As income inequality continues and poor Americans and minorities are further marginalized by policies, we can expect more public antagonism and hate crimes. We must document the impacts on individual, family, and community safety and health. Social media and polls have noted the spike in hate crimes and those communities' anxiety.[4,5] We need formal and consistent local and national surveillance methods to record the impact of recent policies and those to come.

RELATABLE AND ACTIONABLE RESEARCH

Public health must focus on researching the gritty, relatable experiences of working-class American families across geography and demography. There is an important role for qualitative and ethnographic studies describing Americans struggling to meet family needs, from health care access, quality, and costs; food and job security; and affordable housing; to a living wage and employment. Effectively communicated, this information can powerfully inform public opinion.

We also need to better connect research to action. Research on community capacity building and organizing is a critical element of our underutilized public health armamentarium. A recent report from the National Academies[6] highlights the vital role of economic and social conditions on Americans' health and health equity. The report details how local community action can improve health equity. It is time for public health to prioritize the role of community capacity-building and action as strategic levers to improve population health and enrich curricular changes that provide students with skill sets including capacity building and multisector partnerships.

Also, we need a value shift in the academy to validate community-based work in faculty tenure and promotion. Typically, community engagement falls under the service rubric in promotion and tenure, but is not an essential. Because having real-world impact is a universal academy value, community-engaged scholarship and action should be recognized as one avenue for faculty contribution and impact.

COMMUNICATION

Like other scientists, traditional public health researchers have been trained to believe their jobs are done upon publication. We expect that others—the media, policy experts, advocates—will pick up from there. Now, with "alternative facts" and devaluation of scientific evidence, researchers must be proactive in disseminating and conveying their findings to the public.

Environmental scientist Jane Lubchenco, 2017 National Academy of Sciences Public Welfare Medal recipient, encourages us to "stand up for science by demonstrating its value and our relevance," communicating in plain language so that science is accessible, and engaging the public in science so that we produce useful knowledge and solutions and in the process, create trust and shared values.[7]

Public health institutions have important roles to play in helping public health researchers and practitioners build such communication skills.

NOT A TIME FOR ACTION AS USUAL

We need visionary and forceful initiatives from academic and professional public health leaders to make the field relevant to the current political context. Communication has vastly expanded through new technologies, yet public health has not kept pace with these new opportunities. When we connect with those platforms, our work will matter even more and to more people. AJPH

Hortensia Amaro, PhD

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Public Health Policies: Go Local!

See also Galea and Vaughan, p. 646.

Bank robber Willie Sutton is credited with the conventional wisdom about banks: "That's where the money is." However, Sutton was off the mark. There is money in banks, but vault cash in the United States is estimated at approximately $60 billion as compared with the $3000 billion worth of circulating currency. The money that runs the United States is in the hands and wallets of the people. It is not in the bank.

Many in public health follow Sutton's specious wisdom to focus their scholarship and advocacy on national public health spending and policy because they think that is where the money is; however, the bulk of the money and the decisions that drive the health of the public remain in the hands and wallets of the people and their local communities. We highlight three important reasons to stay focused on local public health practice:

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(1) local public health policies have profound effects, (2) local public health policies can address health disparities, and (3) local public health policies counteract national gridlock and regime dysfunction.

EFFECTS OF LOCAL PUBLIC HEALTH POLICIES

Most of what keeps populations healthy happens in their homes, cars, communities, schools, and workplaces. Local city and county policies have profound effects on health. Human bodies are quite small compared with the size of continents. What makes people sick are ideas, behaviors, chemicals, physical energy, and microbes that get close enough to penetrate the body. If you got a cold this year, you got it from somebody in the same room. Whiplash? The shockwave came from a bumper a few feet away. Hangover? Your friends may have poured and clinked the glass that gave it to you.

To be clear, national and international policies do affect health. The risks of pandemics and epidemics are substantial as are harms and threats routinely controlled by the World Health Organization, US Food and Drug Administration, Environmental Protection Agency, Centers for Disease Control and Prevention, and other national agencies. The hopefully obvious point is that the public health policies that matter most are the ones that affect things that people have the most contact with. Safe drinking water, safe food, safe roads, safe air, and the health practices of our neighbors are locally controlled.

The planet has 60 000 health districts at parish, county, or district jurisdictions. The United States has more than 3000 state and local health departments supported by public funds.[1] Public health is also practiced by workplaces, neighborhood associations, schools, hospitals, health insurers, and many others with resources of time, money, and energy that dwarf national budgets for public health. In the United States, the National Health Expenditure Accounts of the Centers for Medicare and Medicaid Services estimate that public health activity in 2015 accounted for $80.9 billion, of which $69.6 billion were state and local public health activities and $11.3 billion were federal public health activities.[2] Nevertheless, US government spending on public health activity is overshadowed by the $3.1 trillion spend on curative care in decisions made by patients and their clinicians. However, local public health practice still matters for the vast expenditures on curative care because local treatment choices depend heavily on local practice patterns, local culture, and local epidemiology.

Imagine the health of a country without state and local health departments. Without restaurant inspections, the approximately 33% of meals Americans purchased away from home would come with more risk and threaten the nation's $783 billion restaurant industry.[3] A reduction in spending on food safety and sanitation would be associated with more salmonellosis and more cryptosporidiosis.[3] Local health departments that scale back their comprehensive services have higher county-level sexually transmitted disease incidence.[4]

LOCAL POLICIES CAN ADDRESS HEALTH DISPARITIES

Local geography spans a shocking diversity in population health measures inside countries. To illustrate this, we examined life expectancy measures from US counties.[5]

In 2010, the bottom decile of US counties had a life expectancy of 73.2 years compared with 80.6 in the top decile, proving that at a local level, American communities can achieve health outcomes that rival those of world leaders like Japan and Singapore. The top performing 10% of US counties were able to gain 2.5 years of life expectancy between 2000 and 2010. Based on data from the Census of Governments, these same top counties spent an average of $124 per capita on health in 2010 out of their county budget (not including hospital spending). The bottom decile of counties spent $80 per capita on health in the same period. Indeed, other factors determine county life expectancy besides public health spending. How the money is spent and what the policies are matter immensely. What is known and practiced in the best-performing communities must be spread throughout the country.

LOCAL POLICIES COUNTERACT NATIONAL GRIDLOCK

If the only arena of policy advocacy is the national arena, and effective policies are blocked or gridlocked, then advocacy efforts can be needlessly bottled up. The same degree of blockage cannot occur at a local level across an entire country. One dysfunctional county board of supervisors or one errant local executive can affect only a small fraction of a nation, so there will always be another place for progress to occur. States and counties will always have a right tail of the distribution that leads the way in innovation and performance. The left tail of the distribution will benefit from coaching and guidance.

Sutton's misguided law can lead to a focus on chasing big grant money rather than unlocking community capability based on local strengths and assets. For too long, the supplication of federal funds tied to specific disease programs has crowded out authentic expressions of community priority setting. Recent gains in the opioid epidemic have come from state and local initiatives. Prescription drug monitoring programs, now in progress in all 50 states, provide the basic surveillance needed to understand and intervene. Project Lazarus in North Carolina developed in response to community-based recognition of the toll of opioids on the community and with the input and skill of local providers.[6] Nonprofit hospitals are required to conduct community health needs assessments and community health implementation plans to maintain their favorable tax status. Infrastructure changes to our communities affect how people travel to work and school and how many among those will arrive at their destinations intact. Vision Zero road safety programs are being adapted to local communities across the nation through multisectoral partnerships involving local transportation, health and planning departments, and community stakeholders all working together to address traffic safety solutions holistically and in support of no traffic deaths being acceptable.[7]

A renewed emphasis of the public health community on local action is long overdue. This need not be done at the expense of national efforts. The time is now to marshal our communities and their resources to improve local public health. AJPH

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