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Not Just a Pandemic: Why COVID-19 Is a Health Equity Issue

Mario:
We've long known that social, economic, and environmental conditions play a sizable roll in health outcomes, and unfortunately, these inequalities have become even more pronounced in a time of a pandemic. So, how can we better respond to the social determinants of health and address the rapidly rising health disparities witnessed during the COVID-19 pandemic and beyond?
You're listening to ReachMD. This is COVID-19: On the Frontlines. I'm Mario Nacinovich, and here with me is Dr. Renata Schiavo, a Senior Lecturer on Social Medical Sciences at Columbia University, Founder and President of the Board of Directors of the Health Equity Initiative, and Editor and Chief of the Journal of Communication in Healthcare, Strategies, Media, and Engagement in Global Health. Thanks so much for joining us today, Renata.

Dr. Schiavo:
Thank you very much for having me, Mario.

Mario:
So let's begin by taking a closer look at COVID-19 through this lens of health equity. First, is this pandemic a health equity issue, and if so, why?

Mario:
As you know, Mario, pandemics do not discriminate, and everyone is susceptible to contract any kind of infectious disease, including COVID-19. Yet, pandemics have a way of showing us the magnitude of health and social inequities that many people experience, which in turn, affect their ability to protect themselves. Pandemics actually thrive on inequalities since what some people may consider easy protective behavior are actually not easy for everyone. For example, hand washing is not easy for homeless people, who often lack access to water and soap and can't even practice social distancing because of the crowded conditions in which they live, if they are in a shelter. If we take factors influencing vulnerability during a pandemic, many of these factors have preexisting to the pandemic itself and have to do with many social and political determinants involved that affect the ability of people to protect themselves, but more, in general, to lead healthy and productive lives.

Mario:
So, which communities or populations specifically have been disproportionately affected by this virus?

Dr. Schiavo:
Well, there are many vulnerable, marginalized, and low-income populations who had been disproportionately affected by this pandemic. As you know, Mario, in the U.S., we have seen that the pandemic is having a bigger toll within communities of color, and this is the result of lack of investment in these communities, social discrimination, races, mild segregation, lack of access to services and opportunities, which in many communities, has resulted in poverty and higher rates of chronic diseases, such as diabetes and asthma, which are all conditions that can increase the risk for severe consequences of COVID-19. Also, I want to speak about children who live in poverty, who may not be at the greatest risk for life-threatening consequences to contracting COVID-19, but in many cases, depend on being in school for their meals and have been short changed by the pandemic and limited efforts, historically speaking, to address poverty elevation. So, the pandemic has shown us that we need to think of additional assistant to deliver nutrition to the 20+ million children who live in poverty in the United States, especially in communities of color that have been marginalized or discriminated against for centuries and experience higher rates of poverty.

Mario:

And what are some of the barriers identified for low income and marginalized communities during a pandemic like this?

Dr. Schiavo:
Well, a few group-specific barriers come to mind. For example, for many the option of staying home and protecting themselves by practicing social distancing or self-isolating is not really an option because many people don't have access to paid leave or paid sick leave and need to choose between staying home and pay rent and putting food on the table. So, I know that the paid sick leave provision in the Family First Coronavirus Act is a step in the right direction, but only addresses a minimal fraction of what we need. In fact, a million workers are left out from this provision, and these workers tend to be specifically from communities of colors or women or other low-income populations. In many cases, it's our workers who are putting their lives at risk so people can stay safe and have access to basic necessities, such as food and pharmacy cashiers. We also know that many marginalized populations, such as, people living with homelessness, disabilities, or mental illness, lack the kind of social support or resources to adopt and sustain protective behaviors. In some cases, such as for the homeless, it may be physical resources, something as simple as water and soap. But others may be the lack of structural or urban or social resources and support to comply with the commanded behaviors. Finally we know that in some hospitals, resources such as ventilators, masks, and other protective equipment may be even scarcer. This is likely to be the case in low-income communities and communities of color because of the historical lack of investment in this communities. This is why I've been advocating for professional association and community leaders to come together and, ultimately, to develop guidelines for the use of scares resources, which should be based on needs and fairness and equity principles.

Mario:
Now another important aspect of this that I'd like to bring up is the influx of inaccurate information about the virus, which itself is often labeled as an info-demic. Can you speak to that issue and how it impacts vulnerable populations, in particular?

Dr. Schiavo:
This is a very important question, Mario. Yes, we are in the midst of a COVID-19 info-demic. There is a lot of misinformation out there on all the topics we have discussed and much more. Social media may not had been an issue in past epidemics and outbreaks, but it's definitely an issue now. This is for me, particularly concerning for low health literacy and other vulnerable populations, who may not have the training, tools, or resources to distinguish between evidence-based information and fake news. For example, many of them may not use social media where a lot of information often happens to circulate, but they're still speaking with people who get information from social media. So, for this, it's important to continue to strengthen this communication system by engaging community leaders as scarce sources address the sources directly and occupy social media with the right information. Because if we don't do it, others will occupy the media with the wrong information.

Mario:
For those just tuning in, this is COVID-19: On the Frontlines on ReachMD. I'm Mario Nacinovich and joining me to talk about COVID-19 as a health equity issue is Dr. Renata Schiavo from Columbia University. So, Renata, now that you've given us a better understanding of the barriers faced by the at-risk populations, what actionable steps can we take to protect them during and after the COVID-19 pandemic?

Dr. Schiavo:
We mentioned before the importance of expanding paid leave provisions to protect all workers now and beyond this pandemic, as well as responding upon current systems to deliver nutrition to children who live in poverty. But an underlying principal among these and other kind of provisions, which all started with collecting real data, race, ethnicity, and language data that can actually give us an idea of who exactly the pandemic is impacting, we know that has a higher burden in community of colors, in disadvantaged, low-income communities, but the data needs to be there and needs to be disseminated broadly, but in addition to which I think that the very big fact is to try to think about advocating for an expanded role of government in stimulating the economy, protecting workers from low-income communities, or are more likely to lose their job during or after this pandemic, as well as for essential services that people need for the response now as well in the future.

Mario:
And that's the perfect segway into our discussion on community engagement and advocacy during and after this pandemic. How do we go about engaging those community leaders and local support networks in public health and get them involved in an unprecedented time like this, but also allowing them to remember that this is something that is pervasive and has happened before this pandemic and will continue to happen after this pandemic?

Dr. Schiavo:
I feel community engagement and advocacy is really key during pandemics because removing barriers to protected behaviors also is linked to community ownership of solutions for implementing such protected behaviors. So, ultimately, this is linked to the sustainability

of the health and social behaviors and policies and goods and services that need to be disseminated and implemented during this pandemic and beyond. So when we involve communities, it is more likely that they are going to endorse protective behavior. They are going to find local solutions to implement them. That this behaviors and recommendations reflect their values and the conditions in which they live, and ultimately, we change the system as a whole, and we create the community and patient ownership of solutions. So, this is a very important action that has been demonstrated to be helpful also in the outbreak control and risk communication across the infinite pandemic and epidemics, such as SARS, HN11, and Ebola. Taking Ebola just like the latest example of those pandemics, several case studies and Sierra Leone Liberia by UNICEF showcase that the Ebola crisis started to be mitigated only when community got involved in becoming the fastest source of information with their community members about developing care centers, finding solutions, and much more. In this COVID-19 pandemic, for example, in the United States, some communities have been installing temporary sinks for the homeless just to provide them a resource for washing their hands. But in order to channel and maximize a path to these community efforts, we need really to connect with our worker's organization and with the research groups, who work directly with these communities, have the ability to actually provide resources and training for community leaders to reach policy makers and influence policy making, and we also need to use the great power of media or blogs or the internet, all of these kind of resources to amplify the voice of community leader. So, I think that community engagement and advocacy are really connected to each other and are very important during the COVID-19 crisis and beyond.

Mario:
So, lastly Renata, you've been very outspoken, even before this current pandemic began, about the need for a paradigm shift and to move from a disease-only based approach to one that's more attuned to the social determinants of health. Can you elaborate more what this looks like compared to the current system and how you would go about changing things going forward?

Dr. Schiavo:
Right, so a disease-based approach tends to focus on health conditions, on the medical courses, on symptoms, how we treat them, how we prevent them, and they focus primarily on the behaviors of patients and the people who can influence them. But these approaches often are very oblivious to the number of barriers that people experience in having to implement this recommended behavior, whether it is protected behaviors or health behaviors in general, and it is a very limited sustainability because it doesn't have a barrier-driven pathergy beyond or commending these health behaviors. So, I have been advocating for a while for a social-determinant approach, to move toward addressing the root courses that people experience in the living and working environment to implement healthy behavior. This approach has to do with community and patient engagement because as I mentioned before, it's important to get the endorsement, the ownership, the communities, the patients, and every kind of change we want to make. So, I feel that this approach is practically important with current talks of reopening many economies in a way, and I feel there are some important conditions to be met, even before we can start contemplating this option. We need an increased amount of funding to strengthen the public health and social infrastructure to build strong surveyance and test assistance and address the many barriers people face, whether it is paid leave or nutrition or others. If we do it right, it will be beneficial for population and community health accounts outside of this pandemic. I strongly believe the systems designed with pandemic in mind are likely to help with chronic disease prevention, with decreasing infant and maternal mortality, but also alleviating mental health issues and preventing substance misuse and suicide, just to name a few of the many issues that a system that is designed with pandemics in mind may help alleviate. This will all see through our preparedness to respond to epidemics and emerging diseases outbreaks, but during this COVID-19 pandemic and in future outbreaks, this is only possible, in my opinion, if we use a health equity lens and methodically address the key social determinants involved to the key barriers people experience in protecting their self and ultimately, leaving a healthy and productive life.

Mario:
Well with that closing comment, I'd like to thank my guest, Dr. Renata Schiavo for your leadership, for your research, and certainly for joining me today to shed light on the rising magnitude of health disparities, but even more importantly the steps we can take to protect these vulnerable and marginalized populations not only during the pandemic but certainly as we look forward to a brighter future beyond COVID-19. Renata, it was great having you on the program today.

Dr. Schiavo:
Thank you very much for inviting me, Mario.

Mario:
For ReachMD, I'm Mario Nacinovich. To access this episode and others from COVID-19: On the Frontlines, visit reachmd.com\covid19 where you can be part of the knowledge. Thank you for listening.