BUSPH PUBLIC HEALTH CONVERSATION:
THE FUTURE OF PUBLIC HEALTH IN THE UNITED STATES
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>> Recording in progress.

>> I love the chatter. Some people are meeting, maybe after some time. Welcome. Welcome to this special event. On behalf of the Boston University School of Public Health, I'm delighted to welcome you, and welcome 1700 people who are registered online. And these days of course that is a much more easy engagement for us to have.

But what I'm really delighted about is all of you taking the time despite the weather out there to come and join us. So, thank you very much for that.

My name is Adnan Hyder, and I have the privilege of serving as Dean of the Boston University School of Public Health.

I've been in this position for nine months. I want to thank my staff and team. They've done an incredible job. We are in D.C. We wanted to do an event here. And you have showed up. This is really good. Thank you for being here.

This year is our 50th anniversary. We are celebrating 50 years. On the one hand, we are celebrating our successes, our

contributions to research in public health. But at this moment in time, we are wondering about the next 50 years.

What types of skill sets, dialogues, are going to happen over the coming decades. And particularly at this point in time, it seemed very poignant to not just do that within the School, but to externalize that conversation. And so I'm delighted that we started this series of conversations called the Future of Public Health.

We did one a couple of months ago, local, in the city of Boston with our Health Commissioner and legislators. Today's conversation is about the future of public health in the country -- our country, the United States of America. And for those who are interested, next month we'll be at the World Health Assembly talking about the future of public health global.

This series will continue with topical discussions in the fall. I'm delighted that I have three amazing colleagues, experts, and experienced individuals. Their CVs are a hundred pages long. So it's impossible for me to go through it. I'm going to give brief introductions. But their words and wisdom will be enough for you to recognize their expertise.

I want to acknowledge, unfortunate, our colleague, Dr. Laura Magana, President of the Association of School and Programs of Public Health, fell ill last night. So she cancelled

this morning. I told her that we will send her lots of positive vibes and positive energy to hope that she has a very quick recovery.

But I was so delighted that Dr. Linda Alexander agreed to fill in, and bring a tremendously important perspective to our conversation. Maybe, Linda, I'll invite you first to come and join me. Dr. Alexander is the Chief -- Officer for the Association of School and Programs of Public Health.

>> LINDA ALEXANDER: I'm not supposed to be --

>> ADNAN HYDER: In Kentucky, brings 30 years of experience. Thank you, Linda, for joining us. We'll figure this out. It'll make it very, very interesting. (Laughing)

I'm delighted to welcome Dr. Georges Benjamin, the extremely well-known figure in public health for the past 30 years, has been leading our Association, a great physician and speaker, and really, I consider Georges one of the advocates for public health for as long as I've known public health in this country. So, thank you, Georges, for joining us today.

And I'm particularly pleased to welcome Dr. Brian Castrucci, President and Chief Executive Officer of the Foundation. He is not shy in terms of his opinions, but brings the expertise, the experience and the knowledge to I think out of the box. At this point in time, we need such thinking in public health. I'm honored. Thanks to all three of you for

joining us today.

I'll begin the conversation allowing each panelist an opening comment on the perspective. What do you think about public health over the next 50 years, what actions do you think as a community we should take in the country for the next 50 years? Maybe we begin with Linda and we go down this line.

>> LINDA ALEXANDER: I took some liberties of poetic license with this question, since I just got it this morning. So I want to slightly modify this to answer this in a historical context. Over the past several months, it's been very hard to miss the focus on celebrating America's 250 years as a nation.

For me, finding something to celebrate has its challenges. When I learned of this opportunity, I thought about what we could celebrate in terms of public health advances and progress -- not 250 years, but using the theme of this evening's focus. Let's look back at 50 years of progress. There are numerous examples I attempted to highlight.

These required a village and political will, significant public health accomplishments include the global eradication of smallpox, massive reductions in child mortality through vaccine programs, major declines in tobacco use and cardiovascular deaths through policy changes. These efforts highlight the power of global collaborative initiatives.

I understand our focus is in the United States, but I don't

think you can talk about one without the other. I'm bringing the U.S. perspective. It'll be interesting to hear what our colleagues globally have to say about this.

So, we did launch a vaccine program for disease eradication, tobacco control, maternal and child health improvement. But each of these milestones required global collaboration, a multi-sectoral approach to education, varied levels of targeted communication, advocacy, policy changes, advanced technology, breakthroughs in science and a focus on equitable distribution of resources.

So with these examples, I encourage, as public health champions, that we think about current and perhaps future threats that would send us backwards. So, to have this level of impact -- and it does remain significant -- we must not only embrace the mechanisms that got us here, but acknowledge what is needed for the next 50 years.

The actions needed in the most basic equations can be reduced to SWOT. Strengths, weaknesses, opportunities, and threats. Strengths -- as a field, we demonstrated resilience, resistance, and renewal. We witnessed this first-hand in COVID.

The look-back period is not so remote that we can't capture the wins. The action that is needed is to take -- capture the wins and model and upscale these for sustainability and growth.

Weaknesses -- the United States public health

infrastructure is under-resourced, undervalued, underfunded, fragmented. As institutions, another weakness, we continue to deliberate the value of artificial intelligence rather than leaning into a world where we prepare our students to be AI-resilient and responsive, and competent rather than reactive.

The action public health institutions must immediately form a collaborative initiative that supports a multifaceted infrastructure, focused on qualified workforce, appropriate data systems, realtime surveillance to capture the threat of emerging diseases and appropriate responses to the next public health emergency.

Opportunities -- we need to build back better. The institutions that support public health were not and are not flawless. We keep telling ourselves that. Sometimes we respond as though we think that they were. We have an opportunity to center equity, have a global footprint with shared decision-making, and utilize our resources and our voices to ensure optimal health for everyone, everywhere.

The action -- seize the moment for growth in the inclusion of voices and systems not currently at the table, and harness the power of these groups to effect real system change. And finally, threats.

The polarization of public health, dismantling of the social justice mantra as the foundation of the discipline of

public health, are all threats to our system. So what is the action? Strategic and active listening for agreement on the end goal. My hope for 50 years as we think forward is that as a profession, we model the strengths, celebrate the wins, embrace opportunities, and eliminate and eradicate the threats.

>> ADNAN HYDER: Thank you, Dr. Alexander. I love your seize the moment phrase. We'll come back to that phrase. Who's going to seize and which moment are we going to seize? We'll come back to this. Georges, opening reflections.

>> GEORGES BENJAMIN: I would argue, imagine a vision where as a society we decide that optimal health for all is a shared national goal, one where community health, preventive care and curative care is seen as a necessary continuum, and that in order to achieve that, we align all of our resources in a way that we move from a secure system to a health system.

I think the challenge though is how do you get there, what do you need to do that, how do you build a system that ultimately gets you there. Obviously, in a federated system like we have in the United States, there is an appropriate role for the federal government, we have a true minister of health.

That minister and the other leaders of our nation decide as a matter of national priority, prestige, that we're going to be amongst, maybe the healthiest nation on the planet. And that we're going to build a system to get there. That means a system

with everyone in it, no one out.

That means that we wrap around the things that we really know work, the social determinants get addressed in a comprehensive way. It means that we build a research enterprise that historically has been the best on the planet, but continues to be, and that we reinvest in innovations that work, that we build a workforce that is trained and a pipeline that ensures everyone has the opportunity to do whatever the heck they want to be.

And if you want to be a scientist, great. Want to be a plumber, great. But recognizing that even the people that are sanitary workers are practicing public health when they pick up the trash.

The government has to take its leadership role, which right now is failing, to lead. And to abide that leadership financially, and policy-wise. When we integrate that across federal, state, local, in a way that makes sense. One that values science and the evidence. One that is willing to engage people where they are.

One where data can move at the speed of electrons and not where public health people continue to be data archaeologists as we are today, where it takes months to decide on getting the data from hospital A to hospital B and we can't move an electrocardiogram across the street, but Uber and Door Dash can

do it.

So one where we're using the tools and technology that we have. And I think where everybody is valued and sees themselves as valued in our society. And I know you're going to do global later, but recognizing that we're part of a global world. And that we cannot be isolationist, because the Martians are coming and we're going to have a rude awakening when they get here and figure out these false geographic boundaries we think we have today, we don't have them.

>> ADNAN HYDER: Great. Thank you so much. Your reminder to us about the failure of leadership and the fact that everyone has to be valued -- we try and figure out how we do that over the next 50 years. Brian.

>> BRIAN CASTRUCCI: 50 years from now I'll be 101, so I've got a chance at still being here. I want us to never be here again. And I want us to recognize where we are in public health has something to do with the President, but has a lot to do with us. I'm not willing to say everything was perfect and then this guy came along. No, guys. We need to get better at our communication.

We need to get better at our partnerships, get ready to do what we do best in public health, which is build deep relationships with people. In 50 years I want to find a community where people value health, not as an afterthought, not

as just through your medical care, but the whole idea of health. But we have to teach people that.

Here is the thing I want 50 years. You're much smarter than I am. You have big ideas. I appreciate that. I want one thing in 50 years -- one definition of public health. I want to take you out of the room 50 years from now. You're still be here.

We're going to take out into a room, into the hallway tonight and ask you what public health is. I'm going to have a different definition from each one of you. In 50 years I want to do it and I want it to be the same! If I ask you to draw a hamburger, everybody could do it. If I asked you to draw public health, you can't.

How is this thing that we care about, that we purport to advocate for, and we can't even define it? Right? Pepsi Cola, Diet Coke, is crap with great sales and marketing. Public health is great stuff with really bad sales and marketing. How do we flip that? We bring the American people 25 more years of life expectancy.

That's 25 more birthdays, Christmases, holidays that we get to spend with our families because of the work everybody in this room does. And yet, how easily President Trump undid it. I'm not mad at President Trump. He did what he says he was going to. He told us. I'm going to let RFK run wild like Hulk Hogan. I'm mad it was so easy.

Where was anybody saying, don't touch public health? Public health gets me and my kids reading on grade level, public health gets me my ability to worship the way I want, public health gets me my employees showing up healthy. We spend so much on workplace wellness, community health is the new workplace wellness. That's where I want us to be in 50 years.

But we're not going to do it sitting around saying, this is what I'd like. This is what I want. Doing the ifs and buts. If they were candy and nuts, every day would be Christmas. It's not what it is. We've got to get to action. We need a plan. We need a national workforce strategy. We need something that aligns us.

Because right now, we are 3,000 individual units working in different directions. We need to start aligning the arrows in one direction. That's how we're going to get to where we all want us to be in 50 years.

>> ADNAN HYDER: Thank you so much, Brian. So, let's get the temperature up a little bit. So, Dr. Alexander, I'm going to go on first names now, Linda. The Association of School and Programs of Public Health -- that's a trade association. Where do you see its role in the next 50 years? Do you think it has a role in 50 years? Should it exist in 50 years? How can it contribute to this single definition that Brian calls for?

>> LINDA ALEXANDER: Okay. That's a tall order, but I think I have an answer for you. So, as the voice of academic public

health, ASPPH has leaned into this contemporary moment in public health with our vision, our values, and our mission. And I think it's very important as a trade association that we listen to and advocate for our members.

And we've done that. I have numerous examples. In a short period of time, I want to name one that happened because, again, Brian reminds us about things that didn't just happen yesterday, or the day before, or are headlined in the New York Times. Things have been going on for a while. I'm proud that we've been a part of that.

In 2023 we joined 45 health professions and organizations with a statement and some strong advocacy around the Supreme Court's decision to remove race in applications to institutions of higher learning. And in this instance our ability to be effective was both in helping members navigate the legislation and the legalities around rules and around this decision and equally important to state our commitment to diversity, equity, and inclusion through this statement.

So our advocacy efforts have been extremely important, historically have been important. The most contemporary examples are around professional degrees and the cap on F&A. If you didn't know what it was a few months ago, you know what it is now. I think those efforts are noteworthy. These examples where we have as a trade association provided guidance, support, and

recommendations that our members can be responsive to require changes while simultaneously providing the evidence through 40 years of data mining for how some changes produce harm, usher in threats, to the professional workforce, and are not aligned with the mission, vision, and values of not just ASPPH, but our world.

And I think both Dr. B. and Brian articulated those things. We take a measured approach to serving our constituency by pushing back on policies that have a negative impact but seeking common ground. And I think that's a huge part of our role now is to be active listeners. And the examples I gave to eradicate and eliminate some of those threats.

We need to be at the table, to actively listen for common ground. With a show of hands, we can find out what do both sides care about. I don't think we have to have siloed, camps. We are very good at harumphing and being right, but I think this moment in our history has shown us that it was very easy for one person to come and dismantle everything that we did.

That was because we were spending a lot of time trying to be right. One clear example I want to give you, and I want to encourage you to listen to this, because I won't do it justice in a few sound bytes. In our 2026 annual meeting we literally focused on reaching behind -- beyond the choir. And this notion of we're always speaking to one another.

And I hope there's some voices out there. And among you, that are beyond the choir, that bring different perspectives. And so we hosted a session with MAHA entitled Why Should I Trust You. We lived to tell the story. I'm here, you know? No animals were harmed in the filming of that session. And so, the idea was to seek first to understand by listening for common ground and finding real opportunity to work collaboratively.

Because the changes that my colleagues have articulated are going to be necessary for both sides of the aisle. And a trade association can lead by example.

>> ADNAN HYDER: That's a great example to lead by. And that conversation hopefully was the beginning of a conversation. Georges, is there really one public health community in this country, or are there multiple public health communities in this country?

Meaning, the constituency of the American Public Health Association, is that truly single-focused, unified, or are we seeing fractures right now? What are your perspectives?

>> GEORGES BENJAMIN: We've been around since 1872. We've been a collection of individuals with different perspectives, different views. I would argue we were the MAHA of the day in 1872. We were disruptive. Think about what we were in 1872. Medicine, the physicians of the world, were really trying to think about the science and evidence around curative medicine.

Then you had this group of folks, eclectic group of physicians, nurses, environmentalists, planners, lawyers, who got together and said you know, there's this thing called the social determinants and environmental health. And, of course, the environmental movement really grew out of that.

But the doctors thought they were kind of soft science. And to some degree, there was, almost like anything, a cross-over. That division has remained. We've always recognized the importance of multi-sectoral, multiple group engagement to achieve a common goal.

I would argue that it doesn't matter how many groups are under the tent. As long as we can get someone to point them to due north, and integrate the way they want to do it, always going to be a little overlap. That's okay. Because I think that results in innovation and growth. And I think there's a way to go. I think we've been around for over 150 years. I think we're at 154 now.

We're not planning on going anywhere, despite the White House's wishes. We're not going anywhere. We're going to be here for the next 50 years for sure. And I think because there's a recognition of the need for this collaborative movement to go forward, and the one piece of the movement that is missing is Uncle John and Auntie Sue.

The average citizen has not become part of that coalition.

That's our quest. How do we get our family members and others engaged. There are groups out there, you know. Moms Clean Air Force, this group for gun violence. There are all these groups that are out there that are in the community. We just have to be more effective in terms of how we bring them into the fold.

But we don't have to be the leader, you know. But it is lead, follow, or get out of the way.

>> ADNAN HYDER: Really important. Uncle Mohammed and Auntie Ravi, maybe. This country is changing. It's not the Uncle Johns. We want Uncle Joe, Mohammed, Smith. But Brian, foundations traditionally often, there are a few foundations that have always been pro public health, but we've seen a growth in foundations, even in your own career.

So, how are -- using you as an example of a foundation, how are foundations looking at this moment right now? What do you think is their responsibility for supporting the next 50 years?

>> BRIAN CASTRUCCI: You have to disentangle this moment from where are we going in 50 years. That's not the conversation we're having. What the administration has done is put us in this fight or flight position. So we're trying to hold on to what we have. What we need is a vision of the future. But I'm going to let you in on something. I shouldn't be sharing this in this venue with this many people.

We are about to rewrite the document, the 1998 Future of

Public Health, we are rewriting that for no money. We've digitized it. We're going to do a find and replace and do the future of today to change the years.

We're going to change nothing else. Because nothing changed from '98, from the last time we did. We've never had an ability, as a community, to push what we need in public health. We have great plans. We have great architectural blueprints. But we have no buildings. And so at some point, philanthropy can bring us together, because I do all these analyses.

What's the problem with public health? How do we make public health better? I come back to alignment. Alignment. We couldn't write the documents that MAHA has written. If we tried to write Project 2025, we wouldn't be able to agree on the font! We'd have whole things -- we'd never get to the meat of it. Because the HIV crew would go, let's center HIV. Let's center infant mortality.

We need to be greater than the sum of our parts. Our parts are pulling us down. I'm the person who has done this in my career when I was in governmental public health practice. I was an MCH guy. That's what I was. That was my identity. Epidemiologist, that's my identity. Somewhere along the line, after New England Patriots football fan I would have said I'm a public health practitioner.

We have to flip that. You need to say I'm a public health

practitioner first. In our schools, we are forcing folks into specialization to early. This is a horrible challenge. I see more and more MPHs doing an MPH in disparities among women who live in Arizona. Like, that's very specific.

The beauty of our degree is that we were generalists and we go anywhere. I could sit at any table I wanted. That's what drew me to public health. I could bring my perspective to the problem that they have. But we've lost that somewhere. So philanthropies have to -- we have to do this ourselves -- align.

If you want to knock somebody out, do you do it with this or with this? You do it with this. We're not even this. We're like this in public health. So, how do we align with -- that's going to mean we're going to trim up a little bit. We can't afford to continue to be a Golden Corral buffet. You eat there? You only do that once.

We need to be a boutique restaurant that delivers on its promises. So, sleep is a public health problem. Social media is a public health problem. Fizzy water is a public health problem. Enough! We haven't solved the public health problems we enumerated yesterday and now we've added five more.

What do the people want? Everybody wants to lead healthy lives. They want to go to work, they want to spend time with their family and the only way you're going to do that is if you're healthy. That health does not start in a clinician's

office. That health starts in your community. The problem is most people who have power, their community is all taken care of, so they never see it.

I had congestive heart failure back in 2022. And when I finished cardiac rehab, from my door to leave my door to go to rehab and back was three hours. It was far away. When the finished, the in nurses kept saying, so many people don't finish. You were committed. I'm not committed, I'm privileged.

I was able to do that. How many hours of time off did I have? Did my workplace say you can't do that? This is the stuff we have to work together on. We have to understand that for me doing cardiac rehab was nothing, easy. But for someone who works two jobs, someone who can't get there between 9:00 and 5:00, how do they do it.

>> ADNAN HYDER: Very important. Great insight. Lots of introspection to be done by public health, including schools of public health. Are we training the right type of individuals that we want? You're commenting on over-specialization. Our accrediting board, the Council, which every dean knows well, has competencies that are being revised.

The current frameworks are being questioned as being too traditional, not up to the mark. I want to open this conversation, because --

>> BRIAN CASTRUCCI: You asked the question earlier, do we

need an ASPPH. Do we need trade associations. Do we need CIF? If they aren't meeting, our requirements as a community, maybe it's time we had a new --

>> ADNAN HYDER: We'll have interesting answers to that question. We are going through our accreditation right now at BUSPH.

(Crosstalk)

>> ADNAN HYDER: I will reserve my comments until July. After July, I will be at liberty to speak. No, but on a very serious note, I think it is incredibly important for that introspection to happen, because the rules by which we are monitoring schools of public health I think need to change. And so I think with due respect to our various councils and associations, I think if we are going to meet the moment, if we are going to be able to say that we talk about health rather than your specialization of epidemiology, that is not necessarily the lessons we are teaching right now.

It's also not the practica that we are doing, not the internships we are promoting, etc. But I'd like to bring in some of you into the conversation. And I also want to ask Erica to give me a heads-up if there's a question online. Do we have microphones? If you can raise your hand, what I'm going to do is entertain two or three questions and then go to the panel to pick and choose.

I do -- would like to remind folks that you're asking the question, you're not on the panel. You get one minute.

(Laughter)

>> ADNAN HYDER: So, take 60 seconds and deliver a brief question which is succinct and full of punch. And identify yourself, please.

>> AUDIENCE: I'm a graduate of the Boston University School of Public Health. I was a global health worker until this historic event. I worked, there was a request for universal health coverage. Georges, you said we need -- you mentioned we need to bring care system to everyone. And you talk about community systems.

And in public health, I think systems-wise instead of fragmentation. And sometimes I say, we may not be able like other countries think nationwide universal health coverage. But can we think at least at the community level, universal health coverage for the community members?

But we don't have a mandate. Public health graduates, we have competencies. We think systems. But we don't have mandate. And then there are no incentives aligned in the systems for us to play this role.

>> ADNAN HYDER: Thank you. Thank you for being our alum. Do I have another hand? Yes. Yes, sir, go ahead.

>> AUDIENCE: Yeah. I'm Neil. I've departed this world for

25 years. Like our colleague there, worked in the international space on maternal and child health. I see at least three people or three organizations who've done tremendous leadership in public health over any number of years. Two of you are involved in Turning Point, which you talked about.

What I was truck by is that Turning Point was an implementation of the future of public health, but guess what it got derailed by? Biosecurity. Public health was viewed as the -- the people could implement it. The same thing with tobacco control. The tobacco control people are good as state, the companies are good at marketing their products.

And so I guess part of what I'd like to ask the panel is about big P and little P. In other words, the politics that actually bring the coalitions together to actually do what you're talking about.

>> ADNAN HYDER: Thank you, Neil. I'm going to take one more and then ask the panel to reflect. The lady there. Yes, please. Go ahead.

>> AUDIENCE: Yes. Thank you, Dr. Hyder. The lady, I was Dr. Hyder's student at GW School of Public Health. So, my name is Val. Right now my research, what happened with a lot of us like research is being gutted. I wanted to share that I had an opportunity a month ago to convene with folks from American Physiological Society.

And I thought that this could be replicated by APHA or ASPPH, because they had a Congressional briefing together with Congresswoman Zoe. And then they came together, discuss about the budgeting and how can both side of the aisles come to agreement. And I think, you know, I'm also an advocate for public health.

And then I would love to support and be supported as well for my, you know, future professionals. Because I am right now wearing many hats, just because my research has been stopped. And right now, I am a birth doula. And birth doula is also facing a lot of things for our workforce. So I think, let's also be intentional.

I think the gentleman over there talking about coalition, let's come together and then again be -- I'm going to say not attacking each other, but listen to, you know, what we have in common. Thank you so much.

>> ADNAN HYDER: Thank you. So, maybe we'll go this direction. Brian, starting with you, we have a universal healthcare question, coalition, and the big P and the small P, and a reminder about looking at maybe nontraditional partners and engaging in different ways with communities.

>> BRIAN CASTRUCCI: That's a lot. That's like the Golden Corral.

>> ADNAN HYDER: Pick and choose.

>> BRIAN CASTRUCCI: We should have universal healthcare. It's a no-brainer. We don't. And so, you know, you ever play Texas Hold 'Em? Two cards, and three community cards. You can win if you have lousy cards. In public health we're waiting for pocket aces before we play.

We have to figure out how we do this. We have to mobilize candidates who are going to believe in this. We have to find a pact. We can't sit out electoral politics and then be upset when the politics don't go our way.

So we need the Abduls, the Amys, people who have heard me speak, I'm un-abashedly a registered Republican. And all of my giving is to progressive Democrats, because they care about public health. That's what I care about. I'm an issue voter. I care about public health. I want Republicans to think about public health. And they did at one time.

We need to find our Bill again. The senator is getting old. I worry who we will go to in public health to be the Republican. We're working with John. We are training county commissioners on what is public health. Because do you know who fired us during the pandemic? It was the county officials. Do you know where public health reports up to in most places? It's the county.

And so I need those county commissioners to understand that if they are doing their jobs, they will have a greater impact on health than every single clinician in their jurisdiction

combined. That's what we have to help people understand. We have to -- to Neil's question, we have to figure out how we build the future without the tools of the past.

I don't know how we got here. I don't want -- I like trade associations. I have a lot of friends, you're my friend. You run a trade association. Ariel works for a trade association. But, what we have created in public health is a continuous environment where we are all hunting to eat.

And we're all sitting at the CDC trough. And so when you start to think about how do we build the future, how do we have an environment that is not so competitive and more aligned, it starts with the funding. because ASTHO competes for fund that CSTE and APHA compete for.

We're all competitive. The only hope I have right now is that given what has happened in the administration that we can find an era of collaborative competition, where we say, look, Castrucci is running the public health communications collaborative, we're going to run our communications through that.

APHA does this really well. Let's all do this together. How many conferences do you go to that's some alphabet organization sponsoring it? I just went to Sophie, and then to NJSACC, which I was like, what is that?

It was the New Jersey State Association of County and City

Health Officials. so there's all these acronyms. We've created this environment. And so we have to now create our way out of it. And so this is -- I mean, APHA is the godfather of them all, but all of these little fiefdoms are competing for a very small piece of pie.

We're all fighting over crumbs. How do we align better? Now, this is admittedly easy for me to say. I live off an endowment. I don't have to hunt to eat. But how do we move forward when we are at the same time competing with each other, when we're trying to support each other? It becomes challenging.

>> GEORGES BENJAMIN: Let me take on the politics question. We all believe that we -- in our evidence. We believe the science speaks for itself. It does not. Because we're missing the most important science, called political science. Every one of you who does not think you do politics, you're fooling yourself.

We do politics each day. You cannot do policy without doing politics. Politics -- political science is the art of convincing people of your perspective one way or another. And so I think we've got to get better at recognizing this, not be so shy about having to do politics. It's got to not be a bad word anymore.

And we've got to get better and teach our students how to engage in the political process. Again, you don't want to be partisan. I want to be clear about that. It's not about being

partisan. You do have to be right. And the evidence and the science guides the direction that we're going in. But realizing that the science and the evidence is a point in time.

It evolves over time. And we have to be real clear with some degree of hubris that when we say something that it might not be true tomorrow. Some days the sky is blue. Some days the sky is gray. And we need to recognize the reasons for that. We need to make sure that we help the public understand that in ways.

And we have failed as a society to help people learn how to think through some of these problems. The challenges we have right now with social media is that they're flooded with information and people can't discern what's real and what's not. Half of the blogs out there today are AI-generated. Half of them. Okay?

Now, they may be actually right. But how do you know? And you have to -- we have to learn ourselves how we dissect that and get better at it.

>> ADNAN HYDER: Linda, reflections on any of these?

>> LINDA ALEXANDER: I don't know whether we're still holding the original three questions, but one of the things that I'm thinking about is while we're debating, literally while we are at this moment having these conversations there are communities that are thriving. And I think that we need to

acknowledge the asset and values that they bring.

And I think about one of the privileges I have in my role is being a part of our awards committee for the Harrison C. Spencer Award in Outstanding Community Service. The examples that I've seen since 2022, I've been in this role, have been extraordinary and they represent models of the in the community of exactly what we're talking about -- community engaged scholarship, opportunities for practice, the inter-sectoral collaborations, unusual partnerships, unusual of what we think about with practicum placements.

Places, populations, groups that come together that we have not historically thought of. And in these communities, they are saving lives. They are understanding the process to effect change. And one of the things that I think our role is as an association -- and I think we need to be here -- is that we are supportive. We recognize we can elevate that. And our role as an association is to help provide some scalable recommendations so that everyone can share in this vision.

And then the other thing that does have to do with politics I would encourage you to read the work that we've done on voting and democracy. We have -- I know we get too much into acronyms and bumper stickers, but public health is democracy and I think that we do have an obligation to share with our constituents and our audiences about the importance of their voice and how they

can make that count by understanding who they're voting for and what bills and what policies will effect change in their neighborhood.

So we've done quite a bit of work in that area as well.

>> ADNAN HYDER: Well, thank you. I want to check in online. Are there questions, Erica? Can I get at least one from online?

>> We have quite a few questions coming from online. Folks are asking if panelists can share their ideas on how to improve the marketing of public health and get more public buy-in. How can we rebuild public health? How do we attract the best talent when MPH, DrPH degrees are being deregistered as professional degrees?

>> ADNAN HYDER: How do we do better marketing, how do we attract great talent, and how do we rebuild? That last question is enormous. But I'll go this way. Linda, any thoughts? You pick a question, any one of them. Thank you to our online participants for those questions.

>> LINDA ALEXANDER: You know, I opened this with one of my comments was about build back better. I just think the acknowledgment of the importance of communication and misinformation and disinformation. And providing an atmosphere for our students to learn first personal agency and their space in terms of human interaction.

And I think that many of the people that I met who were

speakers at our annual meeting said I started this life in public health and I was very drawn to communication, because I want to understand more about how I could effect change by delivering the appropriate messages to the appropriate people. I think that's something that you may have two or three opportunities to have that as a part of your formal training in your MPH or DrPH.

But I think we need to lean into that and have that marketing be more organic and tied better to our field. Because if we don't create the stories and if we're not putting out the information and being guided by science and data, and facts, somebody else will do it for us.

>> ADNAN HYDER: In some ways, schools only talk about their own work. We don't get out there and talk about what the community maybe wants to hear. We are obsessed with our research, and proclaiming. We are all part of the issue here. But I think we need to do a better job at that type of communication. Georges, any reflections on the online questions?

>> GEORGES BENJAMIN: I'm not worried about the pipeline. We have an extraordinary pipeline. No worry whatsoever. We do need to make sure that every lawyer takes a public health class. Judges out there. Most of them are down the street over here, all nine of them.

Maybe only six of them. I think the challenge we have is in

communicating. The biggest issue is that we're very proud of the fact that we do our best work, we're invisible. I think we've got to figure out how we become more visible. I would love to have a press conference, get up and say we have an important announcement. Nobody died from food-borne poisoning in our city. I want to thank the public health workers for doing that, okay?

Short, sweet press conference. You might get laughed at the first time. I tell you the first time you get a food-borne outbreak someone will pay attention. We need to figure out how we articulate the negative. And we spend lots of money, looking at who do we speak to, etc.

I would argue we don't need to do another study on how to speak to each other. We need to start doing it. Maybe some more training. But we need to start doing it. I think for me the biggest issue would be -- the truth, during COVID, you had an unknown bureaucrat who nobody knew telling you you had to wear a mask and stay home.

And that lasted for about 48-72 hours. And then you wanted to go out to get some pizza, you know, or a hot dog. Or other ultra-processed food. And . . . But you couldn't because it was closed. And you couldn't go to work unless you were a sanitary person, a bus driver, someone who had to go to work and be exposed to COVID.

So I think the challenge we had is in those communities we

know for sure, those communities where the health officials were well-known to the community and were in the community when the community needed them, they did much better than those health officials who were not well-known.

And in some cases, had better relationships with their political leaders.

>> ADNAN HYDER: I think you're right. Our pipeline is strong. But our pipeline is demanding us to change.

>> GEORGES BENJAMIN: It is.

>> ADNAN HYDER: Our students are telling us that whatever we have been doing needs to change, because the circumstances have changed. They get news in seconds. 20 years ago that wasn't true. And so they're able to absorb, influence, and react in real time. We aren't there. Our mechanisms of instruction and curriculum aren't there yet.

So I think they are great. I'm not sure we are serving 100% of their interest. The onus is on us. Brian, any of these online questions for your reflections?

>> BRIAN CASTRUCCI: So much to reflect on. Okay. From the workforce standpoint, I agree that we have a phenomenally good pipeline of students who don't go to work in government public health. 80% plus of the governmental public health workforce do not have an MPH, do not have a Ph.D., do not have a DrPH.

Here's the funny part. I love irony. One of my funny

things. We talk about inclusion. We talk about community. We talk about empowering community, bringing people together, but only if you have a master's degree. That's when you're a public health professional, when you have a master's degree.

What about the guy who graduated high school, started off as a WIC outreach worker, running the program? Are they a professional? They're part of the public health fabric, part of my field. So we have to find ways to get those people into public health. When I think about public health departments, I think about places that I work -- Texas Department of State Health Services.

I think about Talbot County in Maryland. They're getting who live there. And we're not wrapping around them. There's a great program that we are partnering with now called New to Public Health. Because again, I love you both. I love you NC where I got my degrees. But give me an MPH in a year and I'll make someone functional in a governmental department.

They're not coming out ready to work there. It's a tragedy that more people in this country cried when Hulk Hogan died than Bill Fagy. We're not here because Hogan did much of anything.

We can't market it until we know what it is. And then we have to market it consistently. And we have to agree. That's the thing that keeps us add-ons. We're not willing to agree. If university X has a great program, we all should do it. But it's

that hunting to eat thing. There's no competitor to the NRA. The NRA is singular. It is the only organization that is promoting guns and gun safety and Second Amendment.

But you give your money to them and they do it. We are a thousand different voices speaking simultaneously. And we can't market it until we can name it. We can't name it until we agree. We can't agree until we align. And that is I'm going to keep saying that. I was at a talk the other day and Kevin Sumner from New Jersey, who's been a health official forever said, Brian, I've heard you say the same stuff since 2015.

When are we going to change? I'm like, I don't know, but I'm not going to stop saying it. I have 50 years. I'll be 101. That's the goal here. We can't market and we can't do some of these things until we know what we are. And the last thing I want to challenge you with, science.

Science is something to guide us. Your values are an opinion. I can have different values from you and we can still work together to achieve health for all. Josh, a senator from Missouri during a hearing asked a woman from D.C. She was a lawyer in D.C. He asked her a simple question.

The government in D.C. allowed the protests to happen after the George Floyd murder during COVID. But in the same week, you disallowed outdoor church. Make it make sense. Because for us, and for the thousand people who signed the letter that said it

is okay to protest, racial justice was very important to us.

It was a value of ours. And maybe our value wasn't getting to outdoor church on Sunday. We are not leading with science. We were leading with our values. And we have to make a decision. If we're scientists, we're scientists. If we're advocates, we're advocates. But if I come up with a research question and write the survey and I write the policy and I do the advocacy, are you taking my science seriously?

These aren't things I have answers to. These are the hard questions I'm trying to challenge our field with. Where did we take into account anyone else's values when we were talking about trust the science, when we know if you're sick, the first thing you're supposed to do is get a second opinion. When it came to COVID we were supposed to trust the science. Bad messaging. Defund the police, bad messaging.

So, we put out bad messages. The political right capitalizes on it and beats our butt all around the street on it. During COVID, we had 3,000 health departments all coming up with their own messages around COVID! That's why we created the public health communications collaborative, John and I.

And Judy. We said there should be one set of messages so when you are a local health official, sitting -- you have a public health background. That's one kind of public health official. Then there's the public health official who last week

was here running the sanitation department. And Tony Fauci gave his comments, the official gave their comments, now the local official. What do you think?

They didn't have messaging. They didn't have support. We have to start wrapping around our own people. We have to find strength in our alignment and ourselves. Stop blaming everybody else for our problems! If we were a team, we'd go to therapy. We have to get our own problems right and not blame -- that's what public health needs. Group therapy.

Can we do that at APHA, have a town hall of group therapy.

>> ADNAN HYDER: We'll do better. Because for -- as you've just reminded us, you've been saying this for 11 years now, according to whatever. So that's a diagnostic statement. Now we need the interventions to go beyond the diagnosis. Now is the moment. It is during crisis. It is during this zero sum game we appear to be playing with each other that we can dig deep into our values, even if we have a diversity of values to get a common vision and common goal.

Which is why this conversation is just a step and a drop in the ocean. Thank you to all of you, first of all, for joining us today. I'm so privileged that Linda, Georges, and Brian joined me in thinking about the future of public health. You can see that we are not proclaiming to have the solution, but we are concerned about the future.

You share that concern, whether you are here physically or online. If you share that concern, and if you've heard a little bit about how there are good examples from the community, that there is a community out there of public health professionals that is willing to talk to each other, that we've got to think out of the box, that we have to challenge ourselves to figure out that single definition, that single messaging, our work is cut out.

At Boston University, we want to be a host of these conversations. We don't need to have all the answers. We don't want to have all the answers, because we can't come up with the most bright solution unless we collaborate. Unless we develop those coalitions. So, I welcome you all to engage with us, to begin these conversations at APHA, at ASPPH, at the Foundation's behest and certainly, from BUSPH we welcome you as we celebrate this year.

We will have many more such conversations. Hopefully some of them will lead to solutions, and to interventions. I want to recognize many of my academic colleagues. Many of you have come from nearby universities, traveled, and foundation leaders are present here, NGO leaders.

Thank you to our alumni and friends. Thank you to I don't know how many hundred people are logged on right now. It was a great pleasure to have this conversation. Thank you to all three

of you as well. Thank you all. And we can continue those present here to our reception. Thank you.

>> Recording --

(Session concluded at 6:36 p.m. ET)