VIEWPOINT

Health Equity During COVID-19

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The story of COVID-19 remains far from over, but we already know a principal lesson: disease prevention requires more than health systems. Although health systems are a critical component of public health, preventing death requires attention to the societal and economic conditions from which poor health emerge. People with chronic conditions are at increased risk of dying from COVID-19. This is, therefore, a disease that disproportionately kills people at the margins—individuals at heightened risk of morbidity and pre-mature death because of social circumstances and structural inequity and racism.

That social and economic inequality is a major proliferative vector of COVID-19 should not come as a surprise. This is not the first time the social forces underlying health have contributed to a public health emergency. Our country is simultaneously battling another public health emergency also fundamentally fueled by social and economic determinants: the opioid overdose crisis. However, our response as a society to the opioid crisis has focused on prescribing as the etiology, largely ignoring the role of social and economic factors, such as the concentrated disadvantage, isolation, and trauma that have come to define the post-industrial landscape for many Americans. The emphasis on opioid supply has come with certain benefits. For example, it has promoted excellent treatments, including medications like buprenorphine and methadone. However, it has also justified mass incarceration for drug offenses and social safety net cuts—policies and practices that exacerbate “diseases of despair” and thus counteract the hard work carried out by people working on the frontlines of our health systems¹.

In this moment, our focus is on curtailing the spread of the SARS-CoV-2 virus, widely considered the major vector of the COVID-19 pandemic. Health systems have done a remarkable job of mobilizing workforces to erect drive-through testing centers, pivoting to telehealth, and, ultimately, facilitating the

“shelter in place” model. However, these interventions require a certain amount of privilege and, in so doing, exclude the millions of people in our country who stand to be the most severely affected by COVID-19 due to the way in which poverty and poor health operate synergistically with addiction, psychiatric disorders, disability, unstable housing, food insecurity, immigration status, and criminal justice involvement. For people on the margins, there is no car available for drive-through testing, no home for sheltering in place, and no money to hoard toilet paper. For people living just inside the margins, there is no sick leave, quality child care, or health insurance or legal aid for when they are fired.

COVID-19 and the opioid crisis demonstrate that social and economic inequities act as ready-made proliferative vectors for large-scale threats. For example, obesity, as well as the respiratory, cardiovascular, and musculoskeletal conditions that may accompany it, seems to worsen the risk of death from COVID-19 and places people at risk of developing opioid use disorder^{2,3}. While we treat obesity as a medical condition, America’s “obesity epidemic” is shaped by policy decisions and systemic inequality, including agricultural subsidies that promote the sale of junk food ingredients, urban design and marketing, access to healthy food and green space, and the inadequate medical care available to many low-income individuals and people of color. This complexity is borne out in the COVID-19 data: in a recent study of COVID-19-positive patients in Louisiana, factors most associated with hospitalization included being black, obesity, utilizing public insurance, and living in a low-income neighborhood⁴.

While there is no short-term solution to long-term neglect, to emerge from the current crises and prepare ourselves for the next public health emergency, it is important that healthcare professionals adopt a health equity lens—one that prioritizes long-term solutions that center at the margins⁵. Ultimately, though, the ability of health professionals to implement an equity-driven framework is at least partially dependent on state and federal policies that dictate how low-income communities are governed and resourced. This reality makes many in medicine feel helpless and hopeless, as federal proposals that aim to strengthen the social safety net in a substantial way have remained out of reach. However, the response to the COVID-19 pandemic has shifted the scales.

This pandemic arrived in the USA during a democratic primary race animated by progressive ideas that would have seemed absurd just 10 years ago. Though they have suspended

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their campaigns, Bernie Sanders and Elizabeth Warren became campaign frontrunners by promoting policies like Medicare for All, free public college, paid family leave, and canceling student loan debt. For months, on the campaign trail and in televised debates, both candidates were repeatedly asked how they intended to pay for even one of these ambitious proposals, but the question was performative—anyone asking it had already decided there was in fact no way the US government would or could foot the bill for these vast expansions of public spending. Just 53 days after the first votes were cast in the primary, the president signed a historic \$2 trillion COVID-19 relief package that includes direct stimulus payments to tax-paying adults; expanded unemployment income eligibility, a \$600 increase in weekly unemployment benefits, and 13 additional weeks of benefits; 6 months of suspended payment and waived interest on federal student loans; and a 120-day eviction moratorium for renters who live in houses with federally backed mortgages. Already our lawmakers are in negotiations to pass another \$3 trillion relief package, with billions more in spending likely to come. These five trillion dollars is not a cure-all—the CARES Act had many deficits and the anticipated HEROES Act will as well. But the fact of this spending is remarkable: five trillion dollars would have covered the projected costs of both Sanders's “unrealistic” proposals for free public college and student loan debt cancellation, and housing for all.

We are all doing our best to reduce the number of COVID-19 deaths, and to keep our patients, ourselves, and our families as healthy as we can. Cynically noting that we seem to have suddenly found the ability to fund social spending and the political will to enact more compassionate policy is not helpful. But COVID-19 is forcing us to reckon with the ways in which we have neglected the holes in our social safety net as we are confronted with the reality that many are limited in their ability to help “flatten the curve.” Structural forces have always limited the options for individuals living at the margins, with insidious repercussions as we have seen with obesity, asthma, heart disease, and more recently the opioid crisis⁶. COVID-19 differs in that the dramatic repercussions for our health system and economy will bleed into the lives of those of us who previously had the privilege to compartmentalize these

truths and have failed to acknowledge the state of crisis many were living in before COVID-19, and will continue to experience long after we have a vaccine. The most effective prevention tool we have is public policy that prioritizes housing, healthcare, poverty reduction, and decarceration, making all of us less vulnerable to a threat like COVID-19. When we emerge on the other side of this pandemic, let us remember that publicly funded, robust, universal intervention felt urgent and necessary. Let us remember it is possible, and not just in times of crisis.

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Compliance with Ethical Standards:

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