Power Up: A Call for Public Health to Recognize, Analyze, and Shift the Balance in Power Relations to Advance Health and Racial Equity

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Strategies such as diversifying the public health workforce; building capacity related to diversity, equity, inclusion, and belonging; and conducting research on oppression are necessary but insufficient to improving health in communities that have been marginalized by systems of oppression. Working toward health and racial equity requires changing the structural drivers of health. Public health interventions must advance widespread and lasting structural change—changes in values and beliefs; culture and norms; governance; laws, policies, regulations, and budgets; and institutional practices.[1]

Structural interventions include, for example, shifting government budgets by increasing taxes on multinational corporations and the wealthy while increasing investment in low-opportunity neighborhoods of color and rural communities. They include changing the US electoral systems to reduce corporate influence, ensuring everyone has a voice that counts equally and can vote freely, and making our elected bodies more democratic and accountable. Structural interventions also include influencing narratives about the virtues of free markets and how the economy works so that the public understands that people govern the economy and can work toward an economy where all can thrive.

Structural interventions require the long-term work of shifting power—both building community power within marginalized communities and contesting the power of those who use it to maintain the status quo. Shifting power means changing who is making public decisions, controlling the political agenda, and influencing dominant narratives. If these are the changes needed to advance equity, does public health currently have the lens, know-how, and audacity to work toward these changes?

Public health needs a power lens: a common, nuanced, and critical understanding of how power works; the potential to mobilize collective power fieldwide; and strategies to shift the balance in power relations to address structural inequity and oppression. We submit that public health must increase its capacity to (1) recognize, (2) analyze, and (3) shift power.

RECOGNIZING POWER

Power remains an underutilized and poorly understood concept in the public health field despite discussion of the topic for decades. Foundational public health frameworks[2,3] and papers[4–6] have described power as a fundamental cause of health inequities and balancing power as an important strategy in advancing health equity, yet those ideas have not been widely integrated into research and practice. Public health research has shown that power imbalance explains inequities across multiple determinants of health, though this insight has been muddied by overlapping terminology, such as "control" and "autonomy."[7] Some in public health have developed and applied frameworks for analyzing power.[8,9] Despite this, a power lens is rarely applied.

Useful frameworks for conceptualizing power can inform how the field

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recognizes power. Feminist scholars and activists have introduced concepts such as power to, power with, and power within, considering power to be a capacity or a resource that can be redistributed.[10] Social theorist Steven Lukes described power as having three "faces."[11] As described elsewhere, these are (1) "Exercising influence in the political or public arena and amongst formal decision-making bodies to achieve a particular outcome"; (2) "Organizing the decision-making environment, including who can access decision-making and what issues are being considered by decision-making bodies"; and (3) "Shaping information, beliefs and worldviews about social issues."[12(p35)]

Black feminist sociologist Patricia Hill Collins articulated four domains of power: (1) structural: the social structures, such as laws, religion, and the economy, that organize power relations and maintain oppression; (2) disciplinary: control and organization of behavior through surveillance and routinization to manage oppression; (3) hegemonic: the shaping of beliefs through the development and normalization of ideology and culture to legitimize oppression; and (4) interpersonal: the personal relationships and interactions that are part of our daily life that uphold oppression.[13]

Each component of these conceptualizations is readily discernible in public health's external research and interventions and in its internal workings, with implications for public health training, research, practice, funding, publishing, and accreditation. As a first step, public health professionals can study these frameworks, critically reflect on how power is relevant to our work, and embed a recognition of power into our training and practice.

ANALYZING POWER

Theoretical descriptions of power are most useful when they can guide research, policy, and practice, such as through the development and answering of questions that prompt analyses of power dynamics. For example, questions that can guide public health analysis based on the "three faces of power" include the following:

1. Who holds decision-making power? How do we influence them? What public health assets (e.g., evidence, framing) will influence them?
2. Who is influencing the decision-making agenda? What organizations need to be built or brought into relationship to move an equity agenda?
3. What dominant worldviews and narratives influence decisions and make harmful viewpoints seem like common sense? What transformative narratives can public health and partners in marginalized communities assert to shift what is considered common sense?

Similarly, questions can be developed from Hill's four domains of power. Examples relevant to public health training include the following:

1. Structural: What are the present and historical relationships between school or program of public health (SPPH) property ownership and land acquisition practices and community housing, and what have been and are the health impacts for residents? How are the SPPH's labor practices assessed and addressed? Are SPPH staff, faculty, and research and teaching assistants paid fairly?
2. Disciplinary: How is power operating to shape public health epistemologies and training requirements? How are various domains and types of knowledge valued within admissions criteria? Which forms of knowledge and ways of knowing are emphasized, prioritized, and centered?
3. Hegemonic: How is power operating in the determination of public health training competencies? Are accreditation entities and program directors sufficiently trained in matters of positionality, power, epistemology, and the social production of knowledge? Do curricula presume public health is an "objective" and "neutral" arbiter of facts, evidence, and health "truths"?
4. Interpersonal: How is power operating to support or inhibit inclusion and belonging within SPPHs? Are there policies in place to disrupt practices of silencing, erasure, and microaggressions in public health classrooms?

Using frameworks of power to develop and answer questions about the power dynamics at play on issues related to health equity is a second step for public health.

SHIFTING THE BALANCE IN POWER RELATIONS

While some may conceive of power as dominance—power over—Dr Martin Luther King Jr defined power more affirmatively as "the ability to achieve purpose."[14(p199)] To advance equity, power must be shifted from those who use power to perpetuate inequity. This requires contesting their power as well as building power with and within marginalized communities.

Answers to the types of questions outlined previously must inform the strategic actions and interventions public health deploys to advance equity. While some in public health are already intentionally working to shift power—for example, using the "three faces" framework[12]—for many, this will mean working differently and starting new activities.

Public health will need to shift the balance in power relations through its community interventions. For example, public health departments can provide services while also building power among those they serve, bringing together marginalized individuals and communities to build relationships, develop a shared understanding of the root causes of the issues they face, and work together to identify and advance solutions that address those root causes. Through Health in All Policies and similar initiatives, public health can engage across sectors to build a shared understanding of equity and support work across sectors to shift power. Every aspect of our community work can be evaluated and shifted through a power lens: What public health assets and actions can be mobilized to grow power within marginalized communities to influence decisions, build the infrastructure necessary to set an equity-focused agenda, and change the narrative?

Shifting power will require new relationships and collaborations—for example, with community organizing groups that have long focused on shifting power to marginalized communities. It will require that public health researchers ask how research contributes to power-building and shift to more inclusive methods such as participatory research.[15] Public health will need to reconsider what is viewed as legitimate data and research, how knowledge is assessed and validated, and how to challenge dominant narratives that block progress toward structural change.[16]

To enable this externally facing work, public health practitioners will need to examine our own power and positionality, understanding the power we have and how it can be harnessed to advance equity. Public health organizations will need to transform institutional practices, critically examining processes for research, funding, publishing, administration, and training.[16] Public health training will need to reorient around advocacy, social action, and political engagement, and abandon teaching that we are "objective" and "neutral" arbiters of science.

Increasingly, public health practitioners recognize that to advance health and racial equity we must change the structures that cause and maintain inequity, addressing structural racism and other structures of oppression. Yet methods and interventions for making those changes are absent from public health's current toolbox. Using a power lens can reveal a way forward. The field of public health must learn to recognize and analyze power, harness our collective capacity, and change our strategies to correct power imbalances. AJPH

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