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COVID-19: Health as a Common Good

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See also the *AJPH* COVID-19 section, pp. 1123–1172.

The public health verdict, which echoes *AJPH* associate editor Lisa Bowleg's heartfelt cry,[1] is clear: we're not all in this together. This pandemic shines a spotlight on the ways injustices intersect and channel the brunt of the burden to low-wage earners, those discriminated against, the poor, and the marginalized. Nothing new here. But today, thanks to rapid communication streams, we see the injustices unfold before us. These are not transient issues that will fade away with the pandemic. These are structural issues, much older than the pandemic, inherent in the way that current public health institutions approach health.[2,3] But why is it that the social and economic disadvantages have to translate into equivalent or worse health disadvantages?

INTERCONNECTEDNESS

The articles assembled in this issue stress how, through this pandemic, inequities interconnect and accumulate to cause harm (see the box on p. 1112). Take the unequal access to broadband Internet (Benda et al., p. 1132): reduced access under COVID-19 means poor or no access to telemedicine, teleschooling, work, job searches, food, social connections, and other services and goods essential to health. People most likely to lack quality Internet access are also, a priori, those most at risk for being infected and suffering major complications; those most likely to have occupations that cannot be relocated away from the regular workplace and those most likely to not be equipped for teleworking (Baker, p. 1148); those among the 38% (38%!) of Americans at risk for food insecurity (Byker Shanks et al., p. 1143; Nestle[4]); those who are incarcerated and without access to telepsychiatry or to virtual family visits (Robinson et al., p. 1138); immigrants, documented and undocumented, blocked from accessing health care by deportation threats or by the public charge rule (Langellier, p. 1145); those exposed to wildfires, the smoke from which irritates airways and increases susceptibility to severe complications from respiratory infections (Henderson, p. 1135); or those who cannot afford a full vaccine schedule to protect them from respiratory infection, which is the most susceptible cooccurring severe complication of COVID-19 (Gilley and Dube, p. 1130).

The structural weaknesses of current public health won't be erased by identifying scapegoats. The chronology of the Chinese outbreak (Liu and Saltman, p. 1164) and of the World Health Organization (WHO) response (Brown and Ladwig, p. 1168) indicate that both the Chinese public sector reporting chain and WHO failed at some point. They are both in great need of reform,[5] but the magnitude of the disaster in the rest of the world stems from a lack of strong public health foundations on which to build an ordered and effective societal response to pandemics. The counterexample may be Vietnam, which seems to have successfully contained the pandemic thus far with low means but strong public health strategies (Trevisan et al., p. 1162).

We just don't know how long the current wave of the pandemic will last because we don't yet have the population surveys that would allow us to determine the fraction of the population infected and where we stand on the epidemic curve.[6] Existing surveillance systems of epidemics and pandemics are failing us globally. We need a dashboard to track the infection with specific metrics (Nash and Geng, p. 1159) broken down by race and ethnic background to map the social inequities precisely (Coughlin et al., p. 1140).

However, we can say with confidence that social distancing for COVID-19 will linger. For all the main influenza pandemics[7] since 1700 it took several waves, more than three to four years, to achieve herd immunity to the virus (Esparza, p. 1171). Hence, we need sustainable, low-cost, distributed fabrication and additive manufacturing of personal protective equipment (Sinha et al., p. 1125), to save and recycle them when possible (Thomasian et al., p. 1128), and community-based volunteer networks to mitigate its mental health impact (Kobokovich et al., p. 1123).

PROMOTE EQUITABLE DISTRIBUTION

But back to the question: why is it that the social and economic disadvantages of vulnerable populations have to translate into health disadvantages that are equivalent or worse? Where is the health in public health? The pandemic is unjust because access to health depends directly on one's social and economic standing. Income, education, poverty, marginalization, and discrimination primarily determine who will suffer the most. Our public health system tries to mitigate the impact of these social and economic factors, patching up the breaches of a makeshift vessel. Our public "health" is a public "patchwork."

Let me leave you with this thought. Hasn't the time come to

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TO OUR AUTHORS

Between March 1 and June 26, *AJPH* has received 1640 submissions. This projects to 5206 submissions in 2020. Over the same period in 2019, we received 1372 submissions. We have been giving the same attention to these submissions that we always do. When declining to have an article peer reviewed for potential publication, we respond within days and, in most cases, propose other venues that might be a good fit. In the set of 1640 articles, there were 817 submissions related to COVID-19. The large number of opinion editorials among them were reviewed by a task force of four deputy and associate editors. We have accepted 55 of them and fast-tracked 12.

Our main criterion for deciding whether an opinion piece is a good fit for *AJPH* is whether it addresses a structural, long-term issue. Given our publication schedule as a monthly journal, we are not able to publish articles that address urgent, time-sensitive matters and that will most likely be outdated when they are published two to three months later if not fast-tracked.

think of health as a common good that we collectively protect, and disconnect, from social and economic forces? As a society we are a collective, and it is only by taking care of ourselves as a collective that we will coexist with inevitable pandemics and other potential natural disasters. "To promote equitable distribution of burden, benefits and opportunities" is a fundamental public health principle (Thomas and Dasgupta, p. 1157). Once we start protecting health as a common good, *then* we can be all in this together. AJPH

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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