Introduction: Politics, Policies, Laws, and Health in a Time of COVID-19

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Has there ever been a more important time to consider how politics, policies, and laws influence health? We are, as a country, in the midst of unprecedented turmoil, all of which has implications for our health. The COVID-19 pandemic is the most obvious clear and present danger, killing more than 500,000 Americans as of this writing, infecting more than 28 million others. Our efforts to mitigate the spread of COVID-19 have resulted in an economic slowdown unparalleled in many aspects for nearly a hundred years. More people have been unemployed than at any time since World War II. More than 26 million Americans, nearly 16% of the entire US workforce, have been either unemployed, otherwise prevented from working, or working for reduced pay during the pandemic. And both these sets of consequences have been experienced inequitably. People of color, particularly Black Americans, have experienced greater rates of, and death from COVID-19, than white Americans. Meanwhile, unemployment has been both deeper, and slower to recover, among the same minority groups who are already bearing the brunt of the COVID-19 pandemic. It is then little wonder that 2020 also saw protests about racial inequity that were probably the largest civil protests ever in American history.

Politics and the Three Crises of 2020

These three crises unfolded against a backdrop of extraordinary political dysfunction. Since early 2020, messages about, and the handling of the pandemic acquired a political hue. President Trump moved quickly to minimize the threat of the pandemic, repeatedly dismissing the danger posed by the novel coronavirus, and failing to take steps to treat it as a growing and real emergency. Meanwhile, in part in reaction to the president, public health opinion hardened into one of deep concern about the pandemic, prioritizing lockdowns of most economic and social sectors around the country, sometimes with little public deliberation about the potential trade-offs this entailed and how the devastating consequences of this approach would influence health in the long term. Efforts to mitigate the virus became issues seen through red and blue lenses. Mask wearing became a political party signifier, as did one’s thinking about whether schools for children should be closed or remain open. Whether or not we should move to protect those living in congregate settings, which included jails, became impossible to consider separate from political leanings. And efforts to mitigate the consequences of the pandemic from falling disproportionately on minority groups became intertwined with political efforts to win over particular groups as the 2020 federal election loomed. In the end President Trump lost the election, exactly the outcome he had tried to ward off in the very early days of 2020 by setting a path of action that rested fundamentally on minimizing the pandemic’s threat.

It is perhaps readily apparent on this retelling of the course of the pandemic during 2020 that political actions, and the policies that flowed from them, were inextricable from the consequences of the novel coronavirus that caused COVID-19. Indeed, it is virtually impossible to imagine a parallel world that asks what the course of the pandemic might have been were the political landscape different. The story of COVID-19 must be understood in tandem with an understanding of how, and why politics, policies, and law influence health.

The Causes of Health

The United States spends more on health than any other country worldwide (Tikkanen & Abrams, 2020). Despite that spending, the country’s health indicators are worse than essentially all other high-income countries. Americans live shorter, sicker lives than their high-income country peers, despite investing more money in health than all these same countries. This is a rather odd state of affairs and one that, arguably, has little parallel among other American endeavors. Simply put, what other sector does the United States spend more on than any other country, but have worse outcomes than all other comparable countries? This observation challenges us to think carefully about how health is produced, thinking that we should have done long before COVID-19 was ever a consideration.

The mismatch between America’s health investment and its outcomes rests on a simple misunderstanding. Health is not the same as health care. While it is commonplace to observe, as I have here, that the United States spends more on health than any other country worldwide, that is not entirely correct. The United States spends more on health care than any other country worldwide. We under-spend on the forces that shape health compared to other peer countries (Dzau et. al., 2020). For many decades the United States has operated on the implicit assumption that health care is the most important factor in shaping our health. That is evidenced by the public narrative around health, symbolized by the lab coat, stethoscope, the caduceus, or the microscope. But this understanding of health is simply wrong. While clearly health care matters — and matters more and more as one advances in age when
health care can offer curative correctives to diseases that emerge over the life course — health care is only responsible for a relatively small fraction of our health. What fundamentally produces our health are the conditions of where we live, work, and play. It is our housing, the quality of our neighborhoods, our access to nutritious food, opportunities for exercise, and whether or not we are exposed to violence that influence health much more throughout the life course than does health care. The latter matters to cure us when we are already sick. The former set of conditions matter to make sure we do not become sick to begin with. And politics, policies, and laws are the fundamental forces that shape the world around us. The quality of housing, whether or not there are guns widely available that facilitate violence, the foods that are subsidized and are widely available, or not, are directly shaped by political decisions, and by the policies that flow from these decisions. The laws that are passed by political actors determine what types of houses are built, where monies are invested to create communities that are walkable, the extent to which we permit pollutants in the atmosphere, and whether we have access to livable wages that in turn allow us to balance work and recreation. These are all a direct result of particular political decisions that then should be appropriately seen as the primary driver of the health of populations.

Rudolf Virchow, the father of microbiology, coined the oft-used aphorism that “politics [is] nothing but medicine on a larger scale” (Mackenbach, 2009). While Virchow made seminal contributions to our understanding of the role of microbes, and how they become disease, he became convinced through his work that social inequality was the cause of poor health, suggesting that unless we aligned those conditions in a way that generated health, we were destined to have worse health than we could have. A particular concern of Virchow’s was the observation that the conditions that generate health are unequally distributed, and as such, health inequities emerge that are not addressable without attention to the underlying unequal distribution of health-producing resources. This observation has been repeated in many forms over the past century, and forces such as power, money, and prestige have been called fundamental causes—causes that are inextricably linked to health and inequities in health (Link & Phelan, 1995). This ties the understanding of politics as the foundational driver of health to the emergence of health inequities. If politics favor one group over another, and if politics and policies are central to the determination of health, it is then entirely to be expected that particular groups will be disadvantaged when it comes to health, and that health gaps will be created. Haves and have-nots become health haves and health have-nots, and the foundational driver that shapes the patterns of both is the political decisions, and the policies that flow from them, that distributes health-promoting resources in our society.

This, of course, bring us back into the COVID-19 moment. While it was political dysfunction that was most eye-catching during 2020 and was immediately and intuitively linked to the tragic course that the country took with the pandemic, more fundamentally, it was decades of political underinvestment in the forces that create health that set the stage for how poorly the country did in handling the pandemic. And, it was the unevenness with which the country had invested in the conditions that shape health, the heterogeneity that characterizes the distribution of health-producing resources across socioeconomic and racial and ethnic groups, that set the stage for the socioeconomic and racial and ethnic differences that characterized the course of the COVID-19 pandemic.

**COVID-19 and Health Inequities**

This is perhaps simply illustrated by considering the disproportionate rate of COVID-19, and the disproportionate death rate from COVID-19 among Black Americans compared to white Americans. Black Americans have died at a rate roughly two times greater than white Americans throughout the pandemic. The rate of death for Black Americans is still less than those among Native Americans, and only a bit higher than those among Latino Americans — all substantially higher than the rates among white Americans—the country's majority group. While these data have been amply publicized and, appropriately, the subject of much public discussion, we have perhaps not paused enough to ask: why? And more specifically why have Black Americans had higher rates of infection, and separately, why have they had higher rates of death once they have been infected by COVID-19?

The answers to the two questions are different, but both illuminate the central role of politics in determining health and health inequities.

First, risk of transmission of an infectious disease that is transmitted person-to-person is directly determined by the likelihood that someone is in contact with other individuals. Therefore, the risk of acquiring COVID-19, particularly early in the pandemic, was determined by whether one could socially distance, and do so quickly. And the extent to which one could do that is socially and economically patterned (Jay, J. et al., 2020). We know, for example, that individuals in the upper quartile of income are more than six times more likely to be able to work remotely than those in the lower quartile of income, as the latter category includes many with service and retail sector occupations that simply cannot be done from one's home. Black Americans are, in turn, disproportionately more likely than other racial and ethnic groups to be employed in these sectors, thereby disproportionately increasing their likelihood of acquiring COVID-19, an observation borne out by the data throughout the pandemic.

Second, risk of severe COVID-19, once COVID-19 is acquired, is a function of many factors, but principally, a function of a person's vulnerability to the infection, and that is linked to prior underlying conditions that have been shown, since the beginning of the pandemic, to be a central determinant of risk of death from COVID-19. The presence of underlying co-morbidities, ranging from heart disease to diabetes is itself racially patterned, with Black Americans long having disproportionately higher rates of disease (Raifman & Raifman, 2020). It is that higher rate of disease then that put Black Americans at higher risk of having severe COVID-19, further embedding the social patterning of the disease.

Understanding these determinants points the way to recognizing the foundational role that politics, polices, and laws play in shaping
health, and during the time of COVID-19, in shaping the patterning of the pandemic. Black Americans have been disenfranchised for centuries, starting with slavery, which shaped the conditions of living for most early Black Americans. This was followed by political actions, from Jim Crow laws, to redlining efforts at segregation, to discrimination in employment opportunities, to harsh penalties for drug-related legal offenses. This is directly linked to lower income, and even lower wealth, held by Black compared to White Americans, and the disproportionate representation of Black Americans in low-income occupations which do not readily lend themselves to remote work. Similarly, these conditions of marginalization led, before COVID-19, to higher morbidity and mortality among Black Americans, which then resulted in a higher burden of underlying vulnerability to COVID-19, manifesting in disproportionate disease severity and death.

It is therefore, literally, centuries of political decisions, and the policies and laws that flowed from them, that determined health of Black Americans before and during COVID-19. This observation has important implications for how we understand health. The higher burden of COVID-19 borne by Black Americans is not due, in any way, to biological difference between Black and white Americans. There is no genetic mapping of particular racialized identities that reflect vulnerability to COVID-19. Rather, it is social and economic circumstances, both long before and during COVID-19 that resulted in the racial patterning of COVID-19, much as these same conditions have patterned health for centuries.

While I use racial differences here to illustrate the more general point, the same argument applies for socioeconomic differences, explaining, for example, the 15-year difference in life expectancy between the poorest and richest Americans and the growing health gaps between the poorest 80% and the richest 20% of Americans (Abdalla & Galea, 2020). The essential explanation for all these differences is the same: social and economic patterning of health producing resources that is determined by politics, policies, and laws.

**A Healthier Politics**

This brings us back to where we started—the broader determination of health. Dramatic racial differences in the impact of COVID-19 emerged that are not linked to any genetic difference in racial identity, or even in particularly different treatment of racial groups within the health care system. These racial differences are driven by differences in the foundational forces that shape health. While there are some health differences that are influenced by genetic makeup certainly, and while health care is important for health when we are sick, particularly at the extremes of life, these forces are relatively minor players in the architecture of health. If we are to create a healthier country, we need to create a politics that values health, and that recognizes that it is political actors—not doctors—who are the key players in creating that healthier world.

COVID-19 laid bare what has long been clear to careful students of the health of populations. Perhaps for the first time ever, mainstream public media has been discussing social and economic patterning of health, and social movements have emerged influenced, in part, by these same differences. The central question seems whether we shall learn from the COVID-19 moment, and whether we shall recalibrate our politics and policies to the end of creating a healthier world.

The core take-away from the COVID-19 moment is that politics are an inevitable determinant of health. The United States has long operated on an implicit assumption that if we spend enough money on biomedical research, and on curative approaches, we will buy our way out of our poor health. The data have long shown that to be a misunderstanding of how health is generated, and COVID-19 has made that plainly obvious for all to see. Therefore, and critically, the engagement of politics, policies, and laws with health is non-discretionary, and requires an explicit commitment to reorient to health producing politics if we wish to become healthier as a country.

The COVID-19 moment suggests that we care immensely about our health. It is hard to think of another reason but a health threat why we would have upended our entire society within the span of a few short weeks and persisted for more than a year with efforts that constrained our function enormously. This holds promise. It may be that this moment is a teachable one where we can all learn, and one where we can perhaps, embed a more productive way of thinking about health in our national politics, policies, and laws once and for all. To do so will require a wholesale shift in our thinking, informed by scholarship and careful explication of the pathways through which policies and laws can be wielded to promote health.

This Report, which identifies and analyzes the policy challenges and opportunities in light of the pandemic, is a welcome step in that direction. 🌟
About the Author

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References


