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The Public Health We Need

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The Public Health We Need



See also Tarantola et al., p. 925, and the *AJPH* COVID-19 section, pp. 939–977.

The problem is not the virus. We can technically and scientifically control its speed of propagation. We should be able to decently manage its impact on the health care system. This was an announced tragedy. Reread our November 2018 issue (https://am.ajph.link/Nov2018_Flu18) or listen to the *AJPH* November 2018 podcast (https://am.ajph.link/POD_November2018). We knew how the scenario would unfold in advance. The problem is all of the policies that let the virus prey on us so easily. The virus has taken advantage of every weakness in the system to create confusion and destruction. Let's take this sad song and make it better.

PRIORITY DOMAINS

These are some domains in which public health is expected to perform efficiently.

SARS-CoV-2, which causes COVID-19, is an airborne infectious agent for which Congress needs to quickly ask the Occupational Safety and Health Administration to release standards for health care workers and all other occupations potentially exposed to it. A draft exists from the previous presidential administration. Congress can do this swiftly (https://am.ajph.link/POD_May2020). And, although biologists are developing a vaccine as quickly as possible, public

health must prepare the population for the arrival of a vaccine and make sure that, by contrast to the H1N1 experience, this vaccine is used.

Public health preparedness and response to natural disasters and climate change are linked domains. Natural disasters, including this pandemic, hurricanes, flooding, fires, and earthquakes, have become the new public health normal.¹ *AJPH*, in collaboration with the Centers for Disease Control and Prevention, has strived to make the evidence and the history available in regular issues and supplements (https://am.ajph.link/Emergency-Management_2017, https://am.ajph.link/Medical-Countermeasures_2018, https://am.ajph.link/Community-Preparedness_2019). These disasters can be, have been (e.g., Hurricane Maria in Puerto Rico²), and will be concomitant³ and compounded with other major structural injustices. Entire communities may continue to be destroyed. The science needs to ramp up and provide the evidence to build socially and environmentally resilient communities in a world that looks today more than ever like a “virtual village.”⁴

This pandemic reveals, with acute clarity, injustices in the public health system. Workers in the health care, mail and delivery, food establishment and restaurant, retail, warehouse,

and transportation sectors are taking huge risks to keep the economy and public health functioning, but they have been neglected—because of the gig economy, precarious jobs, endemic poverty, lack of access to care, insufficient wages and benefits, and so on—for a decade or more. As long as those sectors don't or won't provide such “good (paying and secure) jobs” as those in the industrial sectors did, our public health security will be at risk. These injustices are compounded by gender inequalities, structural racism, and the lingering consequences of slavery for African Americans and genocide for Native Americans.⁵

The consequences of defunding local and state public health programs, cuts in their workforces, and lack of coordination are acutely manifest in this major recession, with historically higher unemployment among middle-aged wage earners, whose life expectancy was already declining, irrespective of race. These public jobs need to recover their attractiveness to reinvigorate our public health workforces.⁶

The fact that tens of millions of people are still not covered by the Affordable Care Act and that whole states (all but Wyoming are in the South and have large minority populations) do not have Medicaid expansion creates large sectors of the population who are utterly vulnerable to the infectious ordeal. Expanding Medicaid may be the one thing that these states can do immediately and that would have a huge impact on access to care and survival. The evidence supporting this is overwhelming.⁷

The pandemic, compounded or not by natural disasters, hasn't put an end to the epidemics of opioid addiction, deaths of despair, mass incarceration, punitive immigration policies, vaping among youths, gun violence and other forms of violence exacerbated by the quarantine, lack of access to food locally and globally, and wide disparities in health between rural and urban regions.

High-quality surveillance data are another key component of the public health infrastructure that we need. The data to track, compare, and predict the evolution of the pandemic are currently hardly interpretable (Pearce et al., p. 949). Reliable and valid assessment of infection rates and case fatality rates are impossible: there are still issues of sampling, misclassification, and

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selection bias at the various stages of the epidemic curve.

LOOKING AHEAD

In this acute phase of the crisis, it is urgent to provide access to testing, to care, and to ventilators. But there will be a recovery phase, a time to examine critically the deficiencies of our public health system highlighted by the crisis and to review the history and the evidence to fix these policies.

We need to revisit our past and see what the lessons of the postcrises were to inform us about the traps keeping us from and the opportunities to get the public health we need. The time has also come to reassess the public health consequences of antiscience and antivaccine ideologies.

AJPH will play its role, providing the history and the recent evidence to determine the public health we need, but also the forum for diverse opinions about how to best construct the public health we need. We want to be careful and right. In a context of misinformation and disinformation, we want to be a place that people trust. And we want our readers and American Public Health Association members to keep supporting the journal because we are rigorous, ethical, professional, and honest. **AJPH**

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CONFLICTS OF INTEREST

The author has nothing to disclose.

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