# COVID-19's First Year: A Bipartisan Appraisal

*Georges C. Benjamin, MD*

**ABOUT THE AUTHOR**

*Georges C. Benjamin, MD, is executive director of the American Public Health Association, Washington, DC.*

**See also the Building Bridges section, pp. 586–613.**

On January 20, 2019, the United States identified its first case of COVID-19. This case was the start of the US component of a global pandemic that has devastated our health, our economy, and almost all facets of our lives. As societal disruptors go, this was indeed the big one. Now one year later, we look back and take measure of what this means to public health and see the extraordinary impact this pandemic has had on our understanding of public health preparedness, health inequities, and the politicization of science and public health.

This issue of *AJPH* contains a series of opinion pieces as points and counterpoints, with opposite partisan perspectives that explore some of the questions this year of turmoil and challenge has unearthed. Jeanette Kowalik (p. 602), a former health officer from Milwaukee, Wisconsin, was among the first officials in the country to recognize and report on the enormous health disparities manifested in the COVID-19 pandemic. Her thesis explores the consequences of the disinvestment of public health to the ability of the agency to do its legislated duty, as well as its effects on a community that is disproportionately minority. She addressed this issue while preparing for the Democratic National Convention, which had been scheduled to take place in Milwaukee in 2020. COVID-19 interrupted that event, as it did everything else and transformed the convention for the most part into a virtual event.

Howard Rodenberg (p. 604) from Jacksonville, Florida—which was expected to host the Republican National Convention, another event that went essentially virtual—builds on Kowalik's concerns about fundamental support for public health by focusing on the disinvestment in its leaders as well. He aptly points out the political element of public health agency leadership and the risks to careers and the hostile work environments that health officials are now finding themselves in. He keenly asks, "Who would want the job? Perhaps a few brave (or foolhardy) souls will continue to venture into the shark-infested waters" (p. 604). In many ways, that is the question the field will have to answer. How do we build principled public health leadership that can build the support of policymakers, earn the trust of the community, and therefore build sustainable systems that are prepared and resilient enough to protect the public's health?

Gee and Khan (p. 594) and Gerberding (p. 596) explore the challenges met while responding to the pandemic and key principles to consider when building the public health system of the future. All have had the experience of leading key public health agencies during infectious outbreaks: Gerberding as director of the Centers for Disease Control and Prevention (CDC) during the anthrax letters; Khan as director of the CDC Office of Preparedness and Response, where he worked on numerous infectious disease outbreaks, including Ebola, hantavirus, and SARS; and Gee, who as a state health official in Louisiana was involved in managing the Zika outbreak. All three leaders acknowledge the poor state of public health but look to opportunities for learning as we move toward building the future.

The point and counterpoint articles by Kassler (p. 606), Fine (p. 608), Butler (p. 610), and Glied (p. 612) explore our fractured health system, which has not yet achieved universality, flexibility, and seamlessness. COVID-19 has laid bare the holes in the delivery system and specifically the inadequacies of the primary care system, which should serve as the foundation of our ability to provide basic care for our population. Butler argues that to achieve a more equitable health system we should do three things: create more community-based health services, transition from employer-sponsored insurance to Medicare Advantage for All, and restructure our national system in a way that permits local variability to meet local needs. Glied counters that we should build on the employer-based system and the Affordable Care Act while working to achieve universal coverage. She acknowledges the strengths of Butler's concepts while pointing out the challenges the nation has had in moving in the policy direction Butler proposes. Nevertheless, achieving universality for

the primary health care delivery system is a key component of a reimagined and more equitable public health system.

Castrucci (p. 598) and Atchison (p. 600) take on the issue of the 10 essential services as the foundational work of public health. They both point out the need for a consensus on how to communicate about these services so all can understand what public health is. We are not there yet! One of the paradoxical lessons of the COVID-19 pandemic is that the world still associates the term "public health" with medical services delivered by doctors and nurses. "Epidemiologist" has become synonymous with "medical expert," and governmental public health practitioners are now viewed as bureaucrats focused on violating individual freedom by promoting mask wearing, physical distancing, and stay-at-home orders. In fact, public health is just the opposite. It is a discipline built on a foundation of freedom, human rights, and equity. Its goal is to ensure that all people in all communities have the opportunity for good health. Castrucci and Atchison are right on: we have work to do to ensure that public health guidance becomes acceptable to all.

The articles by Ferdinand (p. 586) and Rodenberg (p. 588) lay out the ethical reasons public health must continue to act and be vigilant. Ferdinand relates a moving experience involving the role inequity plays in our society, and Rodenberg presents the case of the ethical need to act. Combined, these two authors pay tribute to the work public health must do and lay bare in the starkest terms the counterpoint to those who believe public health practitioners are not operating in humanity's best interest.

The COVID-19 pandemic of 2019–2022 has exceeded 25 million cases in the United States and is projected to peak at more than 500 000 deaths. As of this writing, the US death toll has eclipsed the deaths from the six years of WWII. The economic toll is in the trillions of dollars, highlighting the enormous impact of a global pandemic. Considering that the US investment in health is more than $4 trillion and the public health component is only 3% of this, COVID-19 shows the fallacy of resource allocators' persistent disinvestment in public health. A weakened public health system was an important component of the inability to effectively respond to the pandemic. Indeed, the major lesson of the pandemic is that the United States needs to invest in a well-resourced and sustainable public health system. Pandemics are devastating, and this is not the last one. AJPH

## CORRESPONDENCE

Correspondence should be sent to Georges C. Benjamin, Executive Director, American Public Health Association, 800 I St, NW, Washington, DC 20001 (e-mail: georges.benjamin@apha.org). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

## PUBLICATION INFORMATION

Full Citation: Benjamin GC. COVID-19's first year: a bipartisan appraisal. *Am J Public Health*. 2021;111(4):542–543.

Acceptance Date: February 1, 2021.

DOI: https://doi.org/10.2105/AJPH.2021.306215

## CONFLICTS OF INTEREST

There are no conflicts of interest to report.