CHAIN Centre for Global Health Inequalities Research

The COVID-19 pandemic and health inequalities: *we are not all in it together*

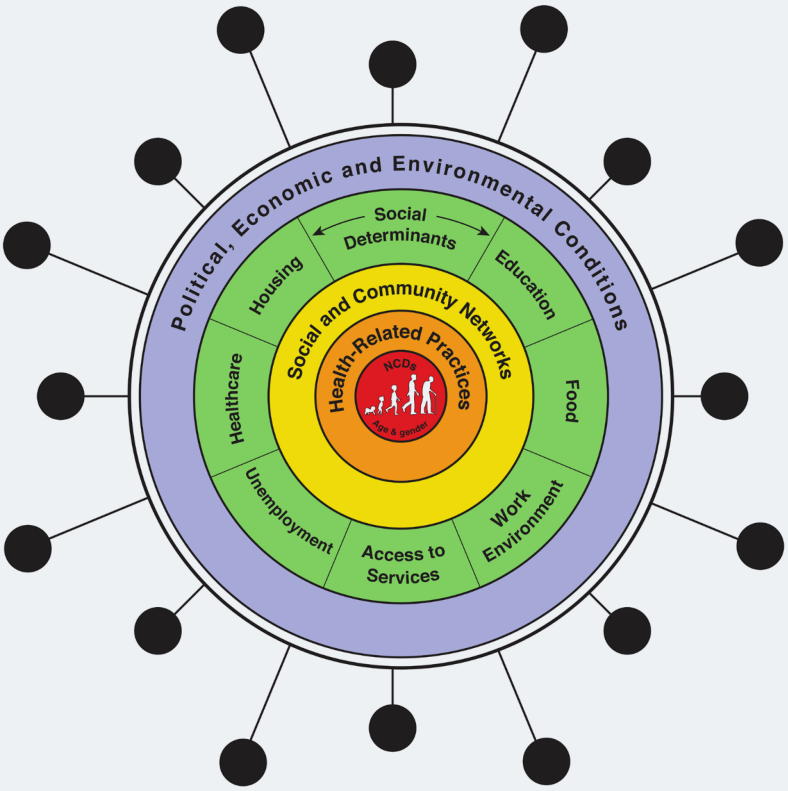
Emerging evidence suggests that COVID-19 is experienced unequally, with higher rates of infection and mortality among the most disadvantaged communities: it is not a socially neutral disease.

COVID-19 is a **syndemic pandemic**: it interacts with and exacerbates existing inequalities in chronic diseases and the **social determinants of health**.

The prevalence and severity of the COVID-19 pandemic is magnified because of pre-existing epidemics of chronic disease — which are themselves associated with social determinants of health, such as housing and work conditions and access to quality healthcare.

The social determinants of health are the conditions in which people live, work, grow and age.

The 1918 Spanish influenza pandemic and the H1N1 outbreak of 2009 were also experienced unequally. Prevalence and mortality rates differed between high- and low-income countries, neighbourhoods, lower and higher socio-economic groups, and between urban and rural areas. In the 1918 pandemic, for example, India had a mortality rate 40 times higher than Denmark.



The syndemic of COVID-19, non-communicable diseases (NCDs) and the social determinants of health (from Bambra et al, 2020)

Health inequalities are the differences in health between different groups of people which are avoidable by reasonable means.

The syndemic pandemic explained

— **What is a syndemic?** *A syndemic occurs when risk factors for illness are intertwined, cumulative, and interactive – thereby increasing the disease burden and its negative effects. It was first defined by Merrill Singer to understand relationships between HIV/AIDS, substance abuse and violence in the USA in the 1990s.*

Who is COVID-19 likely to affect more?

- minority ethnic groups
- people living in areas of higher socioeconomic deprivation
- people living in poverty or working in low income (often key) jobs
- marginalised groups such as homeless people, prisoners and street-based sex workers

Why?

Inequalities in chronic diseases: These groups are more likely to present underlying clinical risk factors such as hypertension, diabetes, asthma, chronic obstructive pulmonary disease (COPD), heart disease, liver disease, renal disease, cancer, cardiovascular disease, obesity and smoking.

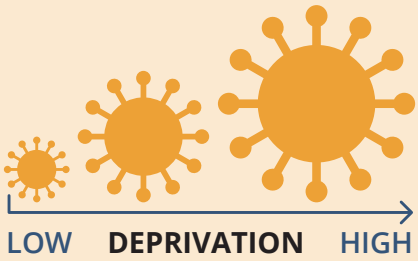
Inequalities in exposure to the social determinants of health: These groups are more likely to face adverse working conditions, unemployment, less access to essential goods and services (water, sanitation and food), poor quality or insecure housing, chronic stress and anxiety, and greater difficulties in accessing healthcare.

Underlying chronic conditions and unequal living and working conditions can increase the prevalence and severity of COVID-19 infections.

Working conditions:
People in lower-skilled and lower-paid jobs are more likely to be exposed to adverse and unsafe working conditions. These in turn are associated with increased risks of respiratory diseases, certain cancers, musculoskeletal disease, hypertension, stress and anxiety. During this pandemic, they are also more likely to be designated "key workers" (e.g., cashiers and delivery service workers), meaning they are required to go to work, even as others work from home. They often need to rely on public transport to do so. All these factors increase their exposure to the virus.

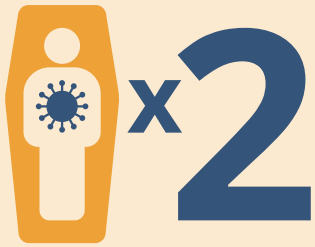
Living conditions:
Lower socio-economic groups more often live in poor quality or unaffordable, insecure housing. They are more likely to experience overcrowding, lack of outdoor and green space, greater exposure to psychosocial stressors (e.g., crime), and increased risk factors for chronic conditions (e.g., damp conditions leading to respiratory illnesses). This is particularly the case for people living in deprived urban areas. They therefore have a higher rate of negative health consequences, which may contribute to inequalities in COVID-19 outcomes. These factors can also increase transmission rates.

COVID-19
is experienced more severely in disadvantaged neighbourhoods



The rate of COVID-19 **infection is three times higher** in the most deprived areas of Catalonia (Spain) compared to the least deprived.

A dramatically **increased risk of deaths** was observed among residents of the most disadvantaged areas the USA.



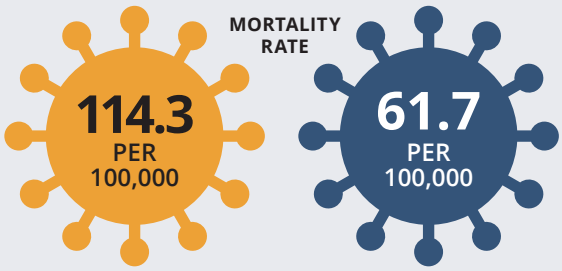
COVID-19 **mortality is twice as high** in the most deprived neighbourhoods in England and Wales.

COVID-19
highlights existing race and socio-economic inequalities: Multiple aspects of disadvantage are coming together.

Black, Asian and **minority ethnic people** accounted for 34% of 10,917 **critically ill** COVID-19 patients in England and Wales (in the period ending August 31, 2020), but only 14% of the **total population**.

In the USA (in the period ending November 10, 2020), the COVID-19 mortality rate for **Black Americans** was 114.3 per 100,000 population compared to 61.7 per 100,000 among **White Americans**. If they had died of COVID-19 at the same rate as White Americans, 21,200 Black Americans would still be alive.

*Source: APM Research Lab



The impact of the 'great lockdown' and economic recession on health inequalities

The policy responses undertaken to curb the spread of the virus, such as lockdowns, are also connected to inequalities.

Lockdowns are experienced unequally. They can have immediate impacts on health inequalities, due to:

Housing conditions: overcrowding, little access to outside or green space

Working conditions: job and income loss, inability to work from home resulting in higher exposure to the virus

Physical health: reduced access to healthcare services for non-COVID-19 reasons

Strain on **mental health** and an increased risk of experiencing **gender-based violence**

The longer-term and largest consequences on health inequalities derive from political and economic pathways.

Sudden economic shocks (like the collapse of communism in the early 1990s and the global financial crisis of 2008) lead to increases in morbidity, mental ill health, suicide and death from alcohol and substance use. These health impacts are not shared equally—during the crisis of 2008, areas of the UK with higher unemployment rates had greater increases in suicide rates, and people living in the most deprived areas experienced the largest increases in psychiatric morbidity and self-harm. Unemployment (and its well-established negative health impacts in terms of morbidity and mortality) is disproportionately experienced by those with lower skills or who live in less buoyant local labour markets.

The health consequences of the COVID-19 economic crisis are likely to be similarly unequally distributed — exacerbating existing health inequalities.

What can be done?

COVID-19 is likely to lead to a global economic recession. The effects of recessions on health inequalities vary by public policy response.

Countries such as the UK, Greece, Italy and Spain who imposed austerity (significant cuts in health and social protection budgets) after the 2008 financial crisis experienced worse population health effects than countries such as Germany, Iceland and Sweden, who opted to maintain public spending and social safety nets.

A global recession could increase health inequalities, particularly if health-damaging policies of austerity are implemented.

It is vital that the right public policy responses are undertaken so that the COVID-19 pandemic does not increase health inequalities for future generations. These include:

- expanding social protection
- expanding public services
- pursuing green inclusive growth strategies.

*The public health community must win the **'peace'** as well as the **'war'**.*

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