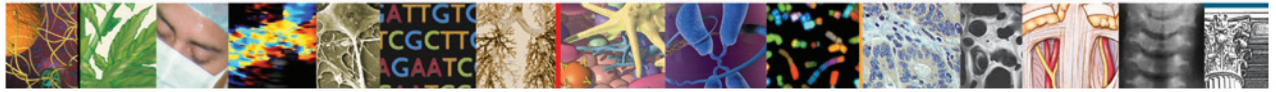

The NEW ENGLAND JOURNAL of MEDICINE

Perspective
SEPTEMBER 17, 2020

Covid-19 and Health Equity — Time to Think Big

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> It is not till it is discovered that high individual incomes will not purchase the mass of mankind immunity from cholera, typhus, and ignorance, still less secure them the positive advantages of educational opportunity and economic security, that slowly and reluctantly, amid prophecies of moral degeneration and economic disaster, society begins to make collective provision for the needs which no ordinary individual, even if he works overtime all his life, can provide himself.
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> — R.H. Tawney, *Equality* (1931)

The Covid-19 pandemic has exposed the magnitude of U.S. health inequities — which the World Health Organization defines as "avoidable, unfair, or remediable differences" in health. It has also highlighted structural racism — institutions, practices, mores, and policies that differentially allocate resources and opportunities so as to increase inequity among racial groups. Covid-19 mortality rates are more than twice as high in Black, Latinx, and Indigenous populations as in White populations, and the data reveal a strong socioeconomic gradient (https://covidtracking.com/race/dashboard).[1-3] As physicians with diverse identities (Jewish male, Black female, and South Asian American male) whose work focuses on health equity, we are acutely aware that our profession failed when vulnerable people needed us.

Recognizing that health inequities have structural causes warranting policy-level solutions, we believe that the Covid-19 health equity disaster carries some lessons from which we can derive actionable policy targets for both advancing health equity and improving the pandemic response.

The pandemic has demonstrated that our public health response cannot be divorced from public policy — federal and state legislation, federal and state program administration, and local ordinances. People cannot adhere to social distancing when it means leaving their basic needs unmet. Even before Covid-19, many Americans faced unmet basic needs. Now, one in four workers have lost their jobs, foreclosures and evictions threaten to reach record highs, and the prevalence of food insecurity has tripled, resulting in miles-long queues for food pantries.[4] These devastating effects pressure the people who are most vulnerable to Covid-19 to take health risks just to make ends meet. Moreover, inadequate federal support for basic needs and insensitivity to variation in what people need to weather this crisis lead to anger misdirected at state-level public health measures such as social distancing. That anger, in turn, contributes to decisions to lift these measures prematurely. Public policy should enable people to socially distance, not motivate them to oppose it.

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Public policy must also equip state and local governments to respond to Covid-19. The Federal Reserve has made available more than $2.3 trillion to support the financial system during the pandemic but has offered far less support for state and local governments. Often unable to run deficits, these governments must cut spending when revenue declines. Such cuts will probably have several detrimental effects: scaling back public health efforts, defunding state programs addressing basic needs, and spurring public-sector layoffs that stall economic recovery.

These policy failures disproportionately affect marginalized communities with high rates of underlying medical conditions. Moreover, in a pandemic, anything that increases the opportunity for disease transmission affects everyone. Such is the paradox of inequity: even the well-off are worse off than they would be if systems were more equitable.

Beyond revealing the need to integrate public health efforts with broader public policy, Covid-19 has demonstrated once again the outsized roles of structural racism and social determinants of health. When exposed to the same virus, Black, Latinx, and Indigenous Americans have more severe disease and higher mortality than White Americans. These disparities are structured by the conditions in which individuals are "born, grow, live, work, and age."[1,2] Greater investment in hospitals and clinics that serve marginalized communities is sorely needed.[3] But clinical care alone cannot compensate for a lifetime of accumulated disadvantage, nor will it dismantle the structures that perpetuate health inequities.

To achieve health equity, we need to reach beyond the health care system — and think big. New social policies on a few key fronts could advance both health equity and the Covid-19 response.

First, we propose establishing a universal food income. Food insecurity is a health equity issue that disproportionately affects racial and ethnic minority groups, people with lower incomes, and rural communities.[4] The Supplemental Nutrition Assistance Program (SNAP) is effective but has its limits: benefit levels are often insufficient to permit a healthy diet, and many people with incomes above the SNAP cutoff are nonetheless food-insecure. Universal basic income is now a serious policy consideration in the United States, but objections that unconditional cash payments might be used insalubriously are common. Alternatively, we suggest a universal food income that would provide all U.S. households with a monthly electronic benefit transfer payment whose use would be restricted to SNAP-eligible foods.

The benefit could be tied to the USDA Moderate-Cost Food Plan, which reflects the cost of a nutritionally recommended diet. The policy could be enacted in federal legislation (e.g., the Farm Bill) and, by guaranteeing sufficient income for a healthy diet, would have a substantial public health effect. Furthermore, food programs typically have high "money multiplier" effects — a dollar put into the program often produces more than a dollar in subsequent economic activity — which would support economic recovery.

Second, we recommend reforming unemployment insurance. Working conditions vary substantially by race and ethnicity, and precarious employment, low wages, and lack of benefits can undermine pandemic-control efforts. Before Covid, the unemployment insurance system had seen declining income-replacement levels and had not adapted to current labor conditions (e.g., independent contractors and "gig economy" workers are ineligible, despite representing a growing segment of the workforce). The Coronavirus Aid, Relief, and Economic Security (CARES) Act addressed many of these issues but will expire on July 31, 2020.[5] The fixes should be extended by federal legislation during the current crisis.

But ultimately, state-level reforms that increase the income-replacement rate and broaden eligibility are needed. Unemployment-insurance reform could enable social distancing by making it possible for more people to stay home. It would also help to improve health equity over time by giving workers a better bargaining position. A more robust unemployment-insurance system would make workers feel less pressure to accept dangerous or inequitable working conditions.

Finally, we need policies supporting investment in community development. Neighborhood-level differences in housing availability, education, and economic opportunity are key drivers of disparities. Historical and ongoing segregation, redlining, and underinvestment have led to a lack of high-quality affordable housing and depleted neighborhood resources.

Two key pieces of federal community-development legislation are the Low Income Housing Tax Credit and the Community Reinvestment Act (CRA). Rulemaking by the Office of the Comptroller of the Currency and the Federal Deposit Insurance Corporation

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also acts as an important lever for influencing CRA implementation. Community-development corporations, affordable-housing developers, and community-benefit financial institutions should take a strengths-based approach that builds on an area's assets by expanding affordable housing, mitigating toxic environmental conditions, and increasing local economic opportunity. Such development would not only help communities respond to the pandemic, but would also advance health equity over the long term by improving living conditions.

Decades of systemic underinvestment have contributed to health disparities, and it is unrealistic to think that health equity will be achieved without a major investment of resources. Where a society devotes its financial resources indicates its values. It is perverse to say that we value health equity if we aren't willing to make the investments necessary to redress inequities. If the Federal Reserve can come up with $2.3 trillion to support the financial system during the pandemic, providing adequate support for individuals is a matter of political will, not economic feasibility.

The Covid-19 pandemic affects everyone, but not equally. The same patterns of power, privilege, and inequality that run throughout American life are recapitulated in this health crisis. Nevertheless, every American is vulnerable to Covid-19. This fact should inspire values of collective action, solidarity, and universalism. Undoubtedly, some people will think these proposals are radical or ruinous. But if we want to take health equity seriously, now is the time to think big.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on July 22, 2020, at NEJM.org.

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DOI: 10.1056/NEJMp2021209

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