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Public Health After COVID-19

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Summary

Background: **This paper reflects on community health components during the COVID-19 epidemic in the light of major and always challenging health system issues from inequities, to financing, to delays in service delivery and the like.**
Method: **This is an invited commentary.**
Results: **The seven issues have been highlighted for the deconstruction of the public health infrastructure since COVID-19 (1) Growing social determinants of health disparities (2) Inadequate investment in public health infrastructure (3) Racial injustice and discrimination (4) Increased anxiety, depression and loneliness (5) Slow response to serious infectious diseases (6) Lack of diversity, equity, and sense of belonging (7) Need to be trustworthy partners.**
Conclusion: **COVID-19 should have taught us to listen, act, engage and educate the public. We have an enormous goal to achieve, but we can do it.**

Keywords: Public health, COVID-19, Social sciences, Community partnership

Since March 2020, when the World Health Organization officially declared COVID-19 a pandemic, I have been convinced more than ever of the absolute necessity of community partnerships and the value of authentic relationships. Community partnerships have deepened and grown so that the health of our community can flourish. However, while they are necessary to positively impact health and well-being, they are not sufficient. What is needed in addition to partnerships is the need to reduce social vulnerability that could eventually reduce health disparities. As leaders in public health, we are obligated to deconstruct the last few years to understand not only what happened but also to ensure that we are working to finally reduce health disparities and improve access for all because it is the right action to take.

The deconstruction of the public health infrastructure since COVID-19 has taught me that there are more similarities than differences in public health needs around the world. Seven important issues are highlighted here, in no particular order (Table 1).

The pandemic uncovered a major issue with **social determinants of health disparities**. Our team discovered that one of the most common community concerns was food insecurity or having enough money to put food on the table. In response, Community Health Workers distributed meals provided by local kitchens, made referrals to local food pantries, and worked with County Extension agents to teach people how to cook locally grown vegetables in a healthy way. Even during lockdown, we found a way to move our operations outdoors to the driveway so we did not turn out back on the community. This was happening all over the world.

The pandemic has also highlighted the **inadequate investment made in the public health infrastructure** and how it is to blame for a lack of public health programming. Inadequate infrastructure for public health efforts at Departments of Health, in Ministries of Health, and other government operations affected a rapid response to standing up vaccination clinics, whether for COVID or other vaccines. These agencies could have been more prepared and could have alerted the field that resources were lacking for fundamental programs that would build the required infrastructure to maintain adequate physical and mental health of community members. Inadequate investments were detected

Table 1. Community issues highlighted by COVID-19

1. Growing social determinants of health disparities
2. Inadequate investment in public health infrastructure
3. Racial injustice and discrimination
4. Increased anxiety, depression and loneliness
5. Slow response to serious infectious diseases
6. Lack of diversity, equity, and sense of belonging
7. Need to be trustworthy partners

around the world, some attributed to politically motivated messaging that caused widespread skepticism.

On May 25th, 2020, early in the pandemic, George Floyd, a Black man from Minneapolis, was murdered by police brutality, resulting in a global protest movement which initiated a call to action against **racial injustice and discrimination**. Most universities, agencies, and organizations have now developed protocols to reject racial injustice and discrimination. At about the same time, we were learning that populations across the globe had not been given access to vaccinations; they felt that the health system was using them to test the effectiveness of the vaccines. Community leaders called for scientific models that shared power, respected all values and engaged everyone fairly and equitably. Reduced public confidence in the research enterprise posed a major issue that has still resulted in high vaccine hesitancy, the spreading of misinformation and a public health system that is mistrusted by the very people it tries to protect.

The pandemic revealed high rates of mental illness expressed as **anxiety, depression and loneliness**. We learned that it was necessary for clinics to screen for these disorders and to reach out to CHWs to begin to screen for them as well. When we could not conduct outreach due to lockdown, we began a phone reconnect campaign to call Registry Members to check in with them and evaluate their current needs. We also asked questions about their level of loneliness and stress on a 10-point scale. We were surprised to learn about the high levels of loneliness and stress reported. We heard stories of how some people had not spoken to anyone in weeks—that people were lonely and wanted us to call them back again the next day to see how they were. In fact, the increase in symptoms of mental illness has resulted in the U.S. Preventive Services Task Force (USPSTF) recommending all adults 18—64 years of age being screened for anxiety. This recommendation should be adopted around the world to help mitigate serious consequences of social distancing, and other practices needed to help

protect from COVID-19 transmission. Data have also shown that rates of other mental illness have increased since COVID-19.

COVID taught us all a lesson on how to respond to a global crisis. Some countries were **slow to respond to this infectious disease;** others were quicker, but eventually we all came together through collaboration. Wealthier nations helped other nations in need with medical equipment, medications and interventions. Individuals responded differently—some were enthusiasts, or so-called early adopters. They made an appointment as soon as they could to get the vaccine. Others were called "the watchful"—those who waited to see what happened to others, but then quickly adopted to the response. A third group was the "cost-anxious"-—those who were afraid of the consequences of the side effects and its toll on them losing time at work, resulting in lost wages. Fourthly, there were the system distrusters—those who had a problem with accepting the news and having low confidence in the vaccine because they felt it had been developed too quickly, without proper oversight, time and research. Lastly, there were the COVID skeptics who did not believe in the infection at all. They had deeply held beliefs against COVID-19. But regardless, the pandemic taught us that we needed to act more quickly to understand the disease, the treatments and the consequences of COVID for the general public, as well as for the workforce in general. These personas continue, as a result of a slow response, and the virus continues to morph. People are also becoming numb to the news that COVID will persist and responses will continue to be sluggish and slow.

The pandemic taught us that communication is important—that different messages are needed for different populations. We learned that to protect the public health, we need to advance the science through partnerships with diverse community members who have a voice in the research enterprise from conception to dissemination. We noted a **lack of diversity, and equity**, because the community has not felt included and that there is a **lack of a sense of belonging**. In general, the community has not felt involved in decision making about treatments, interventions and their health needs and concerns. But because of the pandemic, there are new protocols that will involve people who have been underrepresented in research such as those who are racial and ethnic minorities, people with a disability, people living in rural areas, older adults, and pregnant persons, among others. We also learned the importance of meeting people where they are. Thus, the widespread use of telemedicine

visits, mobile health vehicles and Community Health Workers. All of these interventions help to improve a sense of belonging.

Finally, the pandemic has led us to the most important goal of all—to **be trustworthy partners.** Trustworthiness must be earned. It is not the same as "building trust" with community and partners. It is more what happens when you fulfill your promises, when you roll up your sleeves and work with communities and partners—when you listen and act on concerns and needs. Since the pandemic, those who work to improve the public health have a mission to be trustworthy partners. The next few years will show us just how trustworthy we have been as a partner with the community. The metric for success will be how much less hesitancy there is, how much access to health care and treatments has improved, and how satisfied people are with our interventions. In the end, COVID-19 should have taught us to listen, act, engage and educate the public. We have an enormous goal to achieve, but we can do it.

Conflict of interest

No conflicts of interest.

Acknowledgement