Supporting Solidarity: Public Health's Role in Achieving Social Justice

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ABSTRACT

Solidarity is a concept increasingly employed in bioethics whose application merits further clarity and explanation. Given how vital cooperation and community-level care are to mitigating communicable disease transmission, we use lessons from the COVID-19 pandemic to reveal how solidarity is a useful descriptive and analytical tool for public health scholars, practitioners, and policymakers. Drawing upon an influential framework of solidarity that highlights how solidarity arises from the ground up, we reveal how structural forces can impact the cultivation of solidarity from the top down, particularly through ensuring robust access to important social determinants of health. Public health institutions can support solidarity movements among individuals and communities by adopting a lens of social justice when considering public health priorities and, in turn, promote health equity.

Keywords: Solidarity, Public Health, Health Equity, COVID-19, Autonomy, Social Justice, Priorities, Bioethics

INTRODUCTION

Over the past two decades, scholars have invoked the concept of solidarity when assessing a wide range of topics in bioethics, from CRISPR-Cas9 technology to organ donation to structural racism.[1] However, the growing literature on solidarity has not fully examined the roles and responsibilities of institutions and governments in fostering solidarity, especially regarding public health measures that implicate entire

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populations. We argue that it remains unclear how public health institutions should engage with solidarity and how their engagement will affect public health and its ethics. We first take Prainsack and Buyx' three-tiered framework as an analytical starting point.[2] We then explore how public health institutions can foster solidarity by carefully considering factors that may bolster it on an interpersonal, community, and national scale. We conclude that public health institutions should adopt a lens of social justice to promote solidarity at the interpersonal and community levels, thereby promoting equity in future public health efforts.

BACKGROUND

Calls for solidarity in bioethics raise longstanding normative questions about the nature and limits of our duties to one another and how to weigh autonomy over considerations of justice.[3] Though the term is diversely applied, Prainsack and Buyx propose a potentially unifying definition in the 2011 Nuffield Council report, "Solidarity: Reflections On An Emerging Concept in Bioethics." The report defines *solidarity* as an activity involving "shared practices reflecting a collective commitment to carry financial, social, emotional, and or other 'costs' to assist others." Their conceptualization also includes important features that distinguish solidarity from other values like empathy or altruism: solidarity emphasizes action rather than mere internal feeling and recognition of connection as motivation.[4]

Bioethicists have since applied this conceptualization when analyzing issues in public and global health, given that population-level efforts need cooperation from individuals and communities. Prainsack and Buyx further note that solidarity is relevant in bioethics discourses about justice and equity, in support of providing aid to low- and middle-income countries, and as a value exemplified by European welfare states.[5] Other bioethicists have argued that promoting solidarity can contribute to community engagement, partnership with Tribal communities, and global health equity.[6] Most recently, scholars have applied solidarity as a lens to assess the COVID-19 pandemic, highlighting the pitfalls of national mitigation efforts and global disparities in disease outcomes.[7]

I. Solidarity at Three Levels

It seems impossible to foster solidarity in public health if we cannot identify it in general contexts. Prainsack and Buyx articulate three levels of solidarity: interpersonal solidarity, group solidarity, and legal or contractual codifications of solidarity.[8] They argue that each level inherently informs the one 'above' it in a unilateral direction. In other words, solidarity is fundamentally a bottom-up phenomenon. Solidarity among individuals influences group norms, which then have the potential to shape policy and institutional practice.[9]

Within the Prainsack and Buyx framework, it would seem nonsensical to posit how solidarity might be expressed vertically or from the "top down." It appears intuitively odd to imagine how a government entity might 'be' in solidarity with a person or group if solidarity requires some cognition about their condition per Prainsack and Buyx' definition. Some have argued that solidarity does not seem like something that one can impose, as instances of it arise from agents recognizing and acting upon some bond rather than in response to a command. Indeed, people may be rightfully hesitant to engage in solidarity if the official messaging is overly paternalistic or coercive.[10] However, some authors have countered that governments can express solidarity through enacting structural and policy changes, though it is ambiguous how these actions are distinct from a justice-driven approach.[11]

If a bottom-up approach is thus the most practical means of achieving policy that reflects solidarity, then it does not add much to public health. Institutions would be ineffective without the population's initiation of

the corresponding social norms. However, we find this conclusion overly pessimistic. Fostering a culture of solidarity to improve public health has potential merit. Prainsack and Buyx' framework overlooks how public health actors can influence solidarity between individuals and across communities. To clarify, we agree with the view that solidarity is a bottom-up phenomenon. Solidarity may not be able to *originate* in a top-down fashion, but we suggest that public health institutions can take a more active role in providing the public with accurate information, promoting social justice, and intervening in the social determinants of health.

II. The COVID-19 Pandemic as a Case Study

Lessons learned from the ongoing COVID-19 pandemic support our argument. The pandemic deepened socioeconomic disparities in the US and hindered access to vital resources such as food, housing, and healthcare.[12] Prainsack recently noted: "[n]ext to the immediate health effects of the virus, poverty and grave inequalities have been the root causes of human suffering during the pandemic."[13] Prior to the pandemic, many rural and low-income populations lacked reliable access to the internet and devices like laptops or smartphones. This continued lack of access restricts the flow of information and prevents people from accessing telemedicine services.[14] Preexisting social, political, and health inequities worsened health outcomes among many marginalized racial and ethnic groups. It is well-documented that communities of color, including Black, American Indian or Alaska Native, and Latinx populations, had greater COVID-related mortality and morbidity due to the effects of structural racism.[15] Although federal US agencies such as the Centers for Disease Control and Prevention enacted laws that provided safety nets (e.g., the Federal Eviction Moratorium), the majority of such programs have ended, leaving many with little assistance and the threat of further hardship.[16]

These disparities are relevant because Prainsack, Buyx, and others note that solidarity arises from agents recognizing and acting on some perceived attainable collective goal(s). Income inequality and disparate access to food, education, and health care may lead people to consider public health goals unattainable. This could limit the desire to work toward those goals collectively.[17] The existing literature on collective action theory supports this intuition. It emphasizes that structural conditions, such as an absence of perceived hope for social change among a group, can lead to low 'group efficacy' and little willingness to cooperate, both within and across socioeconomic strata.[18]

The pandemic spurred countless messages from public health agencies. The messaging did not recognize or attend to the different material realities and circumstances of the US population. How can people feel comfortable getting vaccinated if they deeply distrust the government, including public health institutions? How can people remain motivated to wear masks and distance themselves if they cannot afford basic necessities and work jobs without adequate pay and leave policies? We ask these questions to illustrate how socioeconomic disparities can marginalize people if they feel ignored, apathetic, or resentful of those better off or those in power whom they perceive to "not be doing enough." This marginalization precludes the formation of solidarity.

There are instances when a population has disparate access to resources and social capital, but solidarity may still emerge from a shared goal or vision for the future. For example, a heterogeneous population living in the same town may come together to protest an environmental injustice that impacts their water supply with the common goal of securing access to safe drinking water. However, many populations in the US failed to recognize shared goals of this kind during the COVID-19 pandemic. A significant minority of the US population was reluctant to acknowledge the severity of COVID-19 infection and thus refused to participate in efforts to mitigate its spread. Even between groups who shared the goal of slowing COVID-19

transmission, the methods were widely debated. Approximately 20 percent of the adult population eligible for vaccination remains unvaccinated.[19] Governmental bodies responsible for disseminating information, coordinating the allocation of resources, and establishing guidelines have a large role in mediating these disagreements and intervening in socioeconomic conditions that impact people's ability and willingness to engage in solidarity.

III. Solidarity, Social Justice, and the Role of Public Health Institutions

Adopting a lens of social justice provides further insights into how public health actors impact solidarity. Powers and Faden argue that the "foundational moral justification for the social institution of public health is social justice."[20] Their theory of social justice has two aims. First, it ensures that everyone has a sufficient amount of the six core elements of well-being and that public health institutions are responsible for "adopting policies and creating environments" where all can flourish.[21] Second, public health institutions should distribute resources meant to promote well-being and focus on the "needs of those who are the most disadvantaged."[22]

Public health institutions should enact policies that address injustice. In doing so, public health institutions can seed the opportunity to build solidarity from the bottom up. Equipping individuals and communities with resources will foster cooperation and adherence to policies that require solidarity, such as masking and vaccination. This is consistent with arguments illustrating how institutions such as Tribal governments promote the conditions needed for their group, and especially its most vulnerable members, to flourish.[23] Addressing social determinants of health with a social justice lens will create the circumstances under which more individuals and groups can find common causes and foster solidarity. In the long run, such efforts may result in the establishment of values and practices from the bottom up.

There are societal and public health preconditions required before institutions can expect their audience to act in solidarity with one another. Through their great influence over information and resources, public institutions *do* have the power to impact what values are most widespread. Furthermore, public health may foster trust and hope, which are important psychosocial factors that influence collective action,[24] if policies increase access to resources that promote well-being. Messaging efficacy also depends on the context of public trust, education, and whether the institutions meet one's basic needs. Disparate messaging across different public institutions may confuse or disillusion individuals. To apply our theory of solidarity to the decision to vaccinate, a policy would be to foster conditions that facilitate access to vaccines and information about vaccine efficacy instead of imposing a top-down mandate without first eliciting public trust.

IV. Counterargument

Some argue that discordant public health messaging, ineffective government, and inadequate social programs can also bring people together under pressure and foster solidarity. One may argue that the most powerful motivators towards solidarity are strife and disparity, as evidenced throughout history. During the pandemic alone, political struggle and personal hardship inspired solidarity in the US, from individual neighbors helping each other to mutual aid groups forming across communities. We thus do not claim that solidarity is possible *only* when our government programs and public health institutions are most effective. We instead point out that solidarity can be further hindered when people feel alienated, hopeless, and pitted against each other.

CONCLUSION

Many competing conceptualizations of solidarity persist in the bioethics literature, and Prainsack and Buyx offer one compelling framework that public health ethicists continue to draw upon.[25] However, their framework fails to acknowledge how public health institutions impact interpersonal and group solidarity. Public health institutions can foster solidarity through actions other than mere messaging, invoking catchphrases like "we are all in this together." Efforts to address socioeconomic preconditions and alleviate health disparities can cultivate group solidarity. As we saw during the pandemic, cooperation and solidarity go hand-in-hand with disease mitigation efforts; solidarity has clear intrinsic value.[26] As this relationship becomes more apparent, we will continue to see attempts from public health institutions to foster or invoke solidarity. Therefore, public health institutions would be remiss to ignore their role in addressing the social determinants of health. Adopting a social justice lens when planning public health interventions will clarify and strengthen their role in facilitating solidarity. Ultimately, if health disparities continue to persist or widen, it is very hard to imagine how group solidarity can ever be achieved. The widescale adoption of many public health measures needed to promote health and well-being would be conducive to solidarity.

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