COVID-19 exacerbating inequalities in the US

COVID-19 does not affect everyone equally. In the US, it is exposing inequities in the health system. Aaron van Dorn, Rebecca E Cooney, and Miriam L Sabin report from New York.

In the US, New York City has so far borne the brunt of the coronavirus disease 2019 (COVID-19) pandemic, with the highest reported number of cases and the highest death toll in the country. The first COVID-19 case in the city was reported on March 1, but community transmission was firmly established on March 7. As of April 14, New York State has tested nearly half a million people, among whom 195 031 have tested positive. In New York City alone, 106 763 people have tested positive and 7349 have died.

"New York is the canary in the coal mine. What happens to New York is going to wind up happening to California, and Washington State and Illinois. It's just a matter of time", said New York Governor Andrew Cuomo, while asking for greater federal assistance. The response within New York City, known for its historically strong public health responses, has been to ramp up for the surge, but also to tailor the approach to address some of the most basic touchpoints that could worsen health outcomes, including providing three meals a day to all New York residents in need.

Oxiris Barbot, commissioner of the New York City Department of Health and Mental Hygiene stated, "Our primary focus at this moment has to be on keeping our city's communities safe. This means supporting the public hospitals with supplies; connecting underserved people to free access to care; and delivering health guidance through the trusted voices of community organizations. The COVID-19 pandemic will come to an end eventually, but what is needed afterward is a renewed focus to ensure that health is not a byproduct of privilege. Public health has a fundamental role to play in shaping our future to be more just and equitable."

Confirming existing disparities, within New York City and other urban centres, African American and other communities of colour have been especially affected by the COVID-10 pandemic. Across the country, deaths due to COVID-19 are disproportionately high among African Americans compared with the population overall. In Milwaukee, WI, three quarters of all COVID-19 related deaths are African American, and in St Louis, MO, all but three people who have died as a result of COVID-19 were African American. According to Sharrelle Barber of Drexel University Dornsife School of Public Health (Philadelphia, PA, USA), the pre-existing racial and health inequalities already present in US society are being exacerbated by the pandemic. "Black communities, Latino communities, immigrant communities, Native American communities—we're going to bear the disproportionate brunt of the reckless actions of a government that did not take the proper precautions to mitigate the spread of this disease", Barber said. "And that's going to be overlaid on top of the existing racial inequalities."

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Part of the disproportionate impact of the COVID-19 pandemic on communities of colour has been structural factors that prevent those communities from practicing social distancing. Minority populations in the US disproportionally make up "essential workers" such as retail grocery workers, public transit employees, and health-care workers and custodial staff. "These front-line workers, disproportionately black and brown, then are typically a part of residentially segregated communities", said Barber. "They don't have that privilege of quote unquote 'staying at home', connecting those individuals to the communities they are likely to be a part of because of this legacy of residential segregation, or structural racism in our major cities and most cities in the United States."

The negative consequences of health disparities for people who live in rural areas in the US were already a problem before the pandemic. Underserved African Americans face higher HIV incidence and greater maternal and infant mortality rates. Undocumented Latino communities working in rural industries such as farming, poultry, and meat production often have no health insurance. Poor white communities have been badly hit by the opioid crisis and across rural areas, especially in the southern states, high rates

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of non-communicable diseases are driven by conditions such as obesity. With higher COVID-19 mortality among those with underlying health conditions, these areas could be hit hard.

14 US states (mostly in the south and the Plains) have refused to accept the Affordable Care Act Medicaid expansion, leaving millions of the poorest and sickest Americans without access to health care, with the added effect of leaving many regional and local hospitals across the US closed or in danger of closing because of the high cost of medical care and a high proportion of rural uninsured and underinsured people. People with COVID-19 in those states will have poor access to the kind of emergency and intensive care they will need.

Native American populations also have disproportionately higher levels of underlying conditions, such as heart disease and diabetes, that would make them particularly at risk of complications from COVID-19. Health care for Native American communities has a unique place in the US. As part of treaty obligations owed by the US government to tribal groups, the Indian Health Service (IHS) provides direct point of care health care for the 2·6 million Native Americans living on tribal reservations. According to the IHS, there are currently 985 confirmed cases of COVID-19 on tribal reservations, and 536 cases in the Navajo Nation alone (the largest reservation). However, the IHS's ability to respond to the crisis might be limited: according to according to Kevin Allis, Chief Executive Officer of the National Congress of American Indians, the largest Native American advocacy organisation, the IHS has only 1257 hospital beds and 36 intensive care units, and many people covered by the IHS are hours away from the nearest IHS facility. The IHS also does not cover care from external providers. Although there is a provision of the CARES Act stimulus bill that is intended to cover those costs, it is unclear how effective it would be if someone covered by the IHS is transferred to a non-IHS facility.

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The CARES Act also included US$8 billion to supplement the health and economies of Native Americans and Alaska Natives. Even that number was an increase from what President Donald Trump's administration originally wanted. "We knew the White House wanted to give us nothing", Allis said. "And senate Republicans were okay with a billion and it fine-tuned its way to $8 billion." But the deep history of injustice by the US government towards these people means that the US response will be looked on with suspicion.

At the national level, the response has varied widely by state, with many states that voted for Trump in 2016—notably Florida, Texas, and Georgia—responding to the emerging pandemic later and with more lax measures. Florida Governor Ron DeSantis, a Republican Trump ally, was slow to implement social-distancing measures and close non-essential businesses, and Georgia Governor Brian Kemp ordered beaches closed by local authorities to be reopened on April 3. However, the trend has not been universal: in Ohio, Republican Governor Mike DeWine was swift in issuing orders to shut non-essential businesses and in responding to the crisis.

The federal response has also been overtly political. States with governors that Trump sees as political allies (such as Florida), have received the full measure of requested personal protective equipment from the federal stockpile, while states with governors whom Trump identifies as political enemies (such as New York's Cuomo, Oregon's Jay Inslee, and Michigan's Gretchen Whitmer, all Democrats) have received only a fraction of their requests. Trump has also publicly attacked the responses of those governors on Twitter and during his daily briefings. In distributing funds made available by the CARES Act, Trump also appears to be playing favourites: New York received only a fraction of the $30 billion hospital relief funds from the bill ($12 000 per patient), while other states much more lightly affected received more ($300 000 per patient in Montana and Nebraska, and more than $470 000 per patient in West Virginia, all states that voted for Trump in 2016).

Although the numbers of reported cases seem to be levelling off in New York City and other urban areas, perhaps evidence that social-distancing measures are beginning to have an effect, emerging morbidity and mortality data have already clearly demonstrated what many have feared: a pandemic in which the brunt of the effects fall on already vulnerable US populations, and in which the deeply rooted social, racial, and economic health disparities in the country have been laid bare.

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