Commentary

Addressing public health’s failings during year one of Covid-19

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By almost any measure, public health fell short during 2020. In retrospect, the list of what public health professionals, including federal and state public health officials, public health practitioners, and academics, could have done better is easy to articulate, and has already been the subject of angry books about the disastrous responses to the pandemic in Europe and the US [1,2]. It falls to all of us to pause, reflect, and ask: how do we move forward? We have five suggestions.

First, we think public health has far too long considered COVID-19 a “public health emergency.” Emergency framing paints COVID-19 as a problem that would, with enough effort, go away quickly, rather than thinking of COVID-19 as a longer-term challenge to be managed in parallel with the full suite of activities that are needed to keep society functioning [3]. A chronic emergency is no emergency at all. It becomes, rather, a justification for not acting rationally.

Second, many of the early days of the pandemic were characterized by an effort to plot extreme predictions. Experience, and science, both teach us that extreme predictions are almost always counterproductive. Our presumption should be that worst-case scenarios and outlier models are not used for planning purposes. Basing actions on extreme and unlikely models focuses attention on events that will almost certainly not happen.

Third, public health professionals fell short in clear messaging to the public. Failure was not just in the phrasing of recommendations, but also the rationale for each recommendation. What we know changes, and with it what public health as a field would recommend can also change. For example, the initial public health message to not wear a mask was changed months later to its opposite as better evidence came to light, and more masks became available. Changing the public health message is not, in and of itself, problematic, and can be the optimal course [4]. But changing the message becomes deeply problematic if the original and the revised messages do not have a credible rationale.

Fourth, public health has not, as a field, balanced the likely positive effects of proposed interventions with the likely negative effects. Science and facts are necessary, but not sufficient to set public policy. For example, sheltering in place or “stay at home” orders can be justified to slow down community spread, but the costs of more drastic mandatory isolation enforced by police action (as happened in China’s second wave response) will almost always be too steep to justify in western democracies. Draconian action runs the risk of public backlash that make such actions counterproductive, while also potentially infringing on basic human rights, incurring a price that the public is not, and should not, be willing to pay. The Universal Declaration of Human Rights should continue to be public health’s ethical guide [5].

Fifth, public health academics failed to be suitably skeptical of false choices and all or nothing strategies. The most powerful of false choices in the pandemic has been that we must give up economic growth to limit the reach of the pandemic. But this was never the choice. We require a vigorous economy as one of the major determinants—if not the major determinant—of the health of our population. The public health challenge is not to suggest how to shut down the economy, but to suggest how to keep it open to the extent possible while simultaneously protecting the public from the virus.

In a democracy, we are all responsible for a public health approach that prevents disease and promotes health. Public health has a role to play in presenting an approach that will increase the public’s support of, and trust in, the public health enterprise, and providing a bulwark of science and reason against the vagaries of the executive branch’s arbitrary pronouncements and the dangerous fantasies of conspiracy theorists. To do so it calls on public health to keep the health of the public front and center.

While centering health, we must recognize that health is a means to an end, that thriving during a long term pandemic requires cooperation not coercion, and that approaches to mitigation balance real humans on multiple axes, including, for example, the need to be safe from the virus, the need to earn a living, and the need to be with loved ones who are sick and dying. All these should be at the heart of our public health approach going forward, and it falls on all of us to make them so.

Declaration of Competing Interest

The authors have no relevant conflicts of interest.

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