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# The Great Flu and After: Why the Nurses?

**See also Jones and Saines, p. 877.**

In "The Eighteen of 1918–1919," Marion Moser Jones and Matilda Saines do something very important: they introduce Black nurses as important historical actors in the devastating flu pandemic that struck the United States during and after World War I. But they also do something even more significant. Jones and Saines have positioned nurses and nursing as a case study in our quest to understand the broader historical issues that have implications critical to how we understand the cultural and social dimensions of public health policies and practices. In their case, they situate Black nurses in the long battle for civil rights, committed to demonstrating their worthiness for full citizenship and to using the spaces created by a seemingly unending demand for nurses—in disasters, war, and now pandemics—to carve a place for themselves and their peers. But Jones and Saines' conclusion that their gains were "incremental" and "ephemeral" raises equally pressing questions about the nature and consequences of one particular form of political and social change.

## LARGEST GROUP OF HEALTH CARE PROVIDERS

Nurses have been, are, and will always be the largest group of health care providers. Medical treatments—surgeries, prescriptions, inoculations, and vaccinations—are necessary and lifesaving, but they are also episodic and limited by time. By contrast, the care needed for recovery and rehabilitation is labor-intensive, time-consuming, constant—and absolutely necessary. David Barnes' research on yellow fever at the Lazaretto, Philadelphia, Pennsylvania's 19th century quarantine hospital, shows a rather amazing cure rate. In the absence of effective medical treatments, the nursing care provided spelled the difference between life and death.[1] Nurses provided lost fluids, sustaining food, and a healing environment. They also provided the skilled actions that allowed a patient suffering from uncontrolled vomiting and diarrhea to retain the fluids and food offered, to benefit from warmth and good ventilation, and to tolerate a cooling bath without fear of exacerbating a fever. Similarly, Nancy Bristow has argued that it was precisely these forms of care that individuals and families knew were needed during the flu pandemic. Medical care was important, but nursing care was essential. And nursing's response raised nurses' status and public profile in communities grateful for their care.[2]

Other historical analyses have argued that nurses have used opportunities when there were increased demands for their care to challenge their marginalization or exclusion from larger issues of policy or practice. Jones and Saines' article joins a small but significant body of research that examines these issues. Most focus on the inevitable shortages of nurses that develop during wartime conditions. Barbra Mann Wall, for example, argues that the widespread praise of the Sisters of St. Joseph who nursed Union soldiers during the Civil War played a substantive role in mitigating widespread suspicions of American Catholics.[3] But Black nurses themselves were keenly aware of their particular ability to contest racist norms that limited their practice. Elizabeth Jones, a Black public health nurse writing in 1924, laid this out quite clearly. Jones saw herself as an example of the "New Negro Woman." It would be the New Negro Woman's professional combination of education and disciplined integrity that would force White America, however reluctantly, to acknowledge the Black nurse—and, through her, all Black America's "aptness and talent." Nurses would be among the vanguard, and "eventually he [the White man] will be compelled to take us on our merits rather than our skins."[4]

## MABEL KEATON STAUPERS

The 18 nurses in Jones and Saines' article joined with Elizabeth Jones in their larger consciousness of the political as well as healing import of their work. Mabel Keaton Staupers is one such actor whose work begs further analysis. Her frustration around the limited gains made by her Black colleagues who nursed flu victims in 1918 and 1919 gave way to triumph during World War II. In ways we have yet

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to examine in depth, Staupers turned her disillusionment into a powerful political movement among Black nurses, the Black press and clergy, and prominent White supporters waiting for the next inevitable wartime shortage of White nurses. When President Franklin Roosevelt stood ready to draft White nurses, Staupers launched a powerful media campaign challenging such draconian measures when thousands of fully qualified Black nurses stood willing and ready to serve in the military. Almost overnight, the Army Nurse Corps desegregated. A few year later, the American Nurses Association became the first professional health care organization to admit Black nurses as members.

## MORE QUESTIONS

Real issues remained within American nursing—not the least being the different meanings attached to the implications of such words as "integration" and "desegregation." In Jones and Saines' words, these changes in meaning were incremental and, if not ephemeral, then at least constantly contested. But to return to the idea of nurses and nursing as a broader case study, we can see the illustrative power of how this group of clinicians, and the discipline they represent, allow us to more fully understand the nature of social and political change. Should agendas around change in public health policy and practice strive for changes in attitudes and beliefs that are small but steady, or sweeping and transformative? How does self-interest or group interest intersect with broader issues of social justice? Are harm reduction policies appropriate steps when ultimate goals are nothing short of broad-based prevention? These are not easy questions. But we can thank Jones and Saines for allowing us to cast the history of nurses and nursing as an exemplar of a discipline that might provide answers. AJPH

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**CONFLICTS OF INTEREST**

The author declares no conflicts of interest.

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# The Political Economy of the United States and the People's Health

**See also McCartney et al., p. 942.**

The political economy approach argues that the behavioral and social determinants of health are themselves shaped by macro-level structural determinants: politics, the economy, and the state.[1] Population health is thereby politically determined with patterns of health and disease produced by the structures, values, and priorities of political and economic systems.[2] The 2007–2008 global financial crisis, austerity, and the rise of populism (e.g., President Trump, Brexit) has led to a widening awareness in the international public health community of the important influence of political and economic structures on public health.[3]

This issue of *AJPH* engages with this political "public health reawakening" by featuring an important and timely evidence review by McCartney et al. (p. 942) on the impact of political economy on population health. Reviewing a sizeable international literature of more than 50 systematic reviews conducted over the past 25 years, the authors concluded that social democratic welfare states, higher public spending, fair trade policies, compulsory education, microfinance initiatives, health and safety regulation, universal access to health care, and high-quality affordable housing have positive impacts on health while the retrenchment of the public sphere associated with neoliberalism has negative effects.

Nowhere exemplifies the findings of the McCartney et al. review and the importance of political economy for health more than the United States. The United States has a significant health disadvantage relative to other wealthy countries—it punches well below its economic weight.[4,5] For example, infant mortality rates in the United States are almost three times that of Iceland and 50% higher than the Organization for Economic Cooperation and Development average. Likewise, at 79 years, average life expectancy in the United States is three years lower than in Sweden and Costa Rica.[6] This disadvantage became particularly prominent from around 1980—and mortality and morbidity rates are now increasing—particularly among middle-aged, low-income Whites.

Traditional analysis has pointed to the role of differences in health behaviors between the United States and other high-income countries. For example, around 20% of the US health disadvantage is attributable to historical differences in smoking rates, and there are significant differences in diet—the United States has the highest average calorie intake in the world.[4] Health systems researchers have focused on the lack of universal health care in the United States where the market-based system means that around 10% of Americans are without health insurance and millions of others remain underinsured[4]. Given the well-established association between poverty and health,

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