Trust is a great privilege that, for many, affords a great health benefit. However, trust in the governments and institutions tasked with sustaining infrastructure, providing fundamental needs, and producing knowledge has eroded so transparently in the backdrop of the major events of 2020—the COVID-19 pandemic, the U.S. election, civil conflicts across the world, and global uprisings to state-sanctioned violence. It is in these times that experience becomes a highly effective teacher. And this year’s lesson is on the public health consequences of public mistrust.

**Health and the Social Contract**

Nineteenth-century German physician Rudolf Virchow, the founder of modern pathology, provides a simple framework for understanding the role of the state: “Medicine is a social science, and politics is nothing more than medicine on a grand scale.” Political philosophy has long mused on the social contract between the government and citizens, whereby the state yields power and sovereignty on the population that in exchange is provided security and means of living. There is an observable and undeniable role of government in health and welfare, from food, drug, and transportation regulation to sanitation infrastructure. Public health, being a vast, interconnected enterprise of disease prevention and health promotion, is intimately tied to these institutions, for they allocate the means, services, and resources that impact health. Trust in the state from its citizens is critical to uphold the social contract. Current, record U.S. opinions during the pandemic reflect this dynamic—Americans simultaneously want their government to play more of a role in solving the country’s problems, though their trust in the government to do so is near an all-time low. Distrust in these systems, traditionally by ethnic minorities and vulnerable peoples—and now increasingly by the bottom rung of the socioeconomic ladder fashioned by income inequality—has a significant effect on population health.

Historic distrust in medicine and government is associated with poor health outcomes by way of decreased health-seeking behaviors, diminished adherence to evidence-based interventions, and lower self-reported health. Enduring and insidious health disparities in maternal health, sexually transmitted infections, life expectancy, and diabetes among Black Americans can be partially accounted for by such suspicion of the formal medical establishment. This wariness is founded by past experimentation, exploitation and failure of government action to address health and climate disasters, with Hurricane Katrina and the Flint drinking water crisis serving as prominent case studies on environmental injustice. A parallel historical context and its consequences also persist within indigenous communities in the U.S. Harmful government intervention, often under the guise of public welfare, continues today with its consequences divided across demographic lines. The intrusion and rise of state surveillance, disproportionately felt by minority and low-income communities through urban, racialized policing and excessive discipline and control via social welfare programs, represents a modern abuse of state power in the present era of Big Data. However, the broader phenomenon of distrust is not limited to the U.S., nor are its impacts.

**A Global Phenomenon**

Demonstrations objecting to police violence and the greater carceral state is another, quite topical, dimension of the social contract’s failure to extend to particular communities. Government corruption that violates the state’s role in ensuring security and safety lends itself to diminished trust, as evidenced by the unrest in Nigeria objecting against the Special Anti-Robbery Squad, heightened by existing negative sentiments towards the state of the nation’s democracy. The 2014-2015 Ebola epidemic in Liberia provides further attestation that government distrust, most prominent among those with economic hardship, results in less compliance in mandated control policies and precautions. Similar dynamics of low trust in governments and public institutions, encompassing political systems, police, and legal
Looking ahead, the COVID-19 pandemic itself may exploit existing distrust among groups, including the particular example of refugees and migrants. The power wielded to implement restrictions on movement for the purposes of disease mitigation may lay the preliminary groundwork to erode existing human right precedents, doubling down on highly restrictive migration policy, furthering distrust among people on the move. Border closures, lockdowns, restrictions on travel, and temporary suspensions of refugee and asylum resettlement serve dually as COVID-19 protection measures and, paradoxically, mechanisms of indefinite detention, expulsion, and increased infection risk due to unsanitary conditions and health service scarcity.

The Underclass, Science, and Skepticism

Income inequality has itself been established as an integral factor in infectious, noncommunicable, and injury-related health outcomes, particularly among children and young people in low and middle-income countries. The increase in income inequality globally has produced a disenfranchised public, liable to the social, psychological, and economic toll of the pandemic and resentful of their governments. This has resulted in a growing hostility toward the “elitism” of expertise and science as well as a propensity to misinformation, rising from concerns over misaligned incentives between profits and politics and serving in the public interest. Such misinformation, and intentionally deceptive disinfection campaigns, are peddled through siloed social media and internet feeds that undermine health communications and scapegoat the “other” erroneously aligned with “disease.”

The rise of populism often pinned on economic and social anxieties defines the present political zeitgeist and threatens the whole endeavor of public health, which relies on a cooperative global citizenry. And while misinformation is not an unimportant concern, as public health messaging on COVID-19 competes with conspiracy thinking in the virtual space, the public health guided pandemic response has positively swayed global public opinion on the essential role of government investment in research and the merits of science. This is particularly encouraging as COVID-19 vaccine creation and distribution efforts continue to reduce infectious disease morbidity and mortality, which rely on conceptions that science and scientists are serving fundamentally in the public interest. Despite this, there must be efforts to maintain a belief in science and medicine beyond the current public health crises.

Politics as “medicine on a grand scale” lends itself to a politicization of public health. But, political systems and government actors have not and often do not reliably act in good faith or in accordance with the social contract, leading to a crisis of confidence in their legitimacy. This mistrust has implications for the effective application of public health and, by extension, progress toward health equity and justice. This has been grossly apparent during the COVID-19 pandemic, as economic concerns took precedence over health, with public health and science falling to the wayside as political actors stand out front and take hold of the narrative. Public health professionals must now continue to engage more explicitly with politics and stand more visibly on the political stage by leaning into advocacy, adopting transparency, engaging in community-based and culturally informed participatory research, building coalitions, and becoming better communicators of science.

References


