally known health economist who specializes in applying economic analysis in the context of health insurance and health care policy.

It's quite a program today, but to kick things off, let's start with Dr. Brown-Podgorski.

Over to you.

>> BRITTANY BROWN-PODGORSKI: Good afternoon. Thank you for that introduction, Stefanie. I'll go ahead and share my screen.

As Stefanie mentioned I'm Dr. Brittany Brown-Podgorski. I an assistant Professor at the University of Pittsburgh School of Public Health in the Department of Health Policy and management. I'm going to briefly touch on the inner-twined relationship between economic hardship, health and the potential role of the

minimum wage policy specifically to improve that relationship.

So I will provide a brief overview of health and social determinants of health, discuss how we define and/or measure the economy in the U.S., talk briefly about the relationship between economic hardship and health, and then lastly talk about some evidence that we currently have out there in the literature on the current impact of minimum wage policies on health.

So, to kind of kick things off I want to talk about the fact that we have shifted away from the traditional model of how we see health. And getting past this idea that health is merely the absence of disease or poverty. Instead we think about health in a more holistic way. So this having a healthful diet, living in an environment that is conducive to overall wellbeing, physical activity, that sort of thing, and just really getting beyond the idea that health is specific to the absence of disease. And health care, the utilization of health care, how you need health care. While health care is important to our health and our health outcomes, we know that it only accounts for ten to twenty percent of what it means to be healthy. The rest of that, the remaining eighty to ninety percent, is actually attributable to social determinants of health. Which is that broad social context in which individuals live, work, age, play over the life course and how those influence their overall health.

Thinking about that and thinking about health and wellbeing from the holistic perspective we really need to focus on that social context and the fact that social determinants of health and health itself don't just occur. We have this larger social economic and political context that feeds into that. This framework from the WHO puts that in a form where we are able to see health and more broadly the social, economic and political context are really shaped by policy and our economy and government. And the important role that those factors and that context really plays on trajectory to health and wellbeing over the life course.

What do we really mean when we say "the economy"? We can speak broadly based off of definitions that are available just by a quick internet search. So the system of production and distribution and consumption of goods and services in a given area or the structures and conditions of economic life in a given area. But while that's great, that's a very concise definition what does that mean. What are the inputs. Looking at the Bureau of Economic analysis, some of the important factors that are often included in their snapshot reports of the U.S. economy including the gross net domestic product, personal income and spending. Investment. Personal discretionary spending income. Government finances. Consumption. Import, export, labor and workforce. But the one thing that stands out for me and many of you I'm sure as well is all these things are driven by the individuals that are within our country and how they actually

and what is the driving force behind the U.S. economy.

And so that is important to consider given that individuals who experience economic hardship or really struggle financially economic hardship we can define as the inability to pay for your bills or have any extra spending money. It's often in literature it can be named poor social economic status or poverty or material hardship when you are look through the literature. But individuals who face economic hardship are increased risk of negative health outcomes over their life course. That can include overall health, mental health and physical health. The health of their offspring. And then more specifically, we can get down to how economic hardship actually increases the risk of diabetes, heart disease and even premature mortality.

So thinking about the fact that economic hardship or having the funds you need to not only pay your bills but live and survive in life can really be tied to labor and wage policies specifically. And here in the U.S. with a lot of the discussion around minimum wage policy as a specific lever that we can pull to improve economic hardship and thus health in U.S. households.

And individual states have the authority to really increase those wages above the federal limit for workers in their jurisdictions. And many, thirty states plus D.C. have done so. However the evidence of the effectiveness of such increases have been mixed especially when talking about health. For example, the benefits that we see associated with minimum wage increases have been: Improved socioeconomic status, reduce psycho-social stress, I improvements in access to health, and other resources that influence health as well as improved overall health. However there have been unintended consequences. Wage increases have been found to be associated with obesity, tobacco use, poor quality diet, and importantly the impact of minimum wage policy tends to vary by individual social factors such as gender and race. Suggesting these policies themselves can impact groups, especially more vulnerable groups in a different way.

So just to conclude and kind of start off the discussion, individuals and their families are the foundation of the U.S. economy. However, individuals who are experiencing economic hardship have worse health. That poor health can lead to greater economic hardship. And that in turn affects everyone and leads to having negative impact on the economy.

Policies that improve wages, such as the minimum wage increase, could potentially be a solution to improving economic hardship and thus improving health. However this will require large-scale changes that look at health and beyond just the economy but also the trickle down or other impacts of the economy on the individual experience and the changes cannot be incremental. We've been doing that and unfortunately at this time we're seeing that may not be the best strategy for addressing wage and hardship.

And so that is the conclusion of my presentation. And I

will turn it over to your next speaker.

>> STEFANIE ILGENFRITZ: Thank you very much, Dr. Brown-Podgorski for that. I am already seeing questions from the audience in response to your presentation so I was going to suggest to the audience please keep them coming and we will leave some time at the end to answer just as many of them as we can.

For now I will turn it over to our next presenter Dr. Duggan. Over to you.

>> MARK DUGGAN: Thanks so much to the organizers for including me in today's event. I'm excited to be here. I have a long history with BU in the sense that both my parents are alumni of BU so I have a special fondness for the institution. But I'm going to build on some of the remarks from the previous speaker. I'm going to try to share my screen. And it's possible that I will -- I hope I do this very efficiently. And I'm going to try to. That is not -- I want to go to display settings I believe. Is can anyone give me a thumbs up. Does that look good? Okay great.

Thank you so much for being, including me today. I'm going to talk about several things rather than one thing. High-level that I think are very top of mind for me lately when thinking about the U.S. economy, the health of the population. Recently, I'm certainly paying attention to what's happened to people's health over the last few years. We have seen -- and I'm going to give quick bullet points then go more deeply into several points. But there are questions about how long the recovery will take and I'm going to talk about that. The second thing I want to talk about is something that fifteen years ago I had the honor to work in President Obama's Council of Economic Advisors on the Affordable Care Act. At that time something that we were very focused on was the rapidly rising share of our economy being devoted to health care spending. From 2000 to 2010 it rose from thirteen to seventeen percent. One thing I haven't -- and at the time the projections from the leading, sort of leading individuals or organizations in D.C. were that spending growth was going to continue. In when fact over the last dozen years health care spending as a share of GDP hasn't really moved in the U.S. Which is incredible. I encourage everyone to reflect on that. CBO for example projected by now we'd be twenty five percent of GDP. I want to talk about the steadily growing role of Medicaid and Medicare. These are very important programs that ensure 140 million Americans. They have become more and more important over time as a result of demographics and policy changes such as the Affordable Care Act.

Within those programs, there has been just a really massive shift over time from fee-for-service reimbursement of the programs to hospitals, doctors and others, to basically contracting out that care to private insurance companies through a growth in Medicare advantage and Medicaid managed care. While

there has been a huge increase in public health insurance in the U.S. there has been a decline in the public provision. As I'll show you in some current research I'm looking at what are the consequences of that decline in public hospitals on wellbeing of individuals. Given we're talking about the economy and health today I want to point out in recent years earnings in wealth inequality in the U.S. have been declining. Which it's hard to know what the effect of that will be on health, but that is promising. And one of the reasons I think that we in the U.S. have life expectancy of three to four years lower than other industrialized countries as people have estimated that are our inequality here is a contributor to that.

I want to talk about depths of despair and where we think those are headed in the years ahead.

Here you can just see, I'll quickly show that life expectancy at birth had been trending up for both men and women through 2019. As we all know that took a major hit in 2020. And in 2021. And it appears that we are recovering with the hope being we will get back on a good trajectory in the not too -- to the previous trajectory or higher in the not-too-distant future. But even before the pandemic you can see that life expectancy was growing more slowly in the U.S. than previous. And that is something I will talk about at the end with the depth of despair.

The recovery of life expectancy, so it has recovered as you saw from that previous figure from 2020 to 2022. Things are bouncing back a bit. And the extent to which they're bouncing back has varied across groups with underrepresented minorities still having been hit harder at least with respect to life expectancy over these years. So the hope that 2022, 2023, 2024 and so forth that we're back to no longer in definite from where we were at in 2019.

I want to -- most of my relief focuses on the health care sector and government expenditure programs. And I think it is really remarkable to me that here we are today with health care spending as a share are of the economy where it was when Obama care was passed in 2010. If you think about how much more money, pretty much everyone was projecting we were going to be spending now on health care than we are and reflecting on where has that money gone. That six percent of GDP we thought we would be spending on health care. $4,500 a person. How has that benefits us as a country. It has freed up national income or other services and has reduced pressure on State Governments. One of the important findings is Medicare spending has been growing more slowly than expected. That has made the budget situation less negative. It's not great even with this improvement. But how were the projections so off the mark? Or maybe it was driven by policy. Maybe it is the case that the Affordable Care Act and other policies have caused health care spending to, you know, basically level off as a share of GDP. And people were terrified

about that fifteen years ago. Also about the high share of uninsured. Or is it the growing role of public health insurance. It tends to cost less on average since that could be a contributor.

I just pulled up some data from the last twenty years on what is the changing role of health insurance in the U.S. I think it's pretty incredible what has happened during that time period as someone who studies the sector. If you look at employer sponsored insurance, the majority of Americans get their health insurance through their employer or family member's employer. But just in absolute numbers that is if anything declined since two thousand. Modestly increased since 2010. That should be 2000 to 2022. Medicare you can see huge increase. A lot of that is driven by the aging population. But Medicaid absolutely incredible, thirty-four million individuals enrolled in Medicaid in 2000. If you had in chip that gets to 98 million. There have been disenrollments earlier this year but it is remarkable how much this program has increased. Medicaid is the focus of my very first paper as a graduate student. If you told me in the late nineteen nineties that Medicaid would be enrolling almost a hundred million Americans, I couldn't even imagine that then. It's a huge change in our country. And that has been associated, there's research showing that's helped improve our health as a nation. You can see uninsured has declined but it's still the case there are a non-trivial number of uninsured individuals. But the growing role of Medicare and Medicaid, that is just a first order of change in the economy. It's more than doubled since 2000 whereas private insurance hasn't moved much. It's likely there will be further increases in Medicaid enrollment in the coming years. Ten states have not expanded Medicaid. Including Texas and Florida, the second and third most populous state in the U.S. Only half of states immediately expanded Medicaid when they could ten years ago. And in the ten years since, many states, one by one have come in and expanded Medicaid. It seems plausible that some of these ten will as well which would lead to further increase in the role of Medicaid in our health care system.

I do want to call attention to the growing role of public health insurance has coincided with a growing alliance of public health insurance on private insurance. It's sort of an interesting change. So private insurers, while they're getting basically less commercial business from ESI, Employer Sponsored Insurance, they're getting more and more from Medicare and Medicaid. You can see as a share of Medicare more than half are enrolled in Medicaid advantage. And Medicaid enrollment now more than eighty percent of recipients are enrolled in private managed care plans. That is a gigantic change. Between the two they account for almost two trillion dollars in government spending. Increasingly that money is going not directly to hospitals and physicians but to private insurers who are

cooperating and financing the care. The changing role of public health insurance in the backgrounds one thing have focused much less on and some of my own research is decline in public hospital capacity in the U.S. Over the last thirty five or so years there's been a steady decline in the share of hospitals owned and operated by state and local governments. Then federal hospitals have also declined over time. That is good for individuals or not? Public hospitals are often in many communities considered to be the providers of last resort. And so is it the case that the growth in public insurance has made less and less necessary to have a provider of last resort, a public hospital. That's somewhat we're exploring in our resource.

I will say inequality in the U.S. by many measures has been growing for decades. Recent evidence from the census bureau suggest this may be declining. Earnings have been declining for low-income individuals. So that may ripple through. Because to the extent that related to Professor Brown-Podgorski's previous presentation, additional income for low-income families may have a high bang for the buck. Some of this I think has been driven by minimum wage increases which have really been quite striking. Though varying across places. Here in California $16 an hour. Texas $7.25 an hour. And many states in between those two extremes.

I'll just say something about depths of despair. It's a big issue. Something for the country that's affected our life expectancy. Part of the reason our life expectancy was slowing even before the pandemic has been a huge steady increase in suicide rates since basically 2000. And even more jarring increase in drug overdose death rates. The hope, my hope is that these trends, these very troubling trends, if we were to be looking at this twenty years from now, will show a reversal of this upward pattern. But there's a lot of complicated factors driving this increase. And many of them don't have much to do with the health care sector but what's happening in the economy and society more generally. But I think this is a very high priority along with -- I don't have time to cover everything but this is clearly a high priority for us as the research community to figure out how we can as a nation move in a better direction here. With that I will stop sharing and I will hand off to the next speaker who I believe may be Rourke. Professor O'Brien. Or maybe it's Professor Simon. I'm sorry.

>> STEFANIE ILGENFRITZ: I'll answer that. Next up will be Dr. O'Brien.

>> ROURKE O'BRIEN: Great. Thanks so much. Thanks for the introduction, Stefanie. Greetings my fellow panelists. Honored to be on this panel with you. Thanks to Dean Galea and the folks at BU for organizing this discussion.

As mentioned my name is Rourke O'Brien. I am a sociologist and social demography at Yale university. What I want to do is

share the research from the Opportunity For Health Lab which I am part of. It's led my by colleague. We are group of interdisciplinary social scientists that are laser focused on the topic of today. That's the relationship between the economy and population health. Really trying to think of one side of the equation how changes to the economy might help us understand some of these kind of worrying population health trends we've been talking about today including where Mark left of his presentation. This rise and this worrying depths of despair.

So just to kind of frame my short remarks today two points of provocation I want to put out there for our conversation. The first is that I really do think declining economic opportunity is a driver of America's worsening population health trends. And then the second point which doubles down on that observation is that, you know, from our perspective, we think that public policy that specifically promotes economic opportunity is the only way to reverse America's health decline. So we really think the solution to improving America's population health actually sits in how we think about structuring the economy for the twenty-first century, sharing the gains in wealth that our economy generates, and make sure we have an adequate safety net. Those are going to be more important to shaping population health than changes to the health care system.

What's the big thesis? That these macroeconomic shifts that we are all very aware of from globalization to automation have really reduced economic opportunity in America and particularly for Americans without a college degree. We've all seen the many charts that basically show that we now have become kind of two Americas when it comes to health trajectories and outcomes with that bachelor's degree being that dividing line. Of course I don't think it's because there's any kind of secret that we learn in the college classroom, instead that college degree provides some people access to that knowledge economy, those status and benefits that come with it. Whereas those who don't have that credential increasingly find themselves locks out of the opportunity structures in this country. We think that is what's behind these kind of worrying population health trends.

How do we know that? What I want to do the next few minutes is share a few bits of empirical evidence that we have that I think are illustrative of this broader research agenda. Before I do that of course we do love kind of flow dynamics. But just to develop our intuition a little bit, we have many of these different diagrams in our lab trying to think about the different pathways. But here what we're trying to make the point there are multiple ways to think about how economic opportunity, be it real or perceived can actually show up in people's physical and mental health. So of course one direct way is if you happen to be in a place or a community or a time where there's lots of good education opportunities, good labor market opportunities, that's going to probably increase the likelihood

you get a high quality job. And we know that higher income, access to health care, all these things lead to more positive health behaviors and outcomes. At the same time if you find yourself in a place with high opportunity you might be more likely to invest in your own human capital. Think of education and skills training but also our own health as a source of human capital. If you see there's this potential for the future you are more likely to invest in yourself now and that's going to play out in the way that you treat yourself physically and the way you treat your body and the way you think about the future. And that's this last, kind of middle box here. We really do think that there is a growing body of evidence that the way people consider their own aspirations and expectations for the future, and quite simply the extent to which people have hope for the future, that things will get better, that this will also kind of show up in our health statistics both individual and population level. So that's a little bit about how we think about the relationship between opportunity and health in our lab. Now I want to show you some kind of empirical studies to try to better connect these dots.

The first is this question about this kind of increase in depths of despair. This generalized increase or stagnation in mortality we've seen over the last few decade. One of this things we've been doing is trying to make the case the United States is a large and heterogeneous country. One of the things we can see if we break down the top line stats and look at place based measures in the parts of the country where there's low opportunity, that's where we're seeing kind of higher, elevated risks of mortality. Here we're talking a measured economic opportunity these estimates of intergenerational economic mobility from the opportunity insights crowd. Those who might have seen this image in the New York Times. It shows up often and really captures the imagination. This is just asking what's the likelihood that a low income child moves up the income distribution in adulthood. To achieve that American Dream of upward mobility.

On this map the red colors are less mobility. So less opportunity. And the lighter opportunities there's more. Basically what we're able to see is that it's in those parts of the country that are characterized by low levels of opportunity that we see this elevated mortality level. Of course social scientists we all know that good and bad things tend to be correlated. Good goes with good, bad goes with bad, but if we wanted to think about change over time, over the last few decades, again where we've seen this jump in middle-aged mortality, especially among non-Hispanic White population, that too, that's a trend we can talk about at the national level. But when you break it down locally we see it is in those parts of the country that are characterized by this low level of opportunity, low level of upward mobility, in those parts of the

countries we've seen the biggest jump in mortality. Trying to give more texture and understand these depths of despair are responding to structural realities about what the economy is doing on the ground. Frankly the lack of opportunity for certain segments of our population.

So part of what we're trying to do beyond these kind of broader descriptive studies is trying to make the case that acute and long run changes to the economy can help us understand changes in population of health. So one of the things we've been trying to think about of course is this global trend of de-industrialization which is hitting certain parts of our country and think what is it like to be in a community where the local community is really anchored on some sort of heavy manufacturing or heavy industry. What happens when that disappears? Can we trace that through not just to unemployment and income and population level but to population health outcomes. In this first study on the screen what we did was matched counties around the year 2000 around the country that had automotive assembly plants, heavy industry. These were typical rural communities where this was the major employer in town. We followed those and just compared the health outcomes of folks in the community where those plants stayed open versus those in the community where a plant happened to close. And what you see on the right there is that in those communities where the plants closed we saw in pretty short order, eighty-five percent relative increase in mortality. So this is a signal that in these communities when work disappears, especially if it's the only or major employer of folks who do not have a college degree, that this has an acute and rather immediate effect on population health outcomes. And of course mortality being one of the most kind of devastating measures that we can have. So this I think is this first order evidence that again when work disappears in the community we see that shows up in the health statistics of that community.

We also think about the long-run trends. What about right as plants begin to substitute away from human workers toward the use of industrial robots. So here we're building on work and economics. Where they show that the arrival of these industrial robots and here you can think like in the picture those orange arms that are re-programmable that can be put to work on manufacturing floors. When they arrive, this technology arrived in the nineteen nineties and two thousands in the U.S. it displays many workers. Again they can be reprogrammed to do things that previously could only be done by humans. So there's a lot of evidence that the arrival of this technology displaced workers led to increases of unemployment and also drove declines in wages in the local community. We just wanted to simply ask, do we see it show up in the population health outcomes of that community? The answer is yes, absolutely. Communities that were exposed to this increase in industrial automation from the rise

of these robots we saw a jumps in cause mortality for both men and women from both younger cohorts into the middle age. What you note on these graphs is a lot of that is being driven by the increase in despair. Particularly the overdose health's. But also increases in cardiovascular disease for men and late middle age. One of the takeaways is the effects that we estimate are much larger than they would be if it was just limited to affected workers. So it's undermining the health of the community. When jobs disappear it's spilling over and affecting the health of everyone.

In this study we found there was some affects by state policies. This gets to Brittany's and Mark's work. We see the affects were attenuated but only just. So we think that American economic policy hasten these shifts and fail to create new pathways to economic security. We can't just rely on the safety net and they can moderate the effects of the economy but just a bit. Where there are quality jobs, where there is a safety net we see less mortality.

One note we're trying to think of examples of the opposite direction right. Where we see increases in quality jobs, investments in local places, does that have near term positive population health impacts? This lovely paper shows it does. This is looking at the rise for demand for blue collar work by the fracking industry. It looks like the job availability of quality jobs leads to improved health outcomes in that community.

I'll just end on this kind of thinking about what does this mean for policy. One of course I think there's a lot we need to do to increase income support and strengthen the safety nets to make it so that workers who lose their jobs are able to access jobs. That it isn't so high stakes. They're still able to lead a quality of life. So expanding the child tax credit, the earned income tax credit, trying to think about support for non-workers. Expanding access for Medicaid. Making our disability programs more flexible and compatible with work. And of course it means overall trying to make sure that people's paycheck goes further on things that matter -- childcare, education and housing. It also means investing directly in quality jobs through the industrial policy. This is a really exciting thing coming out of the Biden Administration. From The Chips Act to the Inflation Reduction Act to the Infrastructure Bill. This is really I think signaling a sea change in U.S. policy that hit number three. That's being deliberate about making a significant place based investments. We know the parts of this country being disproportionately negatively impacted by changes in the economy. And we also see those parts of the country that are receiving huge large taxable wealth because of the rise of the knowledge economy on the coast. How do we think about sharing that wealth to places. Struggling communities. That itself can be seen as an investment in the population of health.

I'll leave this up as a link for our lab. I'm really excited for the discussion.

>> STEFANIE ILGENFRITZ: Thank you for that. We will now turn to our final presenter Dr. Simon. Dr. Simon, over to you.

>> KOSALI SIMON: Thank you. Thank you to Brown University for getting us together in this vibrant setting because this is going to be quite a discussion I can tell. So I am going to get to my -- I am loading meeting controls so I can see where the buttons are. And hopefully you will be able to see the slide soon. Does that look okay? Great.

So I'm delighted to be in this conversation with Doctors Brown-Podgorski, Duggan, and O'Brien to think of where we can exact the relationship between economics and health and think of in my few minutes lessons we can take from past successes. The way I am going to approach this is to say what has worked and how does that help us going forward. I'm going to start off like several have. Pretty similar to Professor Duggan's intro in thinking about the connection in economics to all of the things that happen are really an interplay. So think of there being some threat to health. And it interacts with policy. Policy comes because of it. Policy has an impact on it. And I'm going to think of economic policy and public health policy as very closely related in that they both affect health and are dependent on people and society's reactions to all the things being changed.

So in the long run you've seen pictures like this. I think we've all had a bit of this motivation. There's really very important things happening here right. By looking at mortality. We had a thirty-year gain in the last century in life expectancy. But in the quarter of a century so far, in this century it's not been very good. We've increased at a much slower rate. Then we had a decrease. And even though there's been a bit of an increase as the latest numbers in 2022 show, it's not close to where we would have been in projected rates from where we got. So there's also a lot that a simple number of the total mortality doesn't show. We've seen pictures of what it is by education, by race. I'm just focusing here on the differences by race. And want to also underlie in addition to thinking about income there are big roles that wealth plays. And that there is a recent paper that does a really good job of showing how wealth accumulation has been by race the large gaps that exist. So trying to think about the role of income, wealth and social determinants as very comprehensively thought of in the connection to health is something. So there was a publication that the CDC put out saying, let's look at the period of the completed last century and what the greatest public health achievements have been. And in that were listed a variety of topics. And you can see the importance of public health and economics in thinking about declines in mortality and improvements in life expectancy. I'm going compare as we go over

time. This was for the last century. Then there was a report the CDC put out that said what about the first decade of this century. And you can see that there are some areas in common. You can see vaccine, motor vehicle safety are being mentioned. A few new things are coming up. Tobacco control and cancer are mentioned here. But there wasn't then in 2020 the CDC was busy with a lot of other things. As far as I can tell there wasn't another publication that does cover this for the twenty years afterwards. But it's very clear there are some big public health achievements that have occurred in that more recent time period. One of which is the really dramatic ties to Professor Duggan's comments on how we can understand this together with the slowed growth rate of health care spending right. These are just unprecedented numbers of declines in insurance in the U.S.

We also know that with the awarding of the Nobel Prize in medicine recently to acknowledge the contributions to humankind from discoveries enabling the development of mRNA vaccines against COVID-19 that there have been other big public health achievements in relation to the topics that have been mentioned before. Think about the role of vaccines has been in all of those time periods.

So lots of common threads here in the types of things we've seen as being effective in the past. But now thinking about you know what are the policies that have the potential to advance health going forward. Again, to come back to think about how economics helps understand, helps in explaining that health impacts come from economic as well as public health. So I'm going to now join these two spheres and think about policy together. But in addition to us having earlier thought about disease and injury threats, what we're all talking about right now I think is centering social determinants in a bigger way and thinking of policy and medicine, recognizing more the role of social determinants. And then I'm going to, in my last minute or so talk about a contrast in two areas that happened very recently. We can all just have lived through some of this and waiting to see what happens. The economics vaccine development as an achievement in public health versus public policy and the opioid crisis. So in the time period right before the pandemic hit we had been seeing a lot of policy that was addressing, trying its best to grappling with the changing sources of the opioid crisis. In 2020 we started to get the bandwidth of policy attention shifted away from the epidemic towards the pandemic. But at the same time you know what we didn't know at the time because all this data is known, you know, even provisionally with quite a lag at the time was this dramatic increase that was happening in overdose rates. When we break down overdoses into how much is due to overdoses that are connected to opioids, and then among opioids, types of opioids it's really coming from fentanyl. We're at a loss when we think about changes in the supply and demand side thinking about how to design policy for

an evolving epidemic. But we had a very different approach to the pandemic. Thinking now bringing back social determinants and thinking even if we can't deal with the supply side of a problem, doing as much as we can on the demand side and on treatment and social determinants, again I'm just going to leave it at that, to think this is all going to be, you know, really important for us to think about where things go next and how much we have learned from the past.

>> STEFANIE ILGENFRITZ: Sorry I had trouble with my tech. Thank you so much for that.

For the audience this is now the moment where we're going to have a little bit of a conversation between some of the presentations and the themes that have emerged. Then we will turn it over to the audience. Please again do put your questions in the Q&A and we will get to as many as we can.

To start off the conversation I thought I'd -- a couple of themes come out as I hear all of you and I've looked at your presentations. You know, we're talking about big ideas of how the economy and policy affects public health. But as many of you have noted it comes down to the individual. And I wanted to maybe start there at a more granular level where it's sort of more boots on the grounds. One of the policies a couple of you have pointed to is wages and the impact of a specific policy like improving minimum wage and what that can affect health. I wanted to start with Dr. Brown-Podgorski and ask if you could talk about how the impact of that specific policy leads to better health but also has tradeoffs.

>> BRITTANY BROWN-PODGORSKI: Absolutely. So there are definitely a number of tradeoffs related to minimum wage policies. For example, kinds of going back to Dr. O'Brien's comments about social safety net. Some many of our means based programs don't take into account the fact that minimum wage increases are so small. But it's enough to make you ineligible for some of your social benefits without replacing the financial aspect of that benefit. So if you're making an additional hundred dollars a month but losing seven hundred dollars a month in childcare, that makes it worse. There's a tradeoff there.

And so I definitely would say just kind of thinking about those two policies together, any change -- when I'm thinking about large-scale changes to wage policies it has to consider the safety net, means testing and those policies which are not only kind of governed at the federal level but at the state level and how eligibility is controlled.

>> STEFANIE ILGENFRITZ: You mentioned the tradeoff of higher wage is leading to things like higher BMI and tobacco use. That's a surprising tradeoff for a lot of people. The idea that more income leads to perhaps behaviors that have an impact on your health. Could you expand on that a bit?

>> BRITTANY BROWN-PODGORSKI: Yeah so with higher income comes more discretionary spending. Some of those more social

behaviors that you engage in when you have extra money, which are in a lot of ways in things we examined considered negative health behaviors. For example if you have a little extra money at the end of the month you may want to go out with your friends and have a couple of drinks. That's considered in certain areas of research a negative health behavior. So I can definitely see how that could happen when you have that increase in discretionary spending. So I think what is important is to make sure that we're contextualizing what that looks like. A lot of times because analysis are looking high level, looking at the state level of those outcomes kind of aggregated. What does that mean in a more granular level I think is going to be important as well to look at. So those are my thoughts on that specifically.

>> STEFANIE ILGENFRITZ: I wonder if any of our other panelists have thoughts on a wage policy that could be more effective?

>> ROURKE O'BRIEN: I guess I would just chime in and say, you know, in addition to wages which are obviously critical when thinking about the quality of work, especially for those who don't have a college degree, we can think about other components of these jobs. So in addition to the wage there's also, you know, the right to unionize, the right for kinds of labor to organize. And that matters for other aspects of a job. So there's a lot of good evidence these days showing that schedule unpredictability or schedule volatility, if a person, imagine a young parent, doesn't have the ability to know on Monday kind of what their shifts are going to be over the week and there at any moment at the beckon call of a manager who can say you are doing tonight's shift, it makes it extremely stressful and borderline impossible to kind of manage a household and also kind of maintain that labor market attachment. So trying to think about what are the structure much these jobs that people are able to build a life around. And so minimum wage is having one of I think a whole suite of labor market policies. Job quality policies that I think will make a really big difference on moving the needle on people's health.

>> MARK DUGGAN: You go ahead, Dr. Brown.

>> BRITTANY BROWN-PODGORSKI: The only thing I was going to drop in is we have to keep in mind the establishment of minimum wage goes back to the 1930's. These are just been around and are being slowly updated. We need to think about the context when they were created and why it may require large-scale changes. But that may an entire overall how we think about wage here in the country. Because a lot has changed since 1938 specifically.

>> MARK DUGGAN: I was just going to add one thing on the minimum wage. That basically today the federal minimum wage in real terms is lower than the 1950's. There's a huge variation across states. California's minimum wage and many other states are in real terms higher than the federal minimum wage has ever

been. I think it's really interesting to sort of think about the heterogeneous evolution of the safety net across states. In that I'm calling in from California. One thing you hear a lot of concern about here and I think similar in states like New York is about a migration of people out of states that have the generous, more generous safety net. So if you look basically the population, if you look at net migration from California to Texas, for example, or net migration from New York to Florida, New York to Florida has always been the retirement thing, but it's much more than that now. I think that really poses a challenge. Because increasingly we're having safety nets driven by state and local policies but people are mobile. To the extent that is inducing, you know, people to move it's just complicated I think. And there's no easy answer. But California and Texas are in two very different places with respect to their safety net. And yet Texas is just about the fastest growing state in California for the first time is losing people. And New York is hemorrhaging people. I mean and it has a pretty generous safety net. So I think it's something important to think about that. The changing role of the federal government versus state and local.

>> BRITTANY BROWN-PODGORSKI: On this point I think what it makes it difficult to change the minimum wage at the federal level is to Dr. Duggan's point is just the different context from state to state and the cost of living state to state. And, you know, you have some states that allow for example their larger cities to raise the minimum wage as needed. But other state is have passed legislation saying you cannot pass a minimum wage increase in your locale so we have to consider that as well.

>> KOSALI SIMON: We also have to remember that we can't just squeeze one part of the balloon. Because if we make wage policy change, we have to remember that we already said automation is a negative. And that employers always have that as an option. So it's such a delicate balance.

>> STEFANIE ILGENFRITZ: The variability that you are talking about, in fact this is a good segue to discussing employers as well, makes me think of another theme that I was hearing a lot of you talk about. Which is the connection between, you know, economic opportunity and mortality and the depths of despair we've seen in some many parts of the country. It's clearly tied from all the research that you all are presenting to loss of economic opportunity in your community. You know, broader even then. The employees of the companies that maybe pull out. And I wonder actually, thinking about the possible solutions to that, I wonder if maybe we start with you, Dr. O'Brien, is a policy to invest more in education and re-skilling one of the answers to this that could help bridge the disparities that we see between the haves and have-nots.

>> ROURKE O'BRIEN: Great question. I definitely think it's

part of the answer. But I really want to stress that it's part of the solution. Because I think one of the problems if you kind of look at the evolution of policy discourse over the last three decades it was this kinds of push for globalization will be good for the United States going to expand the pie. Then there is always a dot, dot, dot and perhaps as long as we make sure we share the pie more equitably and throw in education and retraining it will work out. I think there are obviously some populations, especially if we start targeting young people in those communities where jobs have disappeared, yes absolutely. Investing in education and skills training is the answer. But when we think about folks who are, you know, in middle age, in mid-life who have been kind of in a certain, you know, blue collar occupation their whole life, that job disappears right, you know, I think if our answer from the Federal Government is how about you go out and become a software engineer, I think folks hear that and it falls flat. That's why it's trying to think about how we not only invest in people but also really do invest in the communities. How do we make sure that when a plant closes and those jobs disappear that doesn't also turn into the kinds of falling of the dominos with a declining tax base. So then the school system is hemorrhaging jobs, police and fire and public agencies. Trying to think as we have ebbs and flows of private investment how do we make sure that our public sector investment can kind of, you know, expand and contract to meet those needs. Trying to think of ways to buffer these communities and not just make it so much about sorry you lost your job it's an information economy go get some new skills. I think that's part of it, especially for young people, but I think we need to start becoming more proactive, especially for these cohorts who are really hard hit.

>> STEFANIE ILGENFRITZ: I don't know did anybody else want to speak to that issue of policies to re-skill.

>> KOSALI SIMON: I just wanted to weigh in on this because I think it is a really important point about the lifecycle stages which investments get made. To think of trying to address problems in wage policy or redistribution afterwards is sort of it's after outcomes have occurred. Whereas attempting to intervene at early ages in education, it's like setting up the stage for us not needing to have policies later on right. If we're very successful at being able to have skills that even if job markets and economy-wide changes occur that people have skills that are resilient and can sort of absorb the new shift to where the new opportunities are. So the stages at which to invest in and really thinking about policies that have been successful at alleviating childhood poverty and giving equal opportunity increases that come at formative stages I think is a very important area to think of.

>> STEFANIE ILGENFRITZ: I'll ask one more question before we turn it over to the audience. We have a lot of questions

coming in. A number of you also spoke about one of the big changes in the last generation is, you know, a movement to have more people insured, reduction in the uninsured, but also a big movement to more and more government provided insurance which is ironically increasingly privately run. And I wonder if we can talk about the tradeoffs of more insurance but, you know, at what cost. I think Dr. Duggan you spoke about that. Maybe you could get us started on that.

>> MARK DUGGAN: Absolutely. Thank you for that question. It's something that yeah I've thought a lot about. And I think there can be tremendous benefits to expanding health insurance coverage. I have some recent research and a number of others have done this that basically when people have health insurance they tend to get better care and that tends to lead to improved health outcomes. I do think it is -- one thing that I really agree with so much of what has been said about the need for more investment in education and so forth. But I do think this health insurance price tag is going to keep growing for the government. So we haven't talked much about demographic change in the country and what's on the horizon. But I worry a lot. I stay up at night sometimes thinking about how are we going to do much if you think about right now a $1.7 trillion federal deficit when unemployment is pretty low and our demographics are better than they'll be next year, five years or ten years. So I think that Medicare is going to just grow more and more. Medicaid is likely to grow as states like Florida and others may embrace Medicaid expansion. So the role of government in health insurance is likely to grow. But I think it's going to create a lot of fiscal challenges. Like I really don't know where the resources are going to come from to do this. At the federal level it's tough. At state level as we go increasingly, you know, look at California versus Texas. Two completely different models to this. And it is -- and that poses challenges to the extent that people strategically migrate. A number of states now are trying to finance let's say expansions in their health insurance or in the quality of their health insurance. We talked a lot about coverage. We don't talk much about what it means to be on Medicaid. How good is Medicaid versus how many people are on Medicaid. We tend to focus on the latter than the former. But I do think public health insurance can deliver tremendous benefits. But it is -- I think that the financial constraints are pretty first order. I would really like it -- I'll just say one thing. I'm here in Silicon Valley and I think about all the amazing ways that technology and AI and so far is transforming the productivity of the private sector leading to all these improvements. I would love it if key would figure out a way to leverage technology to improve programs like Medicare and Medicaid somewhat more. We get a new drug here and there but they're just not fundamentally changing. I think we as a nation may find ourselves needing to do more with less. Just as the

workers to retiree ratio is going to fall and fall and fall and fall and how are we going to finance this growing role of public health insurance. I think it's going be a huge challenge and I don't know how we're going do it.

>> STEFANIE ILGENFRITZ: Dr. Simon, you also spoke about the value of improving your health insurance coverage so what why your thoughts?

>> KOSALI SIMON: I think that's absolutely right what Dr. Duggan has been saying that we have problems and we haven't thought about how we're going to be managing these as these challenges become greater in the future. One other factor happening is that that healthcare and health insurers then, what we're expecting as the rule of what you cover and what healthcare is responsible for is growing as we start to put more of the social determinants improvements into that realm right. So it's not just your -- and I think it's for lack of where else to put that right. Because this is the area of growth. This is where insurance coverage is having been expanded makes this a possible vehicle. But, you know, in an ideal setting it's somewhere else that we would be pushing for the improvements in social determinants. And then saying okay healthcare just figure out how to do things efficiently and get the financing right and don't, you know -- we put more into the challenges that healthcare has to grapple with I think by doing this.

>> STEFANIE ILGENFRITZ: I'd like to turn to our audience. The questions are piling up. So I'm going to jump right into the list we have coming in and start with Janelle Coleman. Her question speaks to some of what we've just been talking about. Could the argument be made the burden of health expenditures has been shifted to the individual despite the expanding access to health insurance? That's a really fascinating question to me. We have more health insurance coverage, more spending, but people feel like their out-of-pocket cost in their own situation has not necessarily improved. I don't know if, Dr. Simon you want to continue your thoughts.

>> KOSALI SIMON: Clearly there's been more attention to how financial costs are, first of all not very transparent. And that's another issue in how well can the economics of choice work when there isn't as much transparency in where the costs truly are. But another is that there's more evidence of how toxicity in financial situations. So if you end up with debt, that can really affect other aspects of your life. That again is a social determinant. It's also more apparent with research how sensitive we are to even small out-of-pocket costs and that changes the way we thought about how cost sharing would be something that constrained cost. Instead we're encouraging reductions in cost sharing because it stops us from receiving care when pursuing care. So I think that what it means to be, to have financial responsibility both for financial protection that then affects other aspects of our life but also what the

assumptions are about how to do cost containment are evolving and changing to the future will not be what we thought of in the past.

>> MARK DUGGAN: Can I add one thing. I think the financial distress is, that's there. But I think also the emotional distress for people to navigate the system and figure out what providers they can go to. That is just changing -- it is a harsh world. Things are changing from one year to the next. Every year insurers are negotiating with providers. Providers get kicked out of a network so you've got to figure out what do I do now. Insurers that are contracting with an employer change. So people have to change insurance. It's a harsh -- and people are finding it harder and harder I think to navigate that system. And that burden is borne most by the most disadvantaged. Because a program like Medicaid as much as it ensures ninety plus million people and that's wonderful it reimburses less. So you see doctor after doctor, hospital after hospital just saying we can't do it anymore. We can't treat Medicaid patients. And so you have -- even though we've had this, you know, remarkable expansion in coverage, I don't know that we've looked enough at what that's done to the quality of that coverage. It's really hard for people whose insurance isn't super generous to just navigate, find where do I go. And I think people are on their own in the system. And I think that's harsh.

>> STEFANIE ILGENFRITZ: Any other thoughts on that? We have more questions to get to and I can jump right in. Here's a question that speaks to, I think, some of the misaligned incentives in health care that don't necessarily always shift our resource towards prevention. Sheila asks, how are the trends of hospital privatization and the higher compensation for specialists doctors which discourages medical students from enrolling in primary care being addressed in the context of health care provision and economic impact? Specialists make all the money. The people who try to keep you healthy, not so much. That's my rifting on the question. I'll start with Dr. Brown-Podgorski. Do you have any thoughts on that?

>> BRITTANY BROWN-PODGORSKI: Very brief thoughts. Some states do try to incentivize primary care providers to come to their area via loan repayment or -- especially loan repayment. That's the big one that comes to mind for me. There definitely is the attempt to incentivize. But it's still something that I think is still way beyond just the repaying of loans for sure. But that's the scope of my knowledge on that particular incentive.

>> STEFANIE ILGENFRITZ: Dr. Duggan, you spoke about the privatization of hospitals. What are your thoughts?

>> MARK DUGGAN: I think it's fascinating to me that this has been unfolding in states and cities throughout the U.S. that basically governments are getting out of the business of running hospitals. They just don't want to deal with it anymore. It's

complicated. A drain on energy. They want to focus on other things. And that is increasingly leaving many communities without public hospitals that have often been considered the places of last resort. I think the compensation of physicians is a really important area and under studied area. But it's well-known to every medical student there's huge variation depending on what specialty they choose with respect to what they can earn in the future. As an economist I am very much a believer that people respond to financial incentives. People in primary care, it is a complicated set of reasons that we could spend an hour and a half on. Why is it the case that primary care is so much less. There's so much less financial incentive to do it. It's complicated. I don't have good answers. I do think we need to encourage more medical students to enter primary care because it's so important. I think primary care physicians are really well positioned to help be an ambassador, help patients navigate this just really complicated, opaque health care system. And I think they could do great things if they were rewarded more. But it's complex. I don't have any simple like let's just give everybody hundred thousand dollars a year more and that will so solve it.

>> BRITTANY BROWN-PODGORSKI: To my earlier point and a comment that was made in the chat with the loan repayment opportunities or forgiveness opportunities there's also the requirement that you work in a specific area for an established amount of time. And we know burnout is an issue. So if you are assigned to an area that has lower resources, higher stressors, there may just not be enough, having your loans repaid may not be enough of an incentive to deal with that for five, six, seven years.

>> KOSALI SIMON: I want to connect this discussion to something else I saw in the chat which is that health care workforce issues really important to think about why it is that the rates we have, why the salaries are in the directions they are also has to do with scope of practice and limitations we put on what one has to have achieved as an educational degree and training and where in order to do what. And so if there are, and there are again state laws that try to change this to say what is practicing at the top of your specialty like that is you're trained actually to do a lot more than perhaps you are legally licensed to do. So we could be re-allocating who does what in ways that will lead to changes and incentives for more people to be in parts of healthcare workforces that are not as highly compensated currently.

>> STEFANIE ILGENFRITZ: To follow up on that, the shift away from maybe having physicians deliver so much primary care and shifting more to nurse practitioners and physician assistants. There's a tradeoff there. But do you think that's a potential solution?

>> KOSALI SIMON: Yeah I think that relaxing the scope of

practice, it seems like lots of research that suggests that is, you know, something we're going to have to think about as there aren't other easy solutions to these workforce, healthcare workforce challenges. But there was a comment in the chat about how, what do we think about the scope for nonprofit health insurance companies, or nonprofit health care sector. We're seeing it as Dr. Duggan was talking about shifting so much into private. And within private even to venture capital and ways of really, really so much leveraging of capital. It's because of the complexity. We had in the Affordable Care Act an opportunity to have nonprofit insurance companies be on the same playing field right. And it just didn't work out because I think of the complexity of the issue that it is not easy to solve without having a lot of financial backing.

>> STEFANIE ILGENFRITZ: I think this next question in the Q&A section speak as little bit to that issue of public versus private. An anonymous attendee asks -- it is a pretty basic question but provocative one. What are sources that could provide increased funding for social safety nets? Who wants to take that one?

>> ROURKE O'BRIEN: I'll dive in. I just want to piggyback on one of Professor Duggan's points. As we think about investing more in social safety net which we need to do desperately in the twenty-first century it's going to bring these federalism questions to the forefront. What is the role of the federal versus state and local governments and this kind of federal-state division of responsibilities. We've seen a lot of expansion at the federal level through the ACA, through the Medicaid expansion. But the states play an incredibly important role. One of the things we don't talk about, about the ACA expansion is that states are still on the hook for ten percent of those increased costs going forward. Wealthier states like California, New York, Massachusetts that was a no-brainer. Of course you take ninety cents on the dollar. But places like Alabama, Mississippi that do not have the wealthy tax bases, the fiscal tradeoffs there, the budgetary bite bites a lot harder there. So we have to think about going forward as we see increasing inequality between households, also increasing inequality between places. That the Federal Government is going to have to play a bigger role either directly financing income support programs or more effectively and aggressively subsidizing poor states and localities if we're going to require them to do that work. Because right now we have this system where we're getting pulled apart where wealthy states have the ability and resources to tax to make those investments in poorer states do not. It matters at the state and local level. Those budgets have to balance every year. Whereas the Federal Government for better or worse can run those deficits. We think about where electing this conversation and where the potential for new money can be, we really have to be thinking about both

the Federal Government as an initial kind of funder but also being an important backstop for states as they're becoming increasingly unequal.

>> MARK DUGGAN: A lot of states, to get to your point, are also just to build on what Professor O'Brien was saying are using, trying to implement wealth taxes. So you see a lot of people from Silicon Valley gazing out the window thinking about how wonderful life would be if they were in Texas with zero tax or Washington State with zero state. Washington State implemented a capital gains tax. Which really freaked out a lot of very high income people who are now thinking like maybe I want to move out of Washington. So I think one thing that's really first order, you want to talk about raising serious revenue through state and local policy, state and localities need to be strategic. Because people will move. Companies will move. So I do think I agree that if, you know, if you want to think about this federal government is often more well positioned to think about redistributive policies than state or local policies. But just look at the Federal Government right now. I mean look at the budget situation. It is like unbelievably bad. And I don't know, like I just think there needs to be -- if something's going to happen here there's going to need to be a pretty major shift in the national discussion. And it will be interesting to see. But I think that the aging of the baby boom is going to create -- however hard it is today it's going to be harder in a year, harder in three years, harder in five years financially. And I don't know what we as a nation are going to do. Are we going to talk about moving more of our federal expenditures to investment rather than transfers. Anyone who wants to talk about touching Social Security or Medicare, it's like whoa, not touching those. But anyway so I think it's a conversation that we need to have and not demonize people with one sentence bumper sticker -- like, you know, we got to discuss it because it's a hard challenge. I think if the country would come together -- I think the country could come together to solve it.

>> STEFANIE ILGENFRITZ: You both talked about government solutions for the social safety net. But what about the private sector? Is there a role, increasing or diminishing role from the private sector in the social safety net?

>> KOSALI SIMON: I think like in healthcare what we're seeing is that the government is setting up the financing mechanism but that the provision itself is private sector. So in that sense there's private sector involvement. Managed care taking the role that the Federal Government did in Medicaid and Medicare being a primary example of that. But I think also in other areas the delivery being in the private sector is trying to harness the, you know, is there efficiency from paying this, paying in ways that will put the incentive on to private sectors to deliver more with the same dollars.

>> MARK DUGGAN: I want to give a little bit of a -- I mean I don't study the retail sector that much. But I do want to give a shout out to places like Amazon, target and Walmart that put in place voluntary minimum wage. That doesn't really bind in a state like California or New York but does bind in places like Texas and other states without a minimum wage. I think that that is, you know, many people here have talked about the effects of income on health. Because income can buy you better food, safer housing. You know, just can help in all sorts of ways. And I think that that's not in the health care sector necessarily but I do think some of America's largest companies are stepping up in ways that I think, you know, should be applauded. And maybe other companies will mimic that, too.

>> STEFANIE ILGENFRITZ: So you all have spoken quite a bit about the differences among states and how that experience depending on where you live can vary so much. This next question speaks to another kind of disparity. From Margaret Grady who says, certainly racial disparities are striking but so are rural/urban despairs. Those intersect with economic opportunities and health infrastructure like hospitals and policy which is often bias towards urban areas structural racism. I wonder if one of you want to start speaking to the whole urban/rural issue which intersects with the depths of despair. But certainly even just access to hospitals varies widely between urban and rural right.

>> KOSALI SIMON: I could maybe start that off by saying that this is really a global issue. When we look at where there is fast economic growth and opportunity, things tend to be concentrated in cities right. So people go to where opportunity is. But then there becomes, like we saw during the pandemic there was this exodus of oh there are also negative aspects of being in very densely populated areas and not being able to enjoy. Technology now allows us more of those types of benefits that you don't have to be physically in a place as much as before. So I think it's going to be interesting to see as technology -- you know we just had such a rush of the types of technologies that enable us to not be in that close proximity that was needed. So that was the rise of cities. Now is it that we're going to see more opportunity develop in rural areas because of that. In health care there's always going to be proximity issues. There's some things you just can't have. Even though Telehealth is changing that there is still the need for that to be very approximate. So some areas where there's limits to how much we can think technology can solve the rural/urban issues.

>> STEFANIE ILGENFRITZ: This next question comes from Kaitlyn. A lot of the time economy and health are pitted against each other. We saw this with the pandemic. How can we better communicate the positive links that we are on the same team. Particularly with populations losing trust rapidly in public

health? Dr. Brown-Podgorski I'll start with you.

>> BRITTANY BROWN-PODGORSKI: Just to keep it concisely, just being able to communicate that inequities affect all of us. It's not just those who we may or may not have preexisting ideas about. It really affects all of us. I think it's going to be kind of the first step. If we're able to make that, do that communication consistently, I think that will definitely be important to jump start things.

>> MARK DUGGAN: I also think that the public and perhaps nonprofit sector combine needs to -- we really need to raise its game in this country and get better over time at coordinating. I'll just give you an example of in California over the last eight or nine years homelessness has increased by fifty-one percent. And it is an area where it's really, you know, some really struggling people, lots of kids too, not just single adults. And it is just appalling to me that in aggregate state and local agencies are just all -- they seem to be work across purposes. They're not coordinating. Data is siloed. You want to just ask any even basic question about how are our homeless people doing today, how are they changing over time, how are their kids doing in school, have they recently been incarcerated, are they in Community College, are they, you know -- were they hospitalized with a drug overdose -- all these agencies are operating in these silos that are blindfolded and are not working together. And I think the public sector, and everyone, tons of well-intentioned people that really have their eye on the ball and are trying to help, but it's just incredible to me. You know, I'm trying to do some research on the California homelessness thing and I've been so impressed by many of the people I've met. But just these bureaucracies that don't work well together. And this problem is just, has really spiraled out of control and no one's in charge. It's just very frustrating. That's just a case study. This is not unique to California. This has been an issue in lots of cities, lots of states throughout the U.S. But I think the public sector, it just has to raise its game. Like if you think about how much better -- say what you will about a company like Amazon. You know, whatever. I order from Amazon all the time. The retail sector has just dramatically improved over time from the perspective of consumers with technology and so forth. And the public sector just is not doing it. And we have to demand that from our elected officials. And hold them accountable. I think a lot of people look forward, this is what I want to do, and too infrequently do leaders and the people in their government say, let's look back and see how we did. How did that work. We did this policy, we pushed it through, let's see how we did. There isn't much of that. We're always looking ahead trying to create some new thing and I just think it's really -- the public sector desperately needs to raise its game on this stuff and work together as opposed to cross-purchases.

>> STEFANIE ILGENFRITZ: How fundamental a problem is that thinking about trying to enact all the policies you are talking about and make them successful if we don't have trust in public health?

>> BRITTANY BROWN-PODGORSKI: I think that's the big question going forward especially as we're seeing this alarming kind of distrust of identified or equating, you know, our personal beliefs and feelings and what we've known for a fixed and matter of time and equating that with actual evidence. But then we're going to have to continue to really juggle that for a while when it comes to scientific evidence and evidence-based policy changes.

>> STEFANIE ILGENFRITZ: On that note I think we are out of time for the discussion. Thank you all for a really stimulating dialogue. I will turn it back over to Dean Galea.

>> DEAN GALEA: I'm here to echo thank you. What a terrific conversation. What a terrific set of questions and comments in the chat. I think my simple takeaway is a comment one of made which is none of this can reduced to bumper stickers. I just thought the nuances that were brought to how difficult this is but actually how critical it is to anybody interested in health made an excellent conversation.

To all of our panelists and everybody in the audience, thank you for participating in the conversation and thank you for everything you do. Everybody, have a good afternoon, evening, morning. And best to all of us in 2024 which looks to be an interesting year. Everybody take good care.
(Webinar concluded at 2:29 PM ET)