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COVID-19 and the US response: accelerating health inequities

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Abstract

Health inequities have long defined health and the healthcare system in the USA. The clinical and research capacity across the USA is unparalleled, yet compared to other high and even some middle-income countries, the average health indicators of the population remain suboptimal in 2020, a finding at least in part explained by inequity in healthcare access. In this context, COVID-19 has rapidly emerged as a major threat to the public's health. While it was initially thought that severe acute respiratory syndrome coronavirus 2 would be the great equaliser as it would not discriminate, it is clear that COVID-19 incidence and mortality have rapidly reinforced health disparities drawn by historical and contemporary inequities. Here, we synthesise the data highlighting specific risks among particular marginalised and under-resourced communities including those in jails, prisons and detention centers, immigrants and the undocumented, people with disabilities and people experiencing homelessness across the USA. The drivers of these disparities are pervasive structural risks including limited access to preventive services, inability to comply with physical distancing recommendations, underlying health disparities and intersecting stigmas particularly affecting racial and ethnic minorities across the country, including African Americans, Latinx Americans and Native Americans. Advancing the COVID-19 response, saving lives and restarting the economy necessitate rapidly addressing these inequities rather than ignoring and even reinforcing them.

Introduction

Catastrophic events, from hurricanes to epidemics, are often seen as 'great levellers' where all in affected communities are equally at risk. Tragically, lower income communities may share some risks but generally suffer more in these emergencies and in their aftermath. They not only have fewer resources with which to rebuild lives, but often suffer greater exposures, morbidity and mortality than the employed, insured, stably housed and empowered. During and after Hurricane Katrina, for example, African American mortality in New Orleans was up to four times as high as that for white residents.¹ The same storm, but markedly different outcomes. With threats

directly related to health, lower socioeconomic Americans with limited access to care or health insurance are far more vulnerable than the poor of many higher income nations with national health schemes or universal health insurance. In addition, loss of jobs during a crisis places low-wage earners at risk of losing private insurance connected to employment.

These realities are being starkly laid bare in the COVID-19 epidemic and the markedly inequitable response in the USA. Job losses, already at over 36 million, are unprecedented.² And it is already clear that African Americans, Latinx persons and Native Americans are suffering disproportionately higher exposures to COVID-19, worse clinical outcomes and higher mortality.³ These disparities are complex in origin, and are, at least in part, an outcome of centuries of structural inequities in opportunity, education, employment, housing, healthcare access and income. In the USA, the disparities by race are further exacerbated by often being disproportionately represented in people who are in jails, prison and other forms of detention, the undocumented (who make up some 3% of the US population), those with disabilities, particularly those in institutional facilities, and people who are unstably housed; all are experiencing enormous challenges for which the current COVID-19 response efforts are inadequate. In the immediate term, we need to prioritise those with particular vulnerabilities and ensure that the response to COVID-19 appropriately addresses their health and well-being needs. In the medium and longer term, this great pandemic may force long-overdue structural changes to address persistent inequities in our society—not least, the need for healthcare access for all Americans.

People in prisons and jails

With almost 2.3 million incarcerated people, nearly 25% of the world's prisoners, the USA's vast criminal justice system disproportionately affects marginalised populations, particularly along lines of race and socioeconomic status.⁴⁻⁶ Incarceration rates for African American males are at least six times those of white males across all age ranges.^{5,7} Incarcerated communities are especially susceptible to the spread of COVID-19 due to pre-existing catalysts for disease transmission within prisons, such as close indoor confinement, overcrowding, poor nutrition and inadequate healthcare.⁸ Moreover, limited resources including soap and

cleaning supplies compound the risk of spread of droplet-based respiratory pathogens in jails.⁹ Additionally, the utilisation of prison labour continues to expand, which exacerbates the potential for viral spread and violates the International Labor Organization's Convention on the elimination of forced labour.¹⁰⁻¹² In the context of the COVID-19 epidemic, this prison workforce, largely made up of poor black and brown people, mirrors the demographics of those outside prison walls working in essential services and without personal protective equipment.¹³ As prisons continue to admit and release individuals, these risk factors for disease become a threat to public health both within and beyond prison walls. Although the Eighth Amendment protects prisoners against cruel and unusual punishment, poor conditions that threaten prisoners' health violate this right.¹⁴ Following the UN Standard Minimum Rules for the Treatment of Prisoners, some states have prohibited overcrowding to reduce the risk of disease transmission.^{15 16} Not all states have followed suit, however, with 17% of jails across the USA routinely operating at or above 100% capacity.¹⁷ Louisiana, a state that has the highest incarceration rate in the country and currently one of the worst COVID-19 outbreaks in prisons, now threatens to remove deadlines for prosecutors to file charges against detained people.^{18 19} This would violate their right to due process and poses an increased public health threat by further congesting correctional facilities. Measures to reduce overcrowding, provide adequate cleaning supplies and safely care for those who have been exposed to COVID-19 within prisons would fulfil states' obligations to protect human rights and public health. Only 1 month into the US COVID-19 epidemic, prison and jail related outbreaks had already been documented in numerous US states including New York State's Rikers Island, Marion, Ohio and in Chicago, Illinois.

Immigrants, refugees and asylum seekers

In Fiscal Year 2019, US Customs and Border Protection apprehended more than 474 000 families and 76 000 unaccompanied children, many of whom are asylum seekers who arrive at the southwest border with untreated underlying health conditions that have been worsened by their journey.²⁰ The likelihood of viral transmission among these communities is heightened by conditions of overcrowding and lack of basic sanitation at temporary holding centres and Immigration and Customs Enforcement (ICE) facilities when release combined with community monitoring strategies would serve the same purpose and avoid violations to the obligation for providing environments of humane custody.²¹ Well-documented forms of medical neglect including unreasonable delays, ineffective oversight and substandard practitioner care within ICE facilities further endanger health during this pandemic.²² As of 14 May 2020, ICE reported 943 confirmed cases of COVID-19 among detainees and 44 confirmed cases among employees at detention centres, often located in isolated towns with limited hospital and intensive care unit capacity.^{23 24} Limited resources pose even greater concern at makeshift encampments in Mexico, where over 56 000 asylum seekers, under the Migrant Protection Protocols programme, have been forced to live in unsafe, unsanitary conditions while awaiting their immigration court hearings.²⁵ Anti-immigrant policy and rhetoric are further encapsulated by the administration's new public charge rule, which can affect immigration cases for family members who use public service programmes, including food stamps and Medicare, and presents a deterrent for undocumented persons to seeking healthcare, including testing and clinical care for COVID-19.²⁶ Additionally excluded from healthcare coverage under the Affordable Care Act and working in low-wage essential jobs,

many undocumented immigrants face greater risk of infection, yet fall through gaps in the social safety net, including the recent federal relief packages.²⁶ The COVID-19 epidemic has shed a harsh light on inequities within the US immigration system that have long denied immigrant, refugee and asylum seeker populations of their rights to health and security.

People with disabilities

One in four adults in the USA has a functional disability, with mobility, cognitive and independent living disabilities among the most prevalent.²⁷ Secondary to complex interactions of socioeconomic determinants and access to health, disability rates of African Americans stand above rates of non-Hispanic whites in every age group.²⁸ In a recent study by the Centers for Disease Control and Prevention, developmental disability, independent of underlying chronic conditions such as lung disease, cardiovascular disease and diabetes, emerged as a notable risk factor for COVID-19 infection.²⁹ A larger study in New York offered similar findings, revealing that residents in institutional facilities or group homes for people with disabilities are more than five times more likely to contract COVID-19.³⁰ As of late April, of New York's 140 000 monitored people with disabilities, over 2012 have tested positive for COVID-19 and 300 have died.³¹ This translates to a death rate approximately 2.5 times higher than that characterising the state as a whole, with 214 deaths per 100 000 people with disabilities compared with 86 deaths per 100 000 New Yorkers in general.^{32 33} This high rate of death among people with disabilities is in part attributable to a critical factor: the inability to social distance. Many people with disabilities rely on caregivers for daily living, either in assisted living facilities, group homes or within their own homes, rendering social distancing practices nearly impossible. This pitfall, however, does not act in isolation. Other forms of structural inequity, including being more likely to be unemployed and impoverished relative to the rest of the population, compound this group's vulnerability.³⁴ Compared with those without a disability, adults with a disability account for more than half of the adult population living in long-term poverty, underscoring the inadequacy of public assistance programmes like Social Security Disability Insurance and Supplemental Security Income.^{34 35} In part a corollary of insufficient Medicaid coverage, many people with disabilities also often face immense difficulty affording and accessing needed healthcare, including specialty care, essential medical equipment and prescription medications.^{35 36} Healthcare utilisation challenges have intensified during the COVID-19 epidemic given that, increasingly, these services are harder to physically access especially in the absence of resources to leverage telehealth services. Notably, instead of implementing measures to ameliorate this inequity, policies are threatening to worsen them with some states endorsing guidelines to withhold ventilators and treatment from those with certain intellectual disabilities.³⁷

Unstably housed and homeless communities

On any given night, 550 000 Americans experience homelessness. With homelessness so intricately connected to unemployment and poverty, millions of Americans who have filed for unemployment are at an increased risk of housing instability and homelessness: during the Great Recession, homelessness increased by as much as 40% in some states.³⁸ The COVID-19 epidemic poses an increased threat to the lives of people experiencing homelessness and worsens the sustained inequities affecting these communities. The homeless populations in New York and Boston are currently the most affected, with 460 confirmed cases and 27 deaths among nearly 60 000 shelter residents accounted for by

the Department of Homeless Services in New York and nearly 600 cases in Boston, about 30% of those who have been tested.^{39 40} However, a model estimates that 21 000 hospitalisations and 3400 deaths could occur among homeless communities nationwide, owing largely to the prevalence of advanced or poorly controlled chronic illnesses, limited access to quality healthcare, and the myriad barriers to health and safety they encounter daily.⁴¹ The ability to effectively obtain medical care is secondary to basic human needs of food, shelter and safety.⁴² And the deprioritisation of the health needs of homeless communities will be aggravated as limitations are placed on food and other services provided by shelters, soup kitchens and outreach programmes, endangering the lives of any who become infected and those around them. Moreover, the recommended COVID-19 prevention measures including social distancing and maintaining hand sanitation are often unrealistic for those who live in crowded congregate settings without adequate hygiene facilities. Notably, congested, unsafe and unsanitary living conditions of shelters have long been known to increase potential for infectious disease transmission.⁴³ Fearing infection with COVID-19, some have chosen to leave shelters seeking shelter on the streets where they may be arrested or subway cars where they are exposed to essential workers commuting to work.^{44 45} While emergency housing facilities have been proposed, implementation of these plans has been slow, reinforcing risks of COVID-19 acquisition and transmission among those experiencing homelessness.⁴⁶

Conclusion

The COVID-19 pandemic is expected to have multiple waves associated with significant morbidity and mortality; each wave will likely perpetuate pre-existing disparities among marginalised communities across the USA and more broadly, around the world. Contrary to the oft used phrase that the 'virus does not discriminate', the data presented here suggest that this virus, as many other infectious diseases, has the greatest implications for the most vulnerable people. The intersections between health and human rights are clear—the health of a society and vulnerability to a pandemic are directly related to its human rights track record for those who are marginalised. Governments can ensure that policies respect human rights, including those that could prevent excess risks for people in jails and immigrant detention centres. The protection of rights suggests the need to ensure communities such as those with disabilities or who are unable to afford stable housing are equitably protected from COVID-19. Furthermore, the fulfilment of human rights for all would include access to those services and commodities, the current lack of which represents the crux of underlying health inequities being exacerbated in the context of COVID-19. To date, the response to COVID-19 has been an emergency response with broad police-enforced and population-wide mandates—including physical distancing—that are not feasible for those incarcerated, detained, living in shelters and potentially so for people with disabilities. Taken together, the data presented here suggest that advancing the COVID-19 response in the USA and around the world necessitates strategies of mitigating rather than reinforcing health inequities to be as central as testing, contact tracing, vaccine development and novel treatment strategies.

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