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Covid-19: The Painful Price of Ignoring Health Inequities[1]

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Coronavirus disease (covid-19) provides a painful reminder of why inequities harm all of us. Equity is widely misunderstood as a zero-sum game—i.e. the gain of one individual or group results in the loss to another. Yet, covid-19 is able to enter and quickly spread because of the social cracks and fissures generated by inequities. These inequities, created and sustained by centuries of structural racism and other forms of structural discrimination, make large segments of our society vulnerable to catching and spreading a disease that affects all, with global socioeconomic impacts.

The U.S. is a case example of why racial, economic, and other inequities make us susceptible to pandemics. Ultimately these diseases are preventable only through social dependence and collaboration. 45% of U.S. adults between the ages 19 to 64 are inadequately insured and 44 million are underinsured as of 2018 leading to high co-pays and out-of-pocket costs. [1] These individuals may be less likely to seek care for early symptoms of covid-19, at high-risk of contracting the disease, and to then facilitate spread through whole populations.

Even more sobering is that more than 2 million Americans lack running water at home; and, Native American households are 19 times more likely (black and LatinX are twice as likely) than white households to lack indoor plumbing. [2] Thus, even basic infection control measures like handwashing become problematic. For impoverished countries, such problems can be the norm rather than the exception.

Education systems also face difficult decisions. In hard-hit areas within the U.S. and internationally, schools and universities are closing for weeks or longer. Many families depend on schools for nutrition and daytime supervision for younger children, and housing for older students. They may also lack technology for virtual education, leading to complex decision-making and delays in containment strategies.

The lack of guaranteed paid sick days for many workers, whose average wage is 10$/hour, may cause many to continue to work when they should be self-quarantining. [3] Telework is sometimes impossible for these workers, whose responsibilities require in-person interaction (e.g., home health aides). For households that depend on income from multiple adult workers or adult workers with multiple jobs, quarantine may not be a financially viable option.

Our treatment of undocumented populations, in the U.S. and abroad, also highlights the

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intersectional nature of inequities. These communities, lacking in basic resources like healthcare access, and fearing deportation and retaliation, have little incentive to report symptoms of covid-19. In many countries, they are forced into cramped and overcrowded conditions that expose them to human trafficking, sexual and physical violence, and transmissible diseases including covid-19. Such conditions are mirrored in other marginalized and forgotten communities, like our prison population. Ethnic minorities are grossly overrepresented in these communities—reflecting our historical legacy (and current reality) of racism. They are also the ones affected first and hardest. We see these currents of xenophobia and racism gaining strength as nationalism across the globe, contributing to fear, mistrust, and unwillingness to work together toward a common goal.

Several thoughtful recommendations have emerged for addressing inequities to improve our emergency preparedness for viral pandemics. [4] These recommendations range from the common sense (e.g., identify disadvantaged populations before a pandemic to address barriers to care) to more aspirational (e.g., develop international agreements to enable timely distribution of vaccines to disadvantaged groups). [4] Unfortunately, we are quick to respond when there is an urgent risk to our own safety or those we care about; and quick to forget when the crisis has passed and the only perceivable danger is to 'others.' Our tendency to distance ourselves from those we view as alien or intrinsically different from us puts everyone in danger. It is a fundamental misunderstanding of a risk that is always there and that can be mitigated only through effective contingency planning, requiring trust and a common denominator of commitment to our shared humanity.

With the covid-19 pandemic upon us, there is little question that we must act with urgency. It may be too late to prevent the wide spread of covid-19, but we might be able to mitigate its impact. Recognizing the significant gap in our preparedness around inequities, the state of Massachusetts in the U.S. has created a taskforce convening stakeholders from many different sectors—from healthcare to education. The goal is to rapidly develop a set of policy recommendations focusing on addressing the disproportionate burden that covid-19 will have on disadvantaged populations.

A range of potential approaches to help low-wage workers, people from ethnic minorities, immigrants, older adults, people with disabilities, and other historically oppressed groups all merit consideration. Some are specific to the U.S., like prohibiting Immigration and Custom Enforcement (ICE) from accessing health care facilities, shelters, and quarantine facilities; and assuring residents that medical care, testing, and quarantine facilities will be available to everyone without being questioned about immigration status. Unlike other high-income nations with universal healthcare, the U.S. must also consider whether to offer free treatment and vaccines.

Other potential approaches could be relevant to all states and countries. These include: 1) funding community-based organizations to support immigrant populations; 2) updating unemployment benefits, paid time off, paid family medical leave, and parental leave benefits to cover people across the entire socioeconomic spectrum for the duration of a pandemic; 3) ensuring that public-facing employees (e.g., first responders, health care) have access to the training and tools they need to safely perform their duties; 4) improving sanitation, and providing access to medical services, testing and quarantine facilities, for nursing homes, shelters, prisons,

detention centers, and people living on the street; 5) providing assistance to support basic needs like food for people in quarantine and clothing for those declining emergency shelter; 6) offering free meal delivery or pick-up for children receiving food assistance; 7) bolstering nutrition assistance programs so people have food to endure a 14-day quarantine; 8) increasing accessible care for people with disabilities in the event that normal support systems are disrupted; 9) accelerating broadband internet access to rural communities to increase opportunities for virtual work; and, 10) directing funding to government agencies and health departments to cover unexpected costs.

Other approaches can look toward preventing the next pandemic. For example, increasing investment in homelessness prevention activities will enhance the ability of individuals and families to weather public health emergencies such as infectious diseases.

It clearly serves all of us to end to the covid-19 pandemic quickly. But it is also time that we ensure that this pandemic does not widen the gaps between health haves and have nots. Doing so will require concerted effort towards ensuring health equity in a time of true and unique challenge for all of us.

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