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Pandemic lessons for the 2024 US presidential election

Improving public health and averting mass death in the next crisis require systemic reforms

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During the devastating global covid-19 pandemic, one nation stood out: the United States saw "eye wateringly high" death rates compared with its peer nations.[1] The 1.16 million Americans killed by covid-19 represent 16% of global deaths in a nation with 4% of the world's population.[2] One in three Americans knows someone who died from covid-19,[3] about 300 000 children are estimated to have lost one or both parents,[4] and there is a substantial burden of long covid.[5]

TheBMJ's new series on the US covid-19 lessons (www.bmj.com/collections/us-covid-series) highlights the societal actions that are needed to prevent the loss of another million citizens in the next pandemic and improve and protect population health more broadly. The authors of the articles in this series call for a set of crucial systemic reforms that we believe should be central to the manifestos of the 2024 US presidential candidates. The series follows previous *BMJ* series to inform the UK's covid-19 inquiry (www.bmj.com/covid-inquiry) and on accountability for Canada's covid-19 response (www.bmj.com/canada-covid-series).

Causes of pandemic chaos

The US series documents the many complex, inter-related causes of the poor US pandemic response, underpinned by two key contexts. The first is the nation's pre-existing structural and systemic features, which magnified the pandemic's impact. These include gaps in healthcare and public health systems, the absence of social safety nets and workplace protections, social inequality, and systemic racism. These same features also contribute to the US's poor performance on many health indicators compared with other wealthy countries.[6] From 2010 to 2019, even before covid-19, US life expectancy stagnated while it rose in its peer high income nations,[7] and inequalities in health and healthcare widened.[8]

Over the same period, the US Centers for Disease Control and Prevention had funding for its core budget and public health emergency preparedness activities reduced.[9] From 2010 to 2020, per capita spending for state public health departments fell by 16% and for local health departments by 18%.[9] With the Trump government bungling the federal response,[10] hollowed-out state and local health departments were poorly equipped to step into the breach.[9]

Ingrained inequalities contributed to devastating pandemic outcomes. The US has greater income inequality and more limited worker protections than its peers,[11] and precarious employment was on the rise even before covid-19.[12] These are key reasons why the nation saw higher covid-19 mortality rates than its more equal counterparts,[13] and why pandemic death in the US was so closely patterned by social class.[14] In addition, a history of pervasive structural racism manifested across many aspects of society, which, unsurprisingly, resulted in stark racial inequalities in the US in who lived and who died.[15]

A second context is that while the US had many scientific resources, exemplified by the success of Operation Warp Speed in accelerating vaccine development and the Covid-19 Prevention Trials Network in mobilising critical research, government at many levels showed a surprising inability to generate reliable information, communicate it in a timely and consistent manner, and translate it into sound policy. These failures began at the top. President Trump lied endlessly about the pandemic,[10 16 17] with dreadful consequences.[18] His suggestion of injecting disinfectant into people infected with covid-19 came to symbolise the chaotic presidential communications in the pandemic's first year.[19]

Despite its scientific resources and decades of pandemic preparedness exercises, the country struggled to generate scientific evidence on viral transmission and the coordinated policies needed to prevent such transmission. Poor communication of existing evidence also contributed to confusion and delayed or inappropriate actions, contributing to the partisan difference in how quickly US states instituted public health protections and in excess death rates during the pandemic,[20] especially after vaccines became available.[21]

The absence of timely evidence and delayed or incomplete communication of what was known also led to over-reach, which itself had harmful consequences. For example, even after studies had shown that fomite transmission was rare and transmission outdoors was much less common than indoors,[22 23] some municipalities and states kept parks, playgrounds, and beaches closed. Even after research had shown that schools could be reopened safely with basic public health measures, too many jurisdictions kept teaching online only.[24] Too often, there were failures to learn from evidence based harm reduction approaches that have been successful in curbing other pandemics, such as HIV/AIDS.[25] The communication failures were compounded by federalism—the division of power between the national government and the 50 US states—which ensured that the covid-19 response depended on zip code.[26]

Successes to build on

But despite these failures, the pandemic also showed the US how government and society could have a different role in protecting health. In addition to rapid vaccine development, which was publicly funded, many public policies were put in place that helped to support citizens and curb deaths. These included expanded unemployment benefits, food assistance programmes, a moratorium on evictions, expanded child health insurance coverage and Medicaid enrolment, and federal funding for public school upgrades. These strategies had measurable social and health benefits.[27] Of special relevance to the 2024 US presidential election, they illustrate how a range of government actions, beyond health insurance, can be critical to protecting health in the next pandemic and beyond.

The *BMJ* series includes articles on the effects of systemic racism and economic inequality; mass incarceration and poor prison health; labour market inequalities; legal infrastructure; and the diminished role of the public sector. The aim of the series is not to assign blame—there is plenty to go around—but to look to the future and lay out the critical steps to transform US public health and preparedness and improve population health more broadly.

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Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following. ADR and GY served as guest editors of *The BMJ* series. GY has received research funding to his institution to study pandemic preparedness and response from WHO, Bill & Melinda Gates Foundation, Carnegie Corporation of New York, UN Economic and Social Commission for Asia and the Pacific, the Economic and Social Research Council, and the Duke Global Health Institute. He was a member of the covid-19 vaccine development taskforce hosted by the World Bank, and participated as an unpaid academic adviser in the consultation process that led to the launch of Covax. He was an unpaid adviser to the Justice Collaborative, helping to organise open letters to the Trump Administration and to North Carolina's governor, signed by public health experts, calling for decarceration during the covid-19 pandemic. In a legal case in which seven Manitoba churches and three individuals argued that Manitoba's public health measures violated their charter rights, he provided unpaid scientific guidance to the legal team that argued in support of public health measures. He writes an unpaid column for *TIME* magazine. ADR declares research funding to her institution to document and study health inequities in covid-19 related outcomes. She also served on the 2020 National Academy of Science committee producing a framework for equitable allocation of vaccine for the novel coronavirus.

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