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[01:00:37:24 - 01:01:11:24]
Intro:
Welcome to The Skin You're In, a podcast about health and the forces that shape it. We go beyond medicine to explore how race, place, policy, and culture influence who has the opportunity to live a healthy life and what it will take to achieve health equity. From data to lived experience, from public policy to music and the arts, we connect the dots between systems and stories. Health doesn't happen in isolation. It's shaped by the world around us and the skin we're in.

[01:01:15:20 - 01:01:31:16]
Dr. LaVeist:
Hello and welcome to The Skin You're In podcast. I'm your host, Thomas LaVeist, Dean and Weatherhead Presidential Chair in Health Equity at the Tulane–Celia Scott Weatherhead School of Public Health and Tropical Medicine, and Principal Investigator of Partners for Advancing Health Equity.

[01:01:32:18 - 01:01:51:17]
Dr. LaVeist:
I'm also the writer and director of the documentary The Skin You're In, and I'm excited to introduce today's guest, Dr. Georges Benjamin. Dr. Benjamin is a physician and the Executive Director of the American Public Health Association, recognized as a prominent health policy leader, practitioner, and administrator.

[01:01:52:18 - 01:02:02:01]
Dr. LaVeist:
Prior to joining APHA, Dr. Benjamin was Secretary of Health in Maryland, where he oversaw the expansion and improvement of the state's Medicaid program.

[01:02:03:01 - 01:02:13:24]
Dr. LaVeist:
Today, Dr. Benjamin is known as one of the nation's most influential physician leaders, who speaks passionately and eloquently about the health issues having the most impact in our nation today.

[01:02:15:04 - 01:02:40:22]
Dr. LaVeist:
We're honored to have you today, Georges. Tom, thanks for having me. You know, you've had a long career in public health, but you've had some really hard jobs. You were Washington, D.C.'s health officer and in Maryland for 9/11. You were at APHA for Katrina, heading up APHA during DOGE. What have you learned over the years dealing with these crises?

[01:02:42:23 - 01:02:49:03]
Georges C. Benjamin:
You know, all of these various crises that we've had, it's kind of like working in an emergency department.

Sometimes there are real challenges, and sometimes there are not. I've learned how to triage, to figure out what's important and what to focus on first. And at the end of the day, you know, trying to improve the health of the public is the goal. And so I try to line up everything to achieve that goal.

[01:03:10:08 - 01:03:14:08]
Dr. LaVeist:
But is that different during a crisis or on a day-to-day basis?

[01:03:14:08 - 01:03:42:07]
Georges C. Benjamin:
Yeah, in a crisis, you know, you have to figure out, as you say, which person is going to die in your emergency department waiting to be seen? It usually isn't the one that is the crisis right in front of you. It's the one that is sitting there lurking, that doesn't look like there's a crisis. So you have to address the one that's there in front of you, but you also always have to have another eye looking at what's going to be the next crisis, what's the one that's happening that you haven't thought much about. Remember 9/11, while we were all worried about the airplanes that hit the World Trade Center and the Pentagon, and there were all these concerns about what attack would come next. Months later, we had no thought that somebody would have used that timing to send anthrax through the mail. In fact, we didn't even think the average person could refine anthrax. Of course, it turned out it was someone who was an expert at doing it. But we never even thought that that would be an issue for us. But it turns out it was a big issue.

[01:04:17:07 - 01:04:26:00]
Dr. LaVeist:
So I noted that in these leadership roles, you've been in — sometimes even in government, sometimes you've been outside of government. Where have you found that you can have the most effect?

[01:04:27:20 - 01:04:52:16]
Georges C. Benjamin:
You know, I'm an action guy. So I certainly like to have my hand on the wheel, my hand on the football, as they say. I love to be in government in terms of actually making things happen. Because in many ways, being an advocate is good and wonderful, and you can influence a lot. But actually being the person that makes it happen is very appealing.

[01:04:54:07 - 01:05:02:26]
Dr. LaVeist:
So what are those tools? The tools for making it happen from an advocacy standpoint. And in other words, as Executive Director of APHA, where do you have power? Where do you have perceived power? And where do you maybe not have as much power as others might think?

[01:05:11:15 - 01:05:19:11]
Georges C. Benjamin:
Well, you know, APHA has always been more influential than our size, our budget, has given one the impression that we should be. So we've always had, in many ways, an outsized

influence. Part of that's because we're over 150 years old. Part of that is because my staff and my members have seen things, and we can rely on that. But, you know, there are many people who think that we have billion-dollar budgets like the Heart Association and the Cancer Society have. And when I got there, our budget was $12 million. It's now about $25 million.

[01:05:52:23 - 01:06:04:26]
Georges C. Benjamin:
They think that there are 1,000 staff people under our roof. There are 75 of us. So we do have more influence than one might expect. But I think it's about focusing that influence on the things we think are important. We kind of focus on a few things that we think can make an impact, recognizing what our role in this enterprise is. Our role is that we're not going to be the group that's going to put together a program that's going to make people healthy. But what we can do is we can help build the capacity of the field to make people healthier. And so we focus like a laser on helping build the capacity of the field to do its work.

[01:06:32:19 - 01:06:37:14]
Dr. LaVeist:
So when you say make people happy, what do you actually mean by that?

[01:06:37:14 - 01:06:49:08]
Georges C. Benjamin:
Well, make people healthier. You know, I've always talked about life, living in pursuit of happiness. I think those are fundamental to getting up every day, doing what you do, and feeling well.

So at the end of the day, we're trying to, through what we do, help the field build this capacity to make sure the air is safe to breathe, the water is safe to drink, that when you get up and you move from one place to another, you're not going to be injured by something that's preventable. We give people the assurance that life can be grand if you do things that can give you longevity. We work very hard to do that.

[01:07:16:21 - 01:07:37:26]
Dr. LaVeist:
Yeah. So when you said "happy," I thought what you were talking about was from a political standpoint. We're in public health. We talk about evidence-based approaches and we try to use the science to guide where we go. But there is ideology. There are political perspectives that are dominant in our field, aren't there?

[01:07:37:26 - 01:07:41:11]
Georges C. Benjamin:
Oh, absolutely. I mean, we all bring biases to the table. We all bring our life experiences, our upbringing. It drives what we think, what we do, what we think is valuable.

[01:07:48:19 - 01:07:55:08]
Dr. LaVeist:
Yeah, but as individuals — but there are dominant political ideologies in public health.

[01:07:55:08 - 01:08:01:00]

Georges C. Benjamin:
Yeah, there are. I think we'd be fooling ourselves to think that public health has one ideology.

Half my members live in conservative states. While some of them may be more progressive in some areas, in terms of things they think are important, there are things that they do differently.

We are very much, as an organization, pro-choice by policy, but that means tolerating and accepting pro-life individuals. Choice means that. We have members who want to be very vocal about gun safety being a very important thing. Firearms are a leading cause of death of young people, and yet I've got members who have firearms. They're hunters. They live in the South. They value the Second Amendment as a core principle. If we begin looking at people and thinking that everybody thinks alike, we'll be fooling ourselves. Now, I think everybody in public health believes that it's important to improve the health and well-being of the population.

[01:09:09:08 - 01:09:14:21]
Georges C. Benjamin:
I think most people in public health believe that doing it through fundamental policy work is a very efficient way to do it. We have a lot of people in public health that still do clinical services, that still see their core role in public health as laying hands on patients, making sure they get health care and providing that care directly. It depends on where you are.

[01:09:36:18 - 01:09:57:24]
Dr. LaVeist:
For much of what's been happening over the last year or so, this administration, with DOGE and the programs that were eliminated from the federal government, APHA has been at the tip of the spear in fighting for funding for public health. Talk a bit about what you've been doing.

[01:09:58:26 - 01:10:05:29]
Georges C. Benjamin:
We worked in a very collaborative manner with the Trump 1 administration and then, of course, the Biden administration afterwards.

Towards the end of the Trump administration, many of the things that they were doing were more blatant. We saw a lot of illegality happening, things that we thought were inhumane, such as the parental separation policy the administration had.

[01:10:23:10 - 01:10:41:20]
Georges C. Benjamin:
We knew that, should Trump be reelected, we were going to have to take a much more assertive role as part of our activities. That we would still try to find ways to work with the administration because we're nonpartisan, but that our fundamental goal was to help improve the public's health.

Tragically, when this administration came into office, they began doing a lot of very destructive things in an indiscriminate, and in our mind, illegal manner.

[01:10:53:29 - 01:10:58:19]
Georges C. Benjamin:

For example, when DOGE came in, we knew that DOGE was illegally constructed. They did not follow the Federal Advisory Committee Act in anything that they did. Most of us who've been on Federal Advisory Committees know the exhaustive vetting you go through for conflicts of interest, both financial and personal — that there is a charter that has to be followed for your creation, that you have to be a federal employee, and that, yes, this whole idea of "special government employee" is an interesting way to engage people, but it doesn't take away the responsibilities of the career staff.

[01:11:32:21 - 01:11:38:01]
Georges C. Benjamin:
You have a guy come in and he starts indiscriminately firing people without even understanding what they're doing.

I'll give you an example. The day they came in and fired all the people who were in jobs that they did not think were permanent jobs, and that included a lot of the EIS folks, probationary employees, they called them. When you look at the federal government, a lot of people who are career workers, people who are in well-supported training programs like EIS are considered probationary employees during that period of time, and then they eventually get solidified into permanent jobs.

[01:12:16:09 - 01:12:28:04]
Georges C. Benjamin:
They, in effect, fired all these folks thinking they were doing what they did in the private sector — getting rid of people who were early in their career in government and would be easy to fire. It turns out that's not the case.

In effect, when they fired these EIS folks, they were firing the equivalent of the Navy SEALs of public health. They didn't know that. We called them and told them that. Then the media called them and told them that, and they brought them back.

[01:12:47:26 - 01:12:58:23]
Georges C. Benjamin:
They've done so many things in an indiscriminate manner. The point is we found new tools, and the tool we've most aggressively used has been suing them, going to the courts, getting restraining orders, filing amicus briefs and letting them know where they've broken the law. So far, we've been reasonably successful at getting grants back, getting some funding back, getting some employees reinstated. It's a big task because so many things they're doing are random and illegal.

[01:13:23:18 - 01:13:34:07]
Dr. LaVeist:
That's the plan. You flood the zone with so many different things that being able to organize or respond to every issue that comes up just becomes difficult.

[01:13:34:07 - 01:13:55:19]
Georges C. Benjamin:

Yeah, well, the beauty of the flood-the-zone strategy is that it only works if you don't know how to triage. There are many things that the administration is doing that just drive us nuts. Certainly, I get up and say, "Oh no, they did that as well." We've tried to stay focused on things that we think impact important fundamental areas: people, money, and infrastructure.

[01:13:57:17 - 01:14:07:06]
Georges C. Benjamin:
We have tried to work with Congress to make sure that funding has been restored. We've tried to work with the courts to make sure we pointed out the illegalities in what they've done. Again, that's resulted in some restoration of infrastructure.

A lot of what they've done has been more visible in the media, and they've been less successful than one would actually think by the actions that they've tried.

[01:14:27:02 - 01:14:37:18]
Dr. LaVeist:
It's also our responsibility to work cooperatively with government where there are opportunities to do that. Have you found opportunities with this administration within the MAHA movement?

[01:14:38:26 - 01:14:43:21]
Georges C. Benjamin:
The other day, we put out a press statement supporting the administration's efforts at the EPA, whom, I might add, we had sued the week before on the particulate matter issue.

We supported them on going after plastics in our environment and microplastics in our food. We think that's a worthwhile endeavor. The question is how they're going to do it, but we think the ideas are worthwhile. We have looked to work on the research side with the administration on areas where they want to do research. Of course, we've adamantly opposed their attacks on diversity, equity, and inclusion, which we think are immoral — I would argue racist — and driven by a negative ideology about what DEI actually is.

[01:15:36:06 - 01:15:41:26]
Dr. LaVeist:
Let's talk about DEI. What are the benefits of DEI? Why should we be doing that?

[01:15:42:28 - 01:15:55:28]
Georges C. Benjamin:
Well, we've got to think about what it is. Diversity, equity, and inclusion — and my staff would add accessibility to that. I would argue that if you're not for diversity, you're for homogeneity.

If you're not for equity, you're for inequity. If you're not for inclusion, then you must be for exclusion.

Diversity means making sure that everyone has the opportunity to be involved, that we know that diversity results in a whole range of societal benefits when you bring together diverse thought processes, people, and engagement.

[01:16:28:05 - 01:16:33:23]
Georges C. Benjamin:

Equity is important because it's the ultimate goal — to make sure people can achieve their optimum health.

[01:16:35:01 - 01:16:47:09]
Georges C. Benjamin:
Inclusion, if you think about it, simply means asking: Who's not in the room? Who should be brought in? Whose viewpoint are we missing? It's a fundamental question that we should always be asking ourselves. As you think about this, they've decided that diversity, equity, and inclusion is reverse racism, which it is not. It never has been. It's never been practiced that way. Yet, they try to make that a negative thing. What's disappointing to me is a number of our well-regarded institutions, both on the legal side and on the academic side, that have run for cover. That tells me they weren't committed.

[01:17:18:19 - 01:17:26:02]
Georges C. Benjamin:
We at APHA said we're not changing our language. We're going to continue to support diversity, equity, and inclusion. Equity is the fundamental of human life and value. We think that it's important. We've stayed with that. The American Journal of Public Health has done the same thing. We're not going to tell other people what to do. We're not going to tell other people they can't change their papers, but everything needs to follow the evidence and the science. Otherwise, we're not going to get there. As you know, we worked together on several projects with the National Academy of Medicine. One of those was where we looked at health equity, there was the Unequal Treatment report that came out a little over 20 years ago. Then we got a chance to revisit it on its 20th anniversary and discovered that we've learned a lot about what the causes of health inequities are, but we haven't implemented much of it. We haven't done much to actually accomplish closing those equity gaps,

[01:18:24:02 - 01:18:40:11]
Georges C. Benjamin:
those outcome gaps, where you have them — primarily driven by people in underserved populations, people of color, African Americans, Hispanics, Asians in some cases, not always, but in some cases. There are tools that we can use to address those, and that we're not using.

Why aren't we?

A lot of them are structural racism issues, frankly. Society is structured that way. There's always somebody who benefits when something disadvantages another person — money, resources.

A lot of it's not conscious. It's just the way the system has been set up, but it's set up to benefit somebody, and therefore it may disadvantage others.

[01:19:10:25 - 01:19:21:25]
Georges C. Benjamin:
We have to change fundamental societal structures that benefit some at the expense of others. And then, of course, you have the long history of advantage for certain populations. If you're a first-generation college student, you're not going to have the benefit of your parents having gone to that school. If you're a second or third-generation person whose parents went to a university, you benefit from them having the experience of higher education, and you will sometimes

benefit from them having gone to that school where the school gives a preference to prior graduates' children.

[01:19:52:24 - 01:19:56:03]
Georges C. Benjamin:
Yes, that happens a lot. We know that happens. Is it wrong?

I don't necessarily know that it's wrong, but it certainly is something that one should acknowledge is an advantage for those students.

We should work to make sure that it's okay for those students to get in, but who are we leaving out? Again, sitting at the table saying, "Okay, we have our legacy kids here. Who are we not letting in who have the capacity to do well in our school, who would be the kinds of students we would like to have, and how do we get them in there?"

[01:20:34:28 - 01:20:47:22]
Georges C. Benjamin:
That's what diversity, equity, and inclusion programs do — that's what some of the minority health programs did. In fact, it turns out that if you actually look at who benefited from many of the DEI programs, it turns out it was white women who benefited a whole lot, because what it forced us to do was say, "Okay, wait a minute. There aren't enough women in this class.

[01:20:56:01 - 01:21:01:07]
Georges C. Benjamin:
Why are these qualified women not at the table?" We went out and found highly qualified women.

Quite often, they were minority women who were not being included, particularly in medical school. Now, we're seeing more and more African American women, for example, who are in medical school. My class in medical school, they created an urban health program at the University of Illinois. They made a concerted effort to find people who had various life experiences and who they thought would do well in medicine.

[01:21:31:21 - 01:21:32:06]
Georges C. Benjamin:
Good grades, but had done other things in their life which gave them, based on their experience, the capacity to handle the rigors of medical school. Medical school is a rigorous program. Just because you're very smart doesn't mean you're going to be a good doctor.

[01:21:48:22 - 01:22:01:05]
Dr. LaVeist:
For those of us on the academic side, preparing the next generation of public health leaders, what advice do you give us? What should we be telling these students to help prepare them for this uncertain future?

[01:22:02:14 - 01:22:04:17]
Georges C. Benjamin:

Well, life is very uncertain. My pathway through medicine and into public health was certainly not planned. I did not sit down and map it out. All the people that do sit down and plan their careers and map them out and are successful at doing that — mine was very much about serendipity in getting to where I am.

[01:22:24:15 - 01:22:48:09]
Georges C. Benjamin:
What I tell them is: make sure that those students both have the academic capacity to do the work and are committed to the mission — particularly in public health. They have to be committed to the ultimate goal of helping everyone achieve optimal health. That's a moral imperative. This is not a 9-to-5 job. It's not a 9-to-5, Monday-through-Friday job.

[01:22:53:25 - 01:23:06:08]
Georges C. Benjamin:
It's not a remote job, either, by the way. I know everyone wants to work from home, but it's not a remote job. You've got to get out in the community, and you've got to be comfortable talking to people and engaging with people — that's the job. The job is — even if you're doing high-quality research — you've got to get out into the community to understand why people do what they do.

[01:23:17:20 - 01:23:49:05]
Georges C. Benjamin:
Far too often, we've had researchers saying, "I have the solution to obesity. I'm going to get people to get out and walk more and eat healthier and maybe even go to the gym every now and then." When you go into the community, what you discover is there are no sidewalks, there's no place to play, the playgrounds are dangerous, they don't have money for a gym.

[01:23:50:13 - 01:24:34:00]
Georges C. Benjamin:
After working two jobs, trying to convince them not to eat high-salt, high-fat, low-nutrition food when the only thing in their neighborhood is that — giving them dietary counsel is not the solution. You've got to figure out how you, as a public health person, are going to help make that community walkable, bikeable, and green, with access to fresh fruits and vegetables. By the way, that usually doesn't happen without phenomenal policy change: dealing with zoning laws, talking to public officials to make sure that someone can benefit from putting a grocery store in the community.

[01:24:35:17 - 01:24:49:28]
Georges C. Benjamin:
If you can't make money putting a grocery store in the community, then you're going to make money with a small bodega selling tobacco and alcohol to make your margin. That's how you're going to make money because you've got to survive — that's a business. You've got to know that, and that means you've got to go into the community to see and understand that.

[01:24:57:05 - 01:25:03:19]
Dr. LaVeist:

P4HE brings people together from multiple sectors of society: government, higher education, civil society, private sector, and philanthropy. You've just talked about most of those areas, but talk a little bit more about the private sector. When you engage with the private sector, what's your message around producing a healthier population?

[01:25:23:25 - 01:25:33:03]
Georges C. Benjamin:
I encourage all my public health colleagues, including health officers, to join the Chamber of Commerce in their community and participate in the business of the chamber.

We're a member of the chamber in Washington, D.C. — not as active as we need to be, but we're there. To make sure that people understand that health is a business. In many communities, the hospital is the largest employer in town. If it's not them, it's the medical school or university.

[01:25:53:13 - 01:26:00:00]
Georges C. Benjamin:
They're a major employer, which means they have enormous influence on policies and things that happen in the community. You can be a trendsetter. You can not only provide services, but also help create the environment for people to be healthy. For example, we know that liquor store density correlates pretty highly with not only alcohol use, but other behavioral issues — particularly mental health problems.

Dealing with zoning, going to zoning hearings, and spending some time talking about what should be zoned in the community.

[01:26:30:04 - 01:26:36:13]
Dr. LaVeist:
When the history of this area of public health is written, what do you want the entry about APHA to be?

[01:26:37:14 - 01:26:56:27]
Georges C. Benjamin:
Oh, boy. I want people to think we are a fair and neutral arbiter, that we focus on the health of the public, and that they recognize us as having made a difference. I think that's going to be extraordinarily important for our history. We believe we've been that through the years. We've been viewed as being far to the left. We've never been viewed as being far to the right. I just want people to think that we're an honest organization.

[01:27:09:05 - 01:27:13:28]
Dr. LaVeist:
Well, Georges, thank you for joining me on The Skin You're In podcast. It's always a pleasure to talk to you.

[01:27:13:28 - 01:27:16:09]
Georges C. Benjamin:
Tom, thank you very much for having me.

[01:27:16:09 - 01:27:59:19]

Outro:

Thank you for joining us for this episode of The Skin You're In. Be sure to visit our websites, tsyi.org and partners4healthequity.org. That's "partners," the number four, "healthequity.org." Follow us on your favorite social media platforms and be sure to subscribe wherever you enjoy your podcasts. This podcast is brought to you by Partners for Advancing Health Equity, which is led by Tulane University Celia Scott Weatherhead School of Public Health and Tropical Medicine, is part of the Tulane Health Equity Institute, and is supported by a grant from the Robert Wood Johnson Foundation. Until next time.

[END OF AUDIO]