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Debate

The planet in our backyard: Public health should step up

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Editorial

Under the Trump-I administration, the USA suffered an excess mortality of more than 1.3 million deaths due to the COVID-19 pandemic (1,2). As a result, the country faces a decline in life expectancy across all age groups. This is the first time in history that human health at an aggregate level is declining in a country. In the USA, over a million people and their families have suffered avoidable tragedy that is to a large extent politically determined (3). Yet, the American people chose to elect the culprit for this disaster for a Trump-II government. In an avalanche of Executive Orders that escape democratic checks and balances, this President chose to cease and cancel institutions and mechanisms. These actions have resulted in a new flood of avoidable death and destruction, around the world, and eventually in the USA itself. The funding freeze of PEPFAR will lead to at least 150,000 avoidable fatalities in some of the most vulnerable populations of the world (4). The swathe of cancellations and policy disruptions that withdraw public sector support for protection of the environment, climate, water and soil quality and ecological systems (5) is of an almost evil nature. When Trump-I withdrew from the Climate Change accords in his first term, lower-level US governments (at state, county and municipal levels) quickly stepped up to develop and implement their own climate resilience programmes. Trump-II learned from this 'set-back' and enacted (again, by Executive Order) a broad package of policy interventions that would make it impossible for such authorities to fund their own actions (6). *Making America Great Again* (MAGA) is not only a lie [as is Robert F Kennedy Jr.'s *Making America Health Again* (7)], but these actions severely compromise global ecological health.

At the same time, a greater awareness is growing of gender biases in medical research and its evidence base for clinical and public health action. Australian newspapers report on a phenomenon conveniently labelled 'medical misogyny' (8): - the incapacity of the medical-industrial complex to recognise variability across the human race, and in particular between sexes and genders. Women, the reports say, are suffering from ignorance, bias, malevolence and ill will of doctors and pharmaceutical industries. But something decidedly perverse is going on here. This is not a new discovery. In the 1960s and 1970s the emancipation movement birthed women's health activism, and generations of women (initially in high income countries, and later joined by groups across the world) were inspired by the writings of the Boston Women's Health Book Collective and its sisters elsewhere (9). The rallying cry *"my body, my choice"* is no longer consider an exotic demand, but rather a statement of factual justice. And yet, ignorance about 'medical misogyny' is rife, and in some parts of the world old-fashioned and unhealthy attitudes to people's (and in particular women's) self-determination re-emerge. This ranges from obvious gender obscenities in Afghanistan (10) to the bizarre emergence of groups of women who insist on being suppressed and dominated by patriarchal value systems, the 'tradwives' (11). The Christian orthodox social and funding base of Trumpism (12) is facilitating such developments by, e.g., allowing the toxic masculinity of the Tate brothers (13),

and blatant violation of the human rights of gender dysphoric people in the United Kingdom (14).

The public health movement must have taken a wrong turn somewhere.

Advocacy and activism for (ecological, population, and individual) equity is supposedly embedded in the genes of our profession. So - where is the scholarly activist (15) adherence to the classic definition of our field by Winslow (16), "*the science and art of preventing disease, prolonging life, and promoting mental and physical health and efficiency through the organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of social machinery to ensure to every individual a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity*"? Admittedly, we have evolved. There is no longer a handful white, elitist Schools of Public Health in OECD nations. There are thousands of public health training and advocacy institutions across every part of the world. We write nice pieces about the necessity to decolonise (17), and to act more politically (18). Our professional associations are organised well (19) and share important views regularly in meetings and conferences, enabled by technology spanning the planet. The evidence base for critical public health interventions (and public health functions) is abundant and irrefutable.

And yet – to the fate of the planet, our actions seem to remain abstract and insignificant in the face of brutal Trumpism, war (in the Middle East, Ukraine, Congo, Sudan, Myanmar) and climate destruction. The recognition, emerging from the COVID-19 period, that Earth's biosphere, geosphere, atmosphere and hydrosphere (indelibly altered by the anthroposphere…) are a delicate and yet resilient complex ecosystem is taken for granted (20), rather than broadly re-formulated as an *activist* agenda for inclusive and planetary public health.

Why do we, established health scholars, not stand with groups such as the Peoples' Health Movement (21) more concretely and militantly? Where are the civil society groups, the affected communities, the disenfranchised in slums and institutions that advocate for radical change – supported and inspired by that growing public health world I suggested exists across thousands of educational and research facilities? Why do individuals and electorates around the world seem to farewell the key principles of public health (as an art and community effort) and allow for division, hate, misogyny, racism and violence? And why are we, public health professionals and leaders, not able to speak out in one voice to counter that obscenity?

Perhaps it is useful to channel the words of another Kennedy, JFK, who said (22) "*We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win, and the others, too.*" More than anything, what this quote shows is that our business should not be one of facts and evidence alone, but one of vision and ideals – and therefore politics: in our case, about equity, solidarity, resilience and

sustainability. Yes – public health is politics, since the times of Virchow *("Medicine is a social science and politics is nothing else but medicine on a large scale")* and before.

But we fail to meaningfully embrace this recognition as a community (23). We need to leave the rhetoric and actively *engage* in politics. We need to organise our communities and others'. We need to show and act on our solidarity with the disenfranchised, the alienated, the excluded and move beyond the simple epidemiology of, for instance, race, colonialism and gender differences. We need to work, visibly and tangibly, with people [and ecosystems! (24)] under threat. We have the arsenal of knowledge and tools to do this – from community organisation to citizen science, and from very large data sets showing disgusting inequality to networking capability.

A call to action – or perhaps a wake-up call – for our community could include the following emphases:

- Network and connect like-minded civil society actors and institutions more meaningfully. This includes the health, ecology, urban planning, sustainability and wellbeing spheres, but to be meaningful, such a network needs to embrace key industries (25) and philanthropies, too. Our bodies, including the World Federation of Public Health Associations (WFPHA), the International Association of National Public Health Institutes (IANPHI) and the Agency for Public Health Education Accreditation (APHEA), should establish working parties to reach out to these – sometimes unlikely – friends and allies.
- Some of these friends and allies should be consulted and empowered to consider novel funding mechanisms in more feasible and concrete terms to ascertain global public and ecological health capacities independent from conflict and political whim. This could be, for instance, a small flight ticket solidarity levy (26) that could be compensated through a carbon emissions trading dimension.
- Neither of these courses of action would yield anything without better advocacy and communication prowess. Facts matter, but the stories around the facts matter even more. We will need to understand, with our friends and foes, what stories mobilise and sustain action for true global health and ecological solidarity. Research organisations should be enabled to develop such capacities, including through the training of Large Language Models (i.e., Artificial Intelligence) for equity and solidarity. The Montreal Declaration (27) should remain the pivotal guidance for the development of such capabilities to avoid bias and abuse (28).
- These actions and priorities should be documented and assessed transparently and accountably, published in relevant journals and news outlets, and endorsed by networks of inclusive knowledge institutions (e.g., 'Slow Universities' (29)).

We cannot allow ourselves to see political and health developments in a country such as the United States of America as parochial or separate from our collective fate, health and wellbeing. The slogan 'think globally, act locally' is as valid as ever – and it means that the planet and its integrity start in our backyard.

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