FINISHED TRANSCRIPT

BOSTON UNIVERSITY
AFTER THE ELECTION: WHAT'S NEXT FOR HEALTH?
NOVEMBER 20, 2024
11:45 A.M. CT

Services provided by:
Caption First, Inc.
P.O. Box 3066
Monument, CO 80132
www.captionfirst.com

This text is being provided in a rough draft format. Communication Access Realtime Translation (CART) is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings. This text, document, or file is not to be distributed or used in any way that may violate copyright law.

>> AUTOMATED VOCAL: Recording in progress.

>> MICHAEL STEIN: Good afternoon.

My name is Michael Stein, and I serve as Chair of the Department of Health Law, Policy and Management at BUSPH.

On behalf of our school, welcome to today's Public Health Conversation.

These Conversations are meant as spaces where we come together to discuss the ideas and issues that matter most for health.

Through a process of conversation and debate, guided by expert speakers, we work to build approaches that get us to a healthier world.

Thank you to the many who helped make this conversation possible.

Thanks, in particular, to Deans Fallin, Godwin, Goldman, and Pettigrew for joining us today.

And thanks to the BUSPH Dean's Office and our Communications team, without whose efforts these events would not happen.

This event is part of our fall election series where we are

engaging with leading thinkers for conversations about the election's implications for issues that matter for health.

Throughout the semester, we have hosted conversations about migration, Medicaid policy, reproductive rights, violence prevention, LGBTQ rights, and violence prevention.

At these events, we discussed these issues in the context of a hypothetical Harris or Trump Administration.

Now the election's outcome is no longer hypothetical.

The prospect of a second Trump term poses many challenges for health.

Today we will discuss these challenges, as well as the opportunities in this moment to build a healthier world despite uncertainty.

We have the privilege of being joined by deans of schools of public health from all four regions of the U.S. for a conversation about what the election means for the future of population health in the country.

I look forward to learning from all our speakers over the course of this afternoon.

I now have the privilege of introducing today's speakers.

First, we will hear from Daniele Fallin.

Dr. Fallin is the James W. Curran Dean of Public Health at the Rollins School of Public Health.

With more than 250 scientific publications that have been cited more than 22,000 times, her globally recognized research focuses on applying genetic epidemiology methods to studies of neuropsychiatric disorders including autism, Alzheimer's disease, schizophrenia, and bipolar disorder and to developing applications and methods for genetic and epigenetic epidemiology, as applied to mental health and development.

Then, we will turn to Hilary Godwin.

Dr. Godwin is dean of the UW School of Public Health and Professor in the Department of Environmental and Occupational Health Sciences.

She is best known for her interdisciplinary work elucidating the mechanisms of lead poisoning and the impacts of nanoparticles on ecosystems and human health.

She is deeply committed to promoting the health of all people, locally and globally.

Third, we will hear from Lynn Goldman, the Michael and Lori Milken Dean and Professor of Environmental and Occupational Health at the Milken Institute School of Public Health at the George Washington University and the former Assistant Administrator for Toxic Substances at the US Environmental Protection Agency.

A pediatrician and epidemiologist, Dr. Goldman is a renowned expert in pediatric environmental health and chemicals

policy.
Finally, we will turn to Melinda Pettigrew.
Dr. Pettigrew is the eighth dean of the University of Minnesota School of Public Health, a position she has held since December 2023.
Her research focuses on the epidemiology of respiratory tract infections, the microbiome, and the One Health threat of antibiotic resistance and she is nationally known for her research and leadership in her roles on the steering and executive committees for the Antibacterial Resistance Leadership Group.
Thanks for being here.
As a reminder for our audience, following individual presentations, we will turn to a moderated group discussion.
When we have about twenty minutes left in the program, I will turn to audience questions.
Please submit questions using Zoom's Q&A function, located in the bottom middle of your screen.
Dean Fallin, I will now turn things over to you.
>> DEAN FALLIN: Thank you so much. I will take just a moment to start sharing my screen and adjusting it.
All right. Are we all seeing the right thing now?
I trust someone will unmute and let me know if that's not the case.
Thank you for having this discussion with us. I know we're thinking about strategies and what the future holds. So it's wonderful to have you all here and join in our discussion today.
We, at the Rollins School, had a discussion last week led by students.
The top right of this slide is just reminding you that the students asked us to talk about climate, reproductive health, global public aid and global health work. My colleagues are going to talk and this topics, but it's top of mind for many of the trainees and faculty and staff.
What I hope to do in the next few minutes is just touch on different areas that I think we're think about from health equity to in fact, disease. I will spend a little bit of time on misinformation and mental health.
All of these are kind of shaped by our concerns over changes in federal agencies and critical supports like from the ACA and Inflation and Reduction Act and others.
I'll talk about where we might head next.
So I want to start with health equity. I think probably many of you, if you joined this call today, are very interested in public health and very aware that care is not equally distributed or available in this country or across the world.
The benefits of discovery and innovations that we've all

seen and some of us have been a part of are really incredible but also not available equally.

Then, lastly, policies or consequences of bad policies are also not distributed equally.

And so our marginalized communities are often the ones who have the most harm when there's bad policy or the least advantage when we're able to distribute good policy or discoveries.

And this slide just shows some of the ways that we can envision this.

They span everything in public health from the health effects of climate to the challenges of reproductive health and rights, cancer prevention, insurance access, you name it. We recognize that communities of color, that rural communities that, indigenous communities, LGBTQ communities, and many of these different aspects are unequally affected.

And so when we think about what may happen next, in the next administration, I'm thinking about how those things might be amplified.

I want to, first, start by saying that there's been a lot of great work in the last decade, in particular, holding federal agencies accountable and thinking about metrics and measures of accountability that are part of many of the agencies we work with and that provide support in our communities.

We want to continue to amplify those and make sure those continue to work for us.

When I think specifically about some of the proposed changes about things like ACA support, Affordable Care Act support, or federal aid. Some of those are frank reductions. There are work requirements and things that have been proposed. We've seen that create red tape and limit access that is disproportionate among our communities.

I'm interested in looking at that as we move forward.

Another area that I think is worth mentioning and commenting on in a group like this is just the success of vaccines. One of our great public health stories has been the discovery and innovation that's happened over the last 200 years in terms of infectious disease and so forth.

This came from the "Wall Street Journal." This show what is their case rates looked like before and after vaccine introduction in the U.S.

This is highlighting two of those, but they provide even more of those. I put them up here because it's a good reminder that vaccines save lives and reduce disability.

There was a recent MMR paper that had data from '94 or '95 up until 2023. It showed really great numbers that speak to that point that I just made. Nine vaccinations have reduced or

prevented a million deaths, something like over 30 million hospitalizations and, importantly, saved over $500 billion in direct health care costs.

So we need to keep making those arguments.

Since I am here in Atlanta, I've had the opportunity to get to know Bill Fage and looked into the smallpox vaccinations. 300 million people died of smallpox before global eradication.

We should be shouting that from the rooftops in the best way we can.

We're in a moment of skepticism, which I think is where a lot of questions are coming. I'm an autism researcher. I see the skepticism. We see lower rates of coverage often due to the skepticism and a weaning of best practices in public health with respect to infectious diseases.

We have these beautiful gains, but we cannot take our foot off the pedal in these kind of public health strategies.

Unfortunately, we see what happens if we do that and when we have lower herd immunity or not following best public health strategies, we can start to see resurgences of some of these preventable diseases.

So I think our strategy moving forward should be telling the stories. Tell the stories of people suffering from polio or worried about their children getting polio. Tell the stories of people suffering from measles or other outbreaks.

Continue to practice the sound public health strategies.

And combat misinformation. I will say a little bit more about that, but, also, I can't emphasize this enough. Do this in a way that doesn't alienate or demonize folks that feel different. A lot of times, it's a result of having inappropriate information.

So that's where I think communication is a huge thing we all need to be paying attention to.

Our ASPPH organization as well as the (indiscernible) foundation and many of our schools and programs of public health are thinking a lot about communication strategies. I think some of the lessons learned are: Let's do things that are easy to understand. Let's actually make them entertaining. Meet people where they get their content and partner with influencers, use better tools for AI, et cetera.

So I'm really glad to see we're forming a lot of different strategies around communication.

And then, lastly, I wanted to talk about mental health.

So this was a poll that was amongst Georgians last year. It was remarkable to me that when we just asked folks: What are the health issues you think are facing Georgians Today? the top two or mental health and Substance Abuse Disorders.

Those were different answers than the Georgians before.

It's different across the U.S., particularly post pandemic, but, in general, the increase and awareness of experiences of psychological distress.

I can cite statistics around this. I won't do that in the time we have, but I want to highlight one of the areas, emerging youth or adult mental health. The Surgeon General has talked about this, and many of us are focused on this.

When we think about things that could happen as we move to the next administration, I'm paying attention to things that are relevant in that space, like socio-emotional learning in K-12 education and access to psychology and psychiatric care.

Suicide in this country, firearm safety has to be a part of the discussion. When we're in the crisis of mental health, it would just be really devastating to not focus on some of those areas of policy and action.

Certainly the federal agencies that do work like, this such as SAMHSA and IMH, CDC, many, many others, we want to pay attention to how they're addressing this.

Lastly, I will say that's the state of mental health or public mental health, but when we think about the election or the polarization in society itself, we're creating and having to handle higher levels of psychological distress. Some of my colleagues are going to talk about this. It was interesting to see a report a couple of days ago talk about the Trevor Project, which is a source of support for the LGBTQ community, where they saw an increase of 700% of folks contacting them for support the day after the election.

So we have communities who are particularly worried about what happens next in public health that are really suffering psychologically and otherwise right now.

I think we need to give ourselves the capacity and skill-building to really reach out and to build bridges or directly address this polarity. So we've been doing some things at the Rollins School, training all of our folk, building fellow programs, and engaging in small-group dialogue to help build those skills, which I think are going to be incredibly important for those of us in public health as we move into the future.

I will end by saying that what I've been thinking about is we have a lot of places to keep our eyes on. I'm framing it as these places are also an opportunity to shape what is next if we can look for common ground. I'm trying to listen hard to others so we can build those bridges. I've been really promoting a concept of what I'm thinking of as practical public health.

This idea that, yes, we want to continue to advocate for change, particularly if there are constraints that we're concerned about and do come to fruition. If they even come to fruition, there are things we can do to work in the lanes were

given while also working to change the lanes. We don't have to choose.

So that's what I will leave you with.

Thank you so much for the time.

>> MICHAEL STEIN: Thank you very much, Dean Fallin.

We are off to a great start.

So up next is Dean Godwin.

>> HILARY GODWIN: Yeah. Thanks so much.

Daniele, I couldn't agree more with everything you said. That was really a wonderful introduction.

So one of the things I wanted to talk about is how we make sense of all the different changes that we anticipate happening.

I think, you know, during the last Trump Administration, there was a sense of overwhelm. This time, we have both details in terms of campaign projects but also on Project 2025 that provides inputs into what we can reasonably anticipate. I think it's important for us to start looking through those and, as Dani said, looking for opportunities for alignment with goals but also looking at where we see the greatest risks to the public's health and then collectively focusing on those.

So the approach that I'm taking, would it surprise anyone to know that I come from a mental health background? It's sort of what I call a risk-banding approach, which is to look at both sort of recall your environmental health 101. Looking both at the likely magnitude of the impact of different proposed actions or changes or policies on the public's health as well as the likelihood that those proposed changes would actually go into effect.

And in terms of the potential impact, I want to name that the potential impact differs -- or relative differential impact differs regarding what is being focused on.

In general, I've been thinking about the magnitude of the impact on the U.S. population as a whole and the global population, but I also separately am keeping in mind that we also care deeply about the magnitude of the impact on vulnerable populations. And so I think that's another critical lens, and another lens can also be what is the magnitude of what we're all doing as public health professionals or in academic public health because our work is devoted to improving the health of populations. If we're unable to do our work, that, too, will have impacts on the health of the populations that we serve.

So probably the most common question I've been getting over the last couple of weeks has been: What might happen to Apple Health, which is the name for the Medicaid program in Washington State?

I think, more broadly, what will happen to Medicaid programs in different states?

Here, I think it's important to touch on sort of the context. One is that we have temporary federal subsidies for individuals buying their own health insurance that were extended as part of the Inflation Reduction Act, IRA. Those are expect to expire in 2025.

While those subsidies have pretty strong bilateral support, renewing them will require action from Congress. I think that's something we all need to keep on your radar screens.

A second issue is what will happen to Medicaid specifically, which is what I alluded to. And I think it's worth acknowledge proposals from several groups has included blocking funding to grants for states and also capping funding on a per capita basis. This would also require action from Congress.

On the one hand, this would provide greater flexibility at the state level. Whether or not that is a positive thing for your own state depends a lot on how your state program is organized currently and what future changes look like.

Also, the financial implications of this legislation will vary enormously from state to state, depending on how much of your own state's program is covered by federal dollars.

And I will put a link in the chat after I'm done speaking. People can go and look at potential implications for different states.

The likely impacts for states, like my own state, that have significant federal support for their Medicaid programs will require us -- if that kind of legislation goes through, to really make some tough decisions, decisions about whether or not the state is willing and able to make up the differences in lost federal support, and that comes at a time when we have other budgetary challenges in our state, as is true, I'm sure, in many other states, as well as the options to cut benefits or reduce eligibility.

This is clearly a sense of risk for the United States, especially states that have high poverty rates and individuals who have low income and who are dependent upon Medicaid for health insurance and state Medicaid programs.

The other thing that I wanted to touch on in more detail was something that Dani brought up, which is implications and likelihood of proposed government restructuring for public health and academic public health, in particular.

These are both prominent in Trump's campaign promises and Project 2025's specific proposals.

They call for the government workforce changes, to cut the workforce, including targeted cuts to specific agencies such as HHS, the VA, EPA, the FDA, and the Department of Education that play big roles in health benefits and safeguarding the nation's health and prominent roles in how we all do our work.

Currently, the majority of federal workers are in jobs that are not political appointments. This was an intentional shift that was made historically. For instance, through the Pendleton Civil Service Act which was created to reduce patronage and corruption.

And having the trend, for the most part, not be political participants, is to provide stability in services because we're a country that does rapidly go through changes, in terms of political parties that have power both in the legislature and in the executive branch.

So some of the specific components that have been put forward include consolidating and centralizing executive power to allow for greater adherence to the president's agenda and have workers be political appointees so the structure can be better aligned with the president's agenda and for the total number of individuals working in those agencies could be reduced in a short period of time.

While I readily acknowledge that those efforts are aimed at improving government agencies and giving greater agility, in the short run, I think we can reasonably anticipate that those types of changes will likely result in the work of many agencies that we are dependent upon for the health of our populations grinding to a halt and that we can simply expect to see, in the long run, both significant loss and critical expertise in the federal workforce and also less autonomy and politicalization of those federal agencies, both of which pose a threat to public health.

With that, I will turn it back over to Dr. Stein. Thanks.

>> MICHAEL STEIN: Thank you, Dean Godwin. That was fantastic. And I picked up topics for later on.

Next, Dean Goldman.

>> LYNN GOLDMAN: Thank you. We're in Washington, D.C., so we're closed to a lot of the action. We're also fairly sensitive that that are various people in the community with various points of view.

So I'm going to attempt to provide this in a factual way. I'm going to highlight issues that I think are particularly important because there's areas in which decisions can be made that are very difficult to back pedal or reverse over time.

And so I'm going to start with the issue of climate, air pollution, and health. Those who know me well know that I'm an environmental health person, and I spent my time in environmental health.

Here's the thing that I think is important to understand. With or without a change in administration, there's already a climate for changes in environmental health policy based on decisions that have been made in the last two years by the Supreme Court.

The Supreme Court has put forth new ways of looking at cases. One called them major questions doctrine, meaning that if a regulatory action -- and this is very vague, how they wrote this, and a lot of cases are going to come up under it because we're in the really sure how it's going to be bound by the courts.

Basically, if it's going to cost a lot of money that's going to provide a right to have a court review even where the law doesn't provide that right currently.

Reversal of the so-called chevron doctrine that gave agencies -- not just CPA but FDA and others -- the ability to interpret their laws as things change.

That has been reversed after 50 years of policymaking.

Another case called Loper Bright, which ties into these two.

This allows rules to be litigated regardless of statues of limitations.

This allows reaching back into cases that have been considered settled. And, of course, the decision to reduce the federal right to abortion, which has been taken to say, well, now it's turn to the states, but it's had major consequences for people.

So starting with climate where many of these cases came forth in the context of climate litigation.

But there's some other things that I think are quite salient when it comes to the incoming administration. One is that the Project 2025 report has plans that many of us in public health do not immediately tune into what these words mean and what the import of them is.

I want to make sure that people are aware of these things.

The so-called endangerment assessment, an easy way to understand that is that that is an analysis that EPA did that allows for regulation of climate gases under the Clean Air Act, that they are dangerous. Okay? And the so-called social costs of carbon report that says that this is costly enough, the carbon emissions, to the economy that if you are taking kind of a cost-benefit approach, that it's worth doing.

So Project 2025 says immediately those need to be reconsidered, dropped. You drop those, you take -- you knock the blocks out from under the efforts under the Clean Air Act to regulatory those pollutants.

Also -- and we hear about it all the time, pushes for unlimited oil and gas development rather than what has been a very deliberative transition to clean energy.

Again, this is not a concept we talk about in public health, but out makes sense in public health to say if we reduce the emissions of, for example, diesel exhaust, on the basis of

one pollutant that comes out of diesel exhaust that, the co-benefits -- there are other pollutants package reduced. We're seeing public gain because of those. Can you count that? The EPA has been counting that. The Project 2025 says no.

Other things people are passionate about, EPAs and environmental justice programs certainly are at risk.

And the entire suite of investments and green energy under the Inflation Reduction Act are at risk.

The reproductive health issues, many of these have been at risk because of all the court rulings that I mentioned a couple of slides back.

There are many cases that are moving through the courts to challenge federal government policy, FDA's approval of Mifepristone, the abortion medication. It has been challenged. The requirement by HHS to provide preventive reproductive services, like contraception and immunizations and HIV prophylactics under the Affordable Care Act has already been challenged.

Rules that CMS issued that required transgender care, there's a case that says it's not clear what you mean by that.

Sex should not include gender identity. It is what you are biologically assigned at birth only.

Another thing that the administration put forward requiring that contraception for minors without parental consent, there's more than one case but especially Lober Bright moving in from the state of Texas.

And the emergency -- if you go into an emergency room, they have to treat you if you have an emergency. A guidance by the federal government that that includes if the woman is pregnant and needs to have an abortion because the pregnancy is posing a grave threat to her health.

Remember that about one in four pregnancies terminates on its own due to spontaneous miscarriage or abortion. There are serious medical emergencies that have been challenged.

The point there is that these may continue to roll through the courts. The new administration is very unlikely to support these cases, to defend these cases in the way that the current one does.

Also, the new administration could make administrative rulings to make all of these cases go away.

They could rule in favor of the plaintiffs and all of these policies that had been promulgated by the Biden Administration can just go away.

The most difficult one being the FDA approval of Mifepristone, which would great a tremendously bad precedent, in terms of how FDA's science-based judgments are taken.

And, of course, the Dobson Pact itself has had an enormous

impact on patient care across the country where OB/GYNs in states that continue to have abortion bans feel they are unable to get care for their patients. They feel constrained in managing miscarriages, and they feel constrained in managing pregnant emergencies. They're very common. Pregnancy is an amazingly faulty process. It's amazing the rate at which it's not a perfect process biologically.

So the CDC is the other issue, and it's already been mentioned, but the idea of reorganizing the government, there are already people in Congress who have been talking about pulling all non-communicable disease programs out of the CDC, which would have a profound impact on how public health is delivered at the state and local levels across our country because the other federal agencies don't interdigitate into the public health system like the CDC does.

And vaccines, which has been mentioned, but we're already hearing about how the new HHS secretary who has been named has not been confirmed and may not be the secretary but has been making many statements that are critical of how the FDA has approved the vaccines, critical of the companies that make them, accusing CDC staff of doing things that are not correct, such as hiding data, which I have access to the public data sets, I think all of us do.

I think Dr. Fallin mentioned messaging. This is a message that a lot of my friends are doing, wearing these T-shirts in their practices. Vaccines cause adults.

While there are people who have a lot of concerns about the potential for at-risk affects -- I'm one of them. I've been part of the advisory affects to the CDC. I know they look at that very carefully and very critically, but that overall affects good health.

So what I worry the most about and to stop sharing and talk to you is things that can be done that are irreversible.

For any of us who have served in the government, we know that dismantling an agency like the CDC can be done overnight. It can be done overnight.

In the first Trump Administration, an agency that we don't think about, the Economic Research Service, was moved from Washington, D.C. to Kansas City. Overnight, they lost 50% of their staff, just because of moving them.

And they were not able to recruit those experts in Kansas City. They are still understaffed.

So rebuilding the CDC, if it's taken apart, would be very difficult.

To say the least, rebuilding our planet, if we don't continue to make progress on global warming, is very difficult. We can't reverse that.

If a woman's life is lost in childbirth because we cannot give her emergency medical care, we can't reverse that effect. I think it's those kinds of irreversible impacts that should cause us the most concern moving forward.

Thank you.

>> MICHAEL STEIN: Thank you, Dean Goldman. That was wonderful and scary.

Let's take our last speaker, Dean Pettigrew, why don't you take it from here.

>> DEAN PETTIGREW: Thank you. I really appreciate the opportunity to be here, and I really appreciate the comments from Dean Fallin on ongoing dialogue from Godwin with risk-banding and Lynn Goldman on talk about thing that are irreversible.

I think it's clear that we need to continue this public work and build on the successes we've had.

We really need to stay true to our missions and values. This is the Mission Statement from the School of Public Health here. We're a blue state in Minnesota. We're surrounded by red states.

There are people here with a range of values. We're not a monolith.

We're focused on advancing policies that sustain health equity for all, and I think we need to continue that focus.

I'm going to talk about a couple of points. One is the relationships between voting and polarization as determinants of health. I'm going to talk a little bit about infectious diseases and where we go from here.

In terms of voting and public health, voting is a social determinant of health. We talk about this, and voting is a determinant of health.

I want to reiterate that public health is political. Political determinants help create the social conditions and drivers that impact health. And people who are less likely to vote, even after adjusting for other factors, these are correlated with a lower likelihood of civic engagement. Civic engagement is a populated measure of how people are connected to their communities and elected officials has also been connected to better health outcomes.

So this is bidirectional.

Medicaid expansions have been shown to increase voter turnout among states that have expanded.

This shows interconnectedness between health, policy, and political participation.

If we think about this bidirectional relationship, then there are important health equity that relates to this.

Dean Fallin spoke about that briefly.

If people have poor health and other forms of social marginalization, they tend to not engage.

There's a feedback loop that's going to continue to affect public health.

This inclination to disengage, to stop participating and give up, it's really problematic. We need to keep involved and keep working with our communities.

And we focused a lot on what's going to happen over the next four years. Just as a reminder, a lot of this goes to the state and governments.

There will be elections coming up in two years, so I would like to keep this on the table and not wait four years.

We're at a challenging time. We have a wide range of issues. This is taking place in an increasingly polarized public.

We're in a state where opinions, beliefs, interests are concentrating at opposing extremes. And political polarization is a group phenomenon.

The ship is one that operates at the individual level. The challenge here is that once these beliefs become polarized, they become harder to change. We already know that things like gun control, abortion, COVID, whether systemic racism is a root cause in inequities, these highly polarized, and the way we talk about these issues may have to be a little bit different.

Institutions such as the CDC are also becoming highly polarized. So is trust is medical expertise. We have this us-versus-them mentality. It's something we need to get past.

My concern is about people disengaging. Polarization leads to avoidance behaviors.

25% of Americans say they avoid colleagues with different point of views of views. I'm worried about this getting worse.

Polarization influences how people view or react to public health threats. We saw this with COVID. People engaged in different health behaviors. This can have a real-world impact. There was an excess death rate, about 43%, in the United States, associated with COVID vaccinations. We need to look at this and where people are going to follow recommendations. Trust is going to be a big player here. This is going to help public health and agencies tailor care more effectively.

And the rhetoric can affect this by linking things to healthy or unhealthy behaviors. Again, wearing masks turned into a symbol of partisan affiliation.

This can affect groups engaging in behaviors.

There are also science and places where we agree that may become more polarized.

For example, we're seeing this already with fluoride in water. This is becoming a polarization issue.

So I worry about issues with chronic diseases, mental health. We have agreement on these issues. Opioid use, substance abuse, reducing infant mortality, there's agreement on these spaces now. My concern is these issues will also become increasingly polarized because we're getting our information from different sources.

So there's support for action on the part of the agencies, even in this highly polarized space. We can provide evidence of where we've been effective and then hopefully use these interests to build trust and plan for a more tailored communication related more to the polarized issues.

Again, we don't have the traditional past to rely on. There it's an increase in social media use.

As an action step, we need to learn how to communicate across these many, many different venues.

As a field, I believe we need to start increasing and integrating political data, data on polarization into our public health model. This means cooperation between our health experts and epidemiologists, as an example.

I'm an infectious disease epidemiologist. This work is challenging.

As Dean Goldman mentioned, this administration wants to separate the CDC.

There's data that would be separated from the policymaking entity.

This idea that the decision should be left to medical care providers and individuals sounds good on face value. Many of us have heard the "my body, my choice." We have to listen to these arguments, but this is especially challenging in infectious diseases because these things depend, in many cases, on heard immunity. We have to think about that in context.

As we think about how everything is connected, I would like to try to relate this to some of the other policy changes that are maybe not so health related.

So we've heard talk about mass deportation of undocumented immigrants.

Wisconsin, in the Midwest, is home to approximately 70,000 undocumented immigrants. And this is the conservative estimate from the University of Wisconsin. It's hard to get the total number, but there's estimates that there are (indiscernible) it puts the agriculture industry at risk and the food supply at risk. We're on the verge of an H1NS outbreak. This could be an important driver of behavior. People may stop seeking health care. They may fear discrimination and deportation, so they may adjust their behaviors and may not participate in surveillance efforts.

This includes students and those in the U.S. illegally.

Even if it's not carried out, it will lead to discrimination and other behaviors. We saw it with decreased health care utilization among children. Fewer well-child visits.

The CDC also funds the local and state health departments. 80% of the budget is provided by pass-throughs from the CDC.

So there's also important implications for global health.

And so two areas there, the global fund, it's public-private partnership with donor countries. It funds treatment for AIDS and malaria.

There are concerns that some of the funds may be cut due to the links with these organizations potentially or concern they're providing assistance for abortion-related services.

The WHO, there's a concern that there's a withdrawal. The U.S. provides 110 million manually. How do we interact with our partners around the globe.

Just a reminder, this is an image I love.

Students are concerned. People are stressed.

I worry about this lack of engagement. People wanting to stop reading the news. I think we have to take care of ourselves and get back in there.

I just wanted to acknowledge these concerns that are there.

We don't actually know what all of the specific actions are going to be. We're going to have to shift -- the governments are going to have to shift from rhetoric to governing. So some of these things that have been proposed may not be realized.

And we're going to have to prioritize and be proactive.

We cannot do everything all at once.

I think we're really going to have to think about what are our key priorities. Some of these will be determined by the strengths of the various schools of public health and the needs of the local communities.

I think, in terms of public health and what we can do next, we need to continue to advocate with our legislators. This is a class here from the University of Minnesota where students are going to talk to their state legislatures. We have to maintain our ties to the community to maintain the trust. We have to restore trust in public institutions through greater transparency and accountability. And we can do better with a field of (indiscernible) it's a process and correct things when we make mistakes, and we have to do more about explaining the why of what we're doing.

It's field we need to be open to criticism. We need to continue to develop epidemiologic evidence that will help affect policy decisions, and we're going to have to change how we talk about things. This is something I'm thinking act a lot. We have to tailor our messages, but I'm concerned in our push to modify and tailor our message that we don't lose sight. We cannot

abandon the most marginalized communities to sway the loudest voices in the room, especially when those are not evidence-based.

I think we can partner with trusted non-partisan institutions and messages.

Perhaps rather than focusing on the 5% that are not getting vaccinated, we focus on the 95% that are and tell the stories from a different lens.

Highlight the stories from the consensus and focus on the tailored messages that are more partisan.

I will stop there and look forward to the discussion.

Thank you.

>> MICHAEL STEIN: Thank you, Dean Pettigrew.

Thank you to all these speakers for their fascinating presentations.

I think we'll now move on to a moderated discussion. I will start us off with some questions for our speakers.

As a reminder, I'm going to turn to audience questions when there are about 20 minutes left or so in the program.

So submit your questions through the Q&A function. There are many, many that have already come in, quite wonderful ones. I will get to as many as I can when it's that time.

So let me start. Let me put this out. Starting with Dean Fallin and work through these.

These wonderful, wide-ranging issues that you've listed, you know, speaking about the many social drivers of health that could be changing in the months and years ahead and our fears.

Can we flip it over to begin? Let's flip it over. If you have an HHS secretary who gets chosen, what can that person do that would be good for public health at this moment? What is the best-case scenario? Where would you ask that person to move positively?

Then we can talk about the defensive maneuvers that you've begun to lay out.

Start us off, Dean Fallin, with that.

>> DEAN FALLIN: Sure.

So I think there's a lot we can do that's positive. I will start by just where I ended with the dialogue point. I think you mean positive but in the light of the election results, Michael. Is that what you're getting at?

>> MICHAEL STEIN: I don't think we know, exactly as you've said before, what is coming.

If we had a good, positive result here.

>> DEAN FALLIN: So I think the first is I think we are right to listen the our communities, approximately half of which voted differently than the other half.

So understanding where there are places for common ground

that could be done with rigor and with thoughtfulness at these agency levels.

DHHS is a huge organization that covers everything from our discovery mechanisms like NIH to our delivery systems, including Medicaid and Medicare to many things that are specialized delivery or research entities in between.

Thinking about particular actions that would meet this kind of diverse set of concerns and aspirations while applying scientific rigor and investing in expertise is where I would start.

I know that's a bit vague. I do think it's important that we acknowledge -- one of my colleagues said it's not a monolithic society or field of public health to acknowledge that diversity and then work.

One last thing -- sorry for repeating myself -- is when we do that, it still has to be done with rigor and with respect for the expertise that we bring to the table.

>> MICHAEL STEIN: Okay.

How about Dean Godwin? What do you think about that? Turn us positive for the moment.

>> DEAN GODWIN: Positive. So I think one of the positives they see coming out of the election results are a clear mandate to prioritize rural health, which, you know, granted I'm in the Pacific Northwest, and our catchment Basin is the whole Pacific Northwest, so that includes a lot of rural areas. So it's always been a priority for us.

I see this as an opportunity for us to really -- within the public health community, to jump in on really having conversations with rural communities about what their priorities are and working hand-in-hand with rural communities on implementation strategies.

Those, to me, seem like a really great opportunity that I feel like we have a clear mandate for and bipartisan support for. That, to me, is a plus and something I hope to see.

>> MICHAEL STEIN: Great. Thank you. How about Dean Goldman?

>> DEAN GOLDMAN: I may view things a little differently. I do not believe when people select a candidate on a ballot, that they are down the line saying yes to every single policy that candidate might put forward.

In fact, I know from a lot of research that's been done that many people make that vote on the basis of one or two factors that cause them to lean to that candidate rather than another candidate and maybe completely unaware of what the positions are or that they may feel that, well, I do agree, for example that, the abortion rights issue where you see a difference in how a state is voting about abortion from how they

vote on a candidate. Why does that happen?

The thing about a candidate, it's far more complex than that.

I think that it's incumbent on us to actually get into work with communities to understand how they feel about these things and what is appropriate in those communities.

Just as the first time when Trump was elected with a vow to completely repeal the Affordable Care Act. Now, it may sound negative to some people, that, well, there had to be a huge effort to get into communities and work with communities to find out if that's what people wanted.

It's not what people wanted. That's why it didn't actually happen, even though they voted for that person as the president.

I sees that as a positive, you know that, we have an opportunity to learn about what is needed in communities, that we have an opportunity to inform policymakers about those facts. You know, even if it's a matter of protecting things that have been won in the past, I'm not negative about that. I'm very positive about that.

What I worry about is giving up. I worry about saying, okay, well, you know, 51% of people here voted for X. That means we cannot do Y anymore. I don't think it means that.

It's very possible that we can continue to make a lot of progress on doing why because that's what people want, and all politicians do, at the end of the day, respond to that, even if that was not the position they took in their platforms.

>> MICHAEL STEIN: Okay. Thank you. I think we're leaning toward optimism.

Dean Pettigrew, do you want to give us a push?

>> DEAN PETTIGREW: Yeah. I don't have that much more to add, but I will reiterate what has been said by my fellow Deans. There are positives. There are areas where there's support, maternal child health, Substance Abuse Disorder, mental health, these are priorities. We've done a lot of work in this area already, and we'll continue to do this god work.

I think just continuing that and to storytell and to keep the dialogues open that's a space where we can have continued movement.

There's also been mutuals that people in the new administration want access to data, and they want data. So I think we need to hold ourselves and them to that.

A lot of these data are actually in existence.

And so I think being able to provide the data and our expertise and help interpreting the data and more information about what are good studies and how does the scientific process work, if we have this continued dialogue, the data is there. Folks are saying they want access to data. So we show them the

data and explain to them.

So ensuring that our decisions and policies are evidence-based, if we do that, I think we can be successful.

>> MICHAEL STEIN: So the data matters and speak of it.

Okay. Thank you.

Let me turn it, then, maybe a little bit. Since we have four different places in the country speaking here. You know, federalism has been one line of defense against some of the health impacts in the past. We saw it sort of play out through the ACA, with its patchwork effects.

Do you see federalism and the state-by-state differences -- since you're from four different states -- have an impact on what's coming? Will thereby public health sanctuaries in the United States? Are we considering an entire state a public health sanctuary? Is that the wrong language? Help me understand that again. Let's go down the list because I want to hear from all four corners here.

Thanks.

>> DEAN FALLIN: I can jump in to say, clearly we see a diversity of healthiness across the U.S. We can connect that to particular policies that might be state or even locally driven versus federally driven.

So there's something to your question.

What I was going -- what I smirked at a little bit, though, is one of my concerns, when we have these conversations, is this idea that, oh, if you're a public health worker or interested in public health, don't go to that state because it is an unfriendly state of public health because the need and the work to be done is just as important there and maybe even more so.

And so I get a little worried when we have this concept of moving to more or less friendly places for public health that we will further neglect the real needs of people in communities in states that don't have as strong or welcoming policies.

So it's not quite an answer to your question, Michael, but I just wanted to make sure I highlighted that.

>> MICHAEL STEIN: I think it's important to turn it over the way you did.

Thank you.

How about Dean Godwin? What do you think?

>> DEAN GODWIN: Yeah. I appreciate Dani's comments. I guess I would also say -- I mean, on one hand, I see federalism with public health being sort of a wonderful thing, but we've also seen many examples of where that creates huge disparities between states or between counties.

So it's a double-edged sword.

I guess I would pause it, perhaps. At least, in my state, I don't feel like our state is all of one mind. Right? So we see

such huge -- in our case and in many other states -- rural-urban divides, in terms of priorities. It's not like the state is a monolith.

I want to talk about us training our future public health leaders to be able to work in all of those different settings and to work effectively in all of those different settings, and that requires both the communication and dialogue skills and listening skills but also, as Dani said, the commitment that we need to make progress in public health in all of our communities.

>> MICHAEL STEIN: How about Dean Goldman? Anything to add?

>> DEAN GOLDMAN: I see many comments in the chat about this as well. We all care tremendously about health equity. Some of the states that have fewer policies providing access to public health and prevention services also disproportionately have people in the states with lower income that are more likely to be from minority backgrounds and more likely to have less education.

So there's things created by our system, and there have been things federally to try to overcome that. One of them being, of course, the Medicaid, the Children's Health Insurance Program, the basic levels of coverage that are provided for kids, the vaccines for children's program, all kids, the extension after that of Medicaid to pregnant women.

Now the Affordable Care Act, the fact that there's preventive care that is, at some bay suck level, provided to everybody, including mandates for certain preventions to be provided. All of which is subject to a challenge.

I also think that the women's reproductive health issue has been one of the issues that has led to some of these challenges when you have some of the religious groups saying, wait a minute, we don't want to mandate to provide these reproductive health services. One of the cases in Idaho where a Catholic group brought a challenge on the basis that they should haven't to provide care for health issues that relate to an in vitro-created pregnancy because, in their view, under their religion, a pregnancy has to be created by a loving relationship between a man and a woman and not in a petri dish.

So for someone like me who adopted my daughter, I love her. That's a loving relationship. It's a relationship that caused us to adopt our daughter. If a wedge comes into that kind of ability for the federal government to say these are mandated, then other prevention services would also be subject to the same challenge in the way that the courts are looking at these.

So the one thing I would say about this, Michael, is it's not new for us, in this country, to have a lot of variability in how public health is carried out. Also a lot of tension between

public health measures and freedom.

I think we teach public health 101 about the issues of individual liberty versus public health.

I remember earlier in my career people losing their jobs because of smoking bans that we now accept everywhere. People losing their jobs because of seat belt requirements, which, at that time, was felt to be an enormous interference of personal liberty.

So I think we have to take the longer view that when we have any mandate where people feel there's something we have too, get the vaccines for their kids to enter school, there will be people, because of the nature of our society and our value for personal freedom, who chafe at those requirements.

Time is important, in terms of being able to move through some of those changes.

That's what I would say, taking the longer view.

Maybe that's a positive point of view. I think it is.

>> MICHAEL STEIN: I like the longer view. These things take years and decades, but, let me move into some audience questions and --

>> DEAN PETTIGREW: I'm sorry. I just wanted to jump in on that.

>> MICHAEL STEIN: Oh, I was going to give you the first question.

>> DEAN PETTIGREW: I just wanted to jump in on that quickly. I agree with everything that's been said. I think about this through an infectious disease lens, though. We saw in the Ebola pandemic inconsistent guidance and advice by state. It happened during COVID. Infectious diseases don't respect bounders. I worry about inconsistent messages because it makes it harder to get these messages across about what are effective messages.

So I worry about this idea that we're in a certain state and it's safe and this is a good state and a bad state. There's many things that are national, like food supply. We're in this together.

I would like to say that, with our students, we can take a guide from our colleagues that work in -- they're working in places that are politically repressive and in communities that are not aligned, and we find a way to work in these communities because we have a mission, and we believe in the principles and values and health equity. So I think we can work more to figure out the messaging and how we work across these divides.

So I will let you ask your next question, then.

>> MICHAEL STEIN: Thank you for universalizing us again.

So the questions that are coming in are often -- a portion of them are like this.

How do you handle -- we're talking about evidence here. We all believe in evidence. We talked about data as an important starting point. But we have a large part of the population that says the data we provide is fake. It's fake news. What do we do? We talk about this with misinformation.

More specifically to bring it down to the individual level, folks are asking, well, if I'm in one of these states, I'm a public health professional in one of these states that has a strong resistance to evidence-based, communed-engaged, evidence-focused work, should I stay? How best do I do that without burning myself out?

Dean Pettigrew?

>> DEAN PETTIGREW: I think that's really hard. I think most of us went into public health because we had a light bulb moment and a drive to do good. You want to go where the work is needed most. I think we can leverage that and rely on that.

At the same time, we have to acknowledge that people get burned out. And so I think it's an individual decision. I think we do have ways and tools at our disposal to make this work.

I don't have an answer on how to do this work that's very hard.

There have been states that have been -- had policies that are not public health supportive, and people have been doing that work for decades in very hard environments. So there's a lot to learn from people who have been doing this work in challenging environments.

So I would stay and fight. I think the stakes are very high. There are people that want to do this work where it's needed most.

>> MICHAEL STEIN: Okay. Thank you.

Stay and fight. I like that.

So let me send this one to Dean Fallin.

Many people focused on economic issues when voting in this election, we believe.

So could you help us tie together the work of public health to those who are interested in the economy? Obviously bearing on themselves specifically, how do we message that, that the work we're doing in public health will speak to the economic questions of that hypothetical, average person?

>> DEAN FALLIN: It's a great question. Many, as Melinda indicated, we have this perspective and we think it should be the rationale. For many folks a business rationale is more informative and powerful.

I mentioned in the vaccination data the amount of dollars saved. I just mentioned the 500 billion saved in direct health care costs, not the mention -- I don't remember what the number was but an order after magnitude higher than indirect costs

prevented because of vaccinations.

We can make that argument in mental health as well. We can make the argument that when you have a mentally healthy workforce, how much better businesses do and the less spent.

We can talk about it in terms of school. In any argument that I think we can make in public health, we can make that business case for the actual dollars saved as well as the lives saved and the disability avoided.

And if you don't mind, I just want to say one more thing about the "stay and fight." We have learned, in the last decade, that public health is now sometimes politicized, and public workers have had to face doxxing and/or hate. There are better supports for that. I'm focusing on our own mental health when thinking about the workforce and the own safety in ways that were not traditionally thought or taught about in the public sphere.

So, as we stay and fight, also know that there are supports available and that we should continue to advocate for those supports in the context of that.

>> MICHAEL STEIN: Thank you.

Anybody else want to speak to the business case? Particularly those in poor states that are going to be scratching for every bit of money on the state government level.

>> DEAN GOLDMAN: Well, I mean, I would. I think that everybody is aware of this. We spend a higher proportion of GDP on health and health care than any other country, and a lot of that is because of failure to prevent chronic disease.

We happen to have a person named to be secretary of HHS who seems to have received that message that, chronic disease is important and very costly to our country although not necessarily along with it, all science that needs to go into what do you do about that. Don't get me wrong.

I do think, especially for poor states, that those states, which already have trouble having a strong enough tax base to support themselves, then to be creating a situation where there's an enormous burden from chronic disease, premature mortality, much less the impacts on that on industry in those states and the cost of insuring their employees because of the level of prevention of care that they lack.

There's a strong economic case for public health for all of us.

Anyway.

>> DEAN PETTIGREW: If I could just add, climate change is another great example. For years, we've talked about climate change as this existential threat, you know, this global warming and temperatures, and I think there's room to tie it into real-world things that we're seeing now. We can talk about the

impact of people losing their homes. We can talk about the potential for increasing insurance rates tied to flooding and damage.

And so I think it's storytelling and tying the public health messages to the things that matter to the people in the communities that we serve.

It's upon us, I think, to do a better job with that.

>> MICHAEL STEIN: So it sounds like none of you will take up this charge that I'm hearing about, taking non-communicable disease out of the CDC? None of you think that's a great idea? Anybody want to speak to that? It's on the table, it seems.

>> DEAN GOLDMAN: I would love to talk about it.

I've read some of the papers these people are writing. Well, there's funding for chronic disease in other agencies. There's funding in CMS. There's a lot of information about chronic disease in electronic health records that can be pulled together.

But what the CDC has that these other agencies don't have is actual epidemiologists that are actually able to study the trends and look at risk factors and actually look at and make recommendations. It's interesting to see people that have a conflict of interest with vaccines because I don't think they do. But, interestingly, the agencies that fund health care, it's hard for them to be in a situation where they're making these recommendations.

I think it's important, when it comes to making recommendations about prevention, it's either an agency like the Preventions Services Task Force, which is actually in HHRQ -- I hope everybody on this call knows -- they're not going to be stuck holding the bag of how to pay for that or move the money from one pocket, which is where we have the funding to do emergency medical care or long-term care or whatever kind of care we have to prevention, which is a different budget.

The people at CDC are not involved with financing.

I think they can make these recommendations without having to consider those impacts. They should be talking and thinking about, of course, the economic impacts to our society.

The same is true with environmental protection. There is an agency in health and human services called the National Toxicology Program That Makes Judgments About the Toxicity of Substances.

And they're not in the EPA. It's good that they're not because they can look at the toxicology without thinking, oh, my god, how is that going to impact the regulation I just issued, the superfund I just made.

They start to make decisions (indiscernible) and the EPT can look at these much more objectively.

>> MICHAEL STEIN: Thank you, Dean Goldman.
Among the wide-ranging issues that you covered, one that you didn't cover that has come up a lot in the discussion of these election results is young men, particularly young, low-income men of all races and ethnicities that may have had a particular part of this population, they have, I think, demonstrably more poor outcomes. Is that part of the problem facing public health right now? How do you tie that election result to what we're doing in public health?
Anybody? It's open to anybody who wants to field that one.
>> DEAN GODWIN: I would characterize it as a communication issue. I agree that we need to be looking at all vulnerable populations and using a data-based approach to that. We also need to be communicating in a way that makes it clear to all of those populations that we care about them. And I think that's where I would say that is a group that has not seen themselves necessarily in the communications that have come from our community, and we could do a better job, in terms of reaching that group.
>> MICHAEL STEIN: Okay. I'm going to move on. Nobody else is picking up on that one.
You're all open to it. Going once, going twice.
Let me turn to a student.
How about: I'm applying to an MPH program. I'm interested in social drives and equity. This is causing me to worry. Regarding the stay and fight question, is now a good time go to public health school?
>> DEAN GOLDMAN: I will respond to that. Yes, it's great time.
What I've seen before in multiple cycles of having policy changes federally. Actually, eight years ago, when trump was elected, we had unprecedented number of applicants because students wanted to come to learn public health because they wanted to engage in the issues.
This is a great time to get involved.
By the way, every time their policy changes, that does open up a lot of jobs.
There are a lot of companies, consultants, the government, wherever there might be jobs for public health grants, policy changes actually create job opportunities for our graduates.
I hate to say that, but it's true whether it's a good policy or bad policy. It just opens that up.
>> DEAN FALLIN: I would have answered something similar to Lynn.
Many places offer a diversity of content and training. It is not solely that you will go and work in a State Department of public health or the CDC -- although, both of those would be

great, but there are many other avenues where you're applying those kind of concepts that include all the different community-based organizations that include lots of for-profit and nonprofit non-governmental sectors.

The work is still there. The work will still need to get done. It will shift in how it gets done, but these enable you to engage no matter where the sources or the employment comes from.

>> MICHAEL STEIN: We have just a few minutes left. Quick one to end.

A very simple question to end this.

Are we ready for the next pandemic? Are we prepared for the next pandemic? Where are we? We have a couple of minutes. It's a very simple question.

>> DEAN GOLDMAN: A, better than before. I think we saw that with M pox. B, that could be demolished very quickly. It is very easy to destroy government agencies and capacities. It's very hard to build them. Right now, we're in a pretty good place, but it would be very easy to take us into another place very quickly.

>> MICHAEL STEIN: General agreement about that?

>> DEAN PETTIGREW: Yep.

>> HILARY GODWIN: Yep.

>> DEAN FALLIN: I would say we have learned from our mistakes in messaging. I'm hopeful that we'll do a better job independently and collectively on messaging.

Melinda mentioned the confusion in messaging when you have more messages than one.

>> MICHAEL STEIN: So there's an adequate hot wash of the last pandemic? We learned those lessons?

>> DEAN GOLDMAN: I wouldn't say that. I would slightly disagree with my colleague about that because I think how you can message in real time when everyday thousands of people are dying who shouldn't be diagnose. Everything we know about messaging, you don't just tell people what to do. But we had to.

I think that we have not thought through carefully how to preposition messaging, that part of preparedness is messaging before you have the pandemic. We have not thought that through.

Nobody ever thinks that these things are important.

You know, when we had project warp speed, some of us went to the warp speed people and talked to them about the fact that, you know, they're making these incredible new vaccines, but they're doing nothing with messaging about the public.

How are we going to get the vaccines into people's arms? They the thought we were crazy that there was a problem. They had the view that if we had a great vaccine, everybody would take it.

>> MICHAEL STEIN: So hopefully, this is the beginning of

messages lake that. And there will be more on this subject and others.

I really just want to thank all of you for being here with us today. Very insightful conversation, a lot of area covered.

I would like to thank the audience for sending many dozens of questions. I'm sorry I didn't get to them all.

I really appreciate your engagement with the event. I hope everybody has a great rest of the day.

Thank you so much for joining this Boston University event.

(Collective thank yous)