REIMAGINING THE US PUBLIC HEALTH SECTOR

How five challenging realities are thwarting progress in public health, and how the sector can build strength to advance health equity, prepare for future pandemics, and face other emerging challenges.

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Floyd Warbus, a master weaver from the Lummi Nation, shows Urban Indian Health Institute's Thomas Lawrence (Makah) how to weave a cedar headband as part of the organization's approach to Indigenous evaluation. (Photo courtesy of Urban Indian Health Institute)

It would be hard to imagine a more challenging time than the present for the United States to confront a global public health crisis during which people are asked to trust their government, the medical establishment, and science, and to take steps that impose inconvenience on themselves to protect others.

And yet here we are—and here we likely will remain unless we respond to the perfect storm of social realities that have been growing in intensity for decades and begin to reimagine public health. To do this, we need to redefine what public health means, and change how we collect data, how we design interventions, how we engage champions and allies, and how we build trust, in part by addressing systemic racism in the public health sector.

Five Realities Behind the Public Health Care Crisis

1. Lack of understanding about public health and prevention. The public health system is vast. It includes government agencies—from state and local health departments to the Centers for Disease Control and Prevention (CDC)—public safety organizations, human services providers, educational and philanthropic organizations, the business community, and many others whose actions contribute to or advocate for healthy environments. These entities have collectively achieved success on a wide range of issues, including reductions in child mortality, access to safe water and sanitation, road and traffic safety, prevention of cancer and childhood lead poisoning, and reduced tobacco use. And they have responded heroically to a once-in-a-century public health crisis, even as they've faced inadequate resources, widespread misinformation and disinformation, and even death threats.

But helping people see, understand, and value this broad system is difficult, in part because public health is ultimately focused on prevention, which is defined by the absence of something bad happening. How do you generate excitement about something that didn't happen? Further, most people take for granted many public health advances that were once life-changing (such as vaccination against polio and fluoridation of drinking water). As a result, policy makers at all levels, funders, and voters continue to prioritize and pour resources into treating health crises rather than preventing those crises from happening in the first place.

2. Low levels of social cohesion. The Healthy People 2030 initiative defines social cohesion as "the strength of relationships and solidarity among members of a community." While relationships and solidarity within specific communities can be strong, they are incredibly weak across communities, particularly if we think about

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the United States as an extended community. And without social cohesion, individuals are far less likely to make choices that don't directly benefit them or to sacrifice on behalf of others. We've seen this play out time and again during COVID-19, from the hoarding of N-95 masks to the more-recent opposition to vaccine mandates.

Despite rhetoric that "we're all in this together," the "mob at the gate" meta-narrative that political economist Robert Reich describes in his New York Times article, "Political Parables for Today" is one of the enduring stories in American politics. People have used it—and the intentional "othering" of people unlike themselves—in debates about issues such as immigration reform and gun violence prevention for as long as the country has existed, with sometimes devastating consequences. The rise in hate crimes targeting Asian Americans mirrors the increase in violence targeting Muslim Americans in the aftermath of 9/11, both of which were all-too-inevitable results of these deliberate assaults on social cohesion in the United States.

3. Decreasing trust in institutions. Especially in times of crisis, the institutions of an organized society are supposed to promote stability and a sense of calm, provide accurate and reliable information, and coordinate a successful response. In the first survey on institutional trust in 1958, trust in government was at 73 percent. Gallup's most recent polls found that only about 33 percent of respondents had "a great deal" or "quite a lot" of confidence in 14 major US institutions, including public schools, Congress, the criminal justice system, and television news. And Pew Research Center reports that after reaching a three-decade high in the aftermath of 9/11, the percentage of people who say they can trust the government "always" or "most of the time" has not surpassed 30 percent since 2007.

4. Persistent structural racism. By any measure, Black people, people of color, and Indigenous people have experienced health disparities over generations—if not centuries—resulting from entrenched structural racism and the inequitable conditions it creates, along with inadequate access to quality, affordable health care. Many of these same populations have also experienced a long and continuing history of betrayal by the government, as well as by science, research, and medical establishments. Racism has been considered a social determinant of health for decades, and the CDC, the American Public Health Association, the American Medical Association, and many states and cities have explicitly identified structural racism as a determining factor in public health. Yet efforts to address it are continually tied up in a vitriolic, partisan debate.

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5. Polarization and politicization. Poll after poll has shown a very different perspective about the severity of, reasons for, and response to COVID-19 depending on one's political worldview, and this partisan gap has widened as the pandemic has progressed. For example, Pew Research reports that the percentage of Democrats/Lean Democrats who said it's necessary to ask people to avoid gathering in large groups remained virtually unchanged from 92 percent in March 2020 to 93 percent in February 2021, while the percentage of Republicans who agreed dropped from 82 percent to 56 percent.

This partisanship is naturally influencing policy. As of October 8, 2021, the National Academy for State Health Policy reported that 21 states had banned vaccine passports. The use of public policy to restrict and even prohibit measures the public health

sector recommends has become normalized. In the divisive political culture in which we find ourselves, this development could lead to enormous and deeply troubling consequences down the road.

Five Steps the Health Sector Can Take to Move Forward

COVID-19 didn't create these realities, so bringing the pandemic under control will not automatically resolve them. What's more, variations on these five realities are hindering our ability to address other important issues, such as climate change, gun violence, voting rights, and the opportunity gap. No one sector or set of issue advocates can change these realities on its own no matter how hard it tries. It will take a concerted effort across sectors and issues.

But there are steps the public health sector—including the public, private, nonprofit, and philanthropic organizations that comprise it—can take (and in some cases, is already taking) to work successfully within the context of these realities while doing its part to chip away at them.

1. Use data to see all people. If we've learned anything from the last two presidential election cycles, it's that traditional approaches to research often underrepresent vast segments of the public, including those with a conservative worldview. In addition, sample sizes are seldom large and diverse enough to allow for effective data disaggregation based on race and ethnicity. This means diverse communities are often grouped into singular headings like "Asian Pacific Islander" or "American Indian and Alaska Native," rendering many unique communities invisible.

The same can be said of much public health research, as we've seen during COVID-19. Even the most prominent data sources fail to gather and report anything about Indigenous or Muslim communities; distinct Latinx communities; or underserved groups such as people experiencing homelessness or living with disabilities, or rural populations. These omissions reflect systemic racism and classism in the public health sector and are generating potentially incorrect data and assumptions.

Funding data collection that fully reflects the diversity of the country would enable the public health sector to focus resources where people and communities need them most, and to design more culturally and linguistically relevant interventions. We're eager to hear the recommendations of a new Public Health Data Commission, which is rethinking how we collect, share, and use data, including examining ways of disaggregating data, collecting data with populations considered at-risk, and building data-gathering capacity in communities with less access to resources. We hope the CDC and others will act on the recommendations to ensure that data systems reflect the harms racism and other forms of discrimination have on our communities.

Some researchers and nonprofits are already employing different methods of gathering data, augmenting or replacing traditional telephone polling, online surveys, and focus groups (which are inaccessible to many people) with facilitated community conversations and story circles. Funders are increasingly recognizing the need to fund communities so that they can define their own data needs, evaluate and use data, and retain ownership of that data. Indigenous evaluation, which the Urban Indian Health Institute (UIHI) and others practice, is a good example of employing culturally grounded methods in gathering data with American Indian and Alaska Native communities. For instance, when UIHI pulled together its programmatic team to talk about evaluation, they started with a traditional weaving lesson to convey the idea that documentation and learning should be "woven" into every program. Both the public and philanthropic sectors should prioritize these kinds of efforts and use the data to inform public health efforts at the local, state, tribal, and national levels.

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2. Reach beyond the "low-hanging fruit." For decades, public health campaigns have focused initially on people and communities with the motivation, opportunity, and ability to adopt a new behavior (such as giving up commercial tobacco), rather than on people and communities who are resistant to change or more restricted in making the change due to systemic or structural barriers. This approach assumes that success

with those who are easier to motivate will establish "proof of concept" and generate additional investment, enabling the campaign to expand over time to reach people and communities with less motivation or opportunity to change. But while the method has achieved results in part by creating champions for behavior change, person-to-person advocacy can have the opposite effect of further strengthening the resolve of those who are opposed to adopting a new behavior. We're seeing this all-too-clearly in relation to COVID-19 vaccination.

In addition, by focusing first on people and communities most motivated and able to change, such campaigns can delay efforts—or even fail—to address the urgent needs of people and communities who face structural barriers to change and are often at greater risk of harm. In this way, it reflects and exacerbates systemic racism within the public health sector, contributing to polarization and low levels of trust.

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Instead, government agencies, foundations, and nonprofits advancing public health efforts should consider focusing first on communities most at risk of harm and most limited in their access to opportunity, health, and well-being due to systemic racism, classism, and other forms of discrimination. This requires working with communities to define the need and create the solution, which often necessitates longer timelines, flexibility in what constitutes "evidence-based practices," and greater investment of resources, but it puts greater equity within reach. In Oregon, for example, a recent tobacco tax increase passed with the condition that a share of revenues go to communities most affected by commercial tobacco use and industry marketing, and that a community-led process define solutions. A group of community-based advisors from across the state is now guiding the Oregon Health Authority to redefine commercial tobacco prevention funding, recognizing that initiatives like Quit Lines (which work for those who are already ready to quit) are far less effective for communities where structural racism drives and sustains commercial tobacco use.

3. Take control of the public health narrative. For 50 years, the public health sector has been locked in a defensive posture, battling against a "nanny state" narrative that frames its calls to action as intrusions on individual liberty. Yet COVID-19 has provided a unique opportunity to recreate this narrative, since it's the first public health crisis in living memory that has affected every sector and every aspect of our lives. Public and private discourse—and even social media conversations among friends—is talking about the strengths and weaknesses of the public health system.

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We need to redefine what public health means today, acknowledge the value it provides to us individually and collectively, and commit to shoring up the system against future threats. Public, private, nonprofit, and philanthropic partners must come together to research, develop, test, and widely deploy a new narrative grounded in core values. This narrative can't just "preach to the choir." It must motivate even people who are not ordinarily receptive to public health messaging, because finding our way back to pluralistic, productive dialog is essential to progress. One group doing interesting work here is the New Pluralists collaborative, which is convening people from varied backgrounds and with different beliefs, with the aim of drawing on their differences to solve shared problems.

The collaborative hopes that fostering dialog in this way can "bridge our divides and reweave our social fabric."

To be successful, organizations must focus less on single-issue advancement and more on fundamentally increasing people's understanding of public health more broadly. Advancing this shared narrative as a field—and in collaboration with other sectors—can build the volume and sustained effort needed to drown out a dogged and well-funded opposition with footholds in big tobacco, sugary drinks, and the industrial food system.

4. Engage others as allies and champions. People who don't trust traditional public health voices, including state and federal officials, are more likely to discount what they say. So, some current efforts are bringing unexpected allies and champions to the conversation. For example, the Health Action Alliance is engaging the business community to encourage vaccination and address the needs of communities impacted most by the pandemic. And the Biden Administration's Month of Action on COVID-19 vaccination funded outreach through Black-owned barbershops, college campuses, and private companies, offering incentives like free childcare for people while being vaccinated, as well as on-site vaccination at Major League Baseball games and free tickets for those who got vaccinated. Efforts like these can reach and motivate people who have less trust in the public health sector. And since the notion of public health has become so politicized, engaging other sectors and voices as messengers helps reduce the polarization that encourages taking sides and makes it harder for individuals to consider changes in their own thinking or behavior.

5. Focus on structural racism not just as a determining factor on public health, but a problem to address within public health. While it is certainly true, it is not enough to declare racism a "social determinant of health" or to explore the impact of it on public health. The sector must also examine and address the ways in which public health (like the broader health care system) reinforces structural racism, including policies that harm communities of color, and limit opportunity and access to care.

Addressing racism requires that we understand the complex intersection of systems and structures—including health care, housing, employment, and education—that marginalize and oppress Black communities, communities of color, and Indigenous communities. We must acknowledge that those systems create conditions that put these groups at far greater risk of adverse health outcomes, accept the truth that they were set up to serve that purpose, and then dismantle those systems and create more equitable policies. Voices for Healthy Kids at the American Heart Association is an example of an organization taking concrete action on this, owning up to the harm of past policies and working to secure policy language that focuses first on communities experiencing structural racism. Every organization within the public health system has the obligation and the opportunity to follow suit—both to examine the impact of structural racism on public health and to address it within the field. Success will not only improve public health outcomes, but also help the sector earn and sustain the trust of the people and communities it serves.

Building understanding of and demand for a strong public health system—one that sees and meets the needs of all people, works with communities most at risk to create solutions that work, brings in new allies and champions, and directly combats structural racism—is an ambitious aim. To start, organizations across the field must come together to create a new narrative about public health that is grounded in core values, and clearly articulates both individual and collective benefit. We really *are* all in this together in the end, and there isn't a moment to lose.

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