



HEALTH CARE

A BIENNIAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING

INAUGURAL ISSUE

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aft.org/hc

TOGETHER, WE CAN:

+ REIMAGINE THE
HEALTHCARE SYSTEM

+ RECKON WITH
RACIAL DISPARITIES IN
TOXICANT EXPOSURE

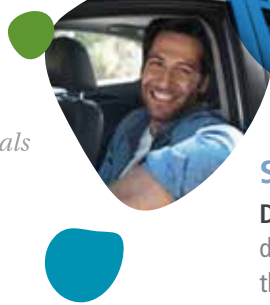
+ SUPPORT
NATIVE AMERICANS
CULTIVATING
THEIR HEALTH

+ HONOR THE LIFE
LESSONS OF CARING
FOR OTHERS

Healing Our Society

As COVID-19 lays bare
systemic racial and
economic injustice,
healthcare professionals
are vital to building a
better nation.

PLUS: A SPECIAL PACKAGE ON SAVING OUR DEMOCRACY



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* New York State United Teachers members have similar programs through NYSUT Member Benefits Trust. To obtain more information about these plans, members can call 800-626-8101.





Trump Chooses Chaos We Choose Community

RANDI WEINGARTEN, AFT PRESIDENT

THE AFT HAS WEATHERED many storms—and many existential threats, natural and ideological. From the *Janus* Supreme Court decision to COVID-19 to divisive politicians like Wisconsin's Scott Walker and New York's Rudy Giuliani, we have fought back against those who would rather starve public services, strip away healthcare, eliminate unions, and polarize the people than help fulfill the promise of America.

The AFT is built for this. We don't back down. We care, fight, show up, and vote. Despite crisis after crisis, we have thrived because of your work and your activism. And even with everything that has been thrown at us, our union is *growing*.

As a union of professionals, one of the ways we engage is by supporting our members and our communities in developing and sharing expertise. That's why we're excited to bring you *AFT Health Care*, a new journal focused not only on the practice of healthcare but also on the social, economic, and environmental factors that powerfully affect our health and the well-being of our communities.



The AFT is honored to represent more than 200,000 health professionals and to stand by you and your communities during this challenging time. You have been on the frontlines of this pandemic from day one—nurses, EMTs, doctors, orderlies, and respiratory techs—putting your lives at risk. I welcome our nation's newfound respect for your extraordinary work (and I hope you enjoy the tribute to the work of caring for others in "Finding Light in the Darkness" on page 30).

This journal is designed to support our shared work of rethinking what healthcare systems should be and how we can provide universal coverage, put patients above profits, and cultivate health. (For a great place to start, see "COVID-19: From Public Health Crisis to Healthcare Evolution," on page 6.) And this union is designed for you. Whatever is needed to keep you, your patients, and your loved ones safe, the AFT has your back.

But make no mistake: the threats before us today are unprecedented.

It is not just the three crises—the pandemic, the worsening economic inequality, and the long overdue reckoning with systemic racism; now we also face very real threats to our democracy and to the ability of every eligible American to safely and freely vote. These crises are all made worse by one person: Donald J. Trump.

These crises have exposed longstanding inequities that our union is committed to challenging. The AFT has a long history of



fighting for economic, health, and racial justice. Everyone should feel safe and able to thrive in our communities; together, we will fight for and build a better, healthier, more equitable society for all. Healthcare is a foundational part of that—ensuring not only that people have a right to healthcare but also that those who work in healthcare have the necessary conditions to keep them safe, as well as the pay and benefits that befit the importance of this work.

As I prepared for the anniversary of the March on Washington—a march that was peaceful in 2020, as it was in 1963—I thought about the last book and some of the final words Dr. Martin Luther King, Jr., left us. He presented a choice: chaos or community. The evening before the march, President Trump was using the White House as a prop as he sowed the seeds of division. Just like he used St. John's Church as a prop in June, after having peaceful protestors tear-gassed, so he could hold up a Bible for a photo op.

The AFT is honored to represent more than 200,000 health professionals and to stand by you during this challenging time.

Trump isn't up to the task of handling this public health crisis.

Let's be clear: we must all take a stand against violence—just as we must all take a stand against systemic racism. Racial bias is built into virtually every system in the United States. It's evident in voter suppression, low wages, high unemployment, discriminatory policing, mass incarceration, and substandard housing, healthcare, schools, and transportation. We see it in racial health disparities that existed long before COVID-19 started disproportionately taking Black and brown lives: Higher maternal and infant mortality. More premature deaths. Greater exposure to unsafe water, unhealthy air, and the environmental conditions that cause asthma (as explored in "Healing a Poisoned World," on page 16).

How does the president of the United States *not* say the names that are on so many of our lips—Jacob Blake, George Floyd, Breonna Taylor—yet call violent white supremacists in Charlottesville "very fine people"? Why has the president cheered on caravans of white supremacists in Portland and refused to condemn the killings of two protesters in Kenosha by a 17-year-old white teenager?

This is not the way any president should act.



COURTESY OF JILL COHENOUR



Rather than calming a tense nation, he is courting violence. Savvy political scientists believe he is not merely energizing his base; he is cultivating chaos to distract the nation from his inept handling of the pandemic. By early September, when the United States had over 6 million cases and 190,000 confirmed COVID-19 deaths, it was clear that many other countries had been far more successful in containing the virus. The US had 4 percent of the world's population but 22 percent of COVID-19 deaths. Think about what could have happened if Trump had decided to fight, not deny or downplay, the virus.

The AFT sounded the alarm about the novel coronavirus back in February. I called on the Trump administration to coordinate, to inform and protect the public, and to act quickly to prevent the virus's spread. Instead, the president denied the virus was even a threat and refused to marshal the necessary resources. Even when our hospitals started becoming overwhelmed and nurses and health professionals were crying out for lifesaving equipment, Trump refused to act and even accused nurses of stealing PPE.

Just imagine how different our situation would be if our nation's dedicated health professionals, world-renowned medical researchers, and esteemed infectious-disease scientists had

been leading a well-coordinated federal response.

President Trump claims that he has created the best economy ever. Before the pandemic, 40 percent of Americans couldn't cover a \$400 emergency, yet the rich were getting far richer. By the end of August, 25 million Americans had lost work—and economic inequality in America was on par with the Gilded Age.

President Trump has obliterated nearly every norm of our democracy, including running roughshod over the laws intended to prevent him from using his office for political or personal gain. It's no wonder that historians are sounding the alarm about the threat he poses to democracy (including in this issue—see "Saving Our Democracy" on page 34).

The choice is chaos or community, as Dr. King wrote.

Trump wants chaos. In addition to trying to turn peaceful protests into violent confrontations, he fomented turmoil in the reopening of schools and colleges. While the AFT created guides for safely reopening (aft.org/coronavirus), Trump made baseless claims that children are "practically immune" to COVID-19, ignored the risks to staff and families, and disregarded the burden on healthcare providers as COVID-19 cases surged. How much more evidence do we need

to see that in this election, we must vote like our lives depend on it?

Donald Trump isn't up to the task of handling this public health crisis. He's desperate to distract us from the fact that most Americans are decidedly *not* better off than they were four years ago.

Donald Trump's economic policies have helped the fortunate



few: millionaires and billionaires, not average Americans. Millions of people are still unemployed, and his administration is still trying to take health insurance away from millions of people *during a pandemic*. As COVID-19 has swept through Native communities, his administration's leadership of the Indian Health Service has been so catastrophic that one request for PPE resulted in a shipment of body bags (as detailed in "Cultivating Our Health in a Time of COVID-19" on page 26). In the face of these failures, Trump's hobbling of the US Postal Service is an attempt to hamper voting by mail and to sow doubt about the election in the event he loses.

Imagine a different future.

Imagine universal health coverage; a social safety net that includes paid leave and affordable childcare; environmental strategies focused on improving health; and a public health infrastructure that values human lives and protects frontline workers. This vision of a better America is straight from the

Democratic Party platform, drawn from the Biden-Sanders Unity Task Force, on which I was honored to serve.

With Joe Biden and Kamala Harris—and a US Senate no longer led by Mitch McConnell—we won't have to imagine these things; we will be creating them.

Biden and Harris have bold, comprehensive plans to

- beat COVID-19, starting with ramped-up PPE production;
- address the climate crisis;
- protect and expand retirement security;
- make college affordable and help borrowers who are buried in student debt;
- give every American access to affordable health insurance;
- have a humane approach to immigration and affirm that Dreamers' homes are here;
- uphold the rights of every American—regardless of gender, race, or religion; and
- create true economic fairness and opportunity.


It's not just that they have these plans. It's that they understand we must contain the pandemic before we can fully and safely reopen the economy and society. Biden and Harris will make sure state and local governments, hospitals, and healthcare institutions have the resources they need.

That is what a caring, competent, effective administration would do. But none of this will happen if we don't elect Joe Biden and Kamala Harris. Go to AFTvotes.org to find out how you can get involved. Make your own voting plan, and help your family and friends make their plans.

Amid all this chaos, you have been the calm. You have been the glue that has nurtured, supported, taught, fed, and cared for our communities.

Our nurses and health professionals who have faced down the pandemic with bravery, compassion, and expert care. Our public employees who have persisted on the frontlines, even though too many have not had the protections afforded other frontline workers. Our professors and teachers who have used ingenuity and expertise to keep students learning under such difficult and unprecedented circumstances. Our food service personnel, custodians, secretaries, counselors, contact tracers, and others who have leapt into action to help feed families, visit homes, clean classrooms and ICU rooms, and do things no one else will ever know about, because they had to get done. You are the light—because of you, in the darkest days, hope has never been extinguished.

That's who we are as a union. We care, we fight, we show up, and we vote. Thank you for all you do. And thank you for all you will do to make sure that on November 3, we elect Joe Biden and Kamala Harris, along with allies up and down the ballot who will help us move forward to create a better life and a better future for all Americans.

As the civil rights leader Congressman John Lewis often said, let's "get into good trouble, necessary trouble." Let's keep doing that. Together. Because we know that, together, we can accomplish things that would be impossible on our own. 

Biden and Harris will make sure hospitals and healthcare institutions have the resources they need.



“Of all the forms of inequality, injustice in health is the most shocking and the most inhuman.”

—Dr. Martin Luther King, Jr.*



AFT Health Care takes these words to heart. This new journal is not only about preventing and curing illness but also about cultivating physical and mental vitality for everyone. It's about toxicant-free playgrounds, healthcare as a human right, and systemic changes to put people above profits. Most importantly, this new journal is about you: professionals dedicated to the health and well-being of individuals, communities, and our nation.

AFT Health Care publishes the highest quality research and

ideas related to healthcare, public health, and the social, economic, and environmental factors that affect individuals' and communities' health and well-being. Because the AFT is committed to advancing equity and promoting wellness for all, **AFT Health Care** is available for free at aft.org/hc.

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To publish the most relevant, trustworthy, and useful articles, we need to draw on your experience and expertise—so we're developing a peer review board. Please visit aft.org/hc/peer-review to learn more about becoming a reviewer and submit your application today.

Submit a Manuscript

We are interested in articles on a wide range of topics, including

- lessons learned from the pandemic and planning for future health crises
- universal healthcare coverage and the politics of healthcare finance
- racial and social equity initiatives to improve community well-being and public health
- staffing and other quality-of-care issues
- new trends in nursing and other health-related fields

For details on submitting your manuscript, visit aft.org/hc/article-submission-guidelines.



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*For an insightful essay, including King's full quote and additional context, see "Getting King's Words Right" by Charlene Galarneau at muse.jhu.edu/article/686948.

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Our Mission

The American Federation of Teachers is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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COVID-19

From Public Health Crisis to Healthcare Evolution



I started practicing emergency medicine when I was 27 years old, and I still remember the vulnerability of the people who came to see me. They were sick or injured, frightened, and asking for help. They didn't know me, and yet they put their trust in me. I did everything in my power to help them and yet, even then, I sometimes failed.

As an ER doctor, being unable to save a life was devastating. The walk across the hall to the small room where family and friends waited always felt like a long hopeless journey. Yet while this poignant intersection of compassion and mortality is difficult, it is that very compassion, and the humility and caring involved, that drew many of us into healthcare in the first place.

Today, much of that compassion is being stripped away. Early in my career, in the 1970s, we had time to build the kind of personal relationships with our patients that often contributed as much to their health and well-being as the medical treatments we prescribed. Sadly, the space in which to cultivate these deeper relationships seems to be slipping away—lost to an electronic medical record that is as much about billing as about caring, and to an impersonal corporate structure that prioritizes revenue generation over a deeper understanding of the social and economic circumstances that contribute to illness.

I became a doctor to improve people's health and well-being, not just to treat their medical conditions. I soon realized, however, that in many cases I was treating the medical complications of social problems. I was trained to treat the medical conditions, which I did to the best of my ability; but afterwards, my patients returned to the same social conditions that had brought them into the hospital in the first place. I eventually realized that our healthcare system is designed *not* to support wellness but rather to profit

from illness. While most healthcare providers certainly don't approach caring for people that way, the underlying business model does.

Serving in public office while still practicing medicine gave me another insight: the realization that the more money we spend on healthcare, the less is available for housing, nutrition, education, or other things that are critical to health and well-being. Since first running for the Oregon legislature in 1978, I have spent 26 years as a representative, as a senator, and as governor trying to develop a new model—one built on the recognition that health is the product of many factors, only one of which is medical care.

In 2012, in the depths of the Great Recession, Oregon established such a model: coordinated care organizations (CCOs) for our Medicaid recipients. The CCOs don't just treat illness; they cultivate health by addressing not only physical, mental, and dental care but also related needs such as safe housing, transportation, and fresh, affordable food. CCOs have also demonstrated that it is possible to expand coverage and reduce the rate of medical inflation while improving quality and health outcomes. Now, with the deep recession triggered by the coronavirus pandemic, it is time to scale this kind of model up for the whole nation. My primary aim with this article is to offer one way in which we might achieve that goal.

From Cost and Coverage to Value and Health

For decades, the healthcare debate throughout the United States has focused almost entirely on coverage—on how to pay for access to the current system—rather than on health. What is missing is a consideration of *value*, which in this context means that the purpose of the system is not simply to

By **John A. Kitzhaber**

John A. Kitzhaber, MD, practiced emergency medicine for 15 years and spent nearly four decades in public service in Oregon's state legislature and then as Oregon's longest-serving governor (1995–2003 and 2011–2015). The author of the Oregon Health Plan and architect of Oregon's coordinated care organizations, he is now a writer, speaker, and consultant on health policy.

finance and deliver medical care but rather to improve and maintain health. Indeed, the things that have the greatest impact on health across the lifespan are healthy pregnancies, decent housing, good nutrition, stable families, education, steady jobs with adequate wages, safe communities, and other “social determinants of health”;¹ in contrast, the healthcare system itself plays a relatively minor part.

Ironically, since the cost of medical care consumes 18 percent of our gross domestic product (GDP), our current healthcare system actually undermines our ability to invest in children, families, housing, economic opportunity, and the many other key social factors important to health and well-being. This is a primary reason why the United States does not compare favorably in terms of health statistics with nations that choose to spend far more on the social determinants and far less on the healthcare system.²

If we could reduce our healthcare spending from 18 to 12 percent of GDP (which is the average spent by most other industrialized nations), we would free up over one trillion dollars a year to invest in the things that contribute more to health.³ Such a reduction in spending might seem impossible, but successful examples of how to bring down the total cost of care do exist, including Oregon’s CCOs. Under these care models, providers receive a fixed amount of money (a *global budget*) to provide quality care with good outcomes for a defined population; if the global budget is exceeded in any given year, the providers are at financial risk for the difference. These care models change the system’s incentives from rewarding sickness to rewarding wellness—and they work. Because they focus on improving health, they prevent illnesses and thereby reduce costs without sacrificing quality.⁴

Effectively addressing the access, value, and cost issues in our healthcare system is one of the most important domestic challenges we face as a nation. Doing so, however, requires both a clear-eyed assessment of what this system has become and the courage to challenge that system. The global pandemic, with its profound economic and social consequences, has brought into clear focus the urgent need for a new model more aligned with caring, compassion, and the goal of improving the health of our nation. And no one is more qualified to lead that effort than the people who have dedicated their lives to the healthcare profession.

COVID-19 and Our Legacy of Inequity

In 1882, the newly formed Populist Party wrote in its platform, “The fruits of the toil of millions are boldly stolen to build up colossal fortunes for a few, unprecedented in the history of mankind.”⁵ Now, over 125 years later, these words aptly describe our current social and economic conditions and how little progress we have made in terms of social justice and equal opportunity. The novel coronavirus has exposed anew

the inequities and the linked class and race divisions within our society, problems that have been with us since before our nation’s founding, almost always churning just below the surface, visible only indirectly when we examine disparities like disproportionately lagging health and education outcomes for chronically under-resourced—and often racially or ethnically segregated—communities. Especially in the past few decades, these inequities have been masked by debt-financed economic growth that has prevented us from mustering the political will and societal solidarity necessary to address them.

Perhaps nothing better illustrates the depth of these disparities, or the extent to which social justice has been eroded, than the US healthcare system. It is a massive corporate enterprise that now consumes nearly one-fifth of our GDP, a huge employer that is increasingly dependent on public debt for its financial stability, and a major driver of income inequality. The pandemic has cast these inequities and contradictions into stark relief.

We see the difficulty nonmedical essential workers have had in obtaining adequate health protections, often resulting in significantly higher rates of infection.⁶ These are people in low-wage positions—often with minimal or no sick leave or insurance—working in grocery stores, warehouses, factories, and food and agricultural production sites.⁷ We also see that Black Americans are dying from COVID-19 in dramatically disproportionate numbers—deaths attributable to the structural inequities in our society that make Black people and other people of color more likely to have diabetes, heart disease, and high blood pressure, and to live near major sources of health-endangering pollutants and far from health facilities and grocery stores.⁸ These are issues we urgently need to address.

At the same time, as I discuss later, the pandemic has for the first time brought the economic interests of those who pay for, consume, and provide healthcare into clear alignment. This gives us a once-in-a-generation opportunity to transform the current system by demanding value as well as universal coverage and by constraining the total cost of care. Let’s examine each of these issues, starting with the difference between coverage and value.

Coverage versus Value

We all know what coverage means—it means having the ability to pay the cost of healthcare without suffering economic hardship, without crippling copayments and deductibles, without having to choose between paying for prescriptions and paying for rent, without fear of surprise billings. Value is something else entirely.

Value is the recognition that not only must all Americans have coverage, but that the care they receive, and the system through which they receive it, must produce value in terms of health outcomes. Value presumes that

90%

Americans dependent on public subsidies to help cover the cost of care

\$35.6

billion

Combined profits
in 2019 of the
seven largest
for-profit insurers

we should not be spending limited public resources on overtreatment, inflated prices, or care that is unnecessary, inefficient, or ineffective. Most of all, value means doing more to address the factors that have by far the greatest impacts on health, especially the conditions of injustice that underlie disease: poverty, hunger, unemployment, the erosion of community, and the lack of hope. Let me offer a tragic example from my own state, changing only the names to protect the privacy of those involved.

Susan was born into a troubled family. She was sexually and physically abused by her alcoholic father and fled from her home to the streets of Portland. Alone, homeless, looking for love and somewhere to belong, she continued to be victimized, abusing alcohol herself and becoming pregnant at 17. Without any prenatal care or support systems, she gave birth prematurely to her daughter, Patty, who was diagnosed with fetal alcohol syndrome.

Homeless and struggling with addiction, Susan placed Patty for adoption. But the cycle was not broken. Patty was diagnosed with depression and multiple mental disorders. Although she was briefly adopted, she subsequently had 26 different foster placements before being admitted to a residential mental health facility, where she now lives. All of this happened before her 10th birthday.

There is no way to measure the depth of this tragedy. The tragedy of a young, abused mother who battles substance abuse and will never know her daughter. The tragedy of a child who is likely to live out her life within the walls of an institution. And the tragedy of knowing that we could have prevented this outcome but failed to do so. If we had a healthcare system designed to maximize value, we would be addressing the social determinants of health that could have given Susan and Patty opportunities to live very different kinds of lives.

If we hope to turn this around, we must focus on four key aspects of our current healthcare system: public resources, our national debt, income inequality, and the important difference between health and healthcare. We must also understand and overcome the major obstacles preventing meaningful reform.

Public Resources

First, we need to understand the central role of public dollars in our healthcare system. Healthcare is the only economic sector that produces goods and services which none of its customers can afford. This system only works because the cost of medical care for individuals is heavily subsidized with public resources. This happens directly through public programs like Medicare and Medicaid. It also happens indirectly through the tax exclusion for employer-sponsored health insurance and through the public subsidies in the individual insurance market established through the Affordable Care Act (ACA).

As a result, about 90 percent of Americans depend on public subsidies to help them cover the cost of their care⁹—all except the 28 million Americans who remain uninsured.¹⁰ These people are not eligible for a public subsidy themselves, but through their taxes they help subsidize the cost of healthcare for everyone else. This egregious situation reflects the systemic inequality that exists not only in our healthcare system but also across our whole society.

Thus, the central issue in the healthcare debate involves the allocation of public resources, which represent a kind of fiscal commons. They are shared resources raised from society as a whole—and they should be allocated in a way that benefits all of us, not just some of us.

The National Debt

We also need to recognize that our healthcare system is increasingly financed with debt. Why? Because public resources are finite and Congress is borrowing ever more money to pay for existing programs and services—including healthcare. This fact is reflected in the congressional budget deficit and in our national debt. The national debt is the accumulation of years of budget deficits and represents the amount of money that has been borrowed to cover the difference between congressional spending and the tax revenue available to pay for it. Since healthcare now accounts for over 28 percent of the federal budget not spent on interest—and is projected to grow to 33 percent by 2028¹¹—it has become a major driver of the national debt.

This means that as the population ages and the cost of care continues to rise, the economic viability of the healthcare system will increasingly depend on borrowing money—and on the capacity of the federal government to absorb more debt. If the capacity to borrow is constrained, the financial underpinnings of the healthcare system begin to unravel. Because COVID-19 has created exactly this constraint on borrowing, a healthcare financing crisis that was on the horizon is now at our door.

Income Inequality

Furthermore, a growing share of the money borrowed to prop up our medical system is not being used to expand coverage. Instead, it is enriching the profits of large corporations and wealthy individuals.¹² Let me be very clear: our current healthcare system is increasing income inequality through a process called *rent seeking*. This occurs when powerful stakeholders manipulate public policy to increase their own wealth without the creation of new wealth (i.e., they take more of the pie without making the pie bigger). For example, when the pharmaceutical industry convinced Congress to prohibit the government from negotiating drug prices for the 60 million Americans on Medicare, it distorted the market by putting the

power in the sellers' hands to set whatever prices they wish. After many news stories about "big pharma," more people have become aware of concerns with drug prices. What seems to be less well known is just how profitable medical insurance is: in 2019, the seven largest for-profit insurers had combined revenue of over \$900 billion¹³ and profits of \$35.6 billion, a 66 percent increase over 2018.¹⁴ The result of the rent seeking that is evident throughout the healthcare industry is lower disposable income for the individuals who have to pay those inflated prices, increased profits, and wider income inequality.

Health versus Healthcare

Finally, we need to recognize that the goal of the healthcare system should be to keep people healthy, not just to finance medical care. In other words, it needs to address the social determinants of health—access to healthy food and clean water, safe housing, a reliable living wage, family and community stability, and more—which have a far greater impact than medical care on the health of both individuals and communities. Yet the ever-increasing cost of care compromises our ability to invest in these things.

Today, healthcare providers and the system have different goals. While most care providers are trying to enhance people's health, they nevertheless work in a system where the incentives are to increase profits and redistribute more wealth to the wealthy.

Confronting the Total Cost of Care

Improving health requires a financially sustainable system that ensures that all Americans have timely access to effective medical care *and* that makes long-term investments in the social determinants of health. To achieve these dual goals requires five core elements:

1. Universal coverage;
2. A defined set of benefits;
3. A delivery system that assumes risk and accountability for quality and outcomes;
4. A global budget indexed to a sustainable rate of growth; and
5. A cost prevention strategy that allocates some of the savings to addressing the social determinants of health.

A system that incorporates these elements can take many forms, but without all five we cannot achieve our goal of improving health in a financially sustainable way.¹⁵

There are two primary obstacles keeping us from moving toward a new system focused on value and health: the way the debate has been framed, and the cost-shifting strategies that—until the pandemic—allowed us to avoid the growing discrepancy between the cost of the system and our ability to pay for it.

How the Debate Is Framed

For decades, the national healthcare debate has been paralyzed largely because neither Democrats nor Republicans have seriously challenged the underlying healthcare business model—the debate has been over what level of funding to provide. The current business model is built around *fee-for-service* reimbursement, in which providers are paid a fee for every service rendered. The more they do, the more they get paid. And since the fees paid for medical services usually are not linked in a meaningful way to a positive health outcome for the person receiving the care, the system incentives are aligned with maximizing revenue rather than maximizing health.

The Affordable Care Act attempted to move away from this model with incentives to participate in accountable care organizations (ACOs), which are networks of providers that shared in savings if they delivered care more efficiently (called *upside risk*). The problem is that the ACOs were not required to assume any significant degree of *downside risk*, in which they had to refund a payer if the actual costs of care exceeded a financial benchmark. Furthermore, the ACA did not take on the rent seeking (transferring wealth to the wealthy) that accounts for so much of the cost in the system. As a consequence, the cost of healthcare grew from \$2.6 trillion in 2010 to \$3.6 trillion in 2019.

In the wake of the Affordable Care Act, both major political parties have continued to debate only the extent to which we should fund the system, creating a false choice between cost and access. This false choice is reflected in the Republican view that the cost of healthcare is unsustainable and must be constrained, and in the Democratic view that any reduction in spending will result in a reduction in access. Both sides are right, if they remain wedded to the current business model. Republican proposals to "repeal and replace" the Affordable Care Act, for example, would simply reduce the public subsidies in the current business model, increasing the number of uninsured Americans and exacerbating the inequity that already exists. Democratic efforts to expand coverage through proposals like Medicare for All would significantly increase public subsidies but within the same inflationary fee-for-service business model, adding to the burden of debt that future generations will have to pay. To put it another way, Republican proposals increase inequity and harm people today; Democratic proposals increase the debt and harm people tomorrow.

Cost-Shifting Strategies

Framing the debate in this way allows legislative bodies to avoid directly addressing the cost of care by simply shifting that cost somewhere else, a strategy used by other third-party payers (insurance companies and employers). As the total cost of care increases, instead of seeking to reduce it, these payers take actions that shift the cost to individuals, who cannot

18%
of GDP

US healthcare
spending
pre-pandemic

afford it, or to future generations. Here are the most common cost-shifting strategies:

- Reducing eligibility, cutting benefits, and/or raising copayments and deductibles—all of which shift costs to individuals;
- Reducing provider reimbursement, which may result in efforts by providers to avoid caring for those who cannot pay and/or lead to increased fees by providers when they are caring for people who are insured; and
- Increasing debt-financed public subsidies, which shifts the burden to our children and grandchildren.

Importantly, none of these cost-shifting strategies reduce the total cost of care, which is the central structural problem in our system. Before COVID-19, we were able to rely on these strategies, particularly debt-financed public subsidies, to avoid the difficult choices necessary for a solution. But given the economic crisis we now face, we must directly confront the total cost of care. Fortunately, this gives us the opportunity to pursue new strategies that both redesign the current hyperinflationary business model *and* invest in those things that have the greatest impact on health and well-being.

Constraining Cost without Sacrificing Value

At long last, we have the opportunity to set aside the circular, dead-end debate about cost and coverage and to engage in a new discussion of value and health. This frees us to begin building a new system that offers universal coverage and caps the total cost of care while holding provider networks accountable for quality and outcomes. Instead of taking pressure off the old system through cost-*shifting* strategies, we must demand that the new system deliver value through cost-*prevention* strategies that include both the provision of affordable, effective medical care *and* sustained investments in the social determinants of health. And instead of the system profiting from illness, we must create a new incentive structure that rewards health.

To achieve this requires moving from fee-for-service to *capitated* payment models, in which providers receive a fixed payment (the capitation rate) for each person enrolled in a health plan. The aggregate of these individual rates forms a global budget for all those enrolled in the plan, and this budget is then indexed to a sustainable growth rate. Because providers are paid per enrollee rather than per service, this model rewards them for helping patients achieve wellness and adopt healthier lifestyles (i.e., require fewer services). At the same time, providers are held accountable for meeting clear quality and outcome measures; if the global budget is exceeded in any given year, the providers are at financial risk for the difference (i.e., they assume downside risk). In short, while the fee-for-service payment model rewards overutilization and sickness, the capitated payment model

rewards efficiency and wellness. Oregon's coordinated care organizations (CCOs), established in 2012, demonstrate one way this can be accomplished.

The coordinated care organizations emerged from the Great Recession when Oregon was faced with high unemployment, falling tax revenues, and a huge budget shortfall in Medicaid because of increased enrollment. Instead of resorting to the traditional cost-shifting strategies, a new care model was created that sought to get more value—more health—for each dollar spent. CCOs are community based and are designed to move beyond a narrow clinical model to focus more broadly on community health. The total cost of care is capped in a global budget that can grow by no more than 3.4 percent per person per year. While maintaining enrollment and benefits, providers are required to meet strong measures of quality, health outcomes, and patient satisfaction.

During the first five years, 2012 to 2017, Oregon's CCOs met the required outcome and quality metrics, operated within the growth cap, expanded enrollment by over 385,000 people, and realized a cumulative total savings of over \$1 billion. Prior to COVID-19, savings were projected to reach \$8.6 billion over a decade—creating a pool of resources to reinvest in the social determinants of health, thereby further reducing the need for medical care. The Oregon CCO experience clearly demonstrates that it is possible to expand access, reduce the rate of medical inflation, and increase value.

The Oregon experience also demonstrated that we cannot fully address the total cost of care by focusing on only one part of the system. Oregon's CCOs were created for Medicaid recipients, but since the rest of the system still followed the old model, many cost-shifting strategies were still available. For example, providers can still compensate for the 3.4 percent per member per year growth cap required by the CCOs by increasing what they charge employers (resulting in increased costs in the commercial health insurance market). To truly address our healthcare and health crises, the United States needs a holistic approach that extends the new health-focused model into the commercial market.

A New Model for the Nation

As discussed earlier, a financially sustainable system designed for value and health can take many forms, but it must include these five core elements:

1. Universal coverage;
2. Defined benefits;
3. Assumption of risk by providers and accountability for quality and outcomes;
4. Capped total cost of care through a global budget indexed to a sustainable growth rate; and
5. Cost prevention by addressing the social determinants of health.

Here is one example of what a model with these five elements could look like.

12%

of GDP

Average healthcare
spending by most
other industrialized
nations

Starting with our current public-private financing structure, modify the three large insurance pools that currently define the US healthcare system.

- **Pool 1:** To achieve universal coverage (element 1), restore the ACA individual mandate but ensure that people have affordable health plans in which to enroll. Expand Medicaid eligibility to include the 28 million people who are currently uninsured or create a new, affordable, publicly subsidized option to offer them. At the same time, move Pool 1 to a CCO-like capitated model that encompasses elements 2 through 5. If coverage in the individual market is unaffordable, those below a certain income level (e.g., 450 percent of the federal poverty level) could buy into Pool 1 with income-based cost sharing, which would make universal coverage more feasible. This is particularly important today as millions of people are losing their employment-based coverage and moving to Medicaid or the individual market.
- **Pool 2:** Because Original Medicare is still paid through fee-for-service, the program must be moved to a capitated model. One approach would be to create incentives to enroll in a Medicare Advantage Plan (most of which are already capitated) and change the Medicare Advantage Plans that are still fee-for-service to capitated models that meet elements 2 through 4. Because reimbursement would now be based on managing cost and improving health, Medicare Advantage Plans would better incentivize providers to view their patients more holistically through nutrition counseling, for example, or coordination with social services for safe housing, thereby meeting element 5.
- **Pool 3:** Allow the remaining markets—employer-sponsored medium and large group and self-insured markets—to operate as they do today, negotiating prices with health plans and using their market power to insist on capitated risk contracts with provider networks. The public sector price negotiations outlined below would provide a benchmark, giving employers additional leverage in negotiating prices in the commercial market. This advantage can be amplified by forming new partnerships with labor, as discussed below under “COVID-19 and the Urgency of Now.”

Continue the transformation by using the consolidated purchasing power of Pools 1 and 2 to negotiate one set of prices for both pools. This would include not only what providers are paid per beneficiary (risk-adjusted according to each beneficiary’s expected care needs) but also prescription drugs, medical devices, laboratory services, imaging, and all the other niche business models that have been established under the fee-for-service model to maximize revenue. This kind of price negotiation is what most large private employers (making up the majority of Pool 3) do today. Public

payers should follow suit by using the consolidated purchasing power of the public sector—which is footing an ever-larger part of the bill—to get the best price and value for its constituents: the people of the United States of America. If the public sector were so inclined, it would also be possible to negotiate limits on individuals’ out-of-pocket expenses and to ensure there are no caps on annual or lifetime benefits.

The result would be a new system of universal coverage built on our current public-private financing structure. With the majority of Americans in some form of capitated risk model, this new system (1) reduces the total cost of care through price negotiations, a global budget indexed to a sustainable growth rate, and provider accountability for quality outcomes; (2) preserves consumer choice and allows current insurers to compete for Pools 1 and 2 in a restructured market; and (3) delivers more and more value and health because it requires strategic, long-term, effective investments in the social determinants of health.

I want to emphasize that this is merely one way to design a new, health-focused, financially sustainable system. There are others. My objective here is not to advocate for the example I have just outlined here, but rather to spark a new debate that will lead to a better system. Instead of being constrained by what currently exists, we need to start with our objective, agree on essential elements, and then let the contours of the new system emerge. Long-term, this will serve us better than starting with a plan that may not meet the criteria needed to achieve our goal. For example, while both Medicare for All and a public option are ways to achieve universal coverage (element 1), neither directly addresses the total cost of care (elements 3 and 4) or focuses on increasing investment in the social determinants of health (element 5). Surely, we can imagine linking the total cost of medical care to a sustainable growth rate within the next few years. Then we can work backward to create a health system that meets the objectives of Democrats by expanding coverage and improving health and meets the objectives of Republicans by reducing the rate of medical inflation through fiscal discipline and responsibility.

COVID-19 and the Urgency of Now

As the healthcare system has become ever more dependent on public debt, its financial underpinnings have become inexorably linked to the capacity of the government to borrow. That capacity has been suddenly and dramatically diminished by COVID-19 and by the business closures and high unemployment resulting from efforts to slow the spread of the coronavirus.

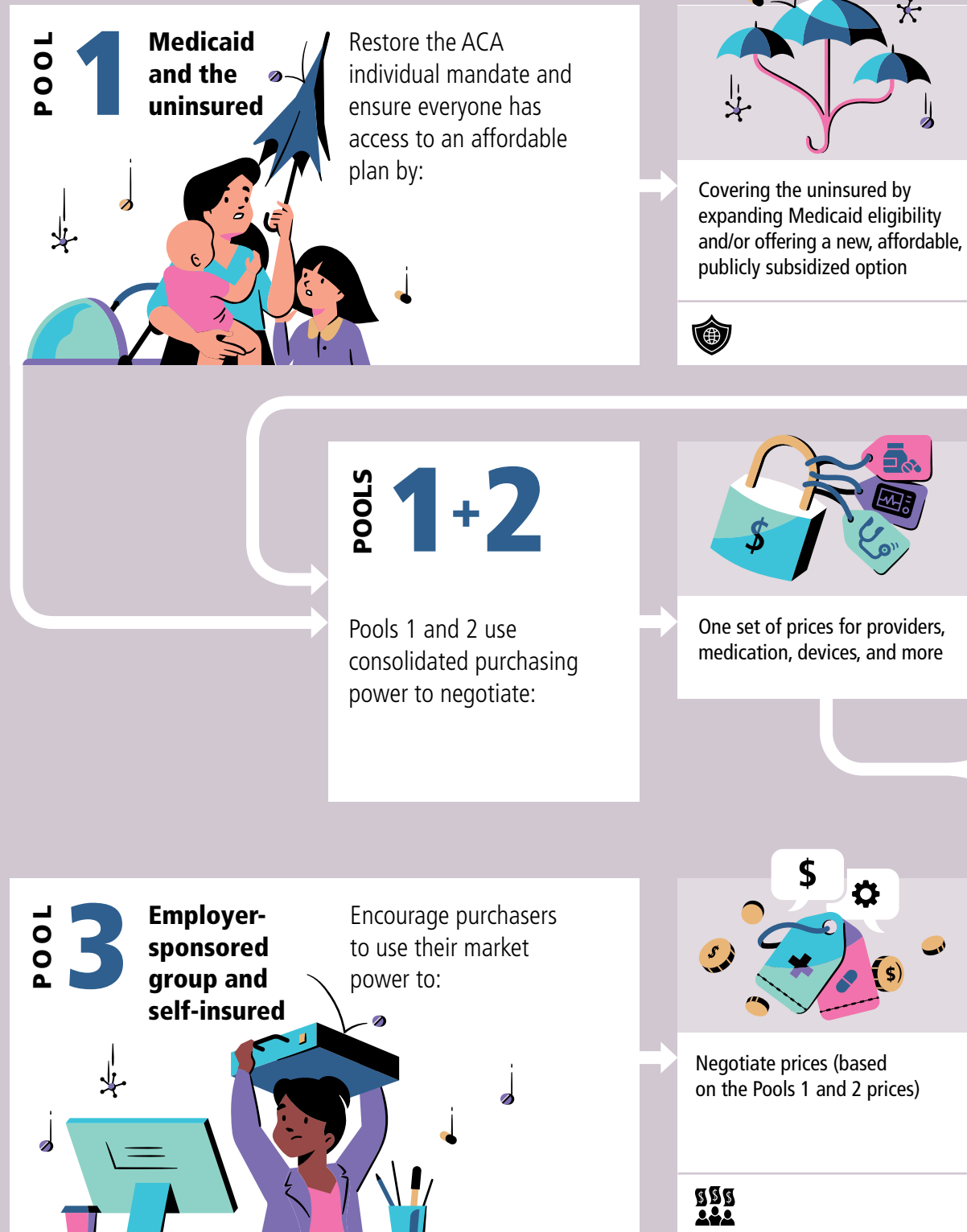
To prevent a complete collapse of the economy, there has been a massive federal intervention to keep credit flowing and to provide loan guarantees and direct payments to businesses and individuals. I believe we will have to spend at least \$5 trillion this year alone to sustain our economic infrastructure and to support unemployed Americans. This will leave us with an

\$1
trillion

Amount that could be invested in promoting health each year if US healthcare spending were 12% of GDP

Designing a System for Value and Health

This three-pool model shows one way to achieve universal coverage in an affordable system focused on health and well-being.



Essential elements



Provider accountability



Universal coverage



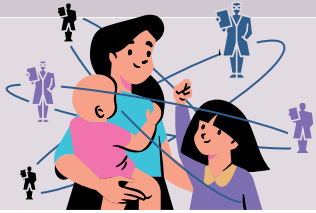
Defined benefits



Capped total cost with sustainable growth



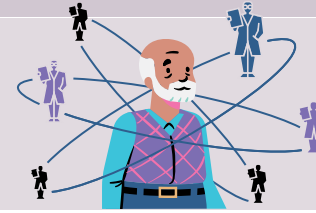
Savings invested in health and well-being



Moving Pool 1 to a CCO-like model



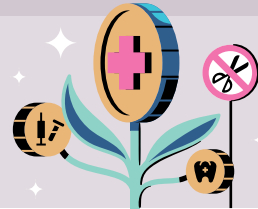
POOL 2 Medicare
Create incentives to move Medicare to a CCO-like model:



Resulting in better value, enabling investments in health and well-being



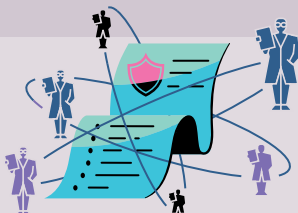
Limits on individuals' out-of-pocket expenses



Prohibition of annual and lifetime benefit caps



Work with employees to invest savings in ways that enhance health and well-being, including wages



Insist on CCO-like contracts with provider networks



Key points

CCO-like models create incentives to



Directly address the total cost of care

Invest savings in ways that maximize health and well-being



Additional Steps



Educate the public to demand value as well as coverage

Support investment in public health and well-being





Let's begin building
a new system that
offers universal
coverage and delivers
value through cost-
prevention strategies.

unprecedented budget deficit and a national debt approaching \$28 trillion—with little or no capacity to absorb the 60 percent growth in healthcare spending that is projected by 2028 (from \$3.7 to \$6.2 trillion), especially when prices for medical goods and services are projected to account for 43 percent of that growth.¹⁶

The pandemic is forcing us into an era of dramatic constraints on the public resources allocated to the healthcare system. Neither the government nor private-sector employers can afford the current system anymore, given the economic losses that both employers and individuals have experienced since February and the massive amount of public debt that has been accumulated just to hold our economy together. At the same time, those parts of the healthcare system that have been hit the hardest by COVID-19 are those most dependent on fee-for-service reimbursement, which exposes the basic flaw in a business model that depends on volume, regardless of the value of the services rendered.

This economic crisis means that, for the first time, the economic interests of workers, employers, the government, and many parts of the healthcare sector are aligned. The time to transform the system is now. We have crossed the Rubicon, and there is no going back. We can either watch our current system unravel, with millions more losing coverage and ever-widening income inequality, or we can work together to design a system that helps stabilize our economy and better serves the needs of the American people.

The Role of Labor

This is the moment for more states, facing huge general fund shortfalls, to move to a CCO-like care model for Medicaid, and for Congress, facing staggering debt, to create incentives for Medicare beneficiaries to enroll in a Medicare Advantage Plan and to move that program to a fully capitated model in which providers assume risk for quality and outcomes. Health professionals should be vocal advocates for both of these changes—and that advocacy should be backed up by the strength of the union movement to bring this model to the commercial market. This will require forging new alliances at the bargaining table between labor and payers—both public and private.

Coverage of the cost of healthcare is, of course, part of the total compensation package, which means that in collective bargaining, wages are often pitted against health benefits. For public employees, general fund appropriations for healthcare compete not only with general funds for wages but also for essentials like increasing nurse staffing ratios, reducing class sizes, and investing in housing and other social determinants of health. The traditional goal for labor in bargaining over healthcare is to reduce, to the greatest extent possible, out-of-pocket costs for union members (which is very important).

The problem is that focusing only on this aspect of the total compensation package—without question-

ing the cost structure, quality, or efficiency of the care being purchased—suppresses wage growth. Without aggressively challenging the cost structure and value of the healthcare being purchased, the dollars spent on rising premiums flow into a system that redistributes them upward, taking money from the pockets of working Americans to enrich the profits of large corporations and wealthy individuals (further exacerbating income inequality).

A CCO-like model would be better because it caps the total cost of care without sacrificing quality and it realizes savings to invest in the social determinants of health—including wages. Particularly for workers making minimum wage or close to it, income is a primary driver of health.¹⁷

Employees and employers have a shared economic interest in reducing the rate of medical inflation and in focusing on value and health. Providers, for the first time, now have an economic interest in changing the payment model from fee-for-service to capitated because this is the only way they can survive in an era that no longer can sustain debt financing. From the standpoint of the labor movement, CCO-like models could result in increased wages, better staffing ratios, and more funding for education and other services that are critical to making our society more just.

This latter point—the need for greater social investment—cannot be overemphasized. Reducing the total cost of care will lift up all working Americans (not just those with union representation) because it will make their wages go further and relieve them of the anxiety of not knowing whether the next illness will push them into bankruptcy. And it will give us, at last, the ability to address the conditions of injustice that underlie disease.

Seizing the Future

On April 5, 1968—the day after Dr. Martin Luther King, Jr., was assassinated—Robert F. Kennedy delivered some brief remarks to the Cleveland City Club. His speech was about the stain of violence in America, but then he said,

There is another kind of violence, slower but just as deadly, destructive as the shot or the bomb in the night. This is the violence of institutions; indifference and inaction and slow decay. This is the violence that afflicts the poor, that poisons relations between men because their skin has different colors. This is a slow destruction of a child by hunger, and schools without books and homes without heat in the winter.¹⁸

Schools without books, homes without heat, children without food, parents without jobs—these things fuel the creeping menace of despair and fading hope of a better future. These are cancers on the body of our community, and they have nothing to do with lack of

access to the healthcare system—but rather with the cost of that system. It is our failure to demand value for the public dollars supporting the system that is directly responsible for our inability to treat the cancer, and thus our inability to give struggling Americans health, hope, and an equal opportunity for a better life.

In the words of Barack Obama, “Change will not come if we wait for some other person or if we wait for some other time. We are the ones we’ve been waiting for. We are the change that we seek.”

Endnotes

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Continued on page 44

Let’s Begin Now

In this essay, I have argued that we need to reframe the healthcare debate from a narrow focus on coverage to a broader focus on value and on directly addressing the total cost of care. This is not to minimize the fundamental importance of coverage and access—an importance made clear by the COVID-19 pandemic, which has exposed both the human cost of our lack of an explicit policy of universal coverage and the deep racial and ethnic health disparities that exist in our nation.

Now, when we as a nation are reckoning with the racism and inequity that structure our society and are focusing on reimagining what we might be, we have the opportunity to create real, lasting change in all of our systems, including healthcare—but we must address the root causes of the problems, not the symptoms. We need universal health coverage, but expanding coverage without demanding value for the public investment involved will only perpetuate an inequitable and unsustainable system that undermines our ability to invest in the social determinants of health.

Creating a new system with the five core elements (see page 10) will take time. But there is much we can, and must, do quickly. Because the economic consequences of the pandemic—particularly the increase in unemployment, with its associated loss of workplace-based coverage—are driving us toward Pool 1 (Medicaid, the uninsured, and the ACA marketplace), this is the logical place to start.

The most urgent coverage problem is for those who are not offered or have lost workplace-based coverage and whose income is too high for Medicaid (above 138 percent of the federal poverty level) but too low to afford the individual market. These struggling individuals are joined by a growing number of

underinsured Americans who are technically covered by employer-sponsored plans but face copayments and deductibles so high that for all practical purposes they are uninsured. People of color—particularly Black, Hispanic, and Native American people—make up disproportionate numbers of both of these groups.

The state of Oregon offers an illustration of both the problem and the opportunity. By the end of April, 266,600 Oregonians had lost their jobs (an unemployment rate of 14.2 percent).¹⁹ An estimated 215,800 of these people will be eligible for Medicaid, 20,500 will move to the ACA exchanges, and 30,300 will remain uninsured.²⁰ Because Medicaid is entirely financed with public resources and the ACA exchanges are heavily subsidized with public dollars, this amounts to a dramatic increase in public sector financing of health-care. In terms of the healthcare model proposed in this essay, Oregon’s Pool 1 enrollees are expected to increase from 34.9 percent to 41.3 percent of the state’s population over the course of just a few months.

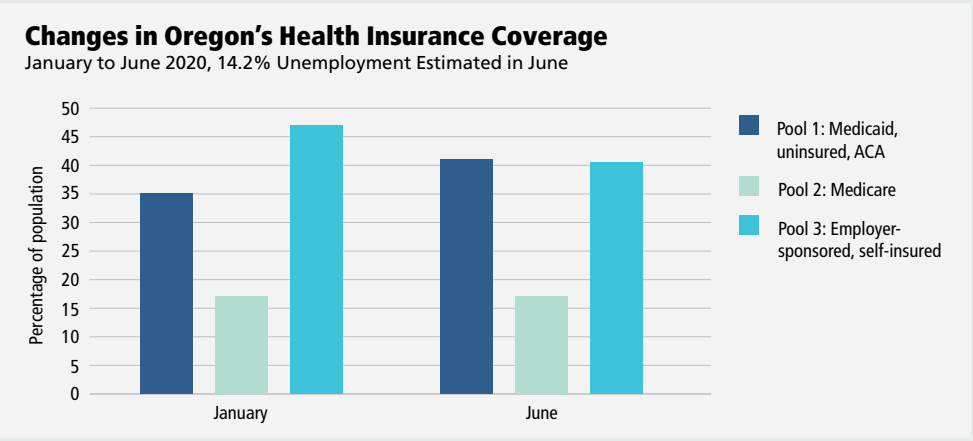
Furthermore, we know that if 80 percent of those who lack health coverage in Oregon

made use of coverage for which they are currently eligible—Medicaid or the subsidies available through the ACA marketplace—the number of Oregonians who are uninsured would drop from almost 250,000 to 34,000 (from 6.2 percent to less than 1 percent).²¹ The only thing standing in our way is the total cost of care.

Since states are facing enormous budget deficits and the federal government is facing a looming debt crisis, it is imperative that shifts toward public financing be accompanied by effective mechanisms to reduce the total cost of care through global budgets (indexed to a sustainable growth rate, with providers at risk for quality and outcomes). At the same time, such global budgets are now more appealing to many hospitals and primary care practices because of the sharp loss of revenue among those with fee-for-service models.

The convergence of these factors creates a significant opportunity to begin transformation of the healthcare system through Pool 1. We can address both cost and access. Let’s not wait any longer.

—J. A. K.



Healing a Poisoned World

Science without conscience is the soul's perdition.

—FRANÇOIS RABELAIS, *PANTAGRUEL*

By **Harriet A. Washington**

Harriet A. Washington is a science writer, editor, and ethicist. She has been the Shearing Fellow at the University of Nevada's Black Mountain Institute, a research fellow in Medical Ethics at Harvard Medical School, a senior research scholar at the National Center for Bioethics at Tuskegee University, and a visiting scholar at DePaul University College of Law. She has held fellowships at the Harvard T.H. Chan School of Public Health and Stanford University. She is the author of *A Terrible Thing to Waste: Environmental Racism and Its Assault on the American Mind*, *Medical Apartheid*, several other books, and numerous articles.

AFT Health Care is committed to advancing equity and promoting well-being. As we strive to publish the highest quality research and ideas for cultivating individuals' and communities' health, one of our core areas of focus will be uncovering and dismantling systemic racism. In this article, Harriet A. Washington addresses environmental racism; discussing the Flint water crisis, she includes a direct quote that uses the N-word in full. The question of how to handle such language is a difficult one: we respect Washington's choice as an African American scholar to convey the full horror of the racist act, and we are also concerned about how it may affect our Black readers. After consulting with colleagues, we concluded that in this case, confronting the harsh reality of racism is part of the way forward. Please help us reflect on our practices by sharing your thoughts on this specific question, or on our broader efforts to reckon with racial injustice, by emailing us at hc@aft.org.

—EDITORS

In 1997, Tyrone Hayes, a professor of integrative biology at the University of California, Berkeley, was hired by a consulting firm named EcoRisk to evaluate the effects of a chemical called atrazine on frogs.¹ Atrazine is a widely distributed and profitable herbicide, second only to Monsanto's Roundup. After discovering that minuscule concentrations dramatically impaired frogs' endocrine systems, rendering them infertile and even causing them to change sex,² Hayes turned his attention to humans. He found that the urine of exposed farm workers had 24,000 times the amount of atrazine needed to chemically castrate a frog³ and that the children of exposed women suffer high rates of birth defects.⁴

The Swiss firm Syngenta, which manufactures atrazine, launched a campaign to discredit Hayes's work. It even had representatives appear at academic conferences where Hayes spoke; those representatives spread vitriolic personal criticisms, organized opposition to his presentations, and accused him of fabricating data. Internal Syngenta documents released as part of a 2014 class-action lawsuit reveal that Syngenta also conspired to convince journals to retract his work and investigate his private life.⁵ (An unabashed Hayes was not above responding testily—sometimes in acerbic rap couplets.⁶)

This is certainly a disquieting image of industry scientists at work, but the disrespect and drama veil a tendency that should worry us more: a scientific penchant for manipulating statistical dangers out of existence.

After Hayes first reported to EcoRisk scientists the hormonal devastation wrought by atrazine, he says they suggested statistical maneuvers that “made the effects appear to vanish.”⁷ And although the United States Environmental Protection Agency (EPA) determined that such “low” levels of atrazine exposure pose no hazard to human health, the EPA's sources are questionable. Fewer than 1 in 5 papers that the EPA uses to support its decision making are peer reviewed; worse, 1 of every 2 are generated by scientists who have a financial stake in the research outcome.⁸

These distortions are important. We have known since 2009 that 33 million Americans drink water tainted by atrazine, and epidemiological studies link prenatal atrazine exposure with birth defects, premature birth, and low birth weight—even at extremely low concentrations.⁹

Scientists often proceed as if very low exposures and doses are innocuous, tacitly assuming that a threshold exists beneath which an exposure is benign. But this is



ILLUSTRATIONS BY OJIMA ABALAKA

not a given. Some chemicals are indeed harmless at very low doses. Not so in other cases: persistent exposure to low levels of some near-ubiquitous poisons causes more cumulative harm than discrete large doses of others.¹⁰ Still other substances, like lead, have no safe level of exposure.¹¹

Many countries, such as those of the European Union, are more suspicious of industrial chemicals even at low doses. They require that the safety of industrial chemicals be determined before they go into uses that can affect humans, an illustration of what's known as the *precautionary principle*. But we Americans do not follow the precautionary principle. We require relatively little safety testing before use, so we typically learn of environmental health hazards only after people are exposed to them.

Greater vigilance and testing in accordance with the precautionary principle help explain why atrazine is banned in Europe¹² but the EPA has approved approximately 200 atrazine-containing products in the United States.¹³ US corporations often cite the additional expense of premarket testing that would be required to follow the precautionary principle, but they tend to downplay the importance of saving the expense of bans, cleanups, and lawsuits—to say nothing of the lives, health, and intellect of millions of Americans poisoned each year.

For industries accused of poisoning the populace, doubt has served as a useful foil against the expense of regulation and restitution.¹⁴ This corporate skepticism is most often articulated as a scientific question, to wit, “Is there really incontrovertible evidence that atrazine in drinking water (or lead in interior paint or mercury in oceans) is a hazard demanding eradication?”

Incontrovertible is a tricky word—any scientific finding can be questioned—but there really is overwhelming evidence that the myriad toxicants being pumped into our environment and our bodies constitute hazards that demand eradication. As surely as radiation exposure after Chernobyl caused cancers and premature deaths, constant exposure to environmental poisons acts as invisible “background radiation” that blinds us to the presence of the subtle but profound harms it generates in affected neighborhoods.

Imaginary Thresholds and Very Real Harms

Low exposure to heavy metals (like lead, mercury, and arsenic) and to inadequately tested industrial chemicals (like PCBs, DDT, and other manmade toxicants that persist in the environment) harm the brain and nervous system, impairing proper brain development. Although they can affect all of us, these toxicants disproportionately affect the people in neighborhoods of marginalized racial groups, such as African Americans, as well as the very young. African American children are at the greatest risk. For example, as lead poisoning vanished from much of the nation, it con-

tinued to impede their brain development, with deficits triggering lost IQ points, behavioral and psychological problems, poor school performance, and decreased job retention.

“Socioeconomic” Is a Semantic Shroud

Despite a wealth of data documenting that there are far greater concentrations of lead, PCBs, other industrial chemicals, and air pollution in communities of color, semantics shroud this powerful causal connection. Far too many American scientists, reporters, and elected officials tend to overlook or downplay the role of racial bias—past and present—in creating residential areas where environmental toxicity is concentrated in sacrifice zones populated by people of color.

The popular news media and many peer-reviewed medical journals have long referred to areas assailed by industrial chemicals, lead, mercury, arsenic, hydrocarbons, and particulate matter as “low-income” and “socioeconomically depressed” neighborhoods. Until 2016, even the principally African American and Hispanic lead-poisoning victims of Flint, Michigan, were described as socioeconomically disadvantaged, “poor,” or lower class. Only after crusading pediatrician Mona Hanna-Attisha decried the targeting¹⁵ was the racial nature of the hazard more broadly acknowledged in news media.

Referring to the risks as “socioeconomic” is a semantic mischaracterization that muddies the picture. A more accurate description of the problem would pinpoint the primary cause: environmental racism. Data from recent publications make it clear that although poverty puts one at higher-than-normal risk for living across the street from a gas-belching bus depot, near a Superfund waste-disposal site, or in a fence-line community that abuts an industrial park, race is a much greater risk factor. For example, a 2014 report determined that middle-class African Americans earning \$50,000 to \$60,000 are more likely to live in heavily polluted environments than are profoundly poor white people with mean incomes of \$10,000.¹⁶

Mythology and Toxicology

The “socioeconomic” nature of concentrated environmental assaults is not the only mischaracterization of risks that has long been refuted by the data. Scientific assessment of environmental harms is far from objective. It is clouded by unsubstantiated beliefs about the nature of industrial chemicals and by frank conflicts of interest that often serve the interests of industry rather than health.

Nationally, approximately 60,000 industrial chemicals commonly used in the United States have never been tested for their effects on humans. In our country, safety tests are undertaken only when a chemical is suspected to be harmful. But even then, definitive findings are elusive, and it sometimes takes years or even decades of expensive research for them to emerge.



African Americans earning \$50,000 to \$60,000 are more likely to live in heavily polluted environments than are white people with mean incomes of \$10,000.



Living with the background radiation of a poison-laced environment is the ultimate risk factor.

Meanwhile, the standard of proof demanded by the industries that use and disseminate these chemicals is sometimes so high that masses of people suffer the chemicals' effects in the time it takes to sufficiently prove their harmfulness.

All too often, industry scientists and leaders already have evidence that their chemicals are harmful—but they hide it. For example, scientists working for the lead industry were deployed to dissuade municipalities from banning lead-lined water plumbing and were allowed to set their own exposure “standards” for use, knowingly employing standards that allowed widespread exposure to lead in homes and workplaces. The lead industry similarly denied the toxicity of automobile emissions from leaded gas (which uses tetraethyl lead as an “anti-knock” additive), although internal industry documents revealed that they had recognized its fiendishly toxic nature from the beginning of their research in the 1920s.¹⁷ Once lead's toxicity proved undeniable, the industry maintained that low levels of exposure were not problematic. Although the Centers for Disease Control and Prevention (CDC) now states that there is no safe level of exposure to lead, it had changed from flagging children with 10 micrograms per deciliter of lead in their blood as a “level of concern” to calling for “case management” among children with 5 micrograms per deciliter.¹⁸ Just a few years ago, the Environmental Defense Fund estimated that thousands of children are still being poisoned (at a cost of \$50 billion per year to the nation) because lead abatement has never been completed.¹⁹

Whether we call them mythologies, unsupported assumptions, assessments biased by industry's pecuniary interests, or simply habits of thought, these distortions keep us from properly analyzing and understanding the risk of environmental exposures. Which exposures are most harmful, what types of harm they do, and who is at highest risk—these are often distorted by such myopia. And in recent years, the situation has grown more dire.

Since Donald Trump appointed Scott Pruitt, a lobbyist who described himself as a “leading advocate against the EPA's activist agenda,”²⁰ as his first chief of the EPA, the agency has consistently diminished protections that sought to limit exposure to environmental toxicity. In 2019, the EPA ended unannounced inspections of industry sites²¹ and relaxed Obama-era regulations that required coal-fired power plants to reduce their carbon emissions or close, thereby maintaining those plants as key sources of mercury pollution.²² As we saw with the atrazine example, the EPA's decision-making process is questionable at best—it eschews the precautionary principle and relies heavily on industry-sponsored, non-peer-reviewed research.

Against this backdrop—disregard for the precautionary principle and for the communities of color bearing most of the burden—we face two enormous challenges: the immediate threat to people of color

from the novel coronavirus and the longstanding threat to these populations from exposure to toxicants.

Coronavirus, in Color

COVID-19 has emerged as a disease that, like HIV infection, preferentially strikes and kills people of color. The accuracy of reported data has been compromised by a paucity of tests and inconsistent reporting, but it remains clear that African Americans have been hit especially hard, with an age-adjusted mortality rate that is 3.6 times higher than the rate for white people (for comparison, the reported mortality rates for Asian, Latinx, and Indigenous Americans are, respectively, 1.3, 3.2, and 3.4 times higher than the white rate as of August).²³

Speculation about why this is indicts the usual suspects. It's often noted that African Americans are less likely than white people to have a personal physician or health insurance and so must rely on emergency departments that are not the optimal sites for preventive care. Less frequently noted is that hospital closings in many neighborhoods of color have escalated, leaving whole communities without medical options.

It's also the case that people of color are least likely to have the option of working from home or practicing social distancing, either in the workplace or while using the mass transit upon which most depend: only 16.2 percent of Hispanic workers and 19.7 percent of African Americans can work remotely.²⁴ As epidemiologist Linda Goler Blount, president and CEO of the Black Women's Health Imperative, has noted, “20 or 25 percent of Blacks and Latinos have to get on a bus, get on a train and go someplace to work on a job where they are in front of people.”²⁵ Even at home, social distancing is difficult: biased credit and mortgaging practices (such as redlining) make it less likely that a person of color will own his own house. This consigns him to apartment life, which also militates against social distancing when one must share corridors, elevators, and crowded living spaces.

Among those fortunate enough to have some personal protective gear, the mandatory wearing of masks presents health hazards for African American men who have been hounded by police and ejected from stores by security guards who claim to have taken the masks for potential criminal attire—when police officers aren't preferentially assaulting people of color for *not* wearing masks in public. Some private citizens have also exploited health concerns to assault people of color, ostensibly for failing to observe social distancing.²⁶ We first saw this in the spate of verbal and violent attacks on people of Asian descent who were blamed for what President Trump—the person who not long ago decried immigration from “shithole countries”²⁷—chose to call the “Chinese virus.”²⁸ Shouted slurs and threats escalated quickly to knife attacks.²⁹ These attacks spread to members of other ethnic groups, including Janie Marshall, an 86-year-old African American woman with

dementia who was killed by another patient in a Brooklyn hospital emergency department for “failing to observe social distancing” when she felt faint and reached for an IV pole to steady herself.³⁰

Xenophobia escalating in accord with people’s fear of infection is far from a new phenomenon: we saw it in violence around the 2014 Ebola outbreak. More ominously, denouncing one’s enemies as agents of pathogenic disease figured prominently in propaganda of the Third Reich in the 1930s and in the Rwandan and Bosnian genocides in the 1990s. It is high time that we recognize, anticipate, and seek to neutralize this tendency when we contend with an emerging disease, especially one with a putative foreign origin.

Environmental Risk and Coronavirus

We must also recognize the environmental roots of heightened coronavirus susceptibility. It is true that ethnic minority groups suffer elevated rates of respiratory disorders, certain cancers, kidney disorders, asthma, immunosuppression (including from cancer treatment and organ transplant maintenance), and other contested conditions, such as obesity, that *may* raise susceptibility to COVID-19.³¹

But it is also true that known risk factors are caused and exacerbated by the environmental exposures that preferentially assail people of color. Air pollution’s particulate matter creates a legion of respiratory ailments.³² Cancers whose therapy generates immunosuppression are too often caused by the witches’ brew of benzene, pesticides, PCBs, and other carcinogens to which people of color are disproportionately exposed. Thus, many of the oft-cited risks may be proximate triggers of coronavirus infection, but living with the background radiation of a poison-laced environment is the ultimate risk factor.³³

Unfortunately, a message we’ve heard many times before has come to dominate discussions of the high COVID-19 rates among African Americans and other people of color: blame the victim. Hard on the heels of the news that African Americans were suffering and dying disproportionately, a Manhattan Republican Party leader tweeted, “Is it about race or obesity? It would seem that obese people fair [sic] worse. Also males as well as people who smoke and drink alcohol.”³⁴

Specifying smoking and drinking invokes personal responsibility, which is important in many health arenas but meaningless when discussing risk factors that are beyond an individual’s control, such as underlying health conditions, proximity to environmental toxicity, and an inability to practice social distancing and still keep one’s job. Obesity—tacitly obesity in African Americans, as in the tweet—is often bandied about as a risk factor, but many question this because attacking those with a high BMI is a form of socially acceptable discrimination. It is true that obese people with COVID-19 are more likely to be hospitalized, some analysts acknowledge, but this is because of policies

that establish obesity as a criterion for hospitalization, not because the obese present with a more dire clinical picture.³⁵ Blaming obesity may be the result of prejudice against the overweight, as happened when it was held to be a risk factor in the H1N1 “swine flu” epidemic. A 2016 meta-analysis of studies on H1N1 and weight shows no increased risk of death from swine flu for people with BMIs of 25 and above. However, smaller-bodied H1N1 patients *were* more likely to receive early antiviral treatment, making bias, not weight, the true risk factor for people with obesity.³⁶

Unfortunately, a long history of blaming people of color for their environmentally mediated illness precedes this stigmatization. When gross poisoning became impossible to ignore, the lead industry worked to deflect blame onto victims. The Lead Industry Association blamed “ineducable” Black and Puerto Rican parents for making lead poisoning a “problem of slum dwellings.”³⁷ In Baltimore, public health workers “taught” homemakers to clean using Spic and Span, to move cribs away from surfaces with peeling paint,³⁸ and to “assume the responsibility for their children and for watching that they did not eat abnormally” (ignoring that lead’s appeal for children is that it tastes sweet).³⁹ Maryland’s state secretary of the Department of Housing and Community Development, Kenneth C. Holt, claimed that mothers could be intentionally causing their children’s lead poisoning by placing lead fishing weights in their mouths.⁴⁰ It would be comforting to believe that such a shocking and unsupported accusation would not be made today, but Holt stated this in 2015. All too similarly, just a few years ago Flint official Phil Stairs attributed Flint’s lead-poisoned water crisis to “fucking niggers who don’t pay their bills.”⁴¹

Although immediate healthcare and policy actions are needed to reduce the devastation of COVID-19, we must also confront the manifestations of racism, from the legacy of enslavement to environmental racism, that make the disproportionate impact of the pandemic yet another example of injustice and inequity. Exposing the harm being done to our children—and demanding change—is the only way forward.

The Exquisite Vulnerability of the Young

As we have seen, industry often discounts exposures at “low” concentrations. Media accounts often cooperate by downplaying small exposures as innocuous—but this has not been proven. For example, in 2000, researchers calculated that a PCB concentration of just 5 parts per billion (ppb) in a pregnant mother’s blood can have adverse effects on a developing fetal brain, giving rise to attention and IQ deficits that appear to be permanent. Five ppb is equivalent to five drops in an Olympic-size pool. Low concentration does not mean low risk.

Ignoring “infinitesimal” doses of heavy metals, industrial chemicals, and even air pollution validates



The disproportionate impact of COVID-19 is yet another manifestation of the racism our society must confront.



The silence on environmental hazards during prenatal counseling of women of color is especially troubling.

industry's message that low concentrations are too small to do harm. The result? These prime causes of sickness and death in the young are often overlooked.

As industry scientists and executives know, the very young are often the most vulnerable. In utero mercury exposure at a concentration of 100 ppb significantly increases learning deficits, but an adult exposed to this concentration will suffer no discernible effect. Prolonged consumption of tap water with 20 parts per million (ppm) of nitrates can kill an infant but have no effect on an adult. And children exposed to radiation have a much higher incidence of cancers than do adults exposed to the same levels.

Children also suffer exposures that are larger, relatively speaking, than those of adults. Children drink more water relative to their size than do adults; their relative lung volume is also greater, causing them to inhale proportionally more air with greater exposure to air pollution. Babies' principal means of exploring the unfamiliar world is to put objects in their mouths, and even noxious tastes won't deter them. When they become toddlers, their exposure to industrial chemicals and heavy metals escalates as they begin to move about independently, mouthing contaminated objects.

Moreover, an exclusive focus on quantity hides a key element of children's vulnerability to toxicants. Paracelsus famously declared that the dose makes the poison, as illustrated by the 2007 death of a California woman who drank two gallons of water in three hours to win a radio contest.⁴² But today, we know that Paracelsus was only half right; sometimes, as Philippe Grandjean, professor of environmental health at Harvard's T.H. Chan School of Public Health, has pointed out, the "*timing* makes the poison."⁴³ This is especially true for fetuses and for children in the first two years of life.

Subtle environmental injuries such as endocrine disruption, cognitive deficits, and reproductive failures often emanate from exposures at the wrong times. For example, at many key junctures during fetal development, even a vanishingly small toxic exposure can wield a devastating effect, although the same exposure a day earlier or an hour later might have no effect at all.

Approximately 83 percent of the brain's development takes place within the last three months of pregnancy and the first two years of life. The seemingly indolent child devotes 86 percent of her metabolic energy to constructing a breathtakingly complex brain by directing events that include neurogenesis, neuronal differentiation, and myelination.

A child who must contend with noxious environmental exposure while devoting most of her energy to constructing a well-functioning brain finds that the brain cannot do both. Brain development will suffer, resulting in malformed or even missing structures and connections. These could manifest as profound birth defects or reveal themselves more subtly later in the form of missed developmental milestones, cognitive disorders, or behavior problems—or sometimes they

are misdiagnosed as psychiatric conditions such as conduct disorder.

Fetal Death in Flint

With regard to lead poisoning in Flint, I doubt that any one aspect of the tragedy can be singled out as the worst. But the silence in the wake of hundreds of dead fetuses is certainly a candidate.

In 2017, health economists found that 218 to 276 more children should have been born in Flint between 2013 and 2015, and that these "missing children" succumbed to fetal death and miscarriages caused by waterborne lead exposure resulting from the city's temporary switch to a new water source.⁴⁴ Even more shocking, the count of missing babies is significantly underestimated because the investigation included only hospital fetal deaths—not miscarriages that occurred before 20 weeks' gestation.

The water purity change was restricted to a specific period, allowing clear comparisons of Flint's fertility and fetal health rates before and after the switch, when fetuses were exposed to tainted water in utero for at least one trimester. Because Flint was the only city in the area that switched its water supply, studies could also meaningfully compare data with surrounding cities. No other Michigan cities recorded such a drop in fertility.

What's truly troubling is that this same tragedy occurred in Washington, DC, several years earlier. During 2007 and 2008, when the city endured its own lead crisis, lead-driven fetal deaths rose as much as 42 percent. Could not the fetal deaths in Flint have been anticipated and protections enacted for pregnant women? Or better yet, could not this danger dissuade the government from subjecting people to exposures that sicken adults and prove lethal to hundreds of fetuses?

Racial Silences

The affected child's race matters too. Banishing lead poisoning among white children, who are less likely to live in crumbling urban housing or in fence-line communities, is a success story. (Though there are alarming pockets of hazard that demand a vigorous public health response; for example, in 2017 the Environmental Defense Fund found that 27 percent of baby foods sampled—and 100 percent of sampled baby food carrots and sweet potatoes—had detectable levels of lead.⁴⁵) But the scourge of lead poisoning rages among African American and Hispanic children. Nearly all of the at least 37,500 Baltimore children who suffered lead poisoning between 2003 and 2015, for example, were African American.

University of Minnesota researchers determined that 69 percent of Hispanic children, 68 percent of Asian American children, and 61 percent of African American children live in areas that exceed EPA ozone standards, compared with only 51 percent of white children. People of color breathe 38 percent more pol-

luted air than white people and are exposed to 46 percent more nitrogen oxide than white people.

Especially troubling from an environmental health standpoint is the silence on environmental hazards that reigns during prenatal counseling of women of color. One doctor explained that she knows of the greater hazards but failed to broach the subject with her patients of color. Although Dr. Naomi Stotland of San Francisco General Hospital knows that her low-income patients on California's Medicaid program are probably at higher risk of toxic exposures, she told *Scientific American* that she didn't discuss environmental health with them for a long time. Why? "The social circumstances are so burdensome. Some colleagues think the patients are already worried about paying rent, getting deported, or their partner being incarcerated."⁴⁶

Central to this problem is the limited exploration of environmental hazards in medical education, even for future obstetricians and gynecologists.⁴⁷ Healthcare professionals would better serve their patients by asking more questions related to living conditions (including pollutants in the community) and sharing more information about minimizing exposure to hazards, especially in prenatal counseling. But truly addressing the issue—and confronting the devastation of environmental racism—will have to involve the whole research community.

Absence of Evidence Is Not Evidence of Absence

I am deeply grateful for the many researchers who lent me their invaluable time and expertise as I prepared my recent book *A Terrible Thing to Waste: Environmental Racism and Its Assault on the American Mind*. However, I occasionally spoke with scientists who pointed to a lack of evidence that exposures are harmful or existed at all. Weighing their skepticism against the data made me realize that an absence of evidence sometimes reflects not harmlessness, but a research vacuum.

The myopia that haunts research into environmental racism was revealed to me as I prepared to discuss the hazards of subsistence fishing among African Americans and other minority groups. Growing up in several Eastern seaboard towns and upstate New York, and occasionally traveling to the Midwest, I saw urban anglers everywhere. My own father and his inner-city friends made frequent excursions into the country, where they fished and hunted to supplement their families' diets. They even pooled funds to buy a boat together.

But for urban anglers' families, and especially for pregnant women and new mothers, subsistence fishing presents dangers to their children's brains, chiefly by exposing them to PCBs and mercury. We know that "as PCBs work their way up the food chain [from smaller fish like smelt to lake trout and ultimately to herrings and the gulls that feed on them], their concentrations in tissue can be magnified up to 25 million times."⁴⁸ Mercury also increases. I wanted people to

understand that they should choose smaller fish rather than larger ones because mercury becomes concentrated in predators higher up the food chain, and that they should choose species of fish that harbored lower amounts of mercury. I knew many people were lulled into a false sense of security when they were told that the waterways near them had only elemental mercury. What many people do not know is that common bacteria such as salmonella can transform elemental mercury into the much more dangerous organic mercury.

But when I broached the subject to a Johns Hopkins University toxicologist, she denied that it was an issue. African Americans didn't engage in subsistence fishing, she said, and so were in no danger. When I protested that I had seen it often, she countered: "Where are the data? There's nothing in the national literature: *if it's not written there, it doesn't exist.*"

She was right that there were no recent national data documenting subsistence fishing by African Americans; however I thought she was wrong to deny it existed. But without national data, how could I make this case? I called Robert Bullard, father of the environmental justice movement, who went straight to the heart of the matter, declaring, "Absence of evidence is not evidence of absence."

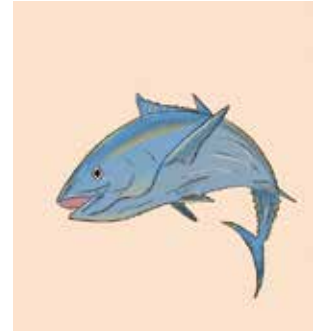
I decided to address the issue, although I knew it could be dismissed as anecdotal. But fortunately, just weeks before my deadline, a comprehensive national report presented data showing that African Americans practiced subsistence fishing at a very high rate.⁴⁹ The report's preface decried the fact that the phenomenon had been ignored for so long, and this experience impressed upon me that we cannot find patterns, trends, and data for which we are not looking. Absence of evidence can cause us to overlook important addressable public health challenges, reinforcing health risks that we choose not to see.

Accurate information in the form of data and analysis is key to solving the health problems confronting all of us, from COVID-19 to lead poisoning, atrazine, and more. But we also need historical and ethical lenses that allow us to recognize and properly understand when we have turned a blind eye to disaster by shrouding racial harms and blaming the victims. Most of all, we need to resist allowing the pursuit of that mythical entity "pure science" to trump the compassion that is an essential element of public health work.

Perhaps Dr. Irving Selikoff said it best: "Never forget that the numbers in your tables are human destinies, although the tears have been washed away."⁵⁰ +

Endnotes

1. D. Slater, "The Frog of War," *Mother Jones*, February 2012.
2. "The Frog Scientist," *What's Happening* (blog), Dennison University, February 24, 2014, 3.



Absence of evidence can cause us to overlook public health challenges, reinforcing risks we choose not to see.

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Traditional Food Knowledge Among Native Americans

Building Trust, Healing Trauma, and Restoring Health



By Valerie Segrest and Janie Simms Hipp

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Janie Simms Hipp (Chickasaw) is CEO of the Native American Agriculture Fund. She was the founding director of the Indigenous Food and Agriculture Initiative at the University of Arkansas and has spent more than 35 years as an agriculture and food lawyer and policy expert.

On a 10-acre farm about 30 miles northeast of Minneapolis, Native youth and Elders together plant, tend, and harvest squash, potatoes, tomatoes, onions, peas, indigenous berries, and more. A dozen or more teenagers from Native nations in the region can often be found gathered around a Native American instructor who leads them in a workshop that cultivates cultural continuity, revitalizing the teachings and responsibilities of a Seed Keeper who cares for more than 200 indigenous varieties of corn, beans, squash, sunflowers, tobacco, and other traditional medicinal plants. The hum of dedicated pollinator meadows nearby is a constant reminder of the interdependence with the natural world that underlies all of these practices.

Thanks to a grant from the Native American Agriculture Fund (NAAF), Dream of Wild Health,¹ a Native-led organization that has been working to restore Native health in the Minneapolis area since 1998, is expanding its reach and impact. Over the course of a year, nearly 100 Native youth will participate in Garden Warrior and Youth Leader programs, and they'll teach what they've learned to 1,800 more. Just as important, through a combination of youth

programs, farmers' markets, a food share program, and donations, 13,500 pounds of fruits and vegetables cultivated on this farm will feed Twin Cities Native Americans this year. Through Dream of Wild Health, Native youth and Elders in the Twin Cities are reclaiming their food heritage—and they are striking back against the dual challenges of chronic disease and cultural annihilation that have threatened Native ways of life for centuries.

Native Americans today have disproportionately high rates of chronic diseases as a direct result of chronic stress, inflammation, and, most significantly, limited access to good nutrition. While there is some variance from community to community, diabetes, heart disease, cancer, and other obesity-related diseases are the top causes of mortality among Native Americans as a group, at rates that are higher than almost any other population group in the country.²

These health problems are a direct result of a painful history that has rippled through generations: federal policy and programs have systematically distanced Native people from their traditional lands, ways of interacting with the natural world, food cultivation practices, and diets. While many communities continue to fight to protect and to access their food systems, new genera-

tions still have little exposure to traditional foods and related teachings, creating a barrier to incorporating these foods into their modern lifestyles.

Feeding Ourselves: Food Access, Health Disparities, and the Pathways to Healthy Native American Communities describes some of the many challenges Indigenous communities face as they work to restore Native health:

When we were strong in our foods on this continent, we were stronger people—we were healthier.... [When] the foods of the settlers and [the federal government's] rationed foods replaced the foods of the communities, ... dramatic shifts occurred in the span of a relatively short period of time and the health of American Indian peoples throughout the United States has never fully recovered....

For example, there was no word for diabetes in traditional Native languages when the Europeans arrived on this continent.... In 1940 the occurrence of diabetes among Native Americans was almost unknown. Diabetes began appearing in 1950, until during the 1960s, it became a common condition. The incidence of diabetes exploded in the 1970s, becoming an epidemic. Beginning in the 1990s and through present day, nearly every Native American is involved either personally with diabetes, or with family and friends with diabetes. It has been called the new smallpox....

A community needs a grocery store every ten miles to ensure some measure of food security, yet there are only ten full-service grocery stores in the entirety of the Navajo Nation, which sprawls over 27,413 square miles—and the Navajo Nation is not alone in this problem. Almost the entirety of Indian Country resides in a food desert. This term is best clarified by saying that almost the entirety of Indian Country resides in a “retail food desert” as the important access to a food production land base creates unique opportunities for successful policy intervention.³

How did the situation become so dire? And what can be done to solve this food crisis and restore Native peoples' health? Answering these questions, and bringing allies to our cause, is the heart of our work.

Many people across the country, including many healthcare professionals, are generally unfamiliar with the history of Indigenous communities and the rich and powerful traditions of what we and our colleagues call *food and health curriculum*. At NAAF, we work to support cultural and economic revitalization through a holistic approach to food, agriculture, and health education. NAAF is the largest philanthropic organization serving and supporting the success of Native farmers and ranchers, fishers and food people; we collaborate with Native nonprofits, community development financial institutions, educational organiza-

tions, and Tribal governments throughout the United States. Our primary work involves providing grants to support business assistance, technical support, agricultural education, and advocacy. Here, we want to take you on a journey of greater understanding.

We'll start with our history, paying special attention to Native food cultivation and its relationship to Native Americans' health and traditional knowledge systems. Some of this history may be uncomfortable to read, but all of it is important to your work as allies to Indigenous peoples. Then we'll explore how you can help shift us from invisible to visible—and to greater understanding among and support from healthcare providers. As we'll explain, embracing the importance of traditional foods and food knowledge for Native Americans' cultures, health, and well-being is vital. As we work together to make sure Indigenous peoples feel seen and respected and live in a broader society where their contributions—and their knowledge systems—are recognized and valued, Native American people can begin to heal.

An American History

Prior to contact with European settlers (generally referred to as *precontact*), America's Indigenous communities thrived for longer than history records—according to many Native traditions, since the beginning of human existence. Archaeological evidence of food processing sites in the high elevations of the Pacific Northwest's Cascade Mountains date back at least 10,000 years,⁴ and evidence of fishery management near the shores of Seattle dates back 10,000 to 14,000 years.⁵ In the Southwest, archaeological evidence traces food systems back 10,000 years or more.⁶ In the Southeast, archaeological evidence also traces agriculture production and communities with significant stability in food and health for thousands of years.⁷ In the context of time, woolly mammoths roamed lands as Native American ancestors dried berries in wild meadows. Rome and Athens, both ancient civilizations revered in history textbooks in the United States, were not even a thought at this time. Native Americans organized entire societies and assembled political structures around the management of food resources. Their societal fabric consisted of intricate storytelling that focused on ancient food systems.⁸

Each Native group has its own distinct traditions, languages, and belief systems, but there are many similarities among groups. Traditional food lessons were interdisciplinary, consisting of science, math, history, social studies, and social-emotional teachings. These lessons were anchored in creation stories, resided at the nuclei of ceremonies, and ultimately manifested the social dynamics of each community. Creation stories revolved around seeking, cultivating, preparing, and sharing the foods that were in many cases at the heart of those stories. Community contributions to and responsibility for foods were integral socioeconomic

Native Americans have high rates of chronic diseases as a direct result of stress, inflammation, and limited access to good nutrition.





The pandemics brought by European settlers meant not only a devastating loss of life—they also meant the collapse of entire knowledge systems.

acts that not only shaped the food system but also upheld ancestral knowledge systems.

A family's wealth was measured by their intimate knowledge of various resources. Each family's understanding of their specific farming, hunting, and fishing techniques reflected their affluence. Preparation to become a contributing member of the community began in childhood. Children gained knowledge through hands-on, experiential learning without age segregation. The "curriculum" was written into the landscape, and the philosophy was propagated by cultivating relationships with the land. The first form of literacy was learning to read the land and the waters for the purpose of food resource management.

The lands and waters abounded with plant life, herbal remedies, mineral-rich sea life, and wild game. In many Tribal communities, the people traveled throughout territories to harvest foods as they became seasonally abundant. Food safety was practiced through deeply engrained norms of food handling, specific to geography and environment, so that food could be safely stored, prepared, and exchanged.⁹ The great diversity of foods consumed also provided a nutrient-rich diet that upheld health by addressing and preventing nutrition-related diseases. Our food systems focused on supporting the health of the land as well as the health of the people, each depending on the other to thrive. It was ordinary to live beyond 100 years old. For thousands of years, our societies thrived in this way. For thousands of years, our health was secure because the very cores of our societies were tied to foods that were deeply nutritionally robust.¹⁰

Cultural Cataclysm

With the arrival of European settlers came wave after wave of pandemics. Recorded history tells us that for more than 300 years, smallpox, measles, the flu, and many other deadly diseases swept through, reducing the Native population by an estimated 80 to 90 percent.¹¹ This was not only a devastating loss of human life—it also meant the collapse of entire knowledge systems. In a matter of days, a disease like smallpox would wipe out an entire community, taking with it the intellectual wealth of understanding the people carried. Compare that with the sudden disappearance of all the world's libraries, museums, or even the entire internet. Based on what we know today about the highly contagious nature of such droplet infections and the havoc they wreak on human immune systems, it's nothing short of a miracle that there were any survivors.

This cultural apocalypse didn't stop with the pandemics. Next came droves of pioneers moving through ancestral territories in the name of Manifest Destiny. Manifest Destiny is the doctrine supported by religious and political leaders that the expansion of the United States throughout the American continents was inevitable and just, part of God's plan. Settlers came through Native lands seeking new business opportunities, fertile

lands for farming and ranching, or simply escape from debt or the unfavorable living conditions of the East Coast (or the countries from which they arrived as immigrants to North American shores). With the infusion of these newcomers throughout Native lands, tensions and violent wars came as well. For hundreds of years, Native communities were in a state of war with settlers coming west.¹² These wars caused countless deaths off the battlefield: the desperate social conditions they created (including malnutrition) catalyzed the spread of infectious diseases.¹³

By the late 1850s, most Tribal communities across the American continent had entered into some sort of treaty negotiation with the United States, resulting in the ceding of hundreds of millions of acres of land to the US government in return for Tribal sovereignty.¹⁴ While some Native peoples negotiated the right to fish, hunt, and gather foods in their "usual and accustomed areas,"¹⁵ many tribes were forcibly removed a thousand miles or more from their original territories and from their traditional harvesting grounds and food sources, severing ties to lands and knowledge systems and to the food and health teachings embedded in place. Witnessing this ongoing cultural apocalypse, followed by and sometimes simultaneous with open war as Native tribes resisted relocation while Americans attempted to seize more lands, wreaked havoc on Native knowledge systems. Immense amounts of intellectual property were nearly lost altogether.

As reservations were plotted out, Native people were forced to move to assigned lands and not allowed to leave. The reservation concept was an intentional act of forced assimilation that superimposed Euro-American values and models onto Native ways of life, disregarding the nomadic—and geographically specific—relationships many communities had with their food systems. Reservation-based land reform also sought to consolidate numerous village sites into confederated "tribes." While Native peoples did what they could to maintain or adapt their food systems to new regions and ways of life, all of these acts diminished or damaged Native food and health curriculum, sometimes beyond salvaging.

The Trauma of "Civilization"

The signing of the treaties, which under American jurisprudence are the supreme law of the land, came with a wave of federal policies that were intended to further disintegrate the culture of tribes across the country. Of greatest significance were the federal food distribution programs (referred to in the early years as rations programs). Food programs further solidified the cycle of dependence that forced relocation had initiated, moving Native people away from their interdependence with natural resources. The logic was that tribes would not need access to their traditional lands if they no longer consumed their traditional foods—foods about which they had deep and centuries-long knowledge

and understanding. The supplied food rations consisted of lard, beans, flour, and sugar, which were both terribly unhealthy and nothing like their ancestral diets.

On the heels of the food programs came perhaps the darkest hour of this period for Native communities, the Indian Boarding School era. This immoral and highly damaging initiative went on for more than 115 years.¹⁶ During this time the US government used threats and coercion to extract Native children from their families, communities, ancestral lands, and food systems. The children were sent to boarding schools that aimed to indoctrinate them as “civilized” members of American society and compel them to fully assimilate into predetermined roles in non-Native culture. Richard Henry Pratt, the army officer who developed the first and most famous of the off-reservation boarding schools, Carlisle Indian Industrial School, proclaimed his desire to “kill the Indian [in each child], and save the man.”¹⁷ This phrase became the mission statement echoed throughout these so-called educational institutions, which numbered more than 350 across the United States.¹⁸

While it is unknown exactly how many Native children were taken in total, by 1926 nearly 83 percent of Native children were attending boarding schools. In 1925 alone, that number was estimated at 60,889 children.¹⁹ Over six decades, at least 600,000 Native children were subjected to the brutality of Indian Boarding Schools, which included vocational training that amounted to forced labor: domestic education for girls and backbreaking agricultural and construction work for boys. As A-dae Romero-Briones states, “Extracting children from their Indigenous food system essentially creates individuals devoid of an understanding of their land, environments, political systems, education systems and spiritual systems, and no understanding of collective resource management.”²⁰

The Indian Boarding Schools were designed with a military mindset. Native children endured full-body makeovers, including military haircuts and Euro-American clothing. They were forced to adhere to rigid daily schedules and strict rules. Children were given English names, were forbidden to speak their Indigenous languages, and were unable to address their siblings or reminisce on their lives before boarding school. The punishments for breaking these rules were gruesome. Children were horrifically abused. Many didn’t make it out alive, and their remains never came home to their families.²¹ These systematic and extensive assimilation practices employed on innocent Native children created generations of Native people severed from their cultures, languages, lands, and traditional food systems.²²

An important part of this militaristic approach was a rigidly enforced nontraditional diet: foods like cornmeal mush, bread, molasses, meat and gravy, and black coffee, with the occasional eggs or potato stew.²³ Attempts to vary from this diet, such as by supple-

menting meager meals with fish caught in local streams or eating the fresh corn or apples the students themselves had helped to grow, were severely punished.²⁴ These genocidal efforts negatively affected the health of Native communities, decimated cultural traditions, and impacted societal behaviors around food for generations. The diet ingrained through Indian Boarding Schools effectively assimilated certain taste preferences for generations, including the consumption of lard, fried meats and bread, starchy root vegetables, and beans.²⁵ Native food and health curriculum was lost to entire generations of young children who acquired taste preferences for fat, sugar, and starchy carbohydrates, and knowledge of traditional food and health systems was nearly lost.

The economic and political upheaval of the early 20th century meant that food was even scarcer. Markets for food were distorted by the Great Depression and the Dust Bowl, as well as the impact of two world wars. In the post-World War II recovery and into the mid-1900s, poverty in significant portions of the United States and rising levels of food insecurity were a potent combination. During this time, several programs to provide some degree of access to food were created at the federal level,²⁶ including the Food Distribution Program on Indian Reservations (FDPIR). While FDPIR was intended by Congress as an alternative to what was then known as the food stamp program, it was actually an outgrowth of those earlier, darker practices, the food distribution and food source substitution programs that had been forced on Indigenous communities for decades.

Today, Tribal communities still rely heavily on government commodities and state and federal food programs to feed their people. Over 80,000 people participated in FDPIR in 2019;²⁷ those eligible (based on income) to receive food assistance who do not participate in FDPIR likely receive food assistance from another federal feeding program. The food provided has improved over the decades—the fresh produce, good-quality proteins, and healthy fats that were the foundation of traditional diets are now more available than in previous years—but much of it is still high in sugar, starchy carbohydrates, and poor-quality fats. And the standardized diet approach to these feeding programs bears little resemblance to the varied diets that Indigenous peoples had access to previously. Even the nutrition education programs sponsored by the FDPIR are minuscule in number, and Tribal governments are excluded from participating in almost all the federally supported nutrition education programs available through USDA.

The issue of limited access to traditional foods and teachings for generations of Native peoples is a significant one with serious repercussions. People’s (especially fetuses’ and young children’s) environments affect their development and health in positive and negative ways—and some of these impacts may carry

Genocidal efforts decimated cultural traditions and impacted societal behaviors around food for generations.





down to future generations.²⁸ For example, researchers are gathering more and more evidence that exposure to environmental toxins is having adverse health effects on individuals and, likely, on their children, too.²⁹ But the human body is also remarkably resilient: when the environment changes in a positive way, say a stress is addressed and removed or more nutritious food becomes part of a person's diet, profoundly positive changes can occur.³⁰

For Native Americans, this isn't a new idea. Traditional systems of ecological knowledge and ecological health hold that human beings are inextricably intertwined with their environments, and food systems are a significant part of this relationship. Ancestral wisdoms point to this lesson time and time again. Many Native Elders give testimony that "our culture is our medicine" and encourage the understanding that a society does not have a culture without its food traditions. Food and health teachings matter, and access to foods that are conducive to health within discrete cultures is incredibly important. What we eat matters as much today as it did to our ancestors.

Our Culture Heals Us

Native people have always innovated, making the best of what was available at the time. They have

always adapted to the environment in which they thrive, attuning themselves to the seasons.

Today, Native-led organizations work to ensure the resilience of their cultures. Some organizations focus on getting more Native learners into higher education, infusing culturally relevant mentorships and support along the way. Others cultivate advocacy so that Native American leaders can increase visibility and stand on platforms where they can share their voice and, more importantly, achieve significant changes that will positively impact communities more specifically. Some focus on Native youth and work tirelessly to develop curriculum centered on the living world that not only spans all disciplines but aims to address preventive healthcare and recovery from trauma, addiction, and incarceration. While many different approaches and community-driven interventions are taking place, Native American communities from every corner of this country stand together when saying "Our foods matter" and "Our culture is our medicine."

While NAAF was not created to support health education per se, we provide funding and support to organizations within our communities who are seeking to restore and strengthen Native foods, food producers, and food cultures. One example is the

Cultivating Our Health in a Time of COVID-19

As COVID-19 has taken root, the impacts on Indian Country have been swift and harsh. Within a few short weeks of the first announcement of community lockdown and isolation, Native leaders began receiving calls concerning the exacerbation of already strained and ill-equipped food supply chains.³¹ Donated foods that were supposed to be delivered to locations within Tribal communities failed to arrive. Places where fresh fruits and vegetables had occasionally been present were devoid of such items, with no clear answer on when deliveries would arrive. Upon checking with the federal government, which has direct legal responsibility as the trustee for all Native American people, strains on food deliveries were confirmed but Tribal leaders were told that *all is well*.³²

The Indian Health Service, already significantly underfunded, has been even more taxed by COVID-19.³³ Native communities, many extremely remote, have no backups for the already low numbers of physicians and nurses in our communities; we have no extra ventilators

(in many cases we have none at all), and needed medical supplies don't make it to our communities.³⁴ In one instance, one Native health facility in Seattle requested personal protective equipment and other medical equipment but received only boxes of body bags.³⁵ And, in yet another episode of history repeating itself, Tribal leaders were forced to sue the US Treasury Department after it failed to provide \$8 billion in aid that was supposed to be distributed in April.³⁶ Such is the failure of the systems that are supposed to provide key support to communities with whom the federal government has a unique trust responsibility.

Among Native people, comparisons between COVID-19 and smallpox started being made early in the spring. By the middle of May, when the Navajo Nation surpassed New York as having the highest infection rate per capita,³⁷ the comparison was all too real.

Health education cannot flourish in situations such as these, and the long-lasting impact of major food access disruptions occurring within communities

(whose comorbidities are already among the highest of any population in the country³⁸) will only deepen health disparities. Occasional absence of food here and there in grocery stores and periodic gaps in supply chains off Tribal lands is not what we are witnessing here. Grocery stores don't even exist in our communities.³⁹ As a result, people from dozens of different communities drive hours to converge on one grocery store, meaning any one person with COVID-19 could cause infections in several other communities across hundreds of square miles.⁴⁰ This is taking a challenging and shameful situation and turning it into a catastrophe.⁴¹ *All is not well.*

Native leaders know what they must do—and they are doing it. First and foremost, they are working to protect the health of their people. They are closing borders and boundaries to their reservation lands and prohibiting access to or exit from communities except for the most essential activities.⁴² Some Tribal leaders are restricting residents to their homes. Many are also slaughtering their livestock

Numu Allottee Association in Madras, Oregon, whose Three Sisters Project supports seasonal food gathering, the revival of Indigenous language, and supplemental food access for youth as ways of building community health; another is the Klamath Trinity Resource Conservation District, located in Hoopa, California, which maintains *traditional ecological knowledge* for the next generations of Native people, including proper techniques of gathering and preserving local traditional foods obtained through hunting, fishing, and harvesting. We also create new educational opportunities and fortify the role of educational institutions in the important tasks that allow Indigenous people to restore their health, culture, and well-being by restoring their food traditions and food systems. But within Indigenous cultures, these goals are not really separate from health education and reclaiming our abilities to feed ourselves healthy and nutritious foods. The organizations we support help to recast the idea of health education by weaving the work of today with the ancestral knowledge of yesterday and make deeper connections to where our foods are and how we can best support access to those foods.

Taking an approach that empowers local knowledge systems provides an opportunity for us all to

deepen our understandings and the teachings of place. This is a tenet of Native knowledge systems, what has also been recently coined traditional ecological knowledge—the underpinnings of which are traditional diets. If we are to do the hard work of healing a dark history, we must collectively learn to be better stewards of the lands on which we all dwell.

Native knowledge systems embody relevant life teachings that are applicable to everyday life and can help individuals to find their ways as contributing members of society. This approach goes beyond providing culturally appropriate instruction to Native learners as interdisciplinary, localized, stewardship-focused instruction. Fusing Indigenous perspectives on ecology and the environment alongside Western understandings addresses the issues of invisibility and ongoing attempts of erasure in Native communities; it also contributes to relationship building across communities, genders, and races and helps close the gaps in crucial systems of economics, food, and health. Simply put, by creating a world in which Native people feel seen and heard with respect and with equality, where their purpose and contributions to society are acknowledged and celebrated, where society values the vast knowledge systems that upheld Native health for thousands of years and



herds so that they can store the meat for the weeks and months to come.

Almost every Native community is jumping into action, employing ancestral food system knowledge to enlarge existing gardens and small farm sites so that more food can be grown during the present growing season and stored for the winter months.⁴³ Advocacy is underway to build and fortify infrastructure so that Native communities will not face food access emergencies that threaten their very existence. Tribal members are sewing personal protective equipment, creating new food distribution networks, and raising funds by selling artwork.⁴⁴ Philanthropy and private sector and concerned individuals are donating foods to reservations in the most need, with noted international chefs arriving on reservations to bolster local efforts to feed people.⁴⁵

As communities are responding, even when they have lost their own local economies, now is the time to enhance relationships with those interested in assisting, and now is the time to take

actions small and large of resiliency and preparation. At the same time, health education is deeply important. But what we need isn't one-size-fits-all health education grounded in choices that aren't available to or relevant for our communities; we need health education grounded in who we are, what strengths our ancestors had, and how we must comport ourselves in the future to help us achieve true food sovereignty and community vitality.

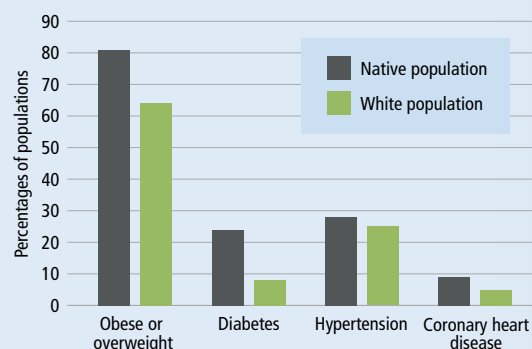
The journey is underway in many Native communities as community gardens, farmers' markets, community food delivery systems, and food production for Native consumption become more prevalent. However, the road will not be easy and time is of the essence because the health problems and food insecurity of our communities have reached crucial breaking points. Now more than ever, we are focused on our greatest asset in this fight for our health: our lands and our ability to grow ourselves out of these problems.

—V. S. and J. S. H.

Although there is still much to learn, early research indicates that people with obesity, diabetes, and cardiovascular disease are at greater risk of contracting and dying from COVID-19.⁴⁶ Native Americans, having long been affected disproportionately by the first three, are now proving especially susceptible to COVID-19 as well.⁴⁷

According to the US Department of Health and Human Services Office of Minority Health, there are stark disparities, shown in the chart below, between Native (American Indian/Alaska Native) and white (non-Hispanic) populations.⁴⁸

Health Disparities Among Adults 18 and Over in 2018





**If we are to
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invests in that system wholeheartedly—people can begin to heal.

Cultivating Our Future

It's crucial that we all work together to re-energize traditional food knowledge and restore Native health. The work of NAAF, which brings together leaders representing nearly every region of Indian Country, supports the revitalization of Native American food systems, employing these four tenets:

1. Cultivating Native American agriculture businesses and economy
2. Expanding culturally based models and practices
3. Strengthening educational pathways
4. Promoting food security for Tribal sovereignty as well as community well-being

We know that by strengthening and restoring cultural values and practices, Tribal communities can heal. In order for that to happen, financial support must be in place for Native agricultural systems, traditional foods must be celebrated, food insecurities must be addressed, and Native agriculture must assume its important role as a model for sustainability and stewardship. The first year of grant funding allowed NAAF to seed over 100 projects in over 80 organizations, all driving toward improving our health and resiliency through our foods.

But NAAF cannot do this work alone. It will take many public health, healthcare, and education initiatives—grounded in Native traditions and focused on healing—to encourage participants to seek out and regain knowledge in how best to cultivate their health through traditional foods. Here are some ways others can be our allies in this work:

- Build your knowledge. While we have focused on broad similarities across Native groups, there is wide variability among them. Cultural competence—which starts with listening to and getting to know the specific Native cultures in your region (and the cultures of people in your care) and understanding their needs and goals—is key to being able to provide effective support. Continue your education by learning about the original inhabitants of the lands you live on (who may be different from those who live near you now) and their food systems, and encourage others to educate themselves too.
- Grow your community. Connect with local Native organizations, build relationships with Tribal leaders, and get to know your Native neighbors. Get involved in existing Native-led health initiatives.
- Question your assumptions. When you think about Native Americans' health, what comes to mind first? If you think about obesity, health disparities, and diabetes, do you also think about food deserts,

forced relocation, and how to help solve the crisis of access to healthy foods?

- Adjust your practices. The more culturally relevant knowledge you have, the more effectively you can inquire about and address challenges a patient may be facing that are reducing compliance.
- Empower Native voices. Seek opportunities to include Native Americans in conversations across your workplace or organization, including in decision-making positions. Support and facilitate the enrollment of Native American students in health-related programs and provide employment opportunities and mentorship to recent graduates.
- Make Native foods central to preventive care. In nutrition programs, public health campaigns, and educational efforts, empower Native people to take charge of their health by drawing connections between traditional Native foods and food systems and better health outcomes, and by showing them practical things they can do to build Native foods into their diets.
- Consider the benefits of traditional healing. If there is no reason to suspect that a traditional medicine or healing ceremony may be harmful, then consider encouraging Native patients to integrate traditional methods with allopathic medicine.⁴⁹ Native patients may experience real relief from healthcare providers' open-mindedness.
- Involve Native Elders. Multigenerational mentorship that creates space for Elders to share their cultural wisdom and experience with youth is key in healing Tribal communities; holding space for Elders also acknowledges the significant place Elders hold in Native cultures.
- Advocate for Native self-empowerment. Push for greater Tribal control of programs and resources, including federal feeding programs. Direct funding for health initiatives to Native-led organizations.

Our work begins in places like classrooms and clinics; they can become powerful places where trauma is replaced with a remedy and where healing can begin. This important work must be done in ways that are intentionally focused on ensuring our rich food histories and cultures are celebrated, leading to a healthier and more sustainable future. **+**

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Finding Light in the Darkness

What Nursing Has Taught Me About Living



I stand in my garden at home on a clear spring day, several weeks into the United Kingdom's COVID-19 lockdown. On the radio, our prime minister has been telling us we must continue to "stay at home" to "slow the spread of infection." Having spent five years as a nurse and now on a year of maternity leave, I feel a sense of guilt knowing that my dear friends are on the frontline while I am at home. I am, of course, fulfilling my own vital role—bringing up my new baby daughter—but seeing the United Kingdom mobilize a field hospital able to hold as many as 4,000 patients, I wonder if I should be there, too.

My colleagues have told me they are going to stage a walkout due to the lack of personal protective equipment provided by the government. I've seen them on the news commemorating Workers' Memorial Day, fists held high, banners out, demanding not better pay but simple face masks and gowns to protect themselves. Still, there are moments when I realize I'm fortunate to be in the UK. Friends and colleagues in the United States are struggling with all of these problems and more: a disjointed healthcare system with millions of people uninsured and a president who has not only avoided responsibility but also recklessly suggested that people inject themselves with disinfectant.

I have been commissioned by the chief nurse of the National Health Service in England to write some words on the strength of our healthcare workers—a poem that I hope goes a small way to showing staff they are seen and heard. I spent three years studying for a degree in English literature and creative writing and have been fortunate to be able to combine nursing and writing after my poem "Nursing the Nation," which I wrote and performed while still a nursing student, went viral on the internet. It is such a joy to be able to both look after people and write for a living.

Standing in my garden, I close my eyes and feel the warmth of the spring sunshine on my skin, hear the sound of birdsong, draw fresh air into my lungs. As I consider these simple gifts, I am taken back to my previous job—working as a registered nurse in intensive care, where life and death are always present for both patients and staff—and to a patient who reminded me, in the midst of all of his own frightening uncertainty, to slow down and remember the small things that make life worth living.

A New Assignment

In 2018, I spent a long, challenging six months learning how to look after patients with external ventricular drains in their brains, on ventilators or dialysis machines, with balloon pumps controlling the flow of blood through their aortas and drugs that had to be minutely titrated because a small mistake could mean the difference between life and death.

The environment in the intensive care was wildly different from where I had spent the previous two years working—in a cardiothoracic high-dependency unit where I welcomed in cheery, suitcase-dragging elderly patients, prepared them for surgery, and nursed them back to full and often better health, with shiny new heart valves and clean coronary arteries. The patients in the cardiothoracic unit had not suffered great trauma. They could be unwell—breathless and in need of surgery—but they could see an end to their hospital admission once the operation was complete. The ward was light-filled, the windows tall, beaded with rain or glinting in the bright sun, and the trains rushing past outside reminded us all, patients and nurses, of faraway places that we could one day go to again.

But intensive care was located at the back of the hospital. To get there, I had to walk through a glass tunnel

By Molly Case

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where the daylight streamed through. It reminded me of the Ocean Tunnel at the Sea Life London Aquarium, where I gazed up as a child hoping to see a shark in the gloom amid the smooth white underbellies of rays and the neon-streaked scales of tropical fish. Here at the hospital, the sky above the tunnel was crisscrossed with netting that trapped birds, their feathers and splayed wings caught in the holes. Even so, I always made sure to walk through the tunnel on my break because inside the intensive care unit there were no windows or natural light. There was only muted fluorescent lighting and the glow of the screens and monitors and flashing infusion pumps that we huddled around in the near-dark.

In the twilight of the ICU, patients died all the time. It seemed full of trauma and sadness. Patients forever brain-damaged from unsuccessful attempts at suicide. Young racecar drivers now unable to do more than blink, their careers ended just as they were beginning. Drug addicts with hearts that no longer pumped, leaving them fluid-filled and coughing up froth. Traffic accidents that brought two devastated families suddenly careening toward each other in the waiting room.

Working in the ICU was an eye-opening experience in my nursing career. My colleagues were at the top of their game, able to look after patients attached to many flashing, organ-supporting machines. But to me, an intensive care rookie, even the mundane routines were mesmerizing. I watched how patients with breathing tubes down their throats had their teeth brushed by the staff day and night. This process involved a nurse carefully holding the breathing tube steady with one hand while wielding a syringe of water, a dab of toothpaste, and a suction tube with the other to thoroughly clean the patient's mouth. It was nerve-racking to watch, and I marveled at how skilled the nurses were. The way they performed these small but vital tasks often astounded me the most.

I soon came to learn that on the ICU, at least the first half-hour of the shift is dedicated to a full body survey, the ABCDE assessment. *Airway, Breathing, Circulation, Disability, and Exposure*. I was used to this type of examination, which is a fundamental part of nursing care, but in other wards we each cared for multiple patients and often had to move quickly. Here, we looked after a single patient. I was amazed at the depth and time given to each part of the process. Behind the blue paper curtains, where the strip lighting becomes moonish and soft, the nurse observes—and tries to perceive—the patient they are to spend the entire shift with, listening to the chest with a stethoscope, feeling the rise and fall, watching the settings on the ventilator, observing the flow of oxygen. One patient, 12 hours, 11 bodily systems to navigate, monitor, and record on the bedside computer. For those 12 hours, the nursing team must become experts in that patient's topography, their steep declines and rocky recoveries, the overnight brain-storms, the flare in the eye that finally opens, the longitude and latitude of swollen limbs, new

wounds opening up like crimson calderas. The patient might drift, but we cling tightly to them, one constant amid a forever-changing current.

A New Patient

Four months into my new role, I felt thick with the trauma and sadness I had seen. During handover one shift I was assigned a young patient, Owen, who had suffered extensive burns; going to retrieve his stray soccer ball, he had fallen down a grassy bank and landed on railway lines, where he was electrocuted. He was airlifted to our hospital and was found to have sustained burns over 35 percent of his body. His legs were stripped of skin and muscle, burnt down to the bone. He was taken straight to the operating room, pieces of skin from his arms and buttocks cut away and sewn to the raw, bare flesh of his legs. He was wrapped and bandaged and kept in an induced coma until the swelling, and the pain, became more bearable. Over our morning coffee, we were told that he was no longer on a ventilator but was unable to move his lower body. Our task was to manage fluid loss and replenish and build his strength, with the aim of getting him to walk again.

I went to his bedside. Owen's eyes were closed, but I didn't think he was asleep. I introduced myself and told him I would be with him for the day. *May I take your observations?* A small nod. I made sure I was quiet as I conducted the ABCDE assessment, letting him rest from everything he had been through.

Airway

Owen was able to speak, but he didn't. I had not looked after Owen when he was ventilated. I watched and listened as my colleagues did so, moving around his bedside quietly and carefully, replacing the filter, the suction bags, the tubing. It took a long time for me to feel confident looking after people with breathing tubes, their lives held literally between the nurse's fingertips. It required patience, concentration, and much skill. Overnight when the lights were dimmed, I was fascinated by how my fellow nurses worked, their hands fluent in the workings of the human body despite the dark.

Now, Owen was able to draw breath without assistance but needed help to cough up the remnants left behind in his lungs. I watched him in silence before moving on with the assessment. He was quiet; there were no signs of obstruction, no need for suctioning. His airway was patent. He could breathe. For healthcare

I was assigned a young patient, Owen, who had suffered burns over 35 percent of his body.



Molly Case is a nurse with the National Health Service and a member of the Royal College of Nursing—but she's also an acclaimed poet and writer. Along with the moving personal essay printed here, we think you'll enjoy her performance of "Nursing the Nation," which was published this spring in *These Are the Hands: Poems from the Heart of the NHS* as part of a fundraising effort for COVID-19 relief: <https://vimeo.com/397463184>.

—EDITORS

practitioners, A—the airway—represents the first part of the assessment and one we continuously monitor. Without a patent airway, a patient is not able to survive.

Breathing

I looked at the way Owen's chest rose and fell. As nurses we are taught to look, listen, and feel in order to assess the intricacies of breath. How fast are the respirations? What sound does the breath make as it passes through the lungs? Is it shallow? Are the muscles around the neck brought in to assist in the work of breathing? Is the patient, therefore, struggling?

During the accident, Owen had suffered a blunt chest trauma, falling and landing awkwardly on his side so that a rib cracked and punctured his lung. In the operating room they had inserted a chest drain to reinflate his lung and reduce the fluid that had leaked into the wrong space. I walked around the side of the bed to where a single lantern-shaped bottle hung, filled with sterile water to maintain subatmospheric pressure in the space being drained. If this subatmospheric seal were left unclamped, the drainage tube would suck and spit like a muddy sump pooling in Owen's chest, allowing air to reenter. I checked the suction and recorded the drainage on Owen's notes. It had become my habit to look back through the patient's notes after I did so, to see how far they had come from when they first arrived. On a particularly challenging day in intensive care, this reflection would remind me that patients *could* improve, that there *could* be small victories, that there *was* progress in less suctioning required and less oxygen being consumed. I looked back at Owen's notes to remind myself of the progress he had made in our care.

Circulation

This was my favorite part of the ABCDE assessment—so much can be learned about a patient by understanding how the blood moves through their body. In my studies of literature, I had felt similarly drawn to the mysteries and movings of our corporeal substance, the lifeblood that carries with it our histories and stories to pass on.

In humanities classes I read about blood in many forms, studying the greats of Western literature. I knew how blood stirred before Shakespeare's Henry V led his men into battle, how it soaked through cloth in the flickering candlelight as Jane Eyre was woken in the dead of night to tend to an injured limb, how in Dostoevsky the smell of it, sticky and warm, might conjure thoughts of a murder somewhere up ahead. Now, working as a nurse, these images of blood and its power to make or unmake a life animate many of my shifts.

Owen had lost blood and leaked fluid from the burns in his legs. When he arrived at the hospital, he was hypovolemic. Even in the months following his admission, the care we provided entered my thoughts and dreams, the fast-paced replacement of fluid bags

and electrolytes to keep his organs working, running blood gases and nervously checking the results, wrapping his wounds, documenting his vital signs every 15 minutes. I looked at the color of his skin, felt his pulses, checked his heart rate and rhythm, tested his capillary refill. Everything looked good, reassuring me that his organs were getting enough blood supply.

Owen was more than his vital signs. On the railway tracks he had been catapulted from the earth, emptied of fluid, then at the hospital refilled and stitched back together. His lifeblood, carrying all its iron and minerals, old stories and memories, had been cast out, forever changed from crossing its cellular border. Owen, too, would be changed after this experience, after glimpsing—if just for a moment—the fast-flowing conduit between two worlds.

Disability

On a previous shift the nurse had reported that she had seen a change in one of Owen's pupils, leading the team to wonder whether he had sustained a head injury in addition to the damage to his legs and chest. In the early hours, the nurse took her penlight and shone it into Owen's eyes every 15 minutes, hoping to see his pupils wax and wane, letting in or shutting out light. Instead, she found one pupil a little larger than the other. The doctors were called, and we nurses were instructed to watch and wait.

How we see our universe depends on our eyes and our experiences. If we suffer a traumatic injury to our brains, our pupils can become dark pools, fixed and dilated, no longer able to absorb anything before them. Medical professionals often refer to this kind of presentation as a blown pupil, staring forward wide and motionless like a black hole swallowing the light.

The ancient Greeks believed we held a divine fire within our eyes that cast outward, illuminating anything we wanted to see. As morning came, Owen's pupils had returned to normal, as if overnight his fire had begun to dwindle before an ember caught again, sparking back to life.

Exposure

The skin on Owen's thighs was gone. What replaced it were two bare patches of red tissue with new skin sewn on. The surgeons wanted to give his body time to get used to the skin grafts before attempting any more repair. It was likely he would need some artificial grafting since the damaged area was so large.

I had almost finished the ABCDE assessment when a voice behind the curtain asked if it was okay to come in. I covered Owen with his sheet and said it was. It was the physical therapist, Sarah. Every day, she asked Owen if he wanted to go outside in his wheelchair. Each day so far he had said no. But today that changed. He opened his eyes, licked his lips, and whispered, "Okay."

It took two nurses, a healthcare assistant, and the physical therapist to get Owen into his tilting wheel-



It took two nurses, a healthcare assistant, and the physical therapist to get Owen to the shady trees with the sun filtering through.

chair and push his equipment out of the ICU, into the elevator, and to the front of the hospital. Next to the parking lot there were some flowers and shady trees with the sun filtering through. We wheeled him there and put the brakes on, checking his vital signs on the portable monitor.

Sarah tilted Owen's chair so that he could see the sky. He lay there for a good 10 minutes. We weren't sure if it was too bright for him or if he had fallen asleep. His lips looked dry, as if he had been out in the sunshine for the whole afternoon. After a while, I asked if he was okay. He opened his eyes, and I realized it was the first time I had properly seen their color. They were green and speckled with yellow, like a cat's eyes.

"Yes," he said. His voice was quiet. I thought that was all he was going to say, but then he closed his eyes again.

"I'm just feeling it," he said, and paused again.

"Feeling it?" I said, worried he meant a missed heartbeat or a pain in his legs.

"Life," he said. "I can feel life on my skin."

In that moment sunlight streamed across his face. He didn't flinch. He smiled as if soaking it all in. We had never seen him smile.

We looked at each other and could see we were all holding tears in our eyes. We kept Owen out in the spring sunshine as long as the oxygen tank lasted, and when we told him we had to go he made us promise we would come back the next day, just to the hospital parking lot, to feel *life* on his skin. We promised we would.

A New Perspective

Owen stays with me, all these months later, when I'm standing in the garden, hearing our leaders on the radio, listening to the birds, thinking of the sacrifices healthcare workers are making, and feeling the sun on my skin. I think, too, of how our healthcare service might be transformed after this pandemic, after the sickness has passed and we are all changed as a result.

In its wake we might just see sweeping transformations in the way healthcare is delivered across the globe. In the midst of this crisis we have seen a dramatic increase in the use of technology, digitalizing how we offer care with phone and video consultations freeing up in-person time slots for sicker patients. China harnessed technology during the COVID-19 outbreak, using artificial intelligence to detect fever in pedestrians through a touchless technique.¹ What if healthcare providers across the world were able to capitalize on technology, using electronic patient notes (easily and securely transferred among providers), online pharmacy transactions, disease tracking and observation, and telemedicine for those who live in rural locations or are hard to reach? These technologies suggest one way we may see reformed healthcare systems that are better able to focus on prevention: allowing systems to "talk" to one another. By connecting digital systems, different areas of health

and social care could work together, supporting wellness both in the community and within the hospital setting, contributing to cost efficiency, and helping to provide high-quality care for all. Imagine this: a patient takes control of their own long-term condition by downloading ECG data from their smartwatch and sending the information directly to their care provider to review. From there, the medical professional can interpret the diagnostic and respond quickly and efficiently, speaking to the patient, prescribing as necessary, and documenting care online.

While there are many possible avenues for improvement in the system and for how we care for one another in our communities, it's clear that changes are needed. The response to COVID-19 has highlighted the cracks in our healthcare finances, supply chains, preparedness, and more—but in the face of it, it has also highlighted the shining value of healthcare staff.

Here in the UK, the National Health Service (NHS) is the fifth-largest employer in the world, behind McDonald's, Walmart, the Chinese People's Liberation Army, and the US Department of Defense.² The NHS is a nonprofit, tax-funded health system. Spending on healthcare in the UK as a percentage of gross domestic product is far below that of countries like the United States with much larger economies.³ Despite this, the British health system is world-envied for its nondiscriminatory, free at the point of service delivery approach. Every 36 hours, the NHS looks after 1 million people.⁴ And yet the number of nurses who have left the NHS due to poor work-life balance has almost tripled in the last decade—and there are an estimated 50,000 nursing vacancies in the United Kingdom.⁵

COVID-19 has taught us that through these uncertain times, through months of social distancing and isolation, we can learn the most from our nurses, doctors, respiratory therapists and other healthcare providers, and healthcare assistants who have given their all. Perhaps in seeing how they have responded, how they have continued to provide care despite lacking so many resources that their jobs require, governments around the world will come to understand their undeniable value and truly learn how to treat people. +

**"Life," he said.
"I can feel life
on my skin."**



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Saving Our Democracy

As COVID-19 devastates our communities, it's clear that we face far more than a health crisis. We're facing crises in economic opportunity and racial justice, both of which have deep roots in systemic bias. And these are made worse by a crisis of politics, in which science is questioned and democratic norms are disregarded. To heal, we need to understand why it is so difficult for our country to come together. These articles on saving our democracy, which begin here and continue at aft.org/hc, explore the polarization and disinformation that are tearing us apart—and offer hope for a better America.

—EDITORS



The Crisis of American Democracy

Nearly all living Americans grew up taking our democracy for granted. No longer. Americans watch with growing unease as our political system threatens to go off the rails: costly government shutdowns, stolen Supreme Court seats, impeachments, mounting concerns about the fairness of elections, and, of course, the election of a presidential candidate who had condoned violence at rallies and threatened to lock up his rival, and who, as president, has begun to subvert the rule of law by defying congressional oversight and corrupting law enforcement agencies to protect his political allies and investigate his opponents.

The problems started long before 2016 and go deeper than Donald Trump's presidency. Electing a demagogue is always dangerous, but it does not condemn a country to democratic breakdown. Strong institutions can constrain corrupt or autocratic-minded leaders. That is precisely what the US Constitution

was designed to do, and for most of our history, it has succeeded. America's constitutional system has effectively checked many powerful and ambitious presidents, including demagogues (Andrew Jackson) and criminals (Richard Nixon).

But constitutions *by themselves* aren't enough to protect democracy. Even the most brilliantly designed constitutions don't function automatically. Rather, they must be reinforced by strong, unwritten democratic norms.

Two basic norms are essential to democracy. One is mutual toleration, or the norm of accepting the legitimacy of one's partisan rivals. This means that no matter how much we may disagree with—and even dislike—our opponents, we recognize that they are loyal citizens who love the country just as we do and who have an equal and legitimate right to govern.

The second norm is institutional forbearance. Forbearance means refraining from exercising one's legal right. It is an act of deliberate

self-restraint—an underutilization of power that is legally available to us. Politicians may exploit the letter of the Constitution in ways that eviscerate its spirit: Supreme Court packing, partisan impeachment, government shutdowns, pardoning allies who commit crimes on the president's behalf, declaring national emergencies to circumvent Congress. All these actions follow the written letter of the law to subvert its spirit.

Unwritten norms of mutual toleration and forbearance serve as the soft guardrails of democracy. America has not always had strong democratic guardrails. It didn't have them in the 1790s when institutional warfare between the Federalists and the Republicans nearly destroyed the Republic before it could take root. It lost them in the run-up to the Civil War, and they remained weak through the late 19th century.

For most of the 20th century, however, America's guardrails were solid. Although the country experienced occasional assaults

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ILLUSTRATIONS BY SONIA PULIDO

on democratic norms (e.g., McCarthyism in the 1950s), both parties broadly engaged in mutual toleration and forbearance, which in turn allowed our system of checks and balances to work.

There is, however, an important tragedy at the heart of this story. The soft guardrails that undergirded America's 20th century democracy were built upon racial exclusion and operated in a political community that was overwhelmingly white and Christian. Efforts to create a multiracial democracy after the Civil War generated violent resistance, especially in the South. It was only after the Republicans abandoned Reconstruction—enabling the Democrats to establish Jim Crow in the South—that Democrats ceased to view their rivals as an existential threat and two parties began to peacefully coexist, allowing norms of mutual toleration and forbearance to emerge. In other words, it was only after racial equality was removed from the agenda, restricting America's political community to white people, that these norms took hold. The fact that our guardrails emerged in an era of *incomplete democracy* has important consequences for contemporary polarization—a point to which we will return.

In our 2018 book, *How Democracies Die*, we show how America's democratic norms have been unraveling over the last three decades. When mutual toleration disappears, politicians begin to abandon forbearance. When we view our partisan rivals as enemies, or as an existential threat, we grow tempted to use *any means necessary* to stop them.

That is exactly what has happened over the last three decades, accelerating rapidly during Obama's presidency. Republicans in Congress treated the Obama administration as an existential threat that had to be defeated at almost any cost. Perhaps the most consequential example during the Obama years was the Senate's refusal to take up President Obama's nomination of Merrick Garland to the Supreme Court. Since

1866, every time a president had an opportunity to fill a Court vacancy before the election of his successor, he had been allowed to do so (though not always on the first try). The Senate's refusal to even consider an Obama nominee thus violated a 150-year-old norm.

The problem, then, is not only that Americans elected a demagogue in 2016. It is that we elected a demagogue at a time when the soft guardrails protecting our democracy were coming unmoored.

What we are experiencing today is not traditional liberal-conservative polarization. People do not fear and loathe one another over taxes or healthcare policy. Contemporary partisan divisions run deeper than that: they are about racial and cultural identity.

Our democratic norms were erected by and for a political community that was overwhelmingly white and Christian—and which forcibly excluded millions of African Americans in the South.

American society has transformed dramatically over the last half-century. Due to large-scale immigration and steps toward racial equality, our country has grown both more diverse *and* more democratic. These changes have eroded both the size and the social status of America's erstwhile white Christian majority.

Not long ago, white Christian men sat atop all our country's social, economic, political, and cultural hierarchies. They filled the presidency, Congress, the Supreme Court, and the governors' mansions. They were the CEOs, the newscasters, and most of the leading celebrities and scientific authorities. And they were the face of both major political parties.

Those days are over. But losing one's dominant social status can be deeply threatening. Many white Christian men feel like the country they grew up in is being taken away from them. For many people, that feels like an existential threat.

This demographic transition has become politically explosive because America's racial and cultural differ-

ences now map almost perfectly onto the two major parties. This was not the case in the past. As recently as the late 1970s, white Christians were evenly divided as Democrats and Republicans.

Three major changes have occurred over the last half-century. First, the civil rights movement led to a massive migration of Southern white people from the Democrats to the Republicans, while African Americans—newly enfranchised in the South—became overwhelmingly Democratic. Second, the United States experienced a massive wave of immigration, and most of these immigrants ended up in the Democratic Party. And third, beginning with Ronald Reagan's presidency in the early 1980s, white evangelical Christians flocked to the Republicans.

As a result of these changes, America's two major parties now represent very different parts of American society. The Democrats represent a rainbow coalition that includes urban and educated white voters and people of color. Nearly half of Democratic voters are non-white. The Republicans, by contrast, remain overwhelmingly white and Christian.

Americans have thus sorted themselves into parties that represent radically different communities, social identities, and visions of what America is and should be. The Republicans increasingly represent white Christian America, whereas the Democrats have come to represent everybody else. This is the divide that underlies our country's deep polarization.

What makes our polarization so dangerous, however, is its *asymmetry*. Whereas the Democratic base is diverse and expanding, the Republican Party represents a once-dominant majority in *numerical and status decline*. Sensing this decline, many Republicans have grown fearful about the future. Slogans like “take our country back” and “make America great again” reflect this sense of peril. These fears, moreover, have fueled a trou-



America's botched response to COVID-19 is the most lethal symptom of a political system run aground by polarization.

The Republican Party has repeatedly abdicated in the face of Trump's violations of our constitutional order.

bling development that threatens our democracy: a growing Republican aversion to losing elections.

Democracy requires that parties know how to lose. Politicians who lose elections must be willing to accept defeat, go home, and get ready to play again the next day. Without this norm of gracious losing, democracy is not sustainable.

For parties to accept losing, however, two conditions must hold: first, they must feel secure that losing today will not bring ruinous consequences; second, they must believe they have a reasonable chance of winning again in the future. When party leaders fear they cannot win future elections, or that defeat poses an existential threat (to themselves or their constituents), the stakes rise. Their time horizons shorten. They throw tomorrow to the wind and seek to win at any cost today. In other words, desperation leads politicians to play dirty.

Republicans' electoral prospects are diminishing. They remain an overwhelmingly white Christian party in an increasingly diverse society. Moreover, younger voters are deserting them. In 2018, people aged 18 to 29 voted Democrat by a more than 2 to 1 margin, and those in their 30s voted nearly 60 percent Democrat. The growing diversity of the American electorate has made it harder for the Republican Party to win national majorities. Indeed, the GOP has won the popular vote in just one presidential election in the last 30 years.

No party likes to lose, but for Republicans the problem is magnified by a growing perception among the base that defeat will have catastrophic consequences. As we noted above, many white Christian Republicans fear they are on the brink of losing not just elections, but their country.

Dimming electoral horizons and growing perceptions of an existential threat have encouraged a "win now at any cost" mentality. This mentality has been most manifest in recent efforts to tilt the electoral playing field. Since 2010, a dozen Republi-

can-led states have adopted new laws making it more difficult to register or to vote. Republican state and local governments have closed polling places in predominantly African American neighborhoods, purged voter rolls, and created new obstacles to registration and voting.

Where Is American Democracy Headed?

President Trump has attacked the media, trampled on congressional oversight, and sought foreign intervention into our elections. Across the government, officials responsible for law enforcement, national intelligence, defense, election security, the census, public health, and even weather forecasting are under pressure to work for the president's personal and political benefit—and, crucially, *against his critics and opponents*. Those who refuse—including inspectors general responsible for independently monitoring government agencies—are being pushed out and replaced with Trump loyalists.

This democratic backsliding has been facilitated by the Republican Party, which has repeatedly abdicated in the face of Trump's violations of our constitutional order. Nowhere was the erosion of our checks and balances made clearer than in the failure of the 2019–2020 impeachment process. Senate Republicans stated from the outset that they would acquit the president no matter what the evidence of wrongdoing. Polarization was so extreme that it was more important for the Republicans to beat the Democrats than to rein in a president who threatened democratic institutions. Impeachment, our most powerful constitutional check on executive abuse, was rendered toothless.

Although the threat of an autocratic turn is real, especially if Trump is reelected, important sources of democratic resilience remain. The United States differs from Hungary, Russia, Turkey, Venezuela, and other recent backsliding cases in important ways. For one,

our institutions are stronger. The courts remain independent and powerful. Federalism remains robust. And within every agency that the White House has attempted to purge, gut, and politicize, committed professional civil servants have resisted vigorously. They may ultimately lose particular political battles, but their resistance slows democratic erosion.

Another difference is that America has a well-organized, well-financed, electorally viable opposition. That opposition includes not only the Democratic Party but also unions and a wide array of activist groups, new and old, that have organized opposition to the current administration's policies since the day Trump took office.

The strength of America's opposition was made manifest in the 2018 midterm elections, when Democrats won control of the House of Representatives, and it makes Trump's defeat in November 2020 a real possibility. If Trump loses, the immediate threat of a slide into autocracy will diminish.

Nevertheless, our democracy also faces a descent into dysfunction. America's system of checks and balances, which often brings divided government, only works with a degree of mutual toleration and forbearance. Indeed, although a return to divided government after 2018 brought welcome constraints on the Trump administration, it did not deliver anything resembling a well-functioning system of checks and balances. In the first year of divided government under President Trump, Americans witnessed the longest government shutdown in US history, a fabricated national emergency aimed at openly defying Congress, and an impeachment process in which the White House flouted subpoenas and other mechanisms of congressional oversight.

America's descent into democratic dysfunction prevents our governments from dealing with the most important problems facing our society—from immigration to climate change to healthcare. Ameri-

ca's botched, slow-moving response to the COVID-19 pandemic is only the latest and most lethal symptom of a political system that has been run aground by polarization.

The November 2020 election is critical. Trump's reelection would accelerate the destructive trends we have seen over the past four years: the erosion of democratic norms, the abandonment of established democratic practice, a sustained assault on the rule of law, and further entrenchment of partisan minority rule. If the Trump presidency were to extend until 2024, we fear American democracy would become unrecognizable.

Thus far, two built-in checks in our political system have failed to protect us against the rise of a demagogue. First, as we argued in *How Democracies Die*, Republican leaders abdicated their democratic gatekeeping responsibilities by allowing a would-be authoritarian to win their presidential nomination and then working to get him elected. Second, as noted above, our system of checks and balances has failed to prevent presidential abuse; in a context of extreme polarization, even the institution of impeachment was ineffective.

The failure of party gatekeeping and congressional oversight leaves us with one final institutional check: the November 2020 elections.

That is why the fairness of the 2020 election is of central concern. Prominent techniques in the autocrat's playbook are out of President Trump's reach: he cannot cancel the election, bar his rival from running, or steal it via outright fraud. However, he may be able to manipulate the election in a more subtle way.

The current public health crisis may allow the administration to deploy an unusual strategy of electoral manipulation that we term *malign neglect*. Consider this: whenever COVID-19 exists, the risks of in-person voting will lead many Americans to forgo voting altogether. Many polling station volunteers, who are typically older Americans, also will understandably choose to

stay home, which could force a dramatic reduction in the number of polling stations. As we saw in Wisconsin in April 2020, the result will be long lines, which will deter voters who lack the time, have difficulty standing for hours, or fear contagion. If conditions are severe enough, we could experience a steep fall in turnout, which could dramatically skew the results. And if the obstacles to voting are greatest in the cities, as was the case in Wisconsin, it could skew the results—without any actual fraud—in Trump's favor.

To protect voters' health and the fairness of the election, a vote-by-mail option should be available to all Americans who need it. Unfortunately, the White House has publicly opposed efforts to expand vote-by-mail options and in many states, the Republican Party challenged such initiatives in court.

We often assume that one must break or change the rules to subvert democracy. But this isn't always true. When changing conditions make it impossible to practice democracy as we did in the past, like when a pandemic makes in-person voting dangerous, *failing* to act—failing to update our rules and procedures—can itself subvert democracy. It is hardly illegal to *not* act or to *not* pass legislation. Maintaining our traditional voting system—one that has worked in the past—doesn't seem very authoritarian. Indeed, it may even seem prudent. Moreover, a chaotic, low-turnout election would violate no laws. Strictly speaking, it would be constitutional. But to do nothing at a time when a pandemic threatens citizens' ability to vote, potentially affecting the outcome of a presidential election, would be an act of malign neglect—and potentially the biggest subversion of American democracy since Jim Crow.

Democracy requires the existence of at least *two* democratically minded political parties. Thus, American democracy will only be secure when both major parties are committed to the democratic rules of the game. For that to happen, the

Republican Party must change. It must transform itself into a more diverse party, capable of attracting younger, urban, and nonwhite voters. A Republican Party that can thrive in a multiracial America will be less fearful of the future. Without the "win now at any cost" mentality of a party facing inexorable decline, Republicans will be more likely to embrace democratic norms.

Such changes are less far-fetched than they may appear; indeed, the Republican National Committee recommended them as recently as 2013. But the Republican transformation will not happen automatically. Parties only change course when their strategies fail. In democratic politics, success and failure are measured at the ballot box. And nothing compels change like electoral defeat.

But there is a hitch: countermajoritarian institutions like the Electoral College, the Senate, and the federal judiciary allow the GOP to hold onto considerable power without winning national popular majorities. These institutions may therefore weaken Republicans' incentive to adapt.

The only way out of this impasse is to double down on democracy, defending the right of all citizens to vote. Since the 1960s, Americans have taken important steps toward the creation of something few societies have achieved: a truly multiracial democracy. Barack Obama's presidency—barely a generation after the end of Jim Crow—was an unmistakable sign of our democratic progress. Those democratic achievements are worth defending. But they are now imperiled. It is a tragic paradox that our country's belated steps toward full democracy triggered the radical reaction that now threatens it.

Americans who are concerned about the threats facing our democracy must not only participate in the 2020 election but also commit themselves to protect our most basic democratic institutions, including voting and civil rights. The stakes are high. We have much to lose. +



The only way out of this impasse is to double down on democracy, defending the right of all citizens to vote.

To read a far more detailed version of this article, visit aft.org/hc/fall2020/levitsky_ziblatt.

One Person, One Vote

America's Ongoing Struggle with Our Most Basic Right



Discrimination and voter disenfranchisement are pervasive problems across America. The election of Barack Obama by a young, diverse coalition of supporters was followed by a new movement of voter suppression. Instead of actively trying to court this rising electorate, too many Republicans set about undermining the principle of “one person, one vote” so they could minimize the voting power of those who disagree with their views.

This work has been done using a number of tools, but the most prominent remain partisan and racial gerrymandering and stringent voter ID laws that overwhelmingly impact people of color and people who are poor. Voter suppression has allowed politicians to hold onto power despite often being out of step with voters on issues such as gun safety, climate change, reproductive rights, and funding for public schools and higher education.

Although gerrymandering has been around since the earliest days of America, what happened in 2011 was without precedent. GOP politicians used sophisticated mapping technology to draw maps that were some of the most anti-democratic in history. The effects were immediate. In 2012, Democrats won 1.4 million more votes than Republicans in races for the US House of Representatives, but

Republicans won a 33-seat majority.

Then in 2013 the US Supreme Court, in a 5–4 decision, opened the floodgates for a renewed attack on who can cast a ballot in America. Starting immediately after the decision, 19 states attempted to enact or successfully enacted voting restrictions like unnecessary photo ID laws. It's not a coincidence that the most gerrymandered state legislatures passed some of the most restrictive voter ID laws. In North Carolina, a federal judge found that a voter ID law targeted African Americans with “almost surgical precision.” Then, in another 5–4 decision, the US Supreme Court struck one more blow to voting rights in 2019 by refusing to rein in partisan gerrymandering.

Restoring Fairness

There are a number of avenues we can pursue to fight gerrymandering in the lead-up to the redistricting process that will take place in 2021. The organization I lead, the National Democratic Redistricting Committee (NDRC), will continue to use every tool at our disposal—reform efforts, litigation, state and local election victories, and citizen advocacy—to restore fairness to our democracy.

In 2018, citizens in Colorado, Michigan, Missouri, Ohio, and Utah supported ballot measures that would either create citizen-led independent redistricting commissions

or significantly reform the process to make it less partisan. Arizona and California, which already have citizen-led commissions, show that this is the best way to draw new lines because it removes power from self-interested politicians and gives it back to the people, where it belongs.


Politically, it is incumbent upon all of us to care more about the state and local politicians we elect. Not only do these people often have control over the redistricting process, they also control funding for education, health-care, and many other pressing needs. We should all pay more attention to these important local offices and the people we elect to fill them.

Election Integrity During the Pandemic

In 2020 and beyond, every eligible American should be able to safely cast a ballot. Throughout the spring and summer, many—but not all—governors, state legislators, and election administration officials took steps to

- Expand no-excuse absentee and vote-at-home measures.
- Make it easier to register to vote, including online options and same-day voter registration.
- Prepare for safe and healthy polling places, including extended early voting and curbside voting.
- Increase voter education so that people know all of the new options.

In other states, we have been forced to file lawsuits to expand access to the ballot and ensure that people are able to vote safely during the pandemic.

We need to stand up for our rights and use the most powerful tool we all have as citizens: the vote. Together, we—the people—can bring about a new era of progress and stay true to our founding ideals. 

By **Eric H. Holder, Jr.**

Eric H. Holder, Jr., who served as the 82nd Attorney General of the United States, is chair of the National Democratic Redistricting Committee (democraticredistricting.com).

To read a far more detailed version of this article, visit aft.org/hc/fall2020/holder.



ILLUSTRATION: LUCY NALAND
PHOTOS: GETTY IMAGES

Social Media, Free Speech, and the Scourge of Misinformation

History is full of ideas that were at some point considered heretical or deviant. The struggles for religious liberty, reproductive freedom, civil rights, and many other forms of progress were thwarted by restrictions on voicing what were once seen as dangerous ideas. For decades, laws prevented the dissemination of information about birth control; in 1929, reproductive freedom pioneer Margaret Sanger was arrested after giving a speech advocating women's rights. Not until 1977 did the Supreme Court extend full legal protection to the ideas Sanger was advancing, ruling that the First Amendment prohibited bans on advertising for contraception. Free speech protections have been essential to ensuring that champions of once-revolutionary ideas could make their case.

One of the most pitched free speech debates of the digital age centers on the degree to which online platforms should remove or hide offensive or harmful speech and bar its persistent purveyors from the platforms. Pandemic misinformation causes avoidable deaths. Cyberbullying contributes to rising teenage suicide. The glorification of violence influences perpetrators of assaults and killings. Targeted misinformation has skewed election outcomes, pulling the rug out from under democracy. With Google, Facebook, and Twitter holding dominions over vast swaths of public discourse, figuring out how to strike a balance that sustains what is best about a free

and open internet while mitigating its manifest harms has bedeviled Silicon Valley executives and civil libertarians alike.

Perhaps the most far-reaching, elusive facet of content moderation is that it occurs passively through algorithmic amplification of content that elicits the most user activity. Many analysts have argued that white supremacist, misogynist, and politically polarizing content has surged in the digital era because of the way algorithms are calibrated to serve us content we are most likely to view and share.

Platforms are also honing algorithms and artificial intelligence to screen impermissible content without human intervention. But machines can't always be trusted to make nuanced distinctions. YouTube removed a video channel tied to California State University, San Bernardino's Center for the Study of Hate and Extremism—a channel that was educating users about bigotry, not promoting it. Increasingly, platforms demote problematic posts, limiting how often they are seen without excising them entirely. While perhaps preferable to out-and-out deletion, this system creates a shadowy realm of quasi-censorship that is almost invisible to users.

Meaningful Accountability

Content moderation needs to be opened up to far greater scrutiny. Platforms must allow researchers to probe how content moves and escalates across populations, how it correlates with offline actions, and how

well countermeasures—including downgrading, fact checking, and algorithmic adjustments—work to counteract it.

Internet companies and civil society organizations should come together to ensure that, as companies take responsibility for cleaning up their platforms, expressive rights remain intact. With a reliable, universally accessible, and publicly accountable system to ensure that erroneous content removals could be quickly reversed, the prospect of companies becoming more aggressive with removals would be less worrisome.

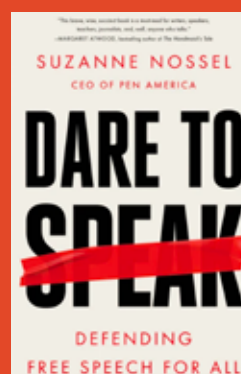
Until such a system is created, here are some steps you can take to be a responsible online citizen.

- Ask questions about how the platforms work and what they are doing.
- Voice outrage when user trust and expectations are breached.
- Don't share dubious content.
- Vote with your clicks—reject platforms that betray their responsibilities to society. +

By **Suzanne Nossel**

Suzanne Nossel is the chief executive officer of PEN America. This article is an excerpt from *DARE TO SPEAK Defending Free Speech for All*. Copyright © 2020 by Suzanne Nossel. Used with permission by Dey Street Books. All rights reserved.

To read a longer excerpt from *Dare to Speak*, visit aft.org/hc/fall2020/nossel.



This article is an excerpt of my new book, *Dare to Speak: Defending Free Speech for All*. The book was printed before the pandemic, but it gains additional currency in the COVID-19 environment. Whether in the context of disciplining doctors who tried to speak out in Wuhan, muzzling US scientists, or seeking to control disinformation and misinformation, free speech and open discourse have emerged as essential to countering this pandemic. —S. N.

WE'RE ON THE BRINK OF HISTORIC PROGRESS

As the nation is confronting three major crises, Joe Biden knows that “the darkest moments in America’s history . . . push forward some of the most remarkable eras of progress.”

In a conversation with AFT members at AFT’s virtual convention, Biden showed that he cares about working people and is ready to build a better America.

Rick Lucas, a registered nurse in Columbus, despaired at Trump’s disastrous response to the pandemic. “Many of us go home at night after our shifts without adequate PPE, unable to sleep because we’re not sure whether we are bringing COVID-19 home to our kids, our significant others or our aging parents,” he said. Lucas asked Biden what he will do to prevent this from happening again.

The Trump administration “ignored the warnings and failed to prepare,” Biden said, outlining a proper response that would have saved lives. Looking ahead, there must be a science-driven plan for producing and distributing a COVID-19 vaccine, he said. Biden’s plan will rely on the independent recommendations of scientists and public health experts and be fully transparent for review by the public.

Marguerite Ruff, a special education classroom assistant in Philadelphia, asked Biden about reckoning with racism. Ruff, whose son was murdered, said, “we took to the streets not only for George, but for all who preceded him.” She wanted to know how Biden would help fix the systemic racial injustice that plagues our society.

Biden, moved by Ruff’s experience and deeply empathetic since he has lost two children, said, “the country has had the blinders taken off.” Racial equity is a central part of the Build Back Better plan Biden has put forward, and he explained that it must be combined with economic opportunity and a healthy environment. Biden closed with his signature caring and decency:

“ I’M GOING TO DO MY BEST NOT TO LET YOU DOWN, I PROMISE. ”

Engage in the Election to Make a Difference

Visit AFTvotes.org to volunteer and learn more about using these tools to get everyone out to vote!

Election Day is only a few weeks away, and it will be like no other. We’ve had to rethink traditional Get Out the Vote strategies, but the work must continue. Volunteers—who make the difference in reaching and mobilizing voters—are needed more than ever.

We are proud to present different ways to help every member connect with, organize and engage other members, friends and family so that each one of us can make a difference in this election.

Peer-to-Peer Texting

Peer-to-peer texting is a fast-growing method of organizing, informing and engaging people. It harnesses the power of one-on-one conversations through text messages with many contacts. Engage in peer-to-peer texting to talk with your friends and family about the importance of voting.

Virtual Phone Banks

Virtual phone banks are an increasingly important way of reaching people and having conversations about the importance of the election. Talk with your colleagues and fellow members about getting out to vote.

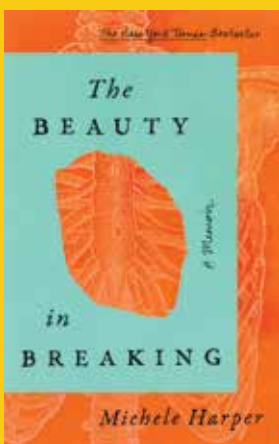
OutreachCircle

Relational organizing is one of the most powerful and effective ways of mobilizing people. It’s using all of our tools to engage our network of colleagues, family and friends. OutreachCircle makes it easier to engage and activate people in our network.

[#AFTvotes](https://AFTvotes)

aft BIDEN HARRIS





COVID-19 Amplifies Moral Injury

Caring for patients during the pandemic brings with it a host of complications beyond the challenges of inadequate physical protection: as a healthcare worker, how can you provide the best possible care to non-COVID-19 patients when attention and resources are focused elsewhere? How can you keep from passing COVID-19 to your loved ones? What do you do when you lack the resources to provide the PPE or treatments likely to save someone's life? These are examples of moral stressors, events that betray your deeply held moral convictions, and they can cause serious harm, undermining your ability to rest and restore yourself when you feel depleted.

Researchers in Canada and Australia have created a valuable resource to address these issues in *Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury* (<https://bit.ly/2D5ZY7g>). The guide supports healthcare workers who are experiencing complex psychological reactions as a result of the pandemic. It explores the possibilities for moral injury (including the relationship between moral injury and burnout), describes the potential short- and long-term effects, and provides strategies to be implemented at organization, team, and individual levels to prevent lasting harm.

Wanted: Equity in Drug Research

The COVID-19 pandemic highlights how critical it is that people of color and women be better represented in drug trials.

- “Racial Disproportionality in Covid Clinical Trials,” published in the *New England Journal of Medicine* (<https://bit.ly/2QuUy90>), focuses on two trials in which Black, Latinx, and Native American individuals were “substantially underrepresented,” despite their overrepresentation in positive COVID-19 cases and deaths. The article calls for prioritizing “inclusion of patient populations that reflect the demographics of the ongoing pandemic” and increasing funding for scientists from underrepresented ethnic groups.

- “Sex Differences in Pharmacokinetics Predict Adverse Drug Reactions in Women,” in *Biology of Sex Differences* (<https://bit.ly/32AOvoV>), notes that women experience adverse drug reactions at twice the rate men do. In their review of more than 5,000 studies of 86 different drugs, the authors found that dose recommendations ignored pharmacokinetic and dimorphic differences between men and women, leading to much greater risk of overmedication for women; women experienced more serious side effects than men and had higher drug concentrations in their bloodstreams with longer elimination times.

Perspective Matters

We cannot address the significant racial and gender disparities or fight injustice in health-related fields without understanding the barriers that deter members of marginalized groups from accessing—or remaining in—health and science professions. The memoir and novel genres offer unique paths toward this understanding because they allow readers to become immersed in the lives of others. Michele Harper's memoir *The Beauty in Breaking* and Brandon Taylor's novel *Real Life* (both from Riverhead Books) are exemplars in this regard.

In *The Beauty in Breaking*, emergency physician Harper examines the links between her personal experiences and larger structural and institutional issues. She looks at how racism, sexism, medical and societal neglect of veterans, and the struggle for civil rights play out in her own life and in the lives of the patients who come into her ED. As she braids these strands into one graceful whole, she also describes the intensity with which she focuses on self-care. For Harper, this looks

like exercise and a nutritious diet, meditation, reflection, and the study of Buddhist principles, all of which enable her to do her job well in the face of numerous challenges and stressors.

Taylor's novel *Real Life* relates the experiences of Wallace, a Black gay man from Alabama pursuing a PhD in biochemistry at a Midwestern university (a trajectory that roughly follows the author's educational path). Like Harper, Wallace finds himself in a community where the professional and the personal cannot help but overlap; one where he is often the only voice speaking up for himself, even among his closest friends; one where, even after several years, he often feels hopelessly alone. As Wallace puzzles through the challenges of his research, his relationships, and his own insecurities, Taylor's novel invites each reader to think about how their perspective shapes their relationships and worldview. It's essential reading, not just for those who work in health and science-related fields but for everyone who wants to build a more just, compassionate world.

AFT Sets a Bold, Progressive Agenda

At the AFT virtual convention in July, delegates passed bold resolutions to confront the crises our country is facing in healthcare and the economy and its long overdue reckoning with racism. To read the full set of resolutions, visit aft.org/about/resolutions.

Reimagining Our Society

The sweeping “Reimagining Our Society and Rewriting the Rules to Enable Opportunity and Justice for All” resolution provides a broad framework for the transformative change we need to fight for. The resolution outlines 15 principles to remake our society for the better, including access to good jobs protected by collective bargaining rights, a basic safety net, a robust public health infrastructure, and the free exercise of our democratic rights. It declares that “healthcare is a basic human right.... Our healthcare system must deliver high-quality care from cradle to grave, based on the needs of every community and not the profits of corporations.”

Healthcare as a Public Good

In our current healthcare system, the profit motive hamstring healthcare providers and harms patients; it ignores the social, racial, economic, and environmental factors that contribute to health and perpetuates disparities in health outcomes. It also drives up income inequality and allows more than 100 million uninsured or underinsured people to go without adequate care. The pandemic has further strained the system—exacerbated by the Trump administration’s chaotic and inept response. “A Healthcare System That Works for All by 2025” seeks to address these problems, calling for universal coverage and a transition to a system “driven by high-value, universal access; sustainable cost; accountability for outcomes; and choice.” It requires the AFT to focus its efforts on the structural flaws that make our healthcare system so inequitable, including fighting for healthcare professionals to have a say in the reshaping of the workforce.

Combating Infectious Diseases

Much of the convention debate touched on the challenges of dealing with COVID-19, but “Infectious Disease Emergency Preparedness Is Essential for Healthcare” looks beyond the present moment to the bigger picture. In addition to addressing federal protocols for COVID-19, it calls on the AFT to pressure “the federal government, states and employers to develop regulations and systems to prevent this mas-

sive failure to protect healthcare workers and the public at large from an infectious disease or other public health emergency from ever happening again.”

Focusing on the Social Determinants of Health

Delegates also passed several resolutions aimed at combating injustices that affect individual and community health and well-being. One of the biggest is “In Support of a Green New Deal,” which commits the AFT to fighting for reduced greenhouse gas emissions, supporting state and local renewable energy plans, helping workers transition to green jobs, and more, funded by a progressive tax on the rich and reduction in defense spending (except for veterans’ benefits). The resolution calls for “prioritizing projects, union career opportunities and investments in working-class communities, low-income communities, and communities of color, which, historically, have been disproportionately impacted by pollution, high unemployment, poverty and environmental injustice.”

In addition, following the AFT executive council’s June resolution “Confronting Racism and in Support of Black Lives,” which makes 19 commitments to combat structural racism and state violence against Black people, delegates approved “Enough,” a resolution that condemns police brutality and requires the AFT to push for a series of police reforms, including demilitarization, increased accountability, and the expansion of first responders to include mental health professionals, social workers, public health officials, and related experts. It also requires the AFT to do its own anti-racist work by mentoring members of color for leadership, providing anti-racist training, and holding fellow unions, particularly law enforcement unions and the AFL-CIO, accountable for similar changes.

Delegates also passed a resolution to protect a key determinant of health—access to employment—for transgender, nonbinary, and gender nonconforming workers. While the Supreme Court ruled in June that they are protected from firing because of gender or sexual orientation, these workers still face discrimination. “Support for Transgender, Nonbinary and Gender Nonconforming Workers” requires the AFT to collaborate with transgender, nonbinary, and gender nonconforming communities to collect information on existing protections and needs related to the workplace, housing, and everyday life, and to develop a set of best practices for supporting and advocating for these workers, to be shared with locals.



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TRAUMA COVERAGE

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