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Commentary

Your health is in your hands? US CDC COVID-19 mask guidance reveals the moral foundations of public health

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In the second year of the COVID-19 pandemic, US public health policy remains at a crossroads. The US Centers for Disease Control and Prevention's (CDC's) May 28, 2021 guidance [1], which lifted masking recommendations for vaccinated people in most situations, exemplifies a troubling shift-away from public health objectives that center equity and toward a model of individual personal responsibility for health. CDC Director Rochelle Walensky emphasized that “your health is in your hands” [2], undermining the idea that fighting COVID is a “public” health responsibility that requires the support of institutions and communities. The social impacts of this scientific guidance, combined with the emergence of new variants, have exposed the fallacy of this approach, with most local mask restrictions lifted and infections rising dramatically among disadvantaged populations [3]. Rapidly rising cases prompted the CDC on July 27th to recommend resuming indoor masking even for vaccinated people in “areas of substantial or high transmission,” [9] but US policy continues to frame the pandemic largely as a matter of individual responsibility – to the detriment of public health. As public health professionals and advocates, we call for a renewed commitment to core public health principles of collective responsibility, health equity, and human rights.

Public health implicates government obligations to realize the health of populations, focusing on “what we, as a society, do collectively to assure the conditions for people to be healthy” [4]. Securing public health does not merely reflect the health of many individual persons, rather a collective “public” good that is greater than the sum of its parts. Public health actions protect and promote the health of entire populations through multi-sectoral interventions to address

underlying determinants of health. This focus on social determinants of health has gained consensus among public health scholars, yet many US public health efforts continue to center individual responsibility for personal benefit, rather than collective responsibility for public benefit.

Individualistic approaches to health, exemplified by the CDC's May 2021 mask guidance, ignore the impacts on health inequities, which have been exacerbated by the pandemic and continue to hinder vaccination access [5,6]. COVID-19 has disproportionately affected Black, Indigenous and People of Color because of structural racial inequities [3,5]. Many are essential workers with high exposure risks and limited workplace protections, who face vaccination barriers due to a lack of sick leave and existing caretaking responsibilities. These inequities compound vulnerabilities for those at high risk for infection and severe outcomes, including older and disabled or chronically-ill adults and children, and institutionalized populations. Overlooked inequities yield disproportionate COVID-19 disease, disability, and death in oppressed and excluded communities—even where there is overall disease reduction. Yet, such groups have often been omitted from discussions of public health policy, with their lives treated as expendable.

Public health protection is inextricably linked with human rights promotion. The right to health has provided normative clarity in public health policy and legal accountability for public health outcomes, focusing on the need to prevent disease at the population level to ensure the highest attainable standard of health for all [7]. In promoting individual rights to protect public health, the pandemic has shown the need for a response that prioritizes community trust and cooperative engagement. The CDC's decision to prioritize individual autonomy over public health ignores disease vulnerability, not only for at-risk individuals but the community.

Ongoing debates about CDC's mask guidance raise foundational questions about the meaning, purpose, and role of public health. Even as public health often seeks to project itself as “apolitical”, moral values permeate public health practice. Purportedly apolitical public health decisions, manifested in policy decisions that rationalize economic “reopening,” employ a cost-benefit analysis that prioritizes some lives over others and makes loss of life, sickness, and isolation seem acceptable, obscuring the reality that morbidity and mortality could be greatly decreased with appropriate structural mitigation.

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The current US approach continues to undermine the fundamental notion that all people are equal in dignity and rights. When the CDC Director speaks of a “pandemic of the unvaccinated,” [10] this implicitly assumes that those who become ill are responsible for their own suffering and that their deaths are acceptable—because they could have been vaccinated. These moral deficiencies reflect a larger neglect of collective responsibility, equity, and human rights in US public health policy. CDC guidance must consider the moral foundations of public health, providing a normative framework to support public health policy and practice.

We can draw inspiration for an alternative moral vision of public health from Native American responses, which centered community and existing networks of connections to successfully implement mitigation and vaccination measures [8]. Resuming masking indoors will be a critical step to reduce transmission and provides an opportunity to reorient the pandemic response to support the health of the public. Structural measures like enhanced workplace protections and sick leave, expanded support for unvaccinated communities and consistent messaging focused on collective responsibility would buttress this approach. These constitute important steps towards realizing the collective benefits of public health, the need to support equity, and the right to health—in the US and throughout the world.

Author statement

CT conceptualized the paper, with participation from all authors. All authors participated in writing the original draft and in reviewing and editing the final manuscript.

Declaration of Competing Interest

The authors have no conflicts of interest to declare.

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