

What 2020 Taught Us about the Politics and Teaching of Public Health

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Abstract

The COVID-19 pandemic has illuminated the critical need to make greater investments in public health and build the capacity of the public health workforce. Among the professional competencies needed to address the ongoing morbidity and mortality associated with COVID-19, as well as other current and future public health challenges, is the ability to effectively engage in the political process. While we acknowledge that public health institutions and workers are under-resourced and are grateful for their tireless efforts to control the pandemic, we argue that their efforts have been severely hampered by a notable absence from politics. We argue that our ability to protect and promote public health has been further challenged by divisive political rhetoric from the former presidential administration, which has amplified a culture of self-interest and individualism. Such values are counter to public health and threaten our ability to address the disproportionate impacts of COVID-19 on low-income communities and communities of color, along with the myriad of health inequities experienced by marginalized communities in the US. We assert that public health professionals must be better equipped and supported in their efforts to challenge powerful majorities that have generated such unhealthy and unequal social and environmental conditions. Policy change related to social determinants of health should be an integral component of our intervention strategies and political advocacy should be considered a core competency for training future public health professionals. The field needs professionals comfortable and adept at working within the political sphere; students are eager for skills that allow them to translate their passion for social justice in health; and the persistent and pervasive health inequities experienced by marginalized communities demand such action.

Introduction

Most of us can agree that 2020 was a year unlike any in our recent memory, characterized by a range of domestic and global challenges affecting our health, economy, environment and even our democracy. Among 2020's litany of challenges, the COVID-19 pandemic obviously stands out as having particular relevance for public health. We argue that the global pandemic provides important, if not new, lessons for health professionals. While much has already been written about this, including for example, the need to invest in public health infrastructure¹ and the need for better coordination across jurisdictions,² we present lessons related to the politics of COVID-19. We argue that staying within the confines of the science of public health without paying appropriate attention to both politics and policy is not sufficient; further, it will stunt our ability to promote health equity. We believe that many of the lessons to be learned from the past year related to the interplay of politics, social justice and science are not new³⁻⁵; but rather, that the events of 2020 and the magnitude of health inequities and their structural precursors that have been exposed by the pandemic,^{6,7} call for increased urgency to apply those lessons. While we recognize that health has always been political,⁵ the devastation associated with COVID-19, especially in communities of color, coupled with the Trump administration's influential disregard for science⁸ and ethnonationalist rhetoric,⁹ have created a particularly polarized

environment for addressing health inequities^{7,8} which requires an enhanced set of competencies for public health professionals. Specifically, public health professionals of the future must be equipped to engage more fully with the political process in order to reduce ongoing morbidity and mortality associated with COVID-19, and to address other current and future public health challenges. This commentary evolved from a graduate Master of Public Health (MPH) class assignment and represents the combined perspective of a first-year MPH student and her instructor.

Disproportionate Impacts of COVID-19

As many have argued, COVID-19 has exposed persistent inequities that have systematically undermined the physical, social, economic, and emotional health of minority populations within the US. The disproportionate burden of COVID-19 on vulnerable communities, especially Black, Indigenous and people of color (BIPOC),¹⁰ should be of no surprise to public health professionals; the economic and health insecurities magnified by COVID-19 have existed for decades and a concerted effort to address them is long overdue. With this in mind, we believe public health professionals must do more to protect at-risk communities from COVID-19. In the short-term, this includes securing protective equipment for essential workers and BIPOC who are less likely to have the privilege of working from home¹¹; expanding testing, contact tracing, and healthcare services (including vaccination) in low-income neighborhoods with overcrowded apartments and high rates of homelessness; and extending the national moratorium on evictions. Public health professionals must also advocate on behalf of the incarcerated population, approximately 40% of which is Black, despite the fact that African Americans make up just 13% of the overall population.¹² Personal protective equipment should be secured for correctional facilities and inmates as social distancing is not possible. Additionally, states should consider policies to release nonviolent inmates, particularly those that are medically compromised, to mitigate inevitable and uncontrollable outbreaks.

Individualism, Nationalism and Health Inequities

While important, the aforementioned strategies are merely Band-Aids, and do not address the years of lacking upstream investment in the country's social and economic system.¹³ More important is the need for the public health sector to lead targeted efforts to address the structural racism that underlies the pervasive and persistent health inequities experienced by BIPOC in the US. Documenting inequities, describing social determinants of health, and developing upstream interventions is necessary but insufficient. As the Black Lives Matter protests of 2020 (and the events that precipitated them) remind us, good intentions are not enough, and we must do more to actively dismantle racist policies, institutions and structures.¹⁴

Despite clear evidence that death and disability are collective problems,¹⁵ progress in responding to COVID-19 through a comprehensive public health approach has been stunted by the debilitating first language of individualism in American culture, described by Wallack and Lawrence.¹⁶ This language and preoccupation with individual freedoms, personal responsibility, and limited government have been amplified by the former administration's nationalist and populist rhetoric,⁸ and has contributed to a fragmented Federal pandemic response, individual non-compliance with COVID-19 safety mandates, and the lack of a coordinated national strategy for disaster relief and vaccine distribution. Stone argues that "presidents lead as much with their rhetoric as with their policy goals" and goes so far as to assert that former President Trump's

rhetoric is “destroying the ‘culture of community’ necessary for progress on health equity”.¹⁷ Encouraging individuals, especially those who have been vaccinated, to behave in ways that prioritize collective well-being over individual freedom may prove to be even more difficult as the pandemic wears on and as vaccines offer a false sense of absolute protection. Individualism is not a sufficient public health strategy¹⁶; nor is an ideology of ethnonationalism, which prioritizes those with a narrowly defined American identity (i.e. native-born, English-speaking whites with a European and/or, Christian background).⁹

Within the US, efforts to mitigate the disproportionate impact of COVID-19 call for prioritizing high-risk communities in vaccine distribution and for targeted strategies to ensure equitable access among BIPOC even within other high-risk categories, such as essential workers and those with underlying health conditions.¹⁸ However, people of color are less likely to be vaccinated compared to their white counterparts for a number of reasons, including distrust of the healthcare system grounded in historical abuses and ongoing racism.¹⁸ We worry that barriers to vaccination among communities of color have been exacerbated by racist rhetoric,¹⁹ which has been demonstrated to have a ripple effect causing others to express racists views.²⁰

While contemporary American politics may prioritize individualism and limited regulation, the nature of disease (including, but not limited, to COVID-19) starkly reminds us that human life is interconnected. Globally, the need for equity in the allocation and distribution of vaccines across wealthy, middle-income and low-income countries is both a matter of social justice as well as one of national self-interest. Achieving herd immunity through vaccination rests on our ability to reach all parts of the globe. Yet, as of mid-January, more than half of the seven billion vaccine doses that have been purchased globally have gone to high-income countries, despite the fact that these countries are home to just 16% of the world’s population.²¹ Further, “vaccine nationalism”²² has economic implications for the global economy. Just as our health is dependent on the health of our neighbors, we must recognize the interconnection of our economic wellbeing. According to a recent study, “the global economy stands to lose as much as \$9.2 trillion if governments fail to ensure developing economy access to COVID-19 vaccines, as much as half of which would fall on advanced economies” such as the US.²³

Market Justice vs. Social Justice

Clearly, the COVID-19 pandemic has raised important considerations regarding the appropriate balance between health and economic well-being, and it behooves us to remember that economic conditions are critical determinants of health. However, the central issue remains the injustice of a dominant market ethic described by Beauchamp in Public Health as Social Justice.²⁴ In this landmark 1976 paper, Beauchamp describes how the market model encourages victim blaming and attention to individual behavior rather than the social preconditions of such behavior.²⁴ In doing so, the market model unfairly protects majorities and powerful interests from their fair share of the burdens of prevention, while spreading the costs of public problems among the general public.²⁴ The free-market ethic is alive and well today, for during the worse economic downturn since the great depression,²⁵ Jeff Bezos added \$74 billion to his networth.²⁶ Meanwhile, 10.7 million people in the US were unemployed as of December 2020,²⁷ and social services are unable to keep up with increasing demand. If public health professionals want to sustainably and meaningfully address the health inequities that have been magnified by COVID-19, we must prioritize addressing poverty and economic inequality—the strongest determinants of health—while developing America’s second language of community.¹⁶ Further, we must do

better at “finding ways to align with constituencies, lend our science and our knowledge, and create a base of power for progressive social change.”²⁸

While the field of public health has already expressed support for reducing income inequality to advance health,²⁹ the current and incoming generation of professionals should push to reclaim public health’s power as a leader of progressive social change on a larger scale. Of equal importance is the need to shift cultural understanding of social welfare and the interdependence of human beings—a shift that has started taking place in the context of environmentalism and ecosystems. Now is the opportunity to initiate a change in conversation and in mindset at the national and global level and push for community values to be reflected in public policy.

Health and Politics

Admittedly, making decisions about mask mandates, restrictions on businesses and vaccine distribution—not to mention things like poverty reduction or income redistribution—is complex, and policymaking invariably results in “winners” and “losers.” Even before COVID-19, health has always been profoundly political.⁵ According to Bambra and colleagues, health is political because 1) it is unequally distributed; 2) social determinants are amenable to political interventions and dependent on political action; and 3) the right to health is, or should be, an aspect of citizenship and a human right.⁵ However, politics is not inherently bad—at its best, it is an essential component of a democracy. It is the process of making decisions, and while those decisions should be grounded in the best possible evidence, science alone does not tell us how to act. Rather, policy decisions are also grounded in values and power. While a full discussion of power in politics is beyond the scope of this paper, we know that those with more power have greater influence in the political process when they wield their influence. Understanding the interplay of science or evidence, values, and power in political decision-making sheds light on why the former administrations’ disregard for science,⁸ their racist and xenophobic rhetoric,^{7,9,17,19} and their powerful influence were such a dangerous combination for efforts to control COVID-19. From a public health perspective, policy decisions about how to protect and promote health must be grounded in accurate information and evidence, as well as the field’s underlying value of social justice,²⁴ and the interests of communities most affected or most at risk (rather than those with the most power).

Public Health’s Role in the Political Process

While public health institutions have been stretched thin and workers deserve our gratitude for their exhausting and important efforts to test, trace, treat and vaccinate against COVID-19 since early 2020, we argue that public health professionals have shied away from political engagement, focusing primarily on epidemiology and the promotion of individual behavior change, at the expense of our collective wellbeing. Active and consistent involvement in the political process is necessary for public health professionals to address this pandemic, and other public health challenges. Fairchild and colleagues describe the shifting mission of the public health profession over time, describing the tension between our science-based identity and one that is more closely tied with social reform, and call for a “Back to the Future” realignment of public health that reclaims its place as part of an emerging reform movement.²⁸ They remind us, for instance, the progress of sanitarians who led reform efforts in the 19th and early 20th centuries.²⁸ Requiring housing to have indoor plumbing, improving tenement laws, and imposing housing density regulations had positive effects on rates of tuberculosis and other diseases.³⁰ We

agree with Fairchild and colleagues that in recent decades “the field of public health has been constrained by self-imposed limitations and, all too often, has avoided engagement with those who challenge complacency and existing power relationships”²⁸ and we argue that being science - or evidence-based is not incongruent with advocating for social change.

Reclaiming our place as part of social reform means advocating for universal policies that protect and promote the health of all, such as paid sick leave policies and stronger social security and income protection programs; as well as targeted strategies to address health inequities. This includes, most notably, advocating for policy and practice changes in housing, healthcare and criminal justice to address residential segregation, implicit bias in the healthcare system, and mass incarceration.³¹ As referenced earlier, the disproportionate burden of COVID-19 on BIPOC is just one of many examples throughout our history where marginalized communities experience health inequities. Improvement in this area thus depends on significant political engagement from public health professionals, challenging the powerful special interests that have generated such unhealthy and unequal social and environmental conditions, and amplifying the voices of communities.

Lessons for Training Future Public Health Leaders

Ultimately, the events of 2020 and their impact on health inequities speak to the need for public health professionals to participate more fully in the political process, and this means training public health students on how politics works and how to work within politics.⁵ We are a field grounded in evidence-based decision making, but we must do a better job advocating for the use of our evidence, and do so in ways that align with the field’s underlying values of social justice and community. This means building skills related to advocacy, communication and community engagement. It also means understanding the ways in which values underlie policymaking and building the capacity of public health workers to confidently engage in political debates from a strong position of scientific authority, as well as moral leadership. Similarly, we need to train future public health leaders to understand their role in building and maintaining trust and collaboration between and among the health system, government entities, and communities. This includes the ability to be empathetic, learning from and respecting diverse perspectives, and holding ourselves and each other to the highest ethical standards. Finally, we need future public health professionals to be better equipped to work within the complexity that is health and politics. This includes communicating in a way that is accessible but not overly simplistic, and building bridges across disciplines, sectors, communities, political parties, and foreign nations.

The Council on Education for Public Health (CEPH), which is an independent accrediting body for programs and schools of public health, has identified a list of 22 competencies meant to be incorporated in training for students preparing for careers in public health.³² While several of the competencies for MPH schools and programs are consistent with our recommendations, we encourage CEPH to consider more explicit language that ensures we are universally training students to be effective in the political sphere, and to address the structural and political determinants of health inequities, as they revise their accreditation criteria this year.³³ As CEPH continues to promote flexibility in the way in which instructors and programs meet the various competencies, we encourage greater attention to public health pedagogy among instructors, such that innovations in how these critical skills may be developed are shared and replicated. In our experience, students are passionate about social justice in health, and are eager for training that allows them to apply this passion in ways to advance public health and health equity. Similarly,

training students to be competent in areas related to politics and advocacy is challenging and often outside of our more “scientific” comfort zones. We look forward to learning from and working with others to help our students meet the public health challenges of 2021 and beyond.

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