



Power Matters: Transforming Systems to Advance Health and Equity

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Across the country, public health departments have been moving their practice further and further upstream to address the root causes of health inequities. Over the last decades, we've evolved from a focus on behaviors to a focus on the social determinants of health. More recently, many have been exploring how various forms of oppression — especially racism — impact health and health equity. Now some public health departments are starting to take action on the root of the root causes: power. **For public health, the next step in our evolution is to understand and focus on the role of power in transforming the systems that create health inequities.**

Inequity is a structural problem. Health inequities — which are defined as systemic, avoidable, unfair, and unjust differences in health outcomes — result from inequities in the social determinants of health. These, in turn, are created by the class, racial, and gender structures that define our society. **But what defines and drives the class structure, the racial structure, and the gender structure in the United States today? Why does the answer to this question matter for health and health equity? And what does it mean for the way we do our work?**

Movement strategist Richard Healey posits that power is “a way of describing a set of relationships between and among people, taking place within a historical context and through social structures.” Simply defined, power is our ability, as individuals and as communities, to produce an intended effect.

Let's examine two health-related inequities — access to paid sick days and occupational injuries. By exploring the progress (or lack thereof) that has been made in these areas over the last decade, we can start to understand how power relationships structure our society in ways that lead to inequities and why building power is an essential — and legitimate — way of advancing health equity.

We know that low-income people, recent immigrants, and Latinx people are disproportionately more likely to suffer occupational injuries and fatalities in industries like meatpacking. Similarly, we know that many people working low-paying service jobs,

including 85% of restaurant workers, lack paid sick days to care for their families or themselves when ill. This increases the spread of influenza and norovirus, unnecessary emergency room visits and hospitalizations, and emotional and financial stress on workers and their families.

The relationship between workers and the owners of large corporations defines our class structure. Running meat-processing lines at higher speeds leads to higher productivity and higher profits, but is known to be unsafe. Not having to pay workers for time they are sick means that corporate owners increase their short-term profits, but research has shown that providing paid sick days in fact decreases the high cost of turnover and increases productivity. In both cases, owners of large corporations may benefit financially in the short term from creating and maintaining the policies that lead to inequities.

How do the workers facing inequities make their voices heard? How do they hold key decision makers accountable and shift policies and systems to advance equity? Over the last decade, paid sick days advocates have won victories at the local and state level all around the country. Workers in industries with high rates of occupational injuries have not. Why?

In the case of both paid sick days and occupational injuries, advocates face a pervasive, dominant narrative created and maintained to keep corporate owners in the driver's seat: society must do everything to improve the economy and create jobs; the free market is the best mechanism for this; private industry is efficient; government and government regulation are inefficient; anything that interferes with the free market will kill jobs; organized labor is corrupt and also kills jobs. This narrative presents the issue as workers versus business and the economy and suppresses a different narrative, one that focuses on society and government setting up rules that create a fair and inclusive economy that works for all, not just a select few.

Owners of large corporations have created powerful alliances like Chambers of Commerce around the country as vehicles through which they can work together to achieve their goals. Both individually and through these alliances, corporate owners propagate the dominant narrative and make large campaign contributions, giving them influence over elected officials and the ability to shape the political agenda, often in the form of less regulation — regulation designed to maintain the checks and balances between worker interest and corporate interest.

Paid sick days advocates have been able to counter these corporate advantages by using power-building strategies so those most impacted by the lack of paid sick days could hold elected officials accountable and bring about legislative change. For example, restaurant workers (e.g., Restaurant Opportunities Center), Latina women (e.g., Mujeres Unidas y

Activas), and mothers (e.g., MomsRising) organized. These groups listened to their members about the issues that affect their lives, built members' skills and leadership, worked with them to develop policy solutions, and built their collective voice to demand change. They also formed alliances (e.g., Family Values @ Work nationally, and its member group, the California Work and Family Coalition) with organized labor and other advocates and with small business owners. These broad and diverse alliances further amplified community voices and successfully put forward a different narrative that gained prominence, one based on facts and evidence. This narrative argued that the lack of paid sick days affected everyone's health and well-being — not just restaurant workers, but anyone who eats in a restaurant; not just day care providers and nursing home workers, but anyone with a child in day care or a parent in a nursing home.

Elected officials felt the pressure: **those ingredients — organizing, alliances, and narrative change — led to the passage of paid sick days legislation across the country.**

Public health played a key role in achieving paid sick days policy change by providing advocates with data about disease outbreaks and avoidable hospitalizations, contributing a public health lens to the transformational narrative, and by advocating publicly and giving testimony in favor of paid sick days. Public health was not the lead on this health equity issue, but by building on existing, trusting relationships with organizers and following their leadership, public health was able to evolve its own practice into the realm of building power.

Similar progress hasn't been made around occupational injuries, though they have huge impacts on workers, their families, and their communities. Corporate owners have used government to successfully limit the influence of unions like United Food and Commercial Workers that represent many workers in the meatpacking industry across the country. New worker or community organizing groups and alliances have not yet gained strength, and the role of OSHA (Occupational Safety and Health Administration) has been limited to activities like inspections and educational efforts, at least partially due to a lack of funding. As a result, the dominant narrative and regulatory environment have not been disrupted.

Public health could choose to take on a leadership role around inequities in occupational injuries, building power for transformational regulatory change. We could support new models of organizing (e.g., among immigrants) as well as organized labor, providing data, capacity building, and/or resources to build worker power. We could use public health's convening power to form alliances among these organizing groups and between them and other potential allies. And we could develop and propagate a transformational narrative that focuses on creating an economy, and in particular a food industry, that support

everyone's health and well-being, and through which food workers and consumers, as well as their families and communities, thrive.

All of these activities are part of public health's mission, as defined by the Institute of Medicine, of "assuring the conditions in which people can be healthy." We just need to choose to do this work and build our capacity to do so.

From these examples, we can see that the power structure between people who control capital and people who must work to earn a living defines our class structure, and that public health can play a role in changing those structures. Similar stories can be told about other pervasive and oppressive power structures that systematically create and re-create health inequities generation after generation.

The power structure between men and people of other genders — women, trans people, and those who are gender non-conforming — results in inequities in such areas as reproductive health outcomes and access to health care. We have a cultural narrative that allows Viagra to be covered by medical insurance while "period poverty" is a concept virtually unknown — even as women continue to earn considerably less than men.

Racial power structures are complex. The dominant structure is the one between White people and other racial or ethnic groups — Black, Latinx, MASA (Muslim, Arab, and South Asian), and others. Corporate capitalists and their allied politicians, with the complicit support of other White people, use policing and incarceration, voter disenfranchisement, racial anxiety, fear and hatred, and the diverting of societal resources away from communities of color to purposely maintain power through racialized hierarchies. There are also power dynamics between communities of color. White people strategically stoke those — for example by furthering the myth of Asians as a "model minority" — to ensure that communities of color do not join together (or with low-income White communities) and increase their collective power. These racial power structures have catastrophic health impacts on communities of color, which, on a population level, have higher rates of every chronic disease and shorter life expectancy.

Health outcomes track along many other dimensions of identity — ability, sexual orientation, etc. These inequities all share as a root cause power structures that advantage one group over another through laws, policies, cultural norms, and practices that simultaneously feed into and re-create oppressive systems that profoundly shape our opportunities and our lives as individuals and communities.

This is not an accident, nor does it have to be this way. The civil rights movement demonstrated how people power can exert a force strong enough to course correct societal injustice.

An analysis of power requires considering how it manifests according to dimensions of particular identities. **Power imbalances, though, are not inherently about dimensions of identity, but about people manipulating those identities to maintain power and control over resources and society.** We must recognize that White supremacy is fueled by politicians and parts of the corporate conservative infrastructure that perpetuate and then take advantage of anxiety about difference in order to augment their power, divide working people, and ally some sections of the White working class and poor to their side.

Power relationships are dynamic and change over time. At various points in US history, workers have exerted more power through organized labor than people who control capital. Recent years have seen a decline in worker power through unions, and some rise in power through worker centers and other new organizing formations. The LGBTQ+ community has made tremendous progress over the last two decades. Yet since 9/11, the power of White people compared to the MASA community has increased with the use of state violence and policing as well as policy change like the Muslim travel ban. Increased surveillance of MASA communities has, in turn, led to increased use of surveillance in policing across the board, but particularly in Black and Latinx communities.

Simply put, power, as a driver of our class, racial, and gender structures, matters for health and health equity. Power structures — maintained by people with power, including people in public health — lead to community conditions in which only the few can thrive and be well, to a health care system in which not everyone has equitable access and outcomes, and directly to health outcomes that result from how people cope with discrimination and feelings of lacking agency. Public health research shows us clearly that the degree of power and control we have as individuals and communities has a direct impact on our health outcomes. And that power concentrated in the hands of a few, and the inequality that follows, hurts the health of everyone in our society, of every racial group, class, gender, and identity.

If we do not help build and support the people power that can change these underlying structures, we will fail to make long-lasting changes that benefit communities facing inequities. **Power structures are the key feature of our society that public health must play a part in transforming so as to advance health equity.**

As others who have studied power have found, we must change who is in charge, making the rules, and dictating who has to follow them. We must redefine what is on the political agenda, moving resources from those who benefit from inequity to those struggling to thrive. And we must shift people's worldviews, expanding what together we can imagine as possible.

Paid sick days advocates did all of this very well, with support from public health. Public health can help lay the groundwork for this kind of change around occupational injuries and so many other health equity issues. Public health can work with organizing groups, build alliances, and shape narratives that center the well-being and health of all people. Public health can do all of this and more. The question is: how willing are we?

Government plays a key role in brokering power dynamics. It is the only entity with sufficient power to contend with corporate power and racist and oppressive practices, and to advance equity. It can also promote community and worker organizing and other expressions of participatory democracy and economics. But government is also contested and, as we have witnessed lately, when it comes under reactionary and/or corporate control, it can be a source of oppression and violence and can be used to maintain current systems of inequity. While we may not want to be part of such an institution, given its unique position, we must work from within to use government's power to advance equity and democracy.

Public health — and particularly governmental public health — has a vital role in shifting power relationships. We must:

- Support community organizing with our resources, data and analysis, and ally-ship
- Contribute to building alliances that cross race, class, gender, and other dimensions of identity
- Use our convening capacity and political capital to shape the political agenda
- Partner with others to shift dominant public narratives and help people recognize the value of radical inclusion, interdependence, participatory democracy, a market that serves the common good, and other key underlying beliefs that advance health equity

Public health must also build its own power in order to be a stronger ally with communities facing inequities and to fight those who benefit from continued inequity.

Public health is in the exciting process of rapidly evolving our understanding of health equity. We know we must center changing structural racism, poverty, patriarchy, and homophobia in order to create community conditions in which everyone can thrive. To achieve health equity, we must change power structures. This is our fundamental work.

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