HPM 860 & 950
Population Perspectives for Health/The Research Process
FALL 2017

Faculty: Thomas C. Ricketts, PhD, MPH
Professor of Health Policy and Administration and Social Medicine
Deputy Director, Cecil G. Sheps Center for Health Services Research

Office: 725 Martin Luther King, Jr. Boulevard CB#7590
Chapel Hill, North Carolina

E-mail: tom_ricketts@unc.edu
Phone: 919-966-7120 office.
Fax: 919-966-5764

Class Meetings: Tuesday evenings various pm ED/ST

Office Hours: My hours are potentially 8-5 M-F US Eastern Time but can be cluttered with various appointments and meetings (Hold it—I’m retired why am I in the office?). I can usually set a time for a phone conversation or a meeting via e-mail or Skype. I have an office at 725 Martin Luther King, Jr. Blvd. You’re welcome to drop in if you’re in town—but call first so I can get there myself. I will be in Chapel Hill most of the time.

Course URL: https://sakai.unc.edu/portal/site/hpm950_860

Course Overview:
This is a two-part course. The first part is intended to allow the learners a chance to understand what they believe and why they work in public health or a field that deals with the health of the public. This initial course will help learners to understand what the terms “population health”, “social determinants of health”, and "health" mean in the context of contemporary politics and public health. Population health is in many ways a loaded term, some call it a “cop-out” alternative to "public health." People who take this view feel that there are multiple public obligations for people and governments to promote and protect health while population health shifts more emphasis to “personal responsibility.” Lately, we hear a lot about population health in the context of discussions about ACOs. I’m not sure that we really know what that means and we are going to explore what the ACO concept means for public and population health. The course provides learners with a basic familiarity of the use of epidemiology and aggregate measures of health in political and policy contexts.

The goal of the first part is to explore population (and public) health perspectives to see if there is something unique about the concept. However, we will spend a lot of time discussing public health and determining if the two are really different. Is population health the appropriate context for social as well as individual development and progress?

In a world of rapid technological progress and an economy more and more dependent upon rapid innovation driven by seemingly younger and younger inventors (think Steve Jobs followed by Bill Gates, then Sergey Brin, Elon Musk, etc.) who have begun to think of age old problems like death as solvable if only we put enough money into the algorithm. There are serious attempts to achieve “immortality”—or at least to extend life by multiple decades (see: Tad Friend. The Good Pill: Silicon Valley’s Quest for Eternal Life. The New Yorker, April 3, 2017. 34-67). For example Larry Ellison, of Oracle said: “Death has never made any sense to me...” While we think of public health as extending and improving life, the question of “for whom?” lies not very far below the surface. For each of us in this class, you will have more or less relevant populations you work to benefit. These can be identified in several ways: the people of the nation or county where you work, the aged, those who are affected by accidents or drug overdoses. These populations are people whom you either see as your equal, your clients or your “subjects”—and, you will likely view them as your peers. In that case, you will be seeking to extend or improve your own life by doing your work. Also, you will likely have developed a sense of justice that includes some element of your own individuality and shared destiny with others. But then, there is the reality of self-preservation and the desire to preserve and protect your own identity and, dare I say, health. I imagine that each of you do things that you see a “healthy” whether it be how you eat or how you
exercise or how you manage your temperament. The economy devoted to "health" products is very large in the developed ("Nutraceuticals Market to Reach $294.8 Billion by 2017" http://www.nutraceuticalsworld.com/issues/2013-09/view_industry-news/nutraceuticals-market-to-reach-2048-billion-by-2017/) and the less developed world in the form of herbal and folk remedies that have been commercialized.

For many years, I worked with a project called “America’s Health Rankings” which is a public relations approach to stimulating change in public health by comparing the US states on their relative “healthiness”. We will review that process as a stimulus for your thinking as well as a platform to discuss your philosophies of public health.

In the second half (HPM950) I will also introduce, very briefly, students to the world of scientific and policy inquiry. This course is intended to start you on the road to the development of your dissertation. In this introductory phase, the emphasis is on the social place of knowledge and the development of new ideas and approaches to solving problems in society. This course is intended to start you on the way toward forming a question that will be the center of your dissertation.

Before you can form a question, you have to have a sense of what you know and how you know it. To that end, we'll read things that are philosophical in nature. We will explore what is real and imagined and how we determine which is which. We will touch on the question “what is truth” but I don't want to pretend that we will be seeking truth, just talking about it.

The dissertation we are asking you to write is, in many ways, more rigorous than a traditional dissertation in that we ask that you focus on a practical problem and develop new ways to deal with problems. We do not ask that you "generate new knowledge" but that you generate new applications and new methods that will effect or create change in the world. That, in itself is a form of new knowledge—the difference being that there is a plan to apply it in the real world.
Course Objectives and CEPH Competencies
By the end of this course, learners will be able to:

<table>
<thead>
<tr>
<th>Course Learning Objectives</th>
<th>CEPH Competencies (by Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss current controversies in population health and contrast it with public health</td>
<td>5. Communicate public health science to diverse stakeholders, including individuals at all levels of health literacy, for purposes of influencing behavior and policies</td>
</tr>
<tr>
<td>Review the history and development of public health statistics, the profession of public health and how it has functioned in the political world, and: Use epidemiology and aggregate measures in political and policy contexts</td>
<td>6. Integrate knowledge, approaches, methods, values and potential contributions from multiple professions and systems in addressing public health programs</td>
</tr>
<tr>
<td>Recognize and apply the work of epidemiological policy entrepreneurs and thinkers who have viewed the world in an “ecological” contest and through an integrative lens.</td>
<td>22. Apply systems thinking approaches to learn about and inform collaborative action targeting complex public health problems</td>
</tr>
<tr>
<td>Use epidemiological analysis and aggregate measures of health in political and policy contexts. Discuss how there are conflicts between aggregate measures and individual experiences and how race and class based analysis can tend to exacerbate rather than ameliorate disparities.</td>
<td>1. Explain qualitative, quantitative, mixed methods and policy analysis research and evaluation methods to address health issues at multiple (individual, group, organization, community and population) levels</td>
</tr>
<tr>
<td>Examine major issues that may be resolved through a population perspective and discuss mechanisms and techniques for doing so</td>
<td>10. Propose strategies to promote inclusion and equity within public health programs, policies and systems</td>
</tr>
<tr>
<td>Reflect on multiple readings that challenge you to explore your beliefs in health and public health</td>
<td>11. Assess one’s own strengths and weaknesses in leadership capacities including cultural proficiency</td>
</tr>
<tr>
<td>Read and analyze definitions of population and public health and develop your own, personal definition and conceptual motivation for improving health.</td>
<td>15. Integrate knowledge of cultural values and practices in the design of public health policies and programs</td>
</tr>
<tr>
<td>Write formal reflections on multiple papers that describe scientific and philosophic approaches to improving health.</td>
<td>16. Integrate scientific information, legal and regulatory approaches, ethical frameworks, and varied stakeholder interests in policy development and analysis</td>
</tr>
</tbody>
</table>

Grading and Assignments:

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Due date</th>
<th>% of Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly “Reflections“ on Readings”</td>
<td>Weekly</td>
<td>35%</td>
</tr>
<tr>
<td>Model of determinants of population health</td>
<td>Sep 12</td>
<td>15%</td>
</tr>
<tr>
<td>America’s Health Rankings critique</td>
<td>Oct 10</td>
<td>15%</td>
</tr>
<tr>
<td>“Book Report”</td>
<td>Oct 31</td>
<td>20%</td>
</tr>
<tr>
<td>Participation / Quality of contributions to on-line discussions</td>
<td>Weekly</td>
<td>15%</td>
</tr>
</tbody>
</table>

Total 100%

You will receive a grade for the course according to the general rules of the Graduate School. Grades are “H” for outstanding contributions to the discussions and on the written materials. The standard is whether the material that you submit can be published with little modification in an op-ed piece in a major newspaper or web site, or in a substantial journal in health policy. The grade of “P” is “normal” and represents mastery of the material and that you have done fully acceptable work and made constructive contributions. The grade of “L” indicates that the individual has not grasped key concepts in the course and has not been able to contribute effectively but can, with work, achieve those levels. Any person doing “L” level work will be counseled by the instructor and given the opportunity to discuss their progress with other faculty prior to assignment of this grade. If you are not contributing substantively and there
appears to be no reasonable way to bring the work up to an acceptable level, you will be counseled and a grade of F assigned.

Send in your assignment as attachment to an email to me (tom_ricketts@unc.edu) I really prefer you not use the Sakai site to transfer material.

**Reflections on Readings:** You are required to write at least one page of reaction to the readings for each session (on-line and off-line). Those are to be sent to me by Monday, 5 pm Easter US time every week. These are an opportunity for you to react to the readings saying whether you learned anything from them or whether you agree or disagree with their content. I will respond with comments as soon as I can, usually before the next on-line session depending on my schedule.

**Model of Determinants of Population Health:** You will create your own causal/explanatory model of the Determinants of POPULATION HEALTH and defend it to the group. Please develop this as a visual (ah yes, the inevitable Powerpoint® but do not feel like you have to use that application, there are other things like Prezi that can do this, but make certain that it can be uploaded to the systems we use) that you will share on line, but you must also submit to me accompanying explanatory text and analysis of your model. **Due Sept 12**

**Technical Presentation/Policy Plan:** Scenario: You are to critique the America’s Health Rankings or the County Heath Rankings process and propose a modification to the ranking system you choose. For those outside the US, you may substitute a ranking such as one done by the WHO, OECD, World Bank or other agency relevant to a nation or region that is more familiar to you. **Due Oct 10.**

**Book Report:** You are to have read one of the books listed below—or an approved substitute—and write a two-to-three page “book report” to your cohort mates that tells how the book affected how you think about public health. No matter whether it is one from the list or one you choose yourself, you must let me know what book you will read and let me know by August 29, 2017. We will try to find the best match of person to book. Please do not pick one you have already read. These are all “fun to read” in some way or another. If you have a book you have read that inspired you that you would like to suggest to others in the cohort, please do.

You can choose from GoodReads Public Heath List: [https://www.goodreads.com/shelf/show/public-health](https://www.goodreads.com/shelf/show/public-health), Or from this list below. The report is Due October 31. Two pages, double spaced (approx. 800 words) is fine but you may feel the need to say more.

1. **A Common Struggle: A Personal Journey Through the Past and Future of Mental Illness and Addiction** by Mr. Patrick Kennedy and Mr. Stephen Fried. Mr. Kennedy, a former member of the U.S. House of Representatives and son of the late Senator Edward “Ted” Kennedy, recounts his personal struggle with addiction, depression and bipolar disorder in the larger context of his family’s mental health issues.
3. Andrea Barrett: **Ship Fever.** Short, included in a collection, not often noticed but it has a lesson for global health that we re-learn.
4. **Between the World and Me** (published in 2017), a profoundly moving essay by Mr. Ta-Nehisi Coates. This highly acclaimed book focuses on the fear of violence and humiliation experienced by the author as a young man in West Baltimore.
5. **Bossypants** by Tiny Fey. “I recently completed reading Tina Fey’s book Bossypants, which I found to be funny, of course, but also touched on gender issues in a unique way.
6. **County** by David A. Ansell, who talks about life, death and politics at Chicago’s public hospital.
7. Daniel DeFoe: **Journal of the Plague Year** (Gutenberg files www.gutenberg.org/files/376/376-h/376-h.htm)
8. Geoffrey Rose: **The Strategy of Preventive Medicine.** The paradox of prevention, for the person who hasn’t read this and loves epidemiology.
10. Michel Foucault: **The Birth of the Clinic.** Medicine as “carcereal”; how power is transmitted in the social construction of medicine. Deep but not too deep, Foucault’s interpreters are far harder to understand than he is.
11. **Random Family** by Ms. Adrian Nicole LeBlanc, an extraordinarily evocative exploration into how cycles of disadvantage influence everything about lives, across generations, and the ineluctable role of social determinants if we want to improve health.

12. Rene Dubos: *Mirage of Health*. I consider this a seminal work on how humans cope, from the man who coined the phrase, “act local, think global”. You may also choose one of his other books like *Man Adapting*.

13. Sinclair Lewis: *Arrowsmith*. A wonderful story of the conflicts between medicine and public health and biomedical research in the 1920s. Complete with the “model family”. A page turner with a story

14. *Sweetness #9* by Stephan Erik Clark. It is a comic novel that depicts the confessional narrative of a food scientist complicit in the development of a chemical additive that has played a sneaky role in America’s obesity epidemic.

15. *The Moral Landscape* by Sam Harris. “Moral Relativism is simply false” This book tries to convince us that science can help us understand values—in fact, develop our values. It's public health angle comes in the valuing of lives part.

**OR**, you may choose a book that you might consider a ‘classic’ of public/population health that I haven’t identified. You must clear your proposed book with me by August 29. Please do not propose a book you have already read, but select something you WANT to read and have felt guilty about—or that has caught your imagination/interest.

**Class Attendance/Participation:** Learners are expected to participate in the on-line sessions and be prepared to participate in discussions with faculty and classmates. Interactions are sometimes difficult due to the limitations of the technology as well as the fact that we will be discussing things where there are disagreements. Our on-line discussions allow you to have “side” conversations that you may conduct in the “chat” window or with your colleagues via other means—but try not to “hide”. I encourage you to use side-stream systems to communicate, but do share them at some time. On-line communications tend to “flatten” communications and hides body language tips that help smooth out misunderstandings. So, be prepared to work in a “moderated” environment.

Credit for this part of the course is divided into two aspects: on-line and off-line participation. The material assigned for readings should prompt you to read further on your own. I am interested in how you pursue certain topics and issues and how you relate your professional lives to the material that is presented—so don’t hesitate to describe in your reflections how you “wandered” around a topic.

**Show and Tell**

We welcome “show-and-tell” where you bring to the discussions current events and specific issues that you encounter in your lives/work. I will likely open each session asking if anyone has a “show and tell” item/issue. I will raise my own as well. Given we are living in tumultuous political times it is likely that some things we not yet heard of will dominate our discussions.

**Course Evaluation**

HPM participates in the UNC-CH’s online course evaluation system, enabled at the end of each semester by DigitalMeasures. Your responses will be anonymous, with feedback provided in the aggregate. Open-ended comments will be shared with instructors, but not identified with individual students. Your participation in course evaluation is an expectation, since providing constructive feedback is a professional obligation. Feedback is critical, moreover, to improving the quality of our courses, as well as for instructor assessment.

**Required Texts:**

How to read "Population Health". This is a very well written book and serve more as a general introduction and discussion of public health and population health that any other general book on the subject. I have assigned sections of the book that will be the focus on discussions in class, and those are not sequential. I do recommend you open the book and start with the Introduction—you will find that T. Kue Young spends time explaining some of the basic things about public health—where it comes from, what it is—and he includes many little "boxes" of neat information, like the derivation of the word "health" in Box 1.1. I recommend to you the humorous description of an epidemiologist on page 8. To the right is a picture of a "Monroe Machine" essential for calculations of rates in the way back times.

Yes, the book is getting dated, but I find that it remains the best of its class. I am someone who feels you should really get an introduction to the history of public health and its "great people" and Young takes time to include discussions or description of the people who really have shaped how Public Health is structured and thought of. People like Rene Dubos, Jerry Morris, and Ivan Illich to name a few of the greats who appear early in the book. You can actually pick up the book and open to random pages and find out new things about public health you will be glad you learned—if not just for their utility at cocktail parties.

I require all of you to read all of the excellent book: The Ghost Map. By Steven Johnson (Penguin, 2006) see his TED talk at: https://www.ted.com/talks/steven_johnson_tours_the_ghost_map?language=en. This is a great book about how evidence and policy sometimes don’t get along. It also tells the story of one of the first epidemiologists and his work. $15.00 in paperback. Due November 8.

America’s Health Rankings™ 2015 Edition. www.americashealthrankings.org for almost 10 years I was the chair of the scientific advisory committee supporting the development of the rankings system. The state rankings spurred the development of the county rankings supported by the RWJ Foundation and are seen as a stimulant to policy makers to think about the integration of public health principles into health policy in general. See October 25 Session.

Supporting and supportive web sites include:

http://www.improvingpopulationhealth.org /

If you have a favorite blog that follows public health—share it with us.

www.healthmetricsandevaluation.org/ Institute for Health Metrics, University of Washington.

http://uwphi.pophealth.wisc.edu/ University of Wisconsin Population Health Sciences

http://www.aihw.gov.au/population-health/ Australia’s population health project


Rose, Geoffrey. The Strategy of Preventive Medicine, Oxford Medical Publications, 1992. ISBN 0-19-262486 5. This book lays out some awkward facts about how “health” is distributed and how our behaviors are constrained by society and how our policies rest on some strange beliefs and values. It appeared in 1992 and has been reprinted every year since. You will have access to an extended article based on the book

UNC HONOR CODE
The principles of academic honesty, integrity, and responsible citizenship govern the performance of all academic
work and student conduct at the University as they have during the long life of this institution. Your acceptance of enrollment in the University presupposes a commitment to the principles embodied in the Code of Student Conduct and a respect for this most significant Carolina tradition. Your reward is in the practice of these principles. Your participation in this course comes with the expectation that your work will be completed in full observance of the Honor Code. Academic dishonesty in any form is unacceptable, because any breach in academic integrity, however small, strikes destructively at the University's life and work. If you have any questions about your responsibility or the responsibility of faculty members under the Honor Code, please consult with someone in either the Office of the Student Attorney General (966-4084) or the Office of the Dean of Students (966-4042). See appendix.
Read "The Instrument of Student Judicial Governance" (http://instrument.unc.edu).
### Class Schedule Summary, please refer to specifics under each data/session:

First class: 4:00 – 5:25pm EST/EDT all sessions are at 4 pm Eastern time
Break: 5:25 – 5:35pm EST/EDT
Second class: 5:35 – 7:00pm EST/EDT

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date</th>
<th>Topic</th>
<th>Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>prologue</td>
<td>Aug 16</td>
<td>In class</td>
<td>Introduction</td>
</tr>
<tr>
<td>1</td>
<td>Aug 22</td>
<td>online</td>
<td>Population Health</td>
</tr>
<tr>
<td>2</td>
<td>Aug 29</td>
<td>online</td>
<td>Measuring Health</td>
</tr>
<tr>
<td>3</td>
<td>Sep 5</td>
<td>online</td>
<td>Communicating Health</td>
</tr>
<tr>
<td>4</td>
<td>Sep 12</td>
<td>online</td>
<td>Modeling Health</td>
</tr>
<tr>
<td>5</td>
<td>Sep 19</td>
<td>online</td>
<td>Risk, Behavior, and Choices</td>
</tr>
<tr>
<td>6</td>
<td>Sep 26</td>
<td>online</td>
<td>Politics and Health</td>
</tr>
<tr>
<td>7</td>
<td>Oct 3</td>
<td>online</td>
<td>Democracy and Health</td>
</tr>
<tr>
<td>8</td>
<td>Oct 10</td>
<td>online</td>
<td>Ranking Health</td>
</tr>
<tr>
<td>9</td>
<td>Oct 17</td>
<td>online</td>
<td>The Sciences</td>
</tr>
<tr>
<td>10</td>
<td>Oct 24</td>
<td>online</td>
<td>Science and Politics in Health</td>
</tr>
<tr>
<td>11</td>
<td>Oct 31</td>
<td>online</td>
<td>Bullshit and Science</td>
</tr>
<tr>
<td>12</td>
<td>Nov 7</td>
<td>online</td>
<td>A Philosophy of Public Health Science</td>
</tr>
<tr>
<td>13</td>
<td>Nov 14</td>
<td>online</td>
<td>Heroes of Public Heath</td>
</tr>
<tr>
<td>14</td>
<td>Nov 28</td>
<td>online</td>
<td>Aristotelian Analysis-Dissertation</td>
</tr>
<tr>
<td>15</td>
<td>January</td>
<td></td>
<td>Wrap Up Session</td>
</tr>
</tbody>
</table>
Session by Session Schedule

**Introduction: 1045, August 16, 2017. On Campus, 2005 Hooker**

Welcome to HPAA 860-950

- Course overview and review of syllabus
- Introduction to a Philosophy of Public Health and Population Health
- Discussion of the ACOs and public health case paper and presentation:

We will discuss some things that have been in the news lately (Zika, health insurance, Migration, War) and the issues that will structure some of our work and study over the next two years. Please pay attention to the world of health ratings and rankings as we will discuss these from time to time.

**T. Kue Young Book.** This is a good introduction to epidemiology and population health and it serves as a self-paced learner with questions included in the text. I expect you to go through the entire book and to work all the exercises. They are not too difficult and will help you become aware of technical terms and processes in the calculation of health indices for populations. Many of you will have had training in epidemiology and this will be a review, others may not be at all familiar with this material. You will not be “tested” on the material, but we will try to review each of the main points throughout the course. In the sections below I refer to the book as **YOUNG**.

You may want to look at some international comparisons of health systems. The Commonwealth Fund has generated a series of these. You can get some charts and graphs and a good report at: [http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017](http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017) The report is downloadable and the first author is Eric Schneider, MD, Senior VP at the Commonwealth Fund. Who is the Commonwealth Fund and why are they rating the US health system in comparison to other nations?

Background to some of the materials you will have been given (Not required). The IHI **Population Health 101** course might be interesting to look at online but it now requires a subscription—if you feel like paying $300.00, go for it. [http://app.ihi.org/lms/onlinelearning.aspx](http://app.ihi.org/lms/onlinelearning.aspx)

**FUN STUFF**

Google “Public Data” Life Expectancy graphs ([www.google.com/publicdata/](http://www.google.com/publicdata/)) Play with the data—you can "animate" fertility rates and life expectancy for example and see who is going down, who is going up.
Session 1, Population Health August 22 online

Readings:
REMEMBER. You are to send me via e-mail a “reflection” on the readings for this session by 5 pm Monday, August 21. Submit these reflections every week by 5 pm of the Monday before class, whether we have an on-line session or not.

These are a selection of readings about public and population health and ACOs, there will be many more out there—these are not necessarily the best. You may suggest some to your colleagues or comment on additional articles in your feedback paper.

YOUNG: Read: Introduction and Measuring Health and Disease in Populations, page 1 through page 62 and the last chapter (yes, we start with the dessert in this class) Improving the health of populations, p. 324-326.

Dave Kindig’s blog entry on population health and population medicine. OPTIONAL
http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/

Session 2, Measuring Health: August 29, 2017

Note reflection due 5 pm August 28, 2017. You should have chosen your book and reported it to Prof Ricketts by this date
We will continue to consider how you measure population health (or public health, or national health or community health...) and you may have been able to reflect on your reflection of last week. But consider how you would measure health and why.

Readings:
YOUNG: Read: Measuring Health and Disease in Populations (II) through page 111. This section will introduce the notion of “summary measures of population health”: See page 81, for descriptions of these metrics.
Alper, Joe. Metrics That Matter for Population Health Action. Washington, DC: National Academies Press, 2017 available at http://www.nap.edu/21899 or in the Resources section on Sakai. This is a relatively long item and you are not expected to read it all, but do read chapters 1, 2 and 6.

You may select another substantial reading on “summary measures of health” and you may want to reflect on how they might be used or not used to assess how ACOs are improving population health.

Session 3, Communicating Health Sep 5, 2017, online

What are disparities? And how do they fit in with Social Determinants of Health...or are they the same thing.

Readings: YOUNG. Planning Population Health Interventions pp 264-295. This moves us forward in the book a bit, but touches on what our initial policy reactions are when we tackle inequities: “Programs” of various sorts intended to change the risk profile for groups. Is that the best way to deal with inequalities?

Pick either one of the next two:
Daghofer, Diana 2011. Communicating the Social Determinants of Health. Wellspring Strategies. (Fort Collins, Colorado). There are many discussions of the social determinants of health. This volume tackles the problem of how to argue about disparities it.
Session 4, Modeling Health: Sep 12 2017  Your "reflection" is in the form of a proposed model of health that reflects your beliefs and helps prioritize decisions to improve health and reduce inequality due Sept 11 2017.

Model of Health Due!!! Send them via e-mail attachment to me (not via the Sakai site) in .ppt format is fine or whatever you can use to “visualize” health.

Modeling Population Health
Politics and policy making are important to population health and the population approach, but the field is equally a technical one. Epidemiology and biostatistics are important parts of the armamentarium of the public health professional who uses a population approach. We are assuming that you have the basic skills of these two disciplines but a review is useful at any time because there are trends and changes in the technical fields as well as in the political aspects of population health.

Readings:
YOUNG: "Modeling Population Health" pp 115-173. The America's Health Rankings technical advisory group has struggled to develop a “model”. For your “reflection” I’d like for you to develop your own causal/explanatory model of POPULATION HEALTH and defend it to the group. Please develop this as a visual that we will share, but you must also submit to me accompanying explanatory text and analysis of your model.

Session 5, Risks, Behaviors and Choice: Sep 19, 2017

Readings:
YOUNG. Three Chapters: Assessing health risks in populations and Designing Population Health Studies. Pages 177-261. This is a big chunk of reading, but you may have gotten to it prior to this week.

This provokes discussions of perception and choice making and evokes Blaise Pascal and the behavioral economists. You should read one of the following:
One of the articles/chapters in: "A Brief History of Decision Making" and "Bounded Rationality":
Or some of Dan Ariely’s material
Or, if you are really ambitious, you can take on: Cass Sunstein’s. . Nudge. 2008NewHaven, Yale Univ. Press. (better yet, look up the New Yorker gloss of it.

Session 6 Politics and Health: Sep 26, 2017

Readings

And, you must at some time in your life (might as well be now) read this:
Geoffrey Rose : “Sick individuals and sick populations.” (Rose Paradox and Rose Challenged in Course Resources) This is the gist of Rose’s “paradox of prevention”. If you find this interesting you may want to purchase his excellent little book, The Strategy of Preventive Medicine. And read the entire book with special emphasis on Chapter 7, “The Population Strategy of Prevention.” pp. 95-106.

Symbols and arguing: Deborah Stone in “Policy Paradox,” wrote that much of the policy process involves debates about values masquerading as debates about numbers and facts. If you do a thesis on policy making, you will need to read that book or understand its contents. I recommend it highly.
**My reflection on a reflection from a prior cohort:**

In a class a year or so ago I responded to a student’s reflection that included a strong concern about the state of politics in public health these days. She had written: "But, in many ways policy making has lost its innocence. It has turned into a way to pool power, increase influence, and strengthen factions." Last evening provided an example of one of those mechanisms. It was a dinner and speech and you simply had to be there if you were trying to be part of the North Carolina Health Policy making universe. As I was a board member of the organization that hosts it, I was there—I generally don’t go to these things anymore. A young lady walked up to the small group I was chatting with and introduced herself…we invite a number of students from the School of Public Health under a mentor program so that they can "network.” She was one of them. It was clear that this person was familiar with the networking drill and I soon learned why. She has worked for three years for Senator Cornyn, the senior senator from Texas. We chatted a bit and found a number of commonalities, she was from Richmond, VA the place I was born and she had a wish to engage in health policy making. I had also worked in the Senate for a brief period in the 1970s (as a journalist) and enjoyed learning the ways of that body and how policy was made. I asked why she left to go back to school and she replied that the "policy making process in the Senate just wasn’t much fun anymore" and that “there wasn’t really all that much real policy development going on.” I replied that I had a similar discussion with an old colleague and two former students who worked "on the Hill" just a week or so before—they talked about how there used to be serious discussions (with no partisanship) among Senator’s and Member’s and, more importantly, the knowledgeable people on committee staffs and that there was really substantive, sequential development of policy related to medical payments, prevention, VA medical care…the gamut of health policy. There would be sharp divisions at times—over policy not ideology, and real debates would ensue. There would be sincere discussions over which way to go on a particular issue, like reform of drug pricing for Medicare. Then a committee hearing would help thrash out differences as Senators (I rarely was on the other side of the building) would state their cases and then make considered votes on the contents of a bill or the report to accompany a bill (at the time, the report was usually a very important part of the framing and later interpretation of legislation). Eventually a full bill reflecting these discussions would go forward for a floor vote and often as not become part of the law—guiding policy.

That doesn’t happen anymore according to the three people I have either reminisced with or discussed current trends in the Senate over the past two weeks. That form of POLICY MAKING has indeed given way to the struggle for abstract "power" and the reasons for that are multiple—but it's an old tale, millennia old. Whether things will return to the old days is difficult to say but not likely. However, the complexities of the system require some degree of dispassionate consideration if our body politic is to, as you quote: "to protect and promote public health and to protect and promote human rights." But as I read those words I realize how not all those who enter this field as politicians or political aspirants feel that that is the job of government—to be part of the process that takes responsibility for public health. Somehow the professional responsibility of protecting the public’s health has been divorced from the symbolic and ideological politics that appear on Twitter. Who will do the serious deciding that will guide the professionals in a revised and reformed system? Or is the next phase of the development of the system just too muddled to anticipate? There are real challenges yet to come for what we call public health and for the public’s health—and the two are not synonymous by any stretch of the imagination. I contend that the requirements for the public’s health are generally apparent and often are achieved without the public policy process really directing it. It might be that the largely undirected public health enterprise in the United States simply follows the evolution of the human population and the nature of the planet without a real centralized guiding structure. We react with rules and structures in response to whatever next tragedy or catastrophe forces us to. So, I haven’t panicked because the Congress (not to mention the Administration) is dysfunctional, I just hope we haven’t damaged the mechanism that relates itself to some degree.

You (referring to the student) called the American political system, “morally questionable”, and I read that in a sense that you see it as not fulfilling its moral duties. That, again, is an old story. There have been many morally questionable political systems, in fact, some might say that it is the very nature of political systems to subvert morality. Nevertheless, political systems are the dominant way to resolve moral conflicts in places where religion does not hold absolute sway and I count the responsibility to protect health a moral responsibility somehow managed by policy and politics. We (the United States) allow a very wide range of moral conflicts to emerge through our liberal ways (liberal in the old sense) and we dampen the effect of religion on purpose. Bad decisions are not necessarily immoral, but those that reduce freedom, injure people’s health, and restrict their opportunities, are.
(The student also asked about why rural populations were being treated so badly in our political system and I replied more or less in this way) Place—I am fascinated by the idea of place—both from my old rural health policy days as well as in a semi-academic role (I am on the editorial board of the journal Health and Place)... 'Place-ness' depends a lot on both the realities of the contents of the place—its people, their skills, their resources—as much as the 'perception' of what is there by both the people who inhabit the place and the people who have to regard the place with some action or policy. I would say that how urban policy makers view rural places has as much to do with the risks that are felt in those places as does the makeup of the population. The key intersection I see is the one between those two competing "gazes"—from the rural or outsider in contrast to the urban or insider perspective. I base this on a fairly long experience living in essentially a rural place (Chatham and Pamlico Counties) and acting as an advocate-researcher in rural health. Rural folks don't necessarily see the balance between their "freedom" and autonomy in a rural place as out of line with their risks for illness and a smaller opportunity space. The urbanites (usually from a University) who wander in with "solutions" to their problems requiring behavior changes don't quite understand why folks resist them.

Session 7 Democracy and Health:  Oct 3, 2017
The relationship between democracy and public health.

That’s the question for your reflection: What is the link between democracy and public health? These are two very central concepts—one would think one would have a good handle on this…but, truthfully, how many times have you considered the relationship between the two—Conceptually? Locally? Nationally?

Readings: You’re on your own here, see what you can find—identify three articles or reports you feel are key to this topic and reflect on their content (emphasize one if need be). You might Google® things like “democracy and health” and I will know what you will find)—or you might dig a bit farther. Ever heard of someone named Paulo Freire.

Some quotations:
"....In recent years, the spread of infectious diseases across national borders has brought the global dimensions of public health to the center of the international political and legal agenda. New outbreaks of diseases such as AIDS and SARS, and the recognition that health and health care are influenced by the global distribution of resources, have challenged traditional legal and regulatory approaches to public health issues.

At the same time, the traditional theoretical preoccupation with the state, in legal and other literatures, began to decline. In its place, scholars from across a variety of disciplines are focusing on "governance," rather than state law, as a paradigm for organized social control of behavior, and on the variety of transnational, supranational and private actors that participate in an emerging system of global governance. Many of these scholars suggest that much governance is achieved without recourse to law, and highlight the expanding roles that markets, international bodies, NGOs, corporations, and other actors play in an increasingly globalized world. In the case of a good traditionally seen as "public," such as public health, the new descriptions of governance raise important practical and normative questions about the responsibilities and accountability of non-state actors. I ask this question: Is this (the focus on governance) a "retreat" from Public Health principles of the past to a new quasi-democratic form? Or is it a recognition that only in a participatory democracy that accepts government by the people can you have true advances in public health? Or, is it a nod to "managerialism" in social issues?

Session 8 Ranking Health:  October 10, 2017
Assignment is not a reflection but a brief one page essay on: “How would you improve America’s Health Rankings®

Deep breath time. I would like for you to review the America’s Health Rankings and tell me how you would improve them, just a page of insight on how you might go about this. Scenario: You are to critique the America’s Health Rankings scores or methods and propose a substitute for a specific nation, region or jurisdiction.

Session 9, Sciences—Consilience:  October 17, 2017
Wilson, Edward O. Excerpts from Consilience. Chapter 3, The Enlightenment” and Chapter 9, “The Social Sciences." Your reflection may prove challenging as Wilson is challenging.
Let's also talk about what we might have learned about learning from the GHOST MAP that speaks to the relationship between science and health.

We are treating public health these days as something of a social science. But public health is very tied into “hard” science and its problems. In fact, public health is the true collision of the natural with the social sciences—but we don’t think much about how well the two get along. Edward Wilson has and he wants us to bring them closer together—to generate “consilience”. But first, how have we looked at the social end of our experience? John Snow’s experiences in London in the 1830s are the perfect example of the collision between the physical, in the form of sewers, cesspits and a vector, the cholera vibrio, and the social, in the form of contemporary norms and behaviors, laws and their absence, and religion and its influence. The lesson of the Ghost Map is that the same factors influence our search for a healthier world and that the “scientist-public health professional” must master the details on both sides.

I am also including a brief description of how some great public health discoveries are made...in the focus case it is the story of how Jerry Morris came to link physical activity and cardiovascular disease. Do you know who Jerry Morris is? Read his story and learn about the origins of some research (materials on Sakai or Google: “Jerry Morris Exercise”). Thinking of Jerry, we can present ourselves with this question, “is his work qualitative? Was his qualitative observation about bus conductors part of his later quantitative analysis or a thing of itself. Qualitative inquiry is controversial, see the debate about it between Greenhalgh and the BMJ. Available on the Sakai site BMJ 2017;352:i563

There is a current debate about some comparative “rates” having to do with Maternal Mortality. I ask you this question “How does the United States compare to other countries in maternal mortality and how has that comparison changed?”

This session will focus on reliable evidence in health policy debates and the role of "bullshit"

Can you provide an example of “bullshit” in public health?


The following is an abstract from "the literature", do you find it bullshit or not?

*Abstract:

Objective: to present a critical reflection upon the current and different interpretative models of the Social Determinants of Health and inequalities hindering access and the right to health.

Method: theoretical study using critical hermeneutics to acquire reconstructive understanding based on a dialectical relationship between the explanation and understanding of interpretative models of the social determinants of health and inequalities.

Results: interpretative models concerning the topic under study are classified. Three generations of interpretative models of the social determinants of health were identified and historically contextualized. The third and current generation presents a historical synthesis of the previous generations, including: neo-materialist theory, psychosocial theory, the theory of social capital, cultural-behavioral theory and the life course theory.

Conclusion: From dialectical reflection and social criticism emerge a discussion concerning the complementarity of the models of the social determinants of health and the need for a more comprehensive conception of the determinants to guide inter-sector actions to eradicate inequalities that hinder access to health.
What are we to expect of “science” and the science of public health? Do we expect to know much more in ten or twenty years and that the discoveries of today are to be replaced by what are often introduced as: “new studies say...”? Science in the 19th century began to show this kind of rapid and displacing pace of change both in the changes it wrought in real life as well as in the theories that underpinned the work. Scientists went from being “artists” of knowledge who were supported by wealthy sponsors to salaried “professionals” certified by the academy and supported by universities or industry.

**Science as a controversial concept**

These are included in one posted reading—Popper Kuhn

Popper, Karl. “The problem of demarcation,” from The Philosophy of Karl Popper. And

https://www.youtube.com/watch?v=wf-sGqBsWv4

Kuhn, Thomas. “Anomaly and the emergence of scientific discoveries,” from The Structure of Scientific Revolutions.

This is where we get the idea of ‘paradigm shifts’.

“As David Hume wisely and provocatively wrote, “Reason is, and ought only to be, the slave of the passions, and can never pretend to any other office than to serve and obey them.” Only now, we must acknowledge that there are sciences that aim to describe and explain the passions.” “David Hume, A Treatise of Human Nature, eds. David Fate Norton and Mary J. Norton (Oxford, England: Oxford University Press, 2000), 264.”

Charles E. Lindblom: “A social scientist (Gregg, 1979) writes: “Most students of human nature and society agree that the common sense knowledge we have of our lives consists largely of misunderstandings.” But, in Popper’s judgment, “All science, and all philosophy, are enlightened common sense.” (Objective Knowledge) A political philosopher who has studied the methods of social science say that “what we have to learn from the social sciences as they now exist is how little understanding the social sciences can give us beyond the everyday understanding of social life that we have anyway.” (Alisdair MacIntyre, “The Survival of Political Philosophy”) But then again Descartes long ago wrote that true knowledge requires an intellectual purge to drive ordinary knowledge out of the mind—presumable a task for professionals, not amateurs.” Charles E. Lindblom. “Professional Dependence on Lay Probing, in Inquiry and Change.

---

**Session 13, A Time for Heroes? Nov 14, 2017**

Your task for the week is to identify your “hero” in public health and explain why they are your hero. Who are your heroes of public health?


30 Most influential people in public health?

http://www.masterspublichealth.net/30-most-influential-people-in-public-health/

When I googled “Women in Public Health” Google unhelpfully suggests the following search terms:

<table>
<thead>
<tr>
<th>Searches related to women in public health</th>
</tr>
</thead>
<tbody>
<tr>
<td>famous female doctors in history</td>
</tr>
</tbody>
</table>

are women left out of the “hero” category? (Yes, I went and saw Wonderwoman when it came out—with my wife.)

---

**Session 14, Aristotelian Analysis Nov 28, 2017**

OK, you’ve struggled with questions, now you are going to have to try out a dissertation question—more formally. So, pose a question that COULD be a dissertation question and then subject that to an ARISTOTLE test..see the file "Aristotestopics" posted on the Sakai site. Fill in the empty parts of the table using your draft dissertation topic.

I often use the term "cocktail party material" to describe what I consider useful information that will help you engage people in a social setting. The rules that govern that process of "capture" apply to dissertations. Consider this from a very nice discussion of how to come up with a topic for writing; "Understand that scholarship is the written exchange of a particular community - in this case, the academic community. As a student, you have joined this community, attending it like you might attend a cocktail party that has the peculiar quality of being centuries-long. In essence, what is expected of you as a student isn’t so very different from what is expected from you as a party-goer. As is true
of any party, there are principles of conduct that govern your behavior. Nevertheless, the basic principles of conversation are the same in the academy as they are at the cocktail party: you must listen well, you must think about what you are hearing and your response to it, and you must contribute to the conversation in a way that is relevant, thoughtful, and interesting. - See more at: https://writing-speech.dartmouth.edu/learning/materials/materials-first-year-writers/coming-your-topic#sthash.fB8Ergof.dpuf

Session 15, Helping you toward a dissertation    January, 2018
We will discuss "strategies" and tactics for getting your dissertation done.
Recognizing, Valuing, and Encouraging Diversity

We, the School’s leadership, are committed to ensuring that the School is a diverse, inclusive, civil and welcoming community. Diversity and inclusion are central to our mission — to improve public health, promote individual well-being and eliminate health inequities across North Carolina and around the world. Diversity and inclusion are assets that contribute to our strength, excellence and individual and institutional success. We welcome, value and learn from individual differences and perspectives. These include but are not limited to: cultural and racial/ethnic background; country of origin; gender; age; socioeconomic status; physical and learning abilities; physical appearance; religion; political perspective; sexual identity and veteran status. Diversity, inclusiveness and civility are core values we hold, as well as characteristics of the School that we intend to strengthen.

We are committed to expanding diversity and inclusiveness across the School — among faculty, staff, students, on advisory groups, and in our curricula, leadership, policies and practices. We measure diversity and inclusion not only in numbers, but also by the extent to which students, alumni, faculty and staff members perceive the School’s environment as welcoming, valuing all individuals and supporting their development.

For more about diversity and inclusion at the School, visit our Diversity and Inclusion page.

Advice on plagiarism
http://writingcenter.unc.edu/handouts/plagiarism/

Disability Accommodation

“UNC-CH supports all reasonable accommodations, including resources and services, for students with disabilities, chronic medical conditions, a temporary disability, or a pregnancy complication resulting in difficulties with accessing learning opportunities.

All accommodations are coordinated through the UNC Office of Accessibility Resources & Services (ARS), http://accessibility.unc.edu; phone 919-962-8300 or email accessibility@unc.edu. Students must document/register their need for accommodations with ARS before any accommodations can be implemented.”

Course Evaluation:

“HPM participates in the UNC-CH’s online course evaluation system, enabled at the end of the semester by Scantron Class Climate. Your responses will be anonymous, with feedback provided in the aggregate. Open-ended comments will be shared with instructors, but not identified with individual students. Your participation in course evaluation is an expectation, since providing constructive feedback is a professional obligation. Feedback is critical, moreover, to improving the quality of our courses, as well as for instructor assessment. For Fall 2017, the system will be open for students to complete evaluations from Date TBD (see announcements).

Attention: Required Human Subjects Training

The University now requires that all faculty, staff and students who are engaged in the planning, conduct or analysis of research at UNC-Chapel Hill involving human subjects complete an online training module. This training must be completed before you can begin work on your dissertation. We recommend that you complete this module during your first semester in the Doctoral Program.

Please refer to the rules at UNC human subjects training at http://research.unc.edu/human-research-ethics/getting-started/training/.