Reimagining Public Health

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A part of the Green New Deal Project Stream

GND
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Executive summary

The public health emergency of COVID-19 has unearthed the fragility of our economic system, forcing us to confront the scale of inequality it has enabled, fuelled by a market-first approach that concentrates wealth and power in the hands of those who already have it. Those who don’t are left to face the sharp end of that inequality, leaving entire communities stripped of the chance to enjoy a long and healthy life, with profound implications for marginalised and oppressed communities.

While the most immediate threat to our collective health is COVID-19, the accelerating climate disaster is even more severe. Health outcomes are shaped by climate change and socio-economic realities. The climate crisis is already here; it is just unevenly distributed. From air pollution to food insecurity, housing and displacement, today’s crises of inequality and climate are intertwined. Their consequences will be immeasurable, unless we act now.

COVID-19 and the climate emergency have both underscored and amplified long standing inequalities, demonstrating the need for an economic transition centred on health and sustainability; which addresses the root causes of wealth, power and income inequalities; and pursues a democratic economy that prioritises self-determination. An ambitious Green New Deal could drive a recovery that builds the regenerative infrastructures we need to live healthy lives in flourishing communities.

Public health is not just a descriptor for the state of the health of the population, but an approach to policymaking that addresses fundamental drivers of ill health that are both avoidable and unfair.

In order for public health to be an effective guide for the Green New Deal, we must first understand how health is compromised by inequity and injustice, using these findings to build a framework for policy design. Without, for example, understanding why the combined impact of air pollution and racial discrimination has increased incidence of asthma in the BAME community, we cannot adequately address inequalities in health outcomes through one-dimensional environmental policies. It is therefore unquestionable that in designing a Green New Deal, experiences of classism, sexism, ableism, racism and gender violence, particularly transphobia, must be prioritised.

To do so, we do not need to start from scratch. Instead, we can learn from the historic work of marginalised communities, learning from their experience of health, and placing that in a broader strategy that adopts our principles of reimagining public health. This report explores key case studies that have taken a comprehensive view of the social determinants of health, with the commitment that the groups at the centre of these efforts are the ones to best understand their own lived experience. This analysis is then used to identify ownership models for collective organising and self-determination, from the Bronx Community Development Model, which sought to build an economic democracy focused on people of colour, to examples of Community Wealth Building through a decolonising lens.

This paper is a rallying cry for decision-makers, the climate movement, new economy organisers, the wider group of civil society organisations, philanthropic bodies, grassroots community groups and social enterprise investors. It is a theory of change that demands a commitment to public health with the following principles: collaborating with public health expertise, particularly from those who are interrogating existing social determinants frameworks; embodying an intersectional analysis in research; focusing on people-centred narratives that support self-determination; designing and carrying out projects with the communities those projects aim to serve; and tackling the historic roots of health inequalities to begin establishing the trust that public infrastructure and collective ownership models require.
For political decision makers, this requires measures including resourcing public health expertise at every level of governance; embedding public health frameworks within key government departments; taking agencies out of politics, but keeping public health practitioners political; prioritising lived experience within governance structures; establishing a long-term target, that transforms our indicators of economic success from GDP towards health and wellbeing; and shifting resources and financial incentives towards health-oriented policies.

For health professionals, this entails using the Green New Deal as a strategy to transform public health. Speaking actively on the intersections of public health and the economy will be vital, as will taking leadership from marginalised experience in health institutions, organising beyond the profession, and ensuring that public health interventions are built on lived experience research.

For campaigners and progressives, there remains a need to embed a radical public health analysis into advocacy and campaigning on ecological and social justice issues through: building long-term mutually beneficial relationships with the public health community; proportioning funds that invest in marginalised communities; focusing on campaigns that reframe the purpose of investments, subsidies and bailouts towards public health and wellbeing; divesting from whiteness and other systems of oppression; and using health improvement as an indicator of impact in your new economy projects.

Preparing for the forthcoming health inequalities at a time of accelerating climate breakdown will be one of the biggest challenges for the Green New Deal. It will require an intersectional and internationalist analysis of inequality, in order to build an economic democracy that supports the health of communities here and across the world.

— Foreword

The Green New Deal seeks to address the climate crisis while attending to inequality through a significant programme of public investment and deep institutional transformation. Though this paper was imagined prior to the Covid-19 pandemic, it was borne out of the idea that economic transformation would be largely ineffective if it did not embrace a public health approach. And now, the overlapping global crises of climate change and Covid-19 have underscored even
more the need for health, environment and economy to be viewed through the same lens.

To use an old expression: everything has changed, and yet everything is still the same. While COVID-19 has propelled public health into the psyche of campaigners and policy-makers, the relationship between health, environment and our economy is not new. My siblings in Wretched of the Earth remind me that for the Global South, and people of colour across the world, “Our house has been on fire for over 400 years.” Both the climate emergency and this health crisis can be traced to European merchants first landing on the shores of Indigenous lands, bringing with them deadly diseases and an intent to extract and oppress for profit.

This paper was written with the belief - built up from a career of policy-making, lived experience of injustice and collective experience of ill health - that power has been at the centre of that struggle. There is a privilege that comes from recording one’s own analysis of the economy and how to change it onto paper and having it read. Through this process, I have been humbled and attempted to act upon guidance from Adrienne Maree Brown, writer and systems change strategist, who reminds us:

“Imagination is one of the spoils of colonisation, which in many ways is claiming who gets to imagine the future for a given geography. Losing our imagination is a symptom of trauma. Reclaiming the right to dream the future, strengthening the muscle to imagine together as black people, is a revolutionary decolonising activity.”

This is simply a guide, inviting you to embrace the depth and complexity of power, beginning with self-reflection and acknowledgment that privilege shapes what we see, and therefore what we value. Through all that has been laid out to you in this paper, I encourage interrogation. These ideas are not new, but rather inspired by ancestral wisdom, lived experience and relationships that are dismissed in the ‘new economy’. This paper is here to provide food for thought on the intersection between climate, health and ownership. Readers are encouraged to use this as a framework in understanding the full dimensions of inequality and injustice, including impacts on the global South; experiences of queer, disabled and working-class communities; or an approach to racialised identities that pays particular attention to Roma, Gypsy and Traveller communities.

Citation is feminist memory.” There will never be enough pages to acknowledge all who inspired this work. For those whose effort is cited as case study or who made time to review, a contribution has been made directly to their community projects or a project they support. Thank you Anya Gopfert; The Bevy; The Bronx Cooperative Development Initiative; Chris Venables; Civic Square Birmingham; David Powell; Dee Woods from Granville Community Kitchen; Delan Devakumar from Race & Health; Elena Blackmore; LIFT Economy podcast; Movement Generation; Nonhlanhla Makuyana from Decolonising Economics; Sally Zlotowitz from Psychologists for Social Change; Siddhartha Metha from Medact; Sridhar Venkatapuram author of Health Justice; and Thunder Valley Community Development Cooperation.

— Glossary

To guide you through this paper, please refer to the following definitions to better understand the political analysis behind the writing:

Economic democracy: Economic democracy is a system where people share ownership over the resources in their communities and participate equally in deciding how they are used.

Epidemiology: The study and analysis of the distribution, patterns and determinants of health and disease conditions in defined populations. It is a cornerstone of public health, and shapes policy decisions and evidence-based practice by identifying risk factors for disease and targets for preventive healthcare.
**Decolonising**: The conscious practice of freeing from the mind of colonial ideology, in which European superiority is valued over all other forms of knowing and doing. This includes oppressive ideas around people of colour, working class communities, LGBTQIA folks, disabled people, people of the Global South and migrant communities that maintain social power in white, middle/upper class, straight, able-bodied, English speaking, and European identities.

**Discrimination**: The process which leads to oppression, by the identification of individuals or groups who are “different”, and treating those individuals or groups less favourably - often through violence, marginalisation, victimisation and exclusion. Discrimination has multiple pathways of operation.

**Health inequalities**: Are generally understood to mean differences in health status across different social groups and between different population groups, that are unfair and avoidable.6

**Public health**: The art and science of preventing disease, prolonging life and promoting health through the organized efforts of society for the sanitation of the environment, the control of communicable disease, the education of the individual in personal hygiene, the organization of medical and nursing services for early diagnosis and preventive treatment of disease, and the development of the social machinery to insure everyone a standard of living adequate for maintenance of health, so organizing these benefits as to enable every citizen to realize their birth right of health and longevity.7

**Marginalisation**: From the theory of mainstreams and margins, mainstream identities can broadly be defined as those who are privileged in today’s economy. Marginalisation is the continuous act pushing individuals and groups to the margins of society, and often refers to those who are oppressed by groups with social and economic power.

**Oppression**: The act of treating a person or group of people unjustly and with cruelty, by exerting power over them in one or several ways. Anti-oppression is the practice of understanding how oppression operates, and working to undo the conditions in which a person or group of people experience that harm.

**Privilege**: Used to describe the multiple ways a person or group of people gain social power, because it refers to the identity, behaviour or cultures that enable them to gain advantages in society. For example, in a society that privileges whiteness, white people are at an advantage. Privilege is only transformed once society is transformed.

**Self determination**: A process in which a person or a group of people control their own lives

**Social determinants of health**: The conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighbourhood and physical environment, employment, and social support networks, as well as access to health care.

**Social power**: Describes a person or group of people’s capacity to have social influence. This may be because that person or group of people hold tools, resources and relationships that enable the maintenance or transformation of cultures, ideas and behaviours in society.

**Wealth**: This is currently understood as an individual or group’s access to valuable resources such as land, bonds, stocks, pensions and other financial assets. Wealth also includes non-financial assets such as leisure time, access to tax relief options because of their wealth and other financial knowledge, all of which support a system that enables those with social power to continue to accumulate resources. Separate to wealth, but showing similar patterns in inequality, is income. Income is determined by the money received through employment including wage, bonuses, pension contributions, investments, savings and social welfare support.
Introduction

The issues prompting many to advocate a Green New Deal are reflections of a broader public health crisis. Both the climate emergency and increasing inequalities are outcomes of an economic model geared toward maximising profits, which is pushing the limits of our collective capacity to survive. There is a growing recognition that the climate and environmental crisis threatens life as we know it - a threat now pushing at the borders of countries in the Global North, who have until now shielded themselves from the worst of environmental injustice. While the UK has only recently begun to connect destructive heat waves and flooding to the climate crisis, communities in the Global South have long been subject to a concentration of extreme weather, environmental destruction, land enclosures and food insecurity. The climate crisis is here, it’s just unevenly distributed.

Many are claiming ‘there will be no back to normal’ after COVID-19, but this is not guaranteed. The current health crisis points to a deeply rooted imbalance in our relationship with the natural world, and with each other, that will require transformative change to overcome. The compounding crises of COVID-19 and the climate emergency, which have underscored and amplified long standing inequalities, demonstrate the need for an economic transition centred on health and sustainability - one that addresses the root causes of wealth, power and income inequalities, and prioritises self-determination. The point of our economy should be to keep people healthy in a flourishing natural environment.

COVID-19, Climate Crisis and Inequality
Through the COVID-19 crisis, the key workers of the economy have shown to be those taking enormous personal risk to keep others safe. They are the very same people who have little to no ability to choose to work from home, self-isolate, access support or stay protected at work. Low-wage precarious workers facing reduced to non-existent income have led to a quadrupling in the number of adults affected by food insecurity, forcing a 122% rise in the need for food banks.

Further, emerging data and a continued public investigation into the impacts of Covid-19 will affirm what we have long known, but too often ignored, about these key workers: early data shows that Black men, for example, are 4.2 times more likely to die from Covid-19 than their white counterparts, and people of Bangladeshi and Pakistani, Indian, and Mixed ethnicities are experiencing a significantly raised risk of death compared with those of White ethnicity. We are still awaiting essential data on the 841,850 adults who receive social care, 35% of whom is comprised of working age adults (18-65), and the long term mental health impacts on children and young adults.

The past decade has offered little to celebrate with respect to health inequalities. The Marmot Review on the health gap in the England, first commissioned in 2010 and updated in the recent 10-year review, referred to this period as the “lost decade”. Life expectancy, the most popular measure for determining good population health, began to slow from 2011 onwards for the first time since the turn of the 19th century. Even Public Health England’s Five-Year Strategy acknowledges that a plateau in length of life is happening alongside an increase in years spent in ill health. This represents such a grave change to health outcomes that it has raised significant debate within the public health field.

Importantly, this analysis preceded the global pandemic, a crisis that has launched public health into our population’s consciousness - perhaps even reshaping our priorities, as some polling has suggested. COVID-19 unearthed the fragile reality of our economic system, forcing us to confront social inequality through the names and faces of those who have been first and worst hit by the
virus. The pandemic is just one crisis affecting our health; the other, of commensurate importance, is the climate crisis.

As the climate crisis advances, the world continues to become more unequal, posing ever greater risk to public health. Right now, around 2000 billionaires have more wealth than 60% of the global population of 7.8 billion people, with 735 million living in extreme poverty - the outcome of an economic system that sustains the concentration of wealth and power among those who already have it. Those left to face the sharp end of that inequality are more than statistics. They are individuals and communities whose choice to live long lives in good health is being continuously stripped away.

The most immediate threat to our collective health is COVID-19, but the accelerating climate disaster is of a scale many times larger. There are many radical visions for an economy that can address existential threats, from degrowth to inclusive growth, each with its own analysis of the problem. But there are few approaches that support all of health equity, sustainability and democratic ownership; for this, we should look to public health. The study of health data, known as epidemiology, is the cornerstone of public health. It is also an instrumental yet under-appreciated evidence-base for interventions focussed on building a more democratic economy. Through epidemiological study, we are able to identify the drivers of ill-health by uncovering patterns of injuries and disease within populations, working out the lived health experiences of specific communities based on data relating to their geography or shared identities.

Historically, epidemiology has informed infrastructure projects involving major changes to sanitation and infectious disease control, increasing life expectancy by twenty years in the first half of the 20th century. An ambitious Green New Deal guided by a public health approach would drive a recovery that centres health and care, and builds the regenerative infrastructures we all need to live healthy lives in flourishing environments, reshaping the cultures and values of society along the way.

A well documented early public health strategy arose in the Victorian era sanitary-environmental movement, a strategy connected to the beginnings of industrialisation. During this period, public infrastructure projects relied heavily on massive economic investment raised largely through British Imperialism, channelling this money into waste and water management systems while engaging town planners, political leadership and architectural expertise to stem the spread of infection and disease.
At the end of the 20th Century, public health practice evolved into the Biomedical model with the development of vaccinations and diagnostic tools, fuelled by a burgeoning and powerful pharmaceutical industry. This model remains driven by a profit-thirsty Big Pharma, which has thrived on deregulation and globalisation. The growing power of this industry forged a culture of medical interventionism reflected in today’s medical-industrial mindset around health, relying heavily on resource-intensive medical interventions to meet the increasingly complex health needs of the population. Screening, vaccinations and other forms of preventative models are essential public health practices, but our fascination with taking a pill or discovering a vaccine have crowded out the space for considering what is driving ill health in the first instance, such as our environments and social structures. It is therefore somewhat ironic that the NHS, which was established to tackle upstream determinants of health, is itself responsible for 5.4% of the UK’s total carbon emissions, equivalent to the greenhouse gas emissions of 11 coal-fired power stations.

— Public health in the UK’s recent history

In very recent years, public health interventions have begun to shift toward the individualised Socio-behavioural model, putting even greater emphasis on personal behaviours through “nudge policies” that appeal primarily to a person’s individual agency. This individualised approach fits neatly with the contemporary neoliberal economic mindset, in which the individual is touted as the key unit of economic success, failure and responsibility.

In health promotion campaigns around alcohol, tobacco and physical activity, we see a reliance on behaviour change social science, an often patronising obsession with individual action, and culturally insensitive programmes that ignore the impact of the conditions in which communities are situated. These approaches align with the way we are encouraged to attend to the climate crisis, where an excess focus on individual responsibility rather than structural change has conned us into thinking individual behaviour change will save us.

The most recent Five-Year Plan from Public Health England takes the individualised approach one step further by engaging personal data technology to drive public health within the frame of personal responsibility and individual efforts. With each passing decade, it seems as though we are moving further from believing that public institutions can and should exist to support us in staying healthy, a trend that reflects the insidious mentality of neoliberalism, which erodes the value placed on shared ownership and responsibility. These profound shifts are also reshaping the narrative and principles of public health in a way that the health and climate community need to reclaim.

Importantly, many local institutions in the UK charged with overseeing public health have struggled not only with austerity, but also with a loss of expertise and collaborative leadership. They have also seen the depoliticisation of the profession through imposing the Civil Service Code on public health registrars. In times of crisis, this means that nationwide interventions lack the infrastructure and resources for public health expertise to respond with coordination, insight and power.

There are examples of forward-thinking public health research and practices which we can turn to for inspiration. For example, in Scotland the public health community have been advocating for economic transformation for the good of the nation’s health and wellbeing for many years. However, aside from these few ambitious leaders, most Directors of Public Health struggle to innovate away from the dominant politics determining the way public health is practiced. The potential for public health expertise and practice to lead in economic transformation has slowly diminished, despite its growing importance.

— Health and inequality: examining the links

“If you want to live longer, above all don’t be poor”
The UK has been in a crisis of health inequalities for some time now. As the Marmot report illustrated, successes made in tackling health inequalities in the UK over the past decade have been lost. By all essential indicators, the gap between poor and wealthy communities in early life years, namely birth weight, infant mortality and overweight adolescents, are almost double in the poorest communities compared with the wealthiest.1

Across local authorities in England, your chances of a long healthy life are considerably higher if you grow up in one of the richest areas in the country: boys in Kensington and Chelsea are expected to live till 83.3 years, and girls in Chiltern are expected to live till 86.7 years. For those in the poorest areas, life expectancy falls by nearly a decade. If, for example, you grew up in Blackpool and Middlesbrough, your life expectancy is likely to be much lower, at 74.7 years for boys and 79.8 years for girls respectively.2 But health inequalities do not just affect your life expectancy, they also determine how many years you live in good health. Incidence of mental health, chronic lung disease and obesity is 50% more in the most deprived areas in England compared to the least deprived.

If poverty is an indication of poor health, public health interventions need to uncover just how racialised,3 gendered and ableist health outcomes are in relation to wealth. Evidence indicates that Black, Asian and Minority Ethnic (BAME) households consistently show up as less well off in comparison to their white counterparts across all social-economic indicators. People of colour are more likely to hold precarious employment within the gig economy4 through agencies and zero-hour contracts, with little to no protection such as sick pay, pensions and union representation. Afro-Caribbean households were most likely out of all minority ethnic groups to have a weekly income of less than £400, and people of colour households in the UK earn as much as £8,900 per year less than their white British counterparts.5

Disabled people are twice as likely to be living off food banks.6 Wealth and income inequality are also gendered, but the scale of this is challenging to pinpoint, not least because ONS data often only operates through household income,7 and there is currently a concerning lack of data that explores trans and non-binary gender identities.8 If we are unable to describe the trans, intersex and non-binary experience, we are not working to understand the multiple ways in which gender oppression operates within the economy.

Most health inequality data is described as differences between ‘the most and least deprived’ because of the reflection it offers on social inequality more broadly. It is for this reason that someone’s socio-economic status enables us to quite successfully predict a group’s long-term health outcomes.

Unhealthy behaviours are often not the origin of poor health, but the result of a long chain of causes and consequences in people’s lives.9 Many illnesses occur not because people are unable to access care, but because they live in an environment that either limits their capacity to escape, or is actively driving, ill-health. Despite this, we continue to refer to chronic diseases associated with poverty and deprivation as “lifestyle diseases” - a term that suggests unhealthy behaviours are a personal choice taken with the individual freedoms afforded to us. But when so much of your life is determined by something out of your control, power - or the lack of - it becomes the biggest influence on your life expectancy and how well you can live it.10
A Global Green New Deal: where climate and public health collides

Health inequalities take on a new dimension in the context of a failure to address the climate crisis. Globally, reaching net zero emissions by 2050 is estimated to give a 50% chance of limiting warming to 1.5°C, the target now widely understood as necessary to mitigate the most catastrophic impacts of climate change. The UK is currently failing to get on track to meet its own 2050 net zero target.58 This is despite the UK needing to go much further and faster than other countries to address its fair share of both emissions reductions59 and contributions to loss and damage.60

The 2015 Lancet Commission on Health and Climate Change61 argued that any progress on health at a global level will easily be reversed by the catastrophic direct and indirect impacts of climate breakdown. The direct effects of climate breakdown,62 including increased floods, heat stress, drought and storm intensity are estimated to cause up to a quarter of a million deaths per year between 2030 to 2050. The multiple pathways in which health is impacted indirectly by climate change are socio-economic in nature, and often rooted in a community’s “adaptive capacity” to respond to radical and abrupt changes to their living conditions.63 It is overwhelming to articulate just how severe air pollution, food insecurity, greater spread of infectious disease, displacement, conflict and the mental trauma associated with these events will be on human health.64 The WHO estimates nine out of ten people in the world now breathe polluted air, killing over 7 million people every year.65

Any potential health improvements that may come from a warmer climate in the Global North, such as milder winters reducing the impact of fuel poverty,66 will be more than negated at the global level, where most climate-related projections show the health gap will increase across all countries. Bearing in mind that such projections are often conservative, some studies have found a rising average temperature combined with an ageing population means we can anticipate an exponential rise in deaths from heat stress.67 Heat stress-related deaths per year are predicted to increase by 66% in the 2020’s, 257% in the 2050’s, and 535% in 2080’s. The Living with Environmental Change report card68, established in 2015, uses similar projections to indicate a concerning future for health in the context of climate breakdown in the UK.

It is vital to remember that these projections reflect the scenario in the UK, the sixth richest country in the world, whose accumulated wealth and power is derived from often highly extractive forms of economic activity. This “domestic product” has enabled a publicly funded health system, public health infrastructure and a social welfare system. Elsewhere, the reality will be considerably
worse. For instance, following unprecedented cyclones in 2019, Mozambique, the world’s sixth poorest country, now shoulders the burden of $3.2 billion in loss and damage. To support their recovery efforts, rather than relieving Mozambique from its debt trap, the IMF attempted to plug the financing with further loans. This is far from an isolated case; it is estimated that by 2030 the costs of climate-related damages worldwide will reach $300-700 billion. These costs are, unsurprisingly, concentrated most in the countries where western dominated trade policies, tax systems and investments have diminished the very public infrastructure that resource-stressed populations rely on.

Finally, climate-related health outcomes are, and will continue to be, particularly life-threatening for women, children, LGBTQi and disabled people who already face significant barriers to accessing support from public services and welfare systems. This reality is far more pronounced in the Global South, where marginalised communities face financial barriers to accessing essential life saving services, or whose public infrastructure has been starved by debt, conflict or natural disasters.

For public health to be an effective guide for the Green New Deal, we must first understand how health is compromised when inequity and injustice exists, using these insights to inform policy design. The WHO argues that achieving health equity requires a redistribution of wealth and income, but is weaker on a strategy that understands justice as a practice, not an ambiguously defined destination. This is backed by the lack of research exploring the ways in which health relates to social power, specifically systems of power such as whiteness, ableism, class privilege and heteronormativity. ‘Social power’ describes who has privilege, and how that privilege influences wealth and income disparities across populations; it can be used to identify who maintains power in society, why they hold power, and how that power operates through discrimination and oppression.

Efforts to tackle health inequalities, even at their most radical, have too often brushed over systems of power, and focused solely on a community’s material circumstances to investigate social determinants of health. Structural inequality, wherein certain groups of people hold power over others, attacks our health at a much more cellular level. The landmark Whitehall Studies released by Michael Marmot in the 1970s concluded that lower grade employees were a third more likely to die than those in higher grade employment in the same working environment. One purported mechanism for this is psychosocial stress associated with “lower social class” status.

What Marmot failed to do until very recently was name the systems of power driving wealth and income inequality, and instead referred to these inequalities as the root cause of psychosocial stress. While this has recently changed, the intersection of the environment, economics and discrimination continues to be neglected as framework through which health inequalities are studied and communicated.

What needs to change in the UK?

“People will fall sick and die at home. We may never know their stories. They may not even become statistics.” Arundhati Roy
Importantly, we will not do justice to health inequalities solely from the perspective of wealth and income data. The WHO’s conceptual framework of Social Determinants of Health asks us to inquire how macroeconomic and social policies shape an individual or community’s socioeconomic position. This should be done by interrogating how each person benefits or struggles from systems of power that make up the economic system, first by naming them and then using health data to explain how they operate. Like every human experience, data needs to be sophisticated and complex in describing the associated experience of discrimination, marginalisation and oppression.

To design transformative economic strategies, we must regularly interrogate the ways in which key institutions continue to demonstrate dynamics of empire and colonialism, in order to contextualise their role in maintaining structural inequality. An evident driver of white dominant culture is the introduction of the Hostile Environment in 2012 by the then Home Secretary, Theresa May. This range of immigration policies penetrated the housing, healthcare, financial and education systems in a perverse outsourcing of immigration enforcement to public sector workers. The Hostile Environment policy to charge migrants for healthcare, for example, is likely to be an important factor in the number of people of colour who died from COVID-19 deaths.

Research for transformation: Valuing lived experience

When there has been a concerted effort to understand the impact of discrimination on health, it has drawn some telling conclusions. A study of the combined impact of air pollution and racial discrimination in East London explored the potential root causes of increased incidence of asthma in the BAME community. The results challenged the assumption that BAME families were at risk of greater exposure to PM2.5 and PM10 pollutants because of socio-demographic factors such as housing, geographical location and income. The study also controlled for anthropometric factors such as the size and length of their upper body, noting that there is a problematic focus on biological determinants of health rooted in eugenics theory. Doing so revealed an additional relationship between asthma and experience of racial discrimination.
suggesting that psycho-social stress could have a negative impact on the body’s capacity to defend against environmental pollutants.

The results of this study prompt the question: what else could we uncover about social determinants by investigating people’s experience of discrimination alongside traditional socio-environmental factors? We might question with greater integrity why over 50% of the LGBTQi community suffer from depression and how their mental wellbeing is so deeply connected to their experience of marginalisation, or why South Asians are six times more likely to live with type 2 diabetes.

The overall experience of discrimination is thought to influence health through the onset of stress and trauma connected to the perception of being treated unfairly compared to others. Through repeated trauma, these experiences - both physiological and psychological—can lead to systemic mental and physical illnesses. Even perceived discrimination is enough to influence unhealthy behaviours that might have been adopted to relieve stress in the short term, but will ultimately increase risk of disease over many years.

In a recent survey by the Equality and Human Rights Commission, 42% of people in Britain said they had experienced some form of prejudice in the last 12 months. Within this cohort, 70% of Muslims surveyed experienced Islamophobia; 64% of people from a black ethnic background experienced racism; 61% of people with a mental health condition experienced ableism, and 46% of lesbian, gay or bisexual people experienced homophobia. Addressing this systemic discrimination must be a core guiding principle of a Green New Deal driven by a public health approach.

How discrimination operates

Research on discrimination and health presents three pathways of operation:

- **Cultural:** The creation and maintenance of an ideology that casts marginalised groups of people as inferior, subordinate and devalued. Cultural racism embeds images and ideas of marginalised groups into the public psyche, often rooted in oppressive generalisations and stigmatising stereotypes.

- **Structural / Institutional:** A route by which the dominant or mainstream group in society ensures it is prioritised in social and economic policies by weighting opportunities and resources in their favour. This dominance further enables the existence of health-harming policies, such as the Hostile Environment, wherein discrimination and the violation of rights are justified under the government’s priorities on immigration.

- **Individual:** Discrimination between individuals, often directly through abuse or attack, or indirectly through micro-aggressions and acts of unconscious bias. Notable in this respect is a doubling of homophobic attacks in England since 2014, and a doubling of hate crimes against people of colour since the Brexit Referendum in 2016 in England and Wales.

Figure 2 illustrates the multiple components of racism and the ways in which these components can affect health. The lower panel serves to further unpack how individual-level discrimination can affect health.

Because of the prevailing medical-industrial approach to public health, strategies for managing the prevalence of mental health disparities in marginalised communities are generally focused on the increased provision or improvement of mental health services. This effort is much needed, but a strategy that focuses solely on mopping up the outcomes of the current system rarely challenges the root causes of psychosocial stress within a community.

If we instead view the health inequalities experienced by people of colour, queer, trans, working class and disabled communities as a form of active oppression, we can focus our efforts on dismantling the
systems that influence the marginalised lived experience with an ‘anti-oppression strategy’. This includes uncovering how oppression has influenced who has wealth, income and the capacity to self-determine, all of which are related to ownership.

The route to building a democratic economy therefore lies in the lived experience of marginalised communities, allowing this experience to guide the design of models of ownership that support self-determination. It is worth remembering in this regard that marginalised communities have survived for generations through cooperative structures. Worker-owned enterprises or community collectives have a long history in Black communities, particularly in the US, and have acted as an institutional part of the struggle for self-determination, economic justice and democratic rights. Cooperation Jackson in Mississippi is one such example, and draws on this history of struggle and the deep knowledge and skills that emerge from decades of collective organising.

There are many interventions already underway that attempt to shift ownership of resources and wealth, or empower communities to take ownership of their services and local governance, ultimately offering community members a sense of agency over their own health and wellbeing. Replicating the successes of these interventions should be a key aspect of the Green New Deal, addressing inequalities in a way that supports public health and builds community resilience to the climate crisis. A favourite example is The Bevy, a community owned pub that functions as a social hot spot for a historically deprived and marginalised community in East Brighton, detailed in Box X.

"Bevendean housing estate is a ten-minute drive from the centre of Brighton, but light years away in terms of wealth and opportunity. Officially ranked among the most deprived 3% in England, the residents suffer from some of the worst health and education statistics in the country. Physically removed..."
from the city centre by distance, a lack of public transport and extremely steep hills, the estate lacks most of the amenities taken for granted elsewhere — a GP surgery, for instance, or shops. And until recently it would have been a four mile walk to get to the nearest pub. The original pub had problems with anti-social behaviour and crime, leading to the withdrawal of its licence and subsequent closure. Local community organisers saw the importance to the community of having a place to gather and wanted to return the building to being the asset it had once been. Over two years, volunteers raised funds and sold shares to hundreds of local people using a community share issue. The Bevy is now a sustainable community business, governed by a committee of volunteers, and answerable to its community shareholders. The Chair's annual report\(^9\) makes it clear how, as a community business, they're much more than just a pub. "You know you're onto something when the doctor recommends you go to the pub. But with a loneliness epidemic that advice might not be as unusual as it sounds. So meeting up with the Friday Friends every week for some food, company, bingo, and a laugh is literally just what the doctor ordered – and a lot more fun than antidepressants."

This is an extract from Beyond the Individual in Mental Health and Wellbeing by Dr Sally Zlotowitz & Jenni Lloyd, first published in Stir To Action in 2019\(^6\) and is a demonstration of building agency, meaning and connection among a historically marginalised community.

Dominator culture has tried to keep us all afraid, to make us choose safety instead of risk, sameness instead of diversity. Moving through that fear, finding out what connects us, reveling in our differences; this is the process that brings us closer, that gives us a world of shared values, of meaningful community — bell hooks

Replicating localised examples of success such as The Bevy (Box X) will be necessary to make some inroads into addressing health inequalities. We have lost years, lives and resources to projects that barely touch the roots of inequality because the analysis of social power and a corresponding political strategy were absent. At best, efforts to “empower communities” have adopted a charitable model of ownership that maintains wealth in the hands of a philanthropic body, or have functioned according to the whim of those with wealth and power.\(^7\)

What would it mean then, to do this work with equity and justice? And how can public health guide our understanding of power at a community level, enabling the design of Green New Deal policy that addresses the root causes of inequality, extraction and ill-health. To answer these questions, we have taken inspiration from decolonising frameworks to examine a number of case studies, and applied a public health lens.

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**Equity lens:**

- Use epidemiological data to understand how power operates across populations, focussing specifically on racial, gender, class and disability disparities.

- Understand how inequality matches health disparities within marginalised communities. Move away from the view that social power relies solely on wealth and income to incorporate the lived experience of discrimination and its impact on health, demanding more from epidemiological studies around self-determination.

- Look at the structural root causes of these problems through a critical analysis of economic policies that are driven by those with historical social power.

- Name what social power looks like, by speaking about the ways in which whiteness, class privilege, maleness, able-bodiedness, cis-genderedness, heteronormativity and entitlement operate.

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**Justice lens:**

- Use public health as an approach to policymaking that aims to reduce...
the health gap between the most deprived and least deprived in society, focusing on understanding and acknowledging the history of racism, sexism, ableism and classism in all its forms

- Use health justice in the vision of a fair and inclusive society, doing more work to bring this into the strategy for building economic democracy

- Prioritise health data to monitor the long-term impact of alternative ownership strategies, focusing explicitly on building civic, cultural and political power of those most impacted

- Emphasise transformative solutions that are needed to impact the multiple pathways in which communities are impacted by discrimination, including in this a transformation in the judicial, education, immigration, financial, media institutions and systems.

Health data in the UK tells us clearly that health inequalities in marginalised communities are the result of centuries old ideologies that maintain systems of power. As long as our institutions reflect these ideas, public policy will continue to misrepresent marginalised experience, misunderstand behaviours and misdirect resources. It is therefore necessary that in the design of a genuinely sustainable and just Green New Deal, class, gender, ability and racialised identities are prioritised as part of a democratic movement to transform prevailing ideologies. Leadership should be taken from the very communities that “new economy practices” aim to support, and strategies should embrace the knowledge and wisdom of these communities. As Dee Woods, co-founder of Granville Community Kitchen in South Kilburn writes:

“Here in the UK, particularly in urban settings, we see the inequality in women’s lives. Particularly for women of colour. Poverty, disability, food insecurity, health inequalities, poor housing all play a role. It is a struggle to see and hear about people’s lives, as someone with those lived experiences and also on the frontlines of a worsening food insecurity crisis. It makes me angry that in the 6th richest economy that this is allowed to happen. We need an intersectional lens that centres race, gender, class, sexuality and ability. Top-down policy responses take time. So we have a collective responsibility to create grassroots solutions while lobbying for systemic change. The voices of those most affected must be centred in both policy and grassroots solutions.”

The good news is that these communities are already organising in this way, having recognised some time ago that the existing economy was not built to support them. Cultural practices around solidarity, care, sustainability, collective ownership and cooperation are the very practices we need to instil back into mainstream public life.

**Case Study 1. The Bronx Cooperative Development Initiative (BCDI) and enabling self-determination through a “Community Enterprise Network” Model**

The Bronx Cooperative Development Initiative emerged from community organizers in the borough who had been working for years to fight back against development projects and gentrification with negative and disruptive impacts on community well-being. After decades of strong and effective organizing - measured in terms of campaign victories, numbers of people mobilized, policy demands enacted - they found themselves in the wake of the recession of 2008/2009, after which their organizing victories were not commensurate with socioeconomic outcomes: people in the Bronx were still generally poor, and the racial wealth and health gaps remained.

In this context, they looked to models of regional economies and place-based development ranging from the Evergreen cooperatives in Cleveland Ohio, to Market Creek Plaza in San Diego, to the Dudley Street Neighborhood Initiative in Boston, to the Mondragón Cooperative Corporation in the Basque region of Spain, for ideas about how to build shared wealth, power, and economic democracy at scale for people of color in the Bronx. After several years of learning and planning together, the working group
of leaders from across the Bronx developed a model for creating and sustaining shared wealth and economic democracy for the Bronx.

This Community Enterprise Network model draws on elements of the Mondragón experience, but is sensitive to the cultural and historical specificities of the Basque region and experience. Emerged out of a response to the growing wealth disparities between people of colour and white people within the US, and is an advanced system aiming to transform urban economies beyond a single project. White households in the middle-income quintile (those earning $37,201-$61,328 annually) own nearly eight times as much wealth ($86,100) as middle-income Black earners ($11,000) and ten times as much wealth as middle-income Latino earners ($8,600).

The initiatives stemming from the BCDI seek to address that disparity, recognising that the small wins that were gained through community organising were not moving the needle against the larger national and global trends of wealth extraction and economic disempowerment. BCDI sought to leverage existing Bronx resources, assets, and organisations, to build a network of institutions that could sustain economic democracy focused on people of colour, prioritising projects that could strategically create impact at scale. For this it relies on strategic infrastructure and collaboration led by the community and organised labour, that feeds into their collective vision.

They have organized this work into a series of six core areas or “infrastructure projects:”

• **Bronx Exchange** - A procurement platform that aims to work out how to localise the wealth that is constantly leaking from the area, so that local spending is enriching the community. Prioritising generational wealth by solving the visibility problem - what is being made and what is being bought locally.

• **Bronx Innovation Factory** - how to leverage the advanced manufacturing and innovation skills that need to be cultivated. Position folks to innovate in ways that are led by women and people of colour.

• **Economic Democracy Learning Centre** - looks at formal and informal education. It thinks about transformation at the individual level by building leadership and support. At the institutional level, it looks at transforming existing organisations in ways that feed into an economic development model which builds the type of economy determined by the community.

• **Policy + Planning Lab** - Develop a way that is participatory, recognising ways in which the community living in the Bronx can drive the political strategy.

• **Bronx Fund** - Explores the ways in which the community can sustainably capitalise all of this.

• **Bronx Civic Action Hub** - Deeply about connecting organisers - the science and art of moving people towards collective action. Moving this towards economic democracy and self determination.

— **Case Study 2. Community Wealth Building through a decolonising framework**

Community Wealth Building (CWB) provides a useful set of principles that aims to increase the wealth of a local community by identifying how value is extracted from their locality over time and intervening in systems to change this. The Preston Model is seen as the leading example in the UK, which has seen unemployment in Preston has fallen from 6.5 per cent in 2014 to 3.1 per cent alongside above-average improvements for health, transport, work-life balance, and youth and adult skills.

The Community Wealth Building model drives changes related to the various social determinants of health outlined by the Institute of Health Equity called *Fair Society, Healthy Lives*, but does not use reporting on health and wellbeing by drawing on public
health evidence to identify what these changes might be. Some useful guidance by Psychologists for Social Change analysed which psychological processes need to be prioritised in policy or systems change interventions to build collective wellbeing. The briefing paper highlights five community determinants that link the structural to individual or collective psychological health, these are: agency, security, connection, meaning and trust among the community.

Of course, the only effective method for Community Wealth Building is one that is grounded in a practice aligned with the lived experience of marginalised communities. In the US, Thunder Valley Community Development Corporation, supported by Democracy Collaborative, undertook a learning exchange that centered on Indigenous wisdom and values, noting that “any community wealth building effort that does not commit to the work of decolonizing its concepts and strategies will fail to accomplish what it sets out to do.”

The project succeeded in part because it set out the principles of a “collaborative, co-learning approach, with participant design through a curriculum advisory committee, and with the adoption of principles of co-learning, co-creating, transparency, trust, and relationship building.” A focus on trust acknowledged the historic harm to that community, using it as an indicator of moving towards justice. The Lakota community used their own language and culture to determine what wealth meant for them: “To live by our virtues in order to have a happy, well-balanced life. It is not about materialistic things but helping, giving, taking care of one another. Our wealth is measured in our ability to care for our people and to provide a strong foundation for future generations.”

Case Study 3. Creating a fairer more equal and just city with Birmingham Civic Square

Birmingham Civic Square began as Impact Hub Birmingham, an arm of the collaborative workspace for “social purpose people and organisations”, and part of the international Impact Hub network. This localised transformation emerged from a dedication to create a ‘faire, more equal and just city’. The project arose out of growing unmet social needs stemming from extractive investment programmes and a flagging public infrastructure. Birmingham is often seen as an “archetype for what the UK is facing more broadly - rising health inequalities and material deprivation, in a city that has one of the youngest and most diverse populations in Europe.”

Civic Square begins by redirecting economic investment into the community it needs to serve, and providing that community with an infrastructure to engage in decision making processes, deliberation, imagination and implementation that addresses their unmet needs. For Co-Founder Immy Kaur, a central approach to building an economic democracy practice is trust. Kaur has said: “Most of what passes as good governance offers no individual agency, no liberation – it leads to people feeling disillusioned, clocking in and clocking out. It doesn’t encourage people to take personal responsibility or personally invest, it starts from assuming the worst in everything and everyone, and mitigates for that, rather than designing for the best possible outcome, and assuming the best in everyone. We have a colonial legacy that leads to deep mistrust on all sides about intentions – what we actually have even in the social sector is an approach to governance which, for all the warm words and nice values statements, is built along the same lines. In the end this serves to perpetuate the same problems rather than tackle the urgent issues.”

Similar to the Bronx Community Development model, Civic Square approaches economic transformation by understanding how finances flow in and out of a city, while at the same time extracting value that comes from the people in that neighbourhood who have so much to offer. They understand change cannot be the sole responsibility of any one sector, business, hero entrepreneur or foundation via a single magic bullet of a product, service, start up or policy. It requires a collaborative effort based in democratic principles.
Investing in lived experience

“Rise up against the organisation of misery” - Pablo Neruda

These are a mere snapshot of projects already underway, whose efforts to generate a more democratic economy could have a significant, long-term impact on public health, and therefore inform an effective Green New Deal approach. They show that a community’s shared experience of ill health is also a shared experience of structural inequality - and that addressing the social determinants of health can be a powerful force for collective action. Collective organising has a history that in the marginalised experience, such as the Free African Society or Black Panthers Breakfast Club, an approach that both meets the immediate needs of a community as well as develops the infrastructure for economic transformation.

When class and racialized privilege ignores these histories, they risk white-washing the politics of collective organising or damaging the existing support infrastructure that marginalised communities rely on. The expansion of Mutual Aid networks that evolved from a response to COVID-19 is an interesting effort, because the long-term infrastructure and material impact for marginalised communities beyond the pandemic is yet to be seen. There is also the huge risk that without being explicit in a strategy around transformation of the economy, localised collective action could be co-opted by a right-wing “small state” mindset in which “localism” relieves the government of holding responsibilities around social welfare systems, tax justice and reparations. There is no doubt that COVID-19 has inspired many more to act outside of the formal institutions of public services or charitable entities, mostly from the universalising risk that is posed by both pandemics, and to a point climate change. Speaking to such fears, writer and activist Arundhati Roy guides us on how to respond:

“Historically, pandemics have forced humans to break with the past and imagine their world anew. This one is no different. It is a portal, a gateway between one world and the next. We can choose to walk through it, dragging the carcasses of our prejudice and hatred, our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us. Or we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it.”

And it is this imagination, or a reimagining of what is possible, towards which we must apply all our efforts. Author and academic Sara Ahmed has a mantra that states “citation is feminist memory”. As we move to build our economic demands for a “Green New Deal” let it be done as respect, acknowledgement and investment towards those who did the work before us.
Principles to reimagine public health

This is a call for the climate movement, new economy organisers, wider civil society organisations, philanthropic bodies, grassroots community groups, political leadership and social enterprise investors to commit to a public health approach to economic transformation. For those ready to do the work, the Green New Deal and its future iterations should adopt the following framework:

Collaborate with public health expertise, particularly from those who are interrogating existing social determinants frameworks. While practice on the ground and within research institutions needs to change, public health also needs a boost within the conversation on economics and climate policy. A political strategy that supports transformative economic practices will thrive from the expertise of public health practitioners and associated health professionals who are energised by systems thinking.

Embody an intersectional analysis in research and policy design. Public health teaches us about intersectionality, because it introduces us to the complex reality of social inequality. Driven by personal experience of marginalisation, discrimination and ill health, we can use epidemiological data to better understand what is going on in the economy, to who and why. There are a substantial number of anti-oppression frameworks and decolonising research methodologies to guide you through this work.

Focus on people-centred narratives that facilitate self-determination. The words and phrases that we hear through dominant institutions such as the media and politics often distort the reality of a person’s lived experience. To shift power, we need to begin to challenge or let go of words that are passive and serve to depoliticise a person’s health condition. This begins at a community level, and will open us to a world of cultures and stories around health and wellbeing.

Design and carry out methodologies that focus on co-production. This will provide integrity, insight and a deeper understanding of the lived experiences your project seeks to address. We need a significantly stronger financial, research and knowledge infrastructure that enables and values communities to undertake this work themselves, at their own pace, in their own ways. Mapping Alternative Impact provides one example of a co-production approach to research, but many others exist.

Understand ownership as a global issue with historic roots. There is an opportunity to feed into values of universalism and solidarity by building trust between groups of people who have historically been pitted against one another by those in power, particularly working class communities. If society is to take shared ownership over everyone’s health outcomes, strategies for public ownership models within the Green New Deal will also need to acknowledge and address how the State has historically marginalised and oppressed communities here and in other countries.
Conclusion: Taking responsibility at every level

Preparing for and addressing forthcoming health inequalities at a time of accelerating climate breakdown will be one of the biggest challenges for the Green New Deal. It will require an intersectional and internationalist analysis of inequality, in order to build an economic strategy that addresses the health of communities here and across the world. For the Green New Deal to be effective and relevant, it needs to consider how it will also significantly shift stalling life expectancy and healthy living years within a much shorter time frame.

But now is the time. The argument for maintaining the existing economic model is untenable. We have now had several decades of neoliberal economic policies under which the health of our communities, of our climate and of our environment have severely diminished. Prioritising health and wellbeing should be a value in itself, and not something that is argued to benefit the economy, as it exists now. Otherwise, we risk strengthening the idea that health is a commodity, and a healthy population of value because it is an investment in economic output. As we look to rebuild after COVID-19 with a Green New Deal, we must shift towards an economy that prioritises public health, so that we can instead begin to value health for everything it offers society, including creativity, care and community.

Afterword: Policy Recommendations

This paper was not written with the intention to identify specific policy recommendations, because its objectives are to shift the practice and purpose of existing knowledge production to influence the design of the Green New Deal. There are, however, certain changes outlined in the following sections that can be made in different sectors to facilitate the reimagining of public health for economic transformation. Each set is focused on a specific group that has the responsibility and power to make these changes. It is noted that certain health powers are devolved in the UK, and many responsibilities fall on varying levels of local authority; however, several of the following proposals could apply to all health policy and service delivery, unless otherwise specified.

Policymakers And Political Decision-makers

To realise a just and effective Green New Deal, it will be vital to embed public health approaches in economic and ecological decision-making by the UK, devolved, regional and local governments, as well as global agencies and bodies. These ideas have been inspired by concepts of a “Health New Deal,” and at a UK level look like:

- **Resourcing public health expertise at every level of governance**, investing in what was lost through austerity policies and more; ensuring that budgets are ring-fenced and flexible; and providing resources for collaboration at a national level by rebuilding infrastructure between public health practitioners, Public Health England, local authorities and commissioning groups.

- **Embedding health and wellbeing frameworks within the work of key government departments** such as the Treasury, DEFRA, BEIS and Foreign and Commonwealth Office, such that there is an aligned approach to pursuing health outcomes...
in economic decisions, using Well-being economics, Health Impacts Assessment and Health in All Policies frameworks to guide policy and decision making.

- **Recognising that public health is deeply political, but its agencies should not be.** In England in 2012, Public Health England was turned into a government agency. It is important to return Public Health England to an NHS agency, which would enable its staff to act in the same way as other healthcare professionals and speak openly about health inequalities and the drivers of ill health. By moving PHE into an NHS agency, we also ensure senior appointments are made independent to political priorities of the government.

- **Prioritising lived experience over politics within boards of Public Health England and NHS England**, including their senior leadership. Appointment should be informed by who is most impacted by health inequalities and ensuring that experience is represented at the most senior levels of decision making, so that power exists to make the necessary changes.

- **Establishing a long-term strategy that transforms our indicators of economic success from GDP towards health and wellbeing**, taking leadership from countries such as Iceland, New Zealand, Costa Rica and others who have prioritised health as a measurement of robust and well-functioning economies.

- **Shifting resources and financial incentives towards health-oriented policies**, so that inequalities can be addressed at a system level. For example, placing a focus on secure, good housing and healthcare as human rights, and ensuring everyone has access to healthy living environments, particularly those who have been subject to ill-health as a result of their geography or living conditions. This approach should inform, for example, retrofitting and Zero Carbon Home building programmes as part of a Green New Deal.

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**Health Professionals & The Health Community**

Healthcare workers from doctors, nurses and paramedics remain among the most trusted professionals within the UK. Healthcare workers are also the first to see the impact of an unequal society brought on by food insecurity, precarious wages, inflated rent costs and barriers to accessing essential services. Yet they are too often left out of the analysis, design and advocacy of policies that could transform the way our economy functions. They are therefore some of the most needed voices to drive the design of and public narratives around the Green New Deal.

- **Use the Green New Deal as a strategy that transforms public health away from medical interventionism towards one that “consider[s] what changes we need to make to the social and ecological determinants of health that will bring about, at the population level, health, well-being, social justice and a sustainable ecosystem.”** Prioritising public health interventions that shift the conditions in which people live, rather than the behaviours they have adopted, requires the boldness of the Victorian-era public investments and the foresight of indigenous wisdom related to nature and the environment. In a time of climate breakdown, we must take inspiration from the Ottawa Charter for Health Promotion, which acknowledges that the ‘inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health.’

- **Speak actively on the economy as healthcare workers**, starting with identifying how the health conditions of its patients have been depoliticised through neoliberal ideology. Health is a collective responsibility, and we do public health a disservice if we continue to feed the individualised mindset. Let us be led by the a
A political view of social determinant theory and practice that moves us from seeing health inequalities as “facts to be known” toward “conditions to be challenged and changed”. We speak about poverty, for instance, as if it was static, rather than a form of active oppression. It means little to refer simply to disparities and inequalities without providing the context in which they operate.

- Support the leadership of marginalised experience in health institutions. This could mean those that hold existing positions of power reconsider the role they are occupying. Leadership from marginalised identities in public health institutions can begin the shift from oppressive cultures and ideologies that shape policy interventions. This includes putting to bed the longstanding fixation that cultural behaviours and genetics are the sole or primary reasons marginalised communities’ struggle with their health outcomes, or the use of categorisations of individuals that invisibilise a person’s experience in the binary identity of gender, or label undocumented people as illegal.

- Get organised, and act beyond the profession. The collective voice of healthcare workers has been proven incredibly powerful, whether in Junior Doctors’ contracts, dropping the Immigration Surcharge, or calling out the deaths of BAME healthcare workers during the COVID-19 pandemic. It’s important for this organising to express how it is in solidarity with those who experience the same injustices. Health professionals should become active union members, work with campaigning organisations, and transform existing institutions, such as their Royal Colleges, into political entities.

- Invest in the design and delivery of research that gives communities power to strategise and self-determine. Health researchers have the power to reflect the lived experience of marginalised communities in a way that could radically shift the types of interventions we adopt in health agencies. This move should see the use of a social determinants framework that explores the shared experience of discrimination, and the lack of control over one’s own health outcomes.

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**Progressives & Campaigners**

- Commit to using public health data in your analysis of the problem to better demonstrate how inequality operates. This can be done by collaborating on advocacy and campaigning on ecological and social justice issues with specifically marginalised experience within the public health community, drawing on their analysis and expertise, while supporting their calls for a Green New Deal.

- Proportion your funds and distribute to community initiatives that are led by marginalised communities, trusting what they identify as their priority and working with them according to their own timelines. The COVID-19 Mutual Aid network has provided a high profile exposure of the gaps in our economy and corresponding impacts on health; we need to build beyond this as energy after COVID-19 recedes. These innovations and efforts are the substance of “new economy” policy ideas; using this knowledge demands citation and reparation.

- Be clear about where wealth is being extracted, and where it needs to be invested. Campaigns should aim to reframe the purpose of investments, subsidies and bailouts - making them less about the economy itself, and more about health equity. As we move out of the pandemic’s lockdown phase, priorities will be placed on “getting the economy up and running”, likely without any critique on how the existing economy undermines public health. [130]
Campaigners, particularly those campaigning for a Green New Deal as part of a recovery from COVID-19, must counter this purely economic focus.

- **Divest from whiteness** and other systems of oppression that have accumulated wealth through extraction and exploitation. State how you are doing this within your own institution, and where the investment will be going as a sustained commitment towards distributing power. Take guidance from marginalised experience within your own organisation. Do this as a minimum before then moving to challenging your funders, board and partners to do the same.

- **Design and implement ownership models that support equity and justice**, by using wealth redistribution and health improvement as essential measures of an anti-oppression strategy. Anti-oppression is not a distraction nor a side-project; it needs to be a core part of any strategy for economic transformation towards equitable and just ownership models. As recent events concerning Black lives have proven, once again, there is no longer time to accommodate moderates’ and liberals’ discomfort regarding power and its imbalance in society. www common-wealth.co.uk
Endnotes


2 See https://twitter.com/wretchedofearth


5 "What is economic democracy", The Bronx Cooperative Development Initiative, https://bcdi.nyc/economic-democracy


9 "How is economic inequality defined?", The Equality Trust, https://www.equalitytrust.org.uk/how-economic-inequality-defined


11 Christopher Haley, Jack Orlik, Eszter Czibor, Hugo Cuello, Teo Firpo, Marieke Goettsh, Lou-Davina Stouffs, Laurie Smith "There will be no ‘back to normal’", Nesta, 9th April 2020 https://www.nesta.org.uk/blog/there-will-be-no-back-normal/


13 "Food banks report record spike in need as coalition of anti-poverty charities call for strong lifeline to be thrown to anyone who needs it", Trussell Trust, 1st May 2020, https://www.trusselltrust.org/2020/05/01/coalition-call/


23  YouGov data, https://yougov.co.uk/topics/politics/trackers/the-most-important-issues-facing-the-country


26  Simon Kuper, "This economist has a radical plan to solve wealth inequality", Wired, 14th April 2020 https://www.wired.co.uk/article/thomas-piketty-capital-ideology


39  Helen Keleher, Berni Murphy, and Colin MacDougall (eds), Understanding Health Promotion, Oxford University Press, 2007.


2020-to-2025


45 Sally Zlotowitz, Christina Cornwell, "The future of health research", Nesta, 18th December 2019, https://www.nesta.org.uk/blog/future-health-research/


51 "Insecure work and ethnicity", TUC, https://www.tuc.org.uk/sites/default/files/Insecure%20work%20and%20ethnicity_0.pdf


54 See ONS "Nowcasting household income in the UK", 26th July 2018, https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/datasets/nowcastinghouseholdincomeintheuk


58 Simon Evans, "CCC: UK has just 18 months to avoid 'embarrassment' over climate inaction", Carbon Brief, 10th July 2019, https://www.carbonbrief.org/ccc-uk-has-just-18-months-to-avoid-embarrassment-over-climate-inaction

59 See Fair Share’s Climate Action Tracker at https://climateactiontracker.org/countries/uk/fair-share/


72 See Common Wealth, "Blueprint for a Green New Deal!", https://www.commonwealth.co.uk/reports/blueprint-for-a-green-new-deal
78 Akala and David Olusoga: Striking the Empire, Southbank Centre podcast, Autumn 2018, https://www.southbankcentre.co.uk/blog/podcast-akala-and-david-olusoga-striking-empire
Reimagining Public Health

Guppi Kaur Bola

23, September 2013, 171-178.


85 Ibid.


89 David R. Williams, Jourdyn A. Lawrence, Brigette A. Davis, Cecilia Vu, "Understanding how discrimination can affect health", Health Services Research, Vol. 54:52.


93 See "Our Story", Cooperation Jackson, at https://cooperationjackson.org/story


100 Evan Casper-Futterman, "We are what comes next: organizing economic democracy in the Bronx", 2019, Rutgers University, accessed via https://rucore.libraries.rutgers.edu/rutgers-lib/61705/


103 See https://www.pwc.co.uk/industries/government-public-sector/good-growth.html

104 See http://www.psychchange.org


107 Ibid.


Ibid.

Tim Horras, "To serve the people', Contribution to a defense of mutual aid, revolutionary culture, and survival pending revolution", The Philadelphia Partisan, December 21st 2017

For more information on local mutual aid groups, see https://covidmutualaid.org

Arundhati Roy, "The Pandemic is a Portal", FT, 3rd April 2020, https://www.ft.com/content/10d8f5e8-74eb-11ea-95fe-fcd274e920ca


"For one example, see The Upstream Lab, https://upstreamlab.org


Mpoe Johannah Keikelame and Leslie Swartz, "Decolonising research methodologies: lessons from a qualitative research project, Cape Town, South Africa", Global Health Action, 2019;12(1).


See, e.g. Sandro Galea, "POV: We need a Health New Deal Now", BU Today, April 2nd 2019, http://www.bu.edu/articles/2019/pov-we-need-a-health-new-deal-now/

See NEF, Building a Wellbeing Economy, https://neweconomics.org/campaigns/wellbeing


Colin MacDougall, Helen Marie Keleher, Berni Murphy, "Re-imagining health promotion", in Understanding Health Promotion, Helen Keleher, Colin Macdougall, Berni Murphy (eds), Oxford University Press: 2007, 355 - 360.

WHO, "The Ottawa Charter for Health Promotion", November 1986, see https://www.who.int/healthpromotion/conferences/previous/ottawa/en/

Michael Bentley, "An ecological public health approach to understanding the relationships between sustainable urban environments, public health and social equity", Health Promotion International, Volume 29, Issue 3, September 2014, 528–537.

Malika Sharma , Andrew D Pinto, Arno K Kumagai, “Teaching the Social Determinants of Health: A Path to Equity or a Road to Nowhere?”, Acad Med, 2018 Jan; 93(1):25-30.


https://twitter.com/khankfarza/status/1267885757244506114