

# Coronavirus Health Inequities in the United States Highlight Need for Continued Community Development Efforts\*

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## Abstract

The coronavirus (SARS-CoV-2) pandemic of 2020 has shown a spotlight on inequity in the USA. Although these inequities have long existed, the coronavirus and its disparate impact on health in different communities have raised the visibility of these deeply ingrained inequities to a level that has created a new awareness across the US population and an opportunity to use this heightened awareness of the existing conditions for change. 'Community and social development' efforts in the post-pandemic USA can be informed by a health justice framework, across economic, societal and cultural, environmental and social dimensions. Dimensions which have all been implicated in the coronavirus response and complement other social and community development models. Although health disparities and inequities did not begin with coronavirus and will not end in the post-pandemic USA, social and community development efforts which value health justice and concentrate on social determinants of health can provide needed policies and programmes for a more equitable US health system.

## Keywords

Coronavirus, COVID-19, community development, macro social work, health inequity

\* All views are of the author's and do not represent those of the schools or agencies.

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The coronavirus (SARS-CoV-2) pandemic of 2020 has shown a spotlight on inequity in the USA. Although these inequities have long existed, the coronavirus and its disparate impact on health in different communities have raised the visibility of these deeply ingrained inequities to a level that has created new awareness across the US population. The US policies addressing existing conditions across multiple dimensions impacting health, for example, economic, ecological, cultural and social, are inadequate to protect many from inequitable health consequences of coronavirus. Increased community and social development efforts are needed following the pandemic to pursue changes to move the country towards equitable conditions for health and health access.

This article will provide a snapshot of the demographics of the USA and the ways that coronavirus has spread through the country. From there it will describe the governmental response, including the policies and programmes put in place during this time. It will analyse the issues encountered as the USA has grappled with the current pandemic as well as lessons learned through these issues. Lastly, there will be a discussion of implications for community and social development practices in the post-pandemic USA if we are to reduce health inequity in the USA.

## **Demographics in the USA**

The USA is a diverse society comprised of 50 states, the District of Columbia and 5 territories. The population of 328 million people is increasingly non-White with 2019 data showing 60.4 per cent White, 18.3 per cent Hispanic or Latino, 13.4 per cent Black, 5.9 per cent Asian, 2.7 per cent Multiracial, 1.3 per cent American Indian or Alaskan Native and 0.2 per cent Native Hawaiian or other Pacific Islander.

A total of 16 per cent of the population is over the age of 65. In comparison, 22.4 per cent of the population is under 18 years old. A large percentage of the population has completed high school or higher at 87.7 per cent with 31.5 per cent completing a bachelor's degree or higher. A total of 3.5 per cent of the US populations is gay, lesbian or bisexual with an additional 0.6 per cent identifying as transgender or nonbinary (Gates, 2011; Herman et al., 2017). One in four (26%) person in the USA have a disability (Centers for Disease Control and Prevention [CDC], 2019). Approximately 12 million persons in the USA are undocumented immigrants (Baker, 2018, p. 13).

Poverty impacts 38.1 million persons in the USA or 11.8 per cent of the population (US Census Bureau, 2020). The impact of poverty is not shared equally. Persons of colour experience poverty at a much higher rate than their percentage of the overall US population (Kaiser Family Foundation, 2019b). The US lesbian, gay, bisexual and transgender (LGBT) populations experience poverty at a higher rate than cisgender straight persons (Badgett et al., 2019, p. 47). Income inequality has been steadily increasing in the USA since the 1980s. The increasing disparity between the higher and lower earners and decline of the middle-income

earners may have a negative impact on political influence and capital for those in lower-earning groups (Menasce Horowitz et al., 2020).

It is also important to understand the data on healthcare coverage and access in the USA when examining social determinants of health and health equity. The Kaiser Family Foundation provides critical information on health coverage in the USA (Kaiser Family Foundation, 2019a). The largest source of health coverage (49%) in the USA is an employer offered programme, through either the persons themselves or an employed family member. The next largest sources are public programmes, Medicaid (20%) for those who are lower income and Medicare (14%) for persons 65 years old and older. It is important to note that in some states a person must meet both financial and categorical (e.g., pregnant or disabled) criteria to qualify for Medicaid. Other categories of coverage include non-group plans (6%) purchased through directly through private insurance companies, including those purchased from insurance exchanges created by the 2010 Patient Protection and Affordable Care Act (PPACA; Rangel, 2010) and military coverage (1%). The remainder is uninsured (9%). Persons who are undocumented immigrants are unable to qualify for any public health coverage programmes. Since the creation of the PPACA, the percentage of those who are uninsured has fallen from 15 per cent in 2008 to 9 per cent in 2018, but still in 2018, 28 million persons were left uninsured. Among those who are uninsured, there are clear racial and ethnic disparities. According to a Kaiser Family Foundation report,

Hispanics are two and a half times more likely to be uninsured than Whites (19% versus 7.5%) and individuals with incomes below poverty are four times as likely to lack coverage as those with incomes at 400% of the federal poverty level or above (17.3% versus 4.3%). (Artiga et al., 2020a, para. 3)

American Indians and Alaskan Natives have the highest uninsured rate at 21.8 per cent and Black persons are uninsured at a rate of 11.5 per cent (Artiga et al., 2020a).

## Coronavirus in the USA

The first documented case of coronavirus in the USA was discovered on 20 January 2020 in Washington State. The patient had recently returned to the USA after visiting family in Wuhan, China. Shortly thereafter, the US president, Donald Trump, closed the US borders to any non-US resident travelling from China. Although this travel ban was in place, travel from the rest of the world continued and, as of May 2020, all 50 states recorded case of coronavirus (CDC, 2020b; *The New York Times*, 2020).

The coronavirus first began appearing on the West Coast of the USA then shifted to the East Coast of the USA. The USA entered a phase of community spread throughout the country. As of 25 May 2020, the USA had 1.67 million cases of coronavirus, nearly 100,000 deaths and an incomplete total of those recovered (Johns Hopkins Coronavirus Resource Center, 2020). Nearly all

counties in the USA now have positive coronavirus cases. While the major hotspots remain in large urban areas, some of the most recent hotspots are in rural countries, with the outbreaks often related to factories and prisons (Dreier, 2020; *The New York Times*, 2020).

It is impossible to ignore the racial, ethnic and income disparities present in those impacted by the coronavirus (Artiga et al., 2020b; Gibson, 2020; Walsh, 2020). Gibson (2020) writes, 'The COVID-19 virus was once called the "great equalizer" because of its potential to infect anyone and everyone at pandemic speed. But data on mortality rates tell a different story'. The CDC released a report on initial racial and ethnic disparities in coronavirus hospitalizations and deaths (CDC, 2020a; Garg, 2020). The data show that Black individuals were overrepresented in hospitalizations. A total of 33 per cent of patients hospitalized were Black though they represented only 18 per cent of the community. Death rates for Black populations (92.3 deaths per 100,000 population) and Hispanic populations (74.3 per 100,000) were higher than White populations (45.2 deaths per 100,000) and Asian populations (34.5 deaths per 100,000; CDC, 2020a).

Poverty and long-standing structures of racism perpetuate health inequities, and the coronavirus pandemic merely reflects what has already been present under the current structures. Theoharis (2020) writes,

In New York City, now the global epicenter of the pandemic, for instance, the areas with the highest rates of positive tests overlap almost exactly with neighborhoods where the most 'essential workers' live ... most of them are poor or low-income ones, 79 per cent of them black or Latino'.

While New York City serves as an example, the disparate impact is present in many other cities throughout the USA, including New Orleans, Chicago and Detroit (Perry et al., 2020).

The impact of poverty and its consequences for health are numerous. Given the US reliance on employment-based health insurance, persons who work in lower-income jobs often do not qualify for public insurance programmes like Medicaid, but also do not qualify for, or cannot afford, employment-based health insurance coverage (Tolbert et al., 2019); notably, people of colour are at higher risk of being uninsured in the USA. Lack of access to coverage can impact the ability to access healthcare services and even create a reluctance to seek healthcare when ill.

Stigma and resultant stress can also impact the health of populations and the frequency of underlying health conditions, which can put persons more at risk for serious health consequences (Kane et al., 2019; Link et al., 2018; Link & Phelan, 2006), including increased vulnerability to coronavirus. Black and Hispanic persons are also overrepresented in industries which are considered essential, putting an increased toll on those in these industries to work outside the home despite stay-at-home orders and risk infection. Many of these jobs do not provide paid sick leave and require persons to choose between going to work sick or losing livelihood. Additionally, Black and Hispanic persons are overrepresented in congregate settings of jails and prisons which also put them at increased risk (CDC, 2020a).

The American Medical Association released a report on 8 April 2020, calling for increased data collection on racial and ethnic data (Maybank, 2020). The impact of coronavirus on different populations is only beginning to be understood, but without data, important health consequences may be missed and will not be prioritized. As of the April report, less than a dozen states were reporting data on race and ethnicity in coronavirus data.

## **Governmental Response**

The governmental response to the coronavirus must be examined with an understanding of the impact on social determinants of health and health inequity if one is to work towards greater health equity. Social determinants of health are ‘the conditions in which people are born, grow, live, work and age’ (World Health Organization, 2020, para. 1).

Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair and could be reduced by the right mix of government policies. (World Health Organization, 2018, para. 4)

The response of the US government at both the federal and state levels contain policies which seek to address some of the social determinants of health, though these policies are generally limited to the duration of the public health emergency. Other areas of need are not addressed. An exploration of the response provides insight into what is possible in the USA when there is political will and can serve as a guide for those working in community and social development to advocate for more long-term use of policies which were effective.

### ***Federal and State Public Health Response***

The US government is designed as a federalist system. Generally, public health powers reside under the police powers of the individual states. Traditionally, the federal government has created strong guidance documents for coordinated state responses and the provision and distribution of scarce resources needed in a public health emergency.

The US government, under President Trump, has changed the traditional federal role and response. The administration created a ‘Coronavirus Task Force’ under the office of the vice president. Previous administrations have had similar groups (Carter et al., 2017) but generally they have resided under science-based agencies (Berman & Carter, 2018). Although he chose to enact a travel ban from China in January, on other issues, such as procurement of ventilators, personal protective equipment (PPE) and testing equipment, the states have been encouraged to create their own plan and contact the federal government for assistance when needed.

As states worked to obtain PPE, ventilators and testing equipment, they reported negotiating against each other, often resulting in higher cost. Some states have responded by creating regional coalitions which work together to procure these resources (Segers et al., 2020). States have described the federal government bidding against them, resulting in their inability to get the resources they need. The federal government, in response, agreed to exit negotiations when states were working to get the resources. The federal government has also worked in more recent days to provide testing equipment and ventilators to the states (Feiner, 2020; McBride, 2020; National Governors Association, 2020).

States have primary responsibility for determining the extent of stay-at-home orders for their states. Some states, recognizing the potential for the spread between states, also created regional alliances to guide their stay-at-home order responses (Davis, 2020; Reston et al., 2020; Segers et al., 2020). The federal government created a 15 days to Slow the Spread campaign designed to encourage persons to stay at home (The White House, 2020a). Soon after, despite public discussions of the economic impact of the stay-at-home orders, the White House changed the recommendation to 30 days (The White House, 2020b). On 13 April 2020 governors from New York and California announced they would let 'science, not politics' guide their reopening plans (Chappell, 2020). On 16 April 2020, the White House released guidelines for states to follow as they began to lift restrictions (Dawsey et al., 2020). The transition to lifting restrictions has been difficult. Some states saw protests in response to governors recommending continued social distancing. And though the White House released guidelines for states to follow to reopen, the president encouraged states publicly through Twitter to lift restrictions even when those states did not yet meet the White House guidelines to reopen (Andone, 2020; Bogel-Burroughs & Peters, 2020; Cook et al., 2020). The result has been inconsistent messaging, which can cause concern in a public health emergency.

Coronavirus continues to be spread in the community across the US, despite some downward trends in new cases and deaths, primarily in New York (*The New York Times*, 2020). As of 18 May 2020, 44 states lifted restrictions or regionally reopened while 2 states planned to begin lifting restrictions soon and 4 states remain closed (Mervosh et al., 2020). Scientists fear reopening may be occurring too fast, and we will not know for another two to three weeks when it will be seen if those states may face another wave of infections (McNeil, 2020).

### ***Economic Response***

In addition to the administration, Congress also worked to address the economic impact of the coronavirus pandemic. To date, Congress passed three separate stimulus bills directly related to the coronavirus. Each bill contained specific provisions to ensure protections for the economy, individuals, state and local governments, and funds for the federal response. States also worked to create meaningful responses to the economic impact in their states. While the federal government can borrow money, most states are required to operate within a balanced budget.

### *Federal Stimulus Acts*

On 6 March 2020, Congress passed the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (Lowey, 2020a). This bill contained emergency funding to support coronavirus research and vaccine development and additional funding aimed at support for medical surge capacity. Shortly following the first bill, Congress passed the Families First Coronavirus Response Act (Lowey, 2020b). This second bill was much wider in scope and sought to address the expanding concerns surrounding the loss of work and resulting loss of healthcare coverage being experienced by a growing number of those in the US. The bill required some safety net mechanisms not currently available in the US. It made changes to administrative requirements for unemployment benefits to allow easier access. It also provided increases for the Supplemental Nutrition Assistance Program (SNAP). Additionally, as people were losing access to their health insurance coverage due to lost work (a unique employment-based structure in the US), the bill provided free access to coronavirus tests.

The bill on 27 March 2020, the Coronavirus Aid Relief and Economic Security Act (CARES Act; Courtney, 2020), was the largest financial provision yet. The bill was broad in scope and not only included expansion to some safety net provisions but also sought to provide direct relief to some citizens. The bill had bipartisan support in both chambers of Congress. The bill provided loans to travel industries as well as other large industries. It also increased small business loans and guidelines allowing tax credits and deferrals as well as specific restrictions requiring a specific percentage to be spent on payroll if loan forgiveness was desired. It provided relief to healthcare sectors including payments to medical providers and hospitals, payments to increase PPE access for medical providers as well as the national stockpile, promotion of telehealth, funding for public health education campaigns and temporary increases in Medicare payment. In addition, the bill supported individuals by providing a one-time payment to those under certain income levels and phased out incrementally above the income guidelines. The bill provided one-time direct payments for qualified children, a drafting choice which left persons with disabilities over 16 claimed as dependents or students still claimed as dependents by their parents with no stimulus payment. No stimulus payments were available for undocumented immigrants. The bill provides for a moratorium on evictions and forbearance on those who have federally underwritten loans. It does not provide for forgiveness of the amounts, meaning that most who have their rent or mortgage payments delayed will have a large payment due at the end of the period of forbearance. It also does not provide that people can be protected from eviction from rentals at the end of the moratorium.

Given the scope of the economic impact, despite the large amount of money already spent, Congress is currently considering another large stimulus bill, this one looking again at another round of individual stimulus payments along with additional monies for business and governmental functions. A crucial conversation for the fourth bill centres around possible liability protections for businesses when employees or customers contract coronavirus and federal pass through funding for states.



## **Issues of Concern in the US Response to the Coronavirus**

Lack of effective policies in multiple dimensions exacerbate health inequities and are impacting the disparate impacts of coronavirus. As highlighted above, the coronavirus is illuminating the structural inequities present across the USA. Economic, societal and cultural, environmental and social dimensions all play a role in continued inequities. The sections below describe each of these dimensions and contain specific examples of the issues of concern in each area which have arisen as the US response to coronavirus. In each area, it is illustrative that the US government implemented some of the social programmes which other countries provide under non-emergency situations, but which have previously been deemed impossible under the US systems of governance. It is also noteworthy that each of these programmes is implemented in a manner which makes them limited to the timeframe of the public health emergency.

### *Economic*

Benfer (2015) writes,

Resource inequality and income distribution in society, and not solely genetics and access to healthcare, explain a person's health status. It is well documented that poverty and low socioeconomic status are strongly linked to poor health outcomes. (p. 518)

Coronavirus and the related social distancing orders impact work attendance and availability. Work disruptions, particularly the long-term ones needed in coronavirus, have the potential to impact the availability of income. While other countries provide liberal leave policies in the workplace (Greenwood, 2018), in the USA, persons are not legally entitled to any paid time off and must be full time and working for a company or organisation of 50 or more people for availability of many benefits. According to the Bureau of Labour Statistics (Bureau of Labor Statistics, US Department of Labor, 2017), the average US worker has 10–14 days of paid vacation time after one year of working, with those who have been in the field for 10 years or more increasing to 15–19 days. For those in hourly positions, there may be no time off or paid leave. Congress responded to the growing concern that many were forced to choose between going to work ill and potentially infectious or staying home by providing limited programmes for paid sick leave for two weeks for those impacted by directly to coronavirus. The struggle between going to work ill or staying home and losing wages is not a new concern and the public health ramifications have always existed but the pandemic has created a new urgency in policy leaders to address it.

Access to childcare is another workplace issue which is not new. For many in the USA, working is problematic due to the lack of access to affordable childcare. Schools can be a welcome relief and allow persons to enter the workforce. As schools and childcare settings closed across the USA, many more people were



impacted by the prospect of no childcare to allow them to work. Congress responded by requiring paid family leave for those who could not work due to childcare issues. The Bureau of Labour Statistics reported that in 2016, only 13 per cent of private workers had access to paid family leave (Bureau of Labor Statistics, US Department of Labor, 2016). This benefit is also designed to be limited to a public health emergency.

Beyond issues with paid leave, the stay-at-home orders have caused many industries to shut down completely. One response has been to provide small business loans, described above, allowing some people to keep their pay and benefits even when the work cannot be performed. Unemployment requirements have been relaxed to allow more flexibility in the type of work which may qualify a person for unemployment and include supplemental payment to those who qualify for payments. In a country where the minimum wage will not allow a person to afford a two-bedroom apartment in any state or county at market rate (Anderson et al., 2018), it is not surprising that traditional unemployment rates will not allow persons to provide for the basic needs of a family. For those who feel unsafe going back to work due to underlying health conditions or high-risk family members, they may be forced back into the workforce before they feel safe doing so or risk losing their income for basic needs (Pinsker, 2020). As with other governmental coronavirus responses, unemployment benefits are time limited.

### *Societal and Cultural*

Benfer (2015) writes,

In addition to economic conditions, the societal and cultural environment, such as societal responses to race or sexual orientation, can also have a significant impact on an individual's health. Discrimination in any form can raise the risk of emotional or physical problems, such as depression, hypertension, breast cancer and early mortality. This is true for both the act of discrimination through institutional mechanisms, such as segregation, and the subjective experience of discrimination, whether it is overt or implicit in nature. (pp. 282–283)

### *Structural Bias*

The coronavirus response leaves holes which further the impact of structural systems of bias. Immigrants who are undocumented are left out of nearly all stimulus relief. As Jordan and Oppel (2020) write, 'If [people] are undocumented, they cannot collect unemployment, which may compel them to work even when they feel unwell, facilitating the spread to their co-workers'. The lack of healthcare in a pandemic is critical but the lack of access to healthcare impacts public health even under normal circumstances. The USA has not created a system to deal with the impact of lack of healthcare on the public health, and certainly not for the undocumented population.

Undocumented immigrants are not the only populations who deal with disparities. Structural racism, defined as 'the policies, programmes and

institutional practices that facilitate the well-being of White families while creating barriers to the well-being of Black families' (Kijakazi, 2020), present within multiple systems in the USA impacting the health outcomes for Black people. The health consequences have been known for decades. Black people in the USA are at higher risk for chronic conditions such as diabetes, high blood pressure and obesity which put persons at higher risk if they contract coronavirus. Disparate access to wealth and the impacts of poverty create situations which make preparing for the financial consequences of a pandemic difficult, creating stress which itself can cause health issues. Perry et al. (2020) highlight these issues with clarity, writing:

Race and place are clearly associated with [coronavirus] spread. While Black Chicagoans represent 29% of the city's population, they make up 70% of COVID-19 fatalities. In Washington, DC, Black people are 46% of the population but 62.5% of COVID-19 fatalities. In Michigan, the heavily Black tri-county area of Detroit has quickly become the epicenter, accounting for nearly 85% of the state's COVID-19 deaths. The coronavirus does not discriminate, but our housing, economic, and health care policies do. Environmental racism, unaffordable housing, a lack of job opportunities, poverty, and inadequate health care are underlying social conditions, strongly influenced by policy, which place Black people and their neighborhoods at risk. To flatten the curve of COVID-19 and prevent future pandemics from wreaking the same havoc, these conditions must be addressed. (Perry et al., 2020, para. 5)

Prisoners also experience structural health inequity. In a pandemic, conditions in prisons do not allow for social distancing, putting those who are detained and those who work in these environments at increased risk. Some advocacy groups are working to provide for the release of persons who are there on technical or nonviolent charges (Klonsky, 2020; The Marshall Project, 2020; Walter-McCabe, 2020). Others are looking at equity issues in bail, a longstanding issue in criminal justice. One judge in Alabama sought the release of those with bail under \$5,000 citing the overwhelming financial issues related to coronavirus. The approach was not well received by the public, raising questions of whether other judges would consider a similar approach (Felton, 2020). Community-led groups and organisations working on prison reforms, including the disproportionate impact of criminal law on race and ethnicity, are facilitating the spread of information and advocating for the prison population to receive adequate healthcare and humane release when possible (Prison Policy Initiative, 2020; The Justice Collaborative, 2020; The Marshall Project, 2020).

## *Environmental*

Benfer (2015) writes,

Poor health is often the result of environmental hazards commonly found in low-income neighborhoods. Individuals and families in poverty have less control over the built and natural environment, and few to no alternatives to substandard housing. (p. 292)

### *Housing*

Access to stable and safe housing is critical for health. Research regarding poverty and its relationship with health risks such as lead paint and mould in housing is plentiful (Bashir, 2002; Benfer, 2017; Rollins et al., 2012). Coronavirus has exacerbated this problem. As unemployment rose and access to income decreased, those already struggling with housing security became more at risk of homelessness, increasing the opportunity for unsafe housing opportunities and overcrowding. Those who previously had been secure were struggling to make rent and mortgage payments. Some states responded by creating eviction moratoriums. The moratoriums provide protection from evictions or late payment fees for the duration of the public health emergency, but in most cases do not protect from collection of all back rent or mortgage payments at the end of the emergency. The Eviction Lab created a scorecard for states and the District of Columbia rating the extent and efficacy of the eviction moratoriums in this public health emergency. Of the 51 examined, only 1 state, Massachusetts, scored above 4 on a 5 point scale. Eleven states scored a zero, meaning no action (Eviction Lab, 2020). The National Housing Law Project created a model law for states who wish to fully protect tenants from eviction due to financial difficulties caused by coronavirus (National Housing Law Project, 2020). For more information on specific state activity, see the tracker on the Regional Housing Legal Services website (Regional Housing Legal Services, 2020).

### *Food Insecurity*

Food insecurity, or ‘the disruption of food intake or eating patterns because of lack of money and other resources’, is a health concern (Office of Disease Prevention and Health Promotion, 2020). The health impacts of food insecurity are broad and can include items as varied as increased incidence of tooth decay, asthma, and anxiety and depression. As unemployment continues to rise from the impact of social distancing and coronavirus, the impact on food insecurity is increasing. When schools closed due to coronavirus, it impacted the meals available to low-income students. Many state and local governments have been working to find ways to continue to provide the meals outside the structure of the school day. People who have not needed to access food banks previously are turning to them in this pandemic (Feeding America, 2020). Some people who might otherwise access grocery stores are not comfortable going to the store due to age or underlying health conditions. SNAP benefits traditionally have been an ‘in person’ only benefit, but a recent pilot programme has now been expanded to allow SNAP benefits to be used ‘online’ in 18 states and the District of Columbia (Food and Nutrition Service, US Department of Agriculture, 2020). States continue to examine how to handle these issues with the tools available.

### *Social*

Tobin-Tyler & Teitelbaum (2018) writes,

As our understanding of health has expanded to include the importance of nonmedical and structural factors, researchers have pointed to the fact that the USA stands alone (among its peer nations) in allocating far more resources to medical care than it does to social services and supports. In fact, some argue that we have ‘medicalized’ poverty and social problems rather than address them as root causes of poor health.

### *Mental Health Issues*

The mental health consequences of stay-at-home orders are becoming more apparent at the same time care is no longer easily available via traditional face to face therapy. A total of 45 per cent of adults in the USA report that the pandemic is negatively impacting their mental health (Kirzinger et al., 2020). Along with general concerns about a rise in anxiety and depression directly related to coronavirus, there is concern about continued anxiety and depression in relation to job loss and foreclosure as the economic impacts of the coronavirus crisis continue in the future (Powell, 2020). The mental health of frontline healthcare workers (HCWs) will also be a growing concern (Ayanian, 2020). In this crisis, many HCWs have had to work without sufficient PPE, knowing they were putting themselves at risk. Some have had to care for their co-workers as they have gotten ill. Nearly all watched patients die in isolation without access to family and friends due to the need to protect others from the virus (Dean, 2020). The impact is likely to be profound.

Those who experience substance use disorders are at increased vulnerability if they contract coronavirus. The depression and anxiety created by the isolation may exacerbate current addiction issues. Alcohol sales in the USA soared by 55 per cent in March 2020. The stay-at-home orders have made seeking traditional treatment mechanisms and supports more difficult, resulting in quick transition of some, though not all, services to a virtual arena (Grinspoon, 2020; Polakovic, 2020). Pre-existing weaknesses in the system have become more apparent. Treatment for persons with opioid use disorder often requires daily visits for Methadone treatment. In response to coronavirus, the Substance Abuse and Mental Health Services Administration (SAMHSA) began allowing for 14- to 28-day dispersion of treatment medication, depending on the assessment of the person’s stability (SAMHSA, 2020, p. 1).

This is a positive change and one that could benefit persons needing treatment long after the coronavirus is gone. Additional policy discussion on how to support this population is needed.

### *Violence*

As families are staying home, stress and financial uncertainty increase the risk for domestic violence and child abuse and neglect (Campbell, 2020; Usher et al., 2020). Those experiencing abuse have decreased access to support services and assistance from extended family or friends. Opportunities for interaction with others who might identify and report the abuse are minimized with school and childcare centres closed (Jonson-Reid et al., 2020). Recommended safety plan actions are not available and risks associated with calling hotlines or seeking

online assistance are higher given the constant presence of others in the home (Abramson, 2020). Recent reports have shown a decrease in calls regarding domestic violence, a concerning statistic in a time when research suggests that the violence is likely increasing (Stone et al., 2020). Persons who are gay, lesbian, bisexual and/or transgender are at increased risk if they are home with families who are not accepting their identities (D'Augelli et al., 1998; Valentine et al., 2003). Additionally, this population is at increased risk for homelessness, housing instability and unemployment, which are exacerbated under the current circumstances and increase risks of experiencing interpersonal violence (Abramson, 2020). Policies have yet to keep up with the needs in these areas and they may be ripe for increased concerns if services and funding for these services are not provided even after the acute crisis.

### *Health Insurance and Healthcare Access*

As the coronavirus spread, the public health impact of persons being uninsured became clear. People who may be infected need to be identified and isolated. People weighing the benefits of getting medical attention against the financial burden of uncovered medical bills may cause delays in care that could be critical, and sometimes deadly, in a pandemic. People who did not need to make such decisions earlier were suddenly without any healthcare and were concerned about these issues. In response, Congress included payment for coronavirus testing and some treatment in the stimulus bill. As with other items in the stimulus bill, the coverage is for a limited timeframe. Theoharis (2020) writes,

About 31 million people today are uninsured in America, and 14 states have not even expanded Medicaid under the Affordable Care Act.... In this coronavirus moment, many more Americans are finally awakening to the bitter consequences, the damage, wrought when even a single person does not have access to the resources he or she needs to live decently or, for that matter, survive. With the spread of a pandemic, the cost to a nation that often treats collective care as, at best, an afterthought should become apparent. (para. 4)

Coronavirus has also highlighted the difficulty of face-to-face health and mental healthcare. The disability community and some rural communities have advocated for telehealth for years (Powers et al., 2017) but been told that the healthcare system could not accommodate a change to provide telehealth universally, or even in a broad manner. When telehealth was made available in limited circumstances, public and private insurance providers often declined to cover it. On 6 March 2020, the Centers for Medicaid and Medicare services began providing coverage through Medicare on a 'temporary and emergency' basis. Many private insurance companies have also begun to provide at least temporary coverage for telehealth. Health and mental health providers quickly transitioned to telehealth. As these changes occurred swiftly, no planning for clients without access to the needed technology occurred which raised concerns about clients left with no meaningful access to care.

## **Lessons Learned in the USA**

The coronavirus pandemic provides a clear window into how an emergency has exacerbated pre-existing disparities which create health inequity in the USA. The US response provides an opportunity to examine what has worked and what is possible from a policy and social service perspective, sometimes even policies and programmes which previously have been designated as unattainable.

Lack of healthcare coverage and access and its impact on public health was a critical issue in the coronavirus response. When people cannot access healthcare in a public health emergency involving infectious disease, it impacts not only that person but the health of the entire population. The USA has struggled with how it covers healthcare costs for the population for decades. PPACA was a step towards providing additional access to people previously unable to access the system, with some success. Despite some gains, disparities remain.

[M]ost groups of color remained more likely to be uninsured compared to Whites as of 2018. Moreover, the relative risk of being uninsured compared to Whites did not improve for some groups. For example, Blacks remained 1.5 times more likely to be uninsured than Whites between 2010 and 2018, and the Hispanic uninsured rate remained over 2.5 times higher than the rate for Whites. Lower-income individuals also experienced large coverage gains that narrowed percentage point differences in uninsured rates for poor (<100% of the federal poverty level, FPL) and near-poor (100–299% FPL) individuals compared to those at higher incomes (400% FPL and above). (Artiga et al., 2020a, para. 12)

Universal coverage provided for coronavirus tests and for some coronavirus treatments showed that when prioritized, universal coverage can be achieved and even desired. Policies in the USA, such as single-payer health insurance or universal coverage, should be considered for longer term to increase health equity. Universal coverage will not fix all healthcare issues. Implicit bias and structural racism, classism, homophobia and other structural biases will still exist in the healthcare system itself, but without healthcare coverage itself, the doors to healthcare are closed before those issues can even be addressed.

Economic issues must also be considered. The gaps in current workplace protection policies, as addressed above, became critical for many with coronavirus, but the impact of no paid sick or family medical leave creates more opportunity for moving workers closer to poverty with just one illness under regular circumstances. Poverty, with its related health impacts, is a public health issue. The issue can be addressed with policies such as the ones required during coronavirus being required regularly. When even hourly workers are provided with paid leave, risks for poverty and its related health disparities can be reduced.

Social policies directed at safe housing and food security also position the USA for better population health. The SNAP benefits put in place for coronavirus can create easier access to food if expanded routinely. Reducing administrative barriers to SNAP would also improve the system. SNAP benefits have been linked with reduced healthcare spending and improved long-term health. Additionally,

after just six months of receiving benefits, food insecurity among children fell by nearly one-third (Carlson & Keith-Jennings, 2018). Housing policies can similarly impact health by providing for safety and stability. Long-term rent and mortgage moratoriums may be difficult to achieve but acknowledging the necessity of housing in the public health emergency allows an opportunity to examine policies to address housing insecurity and safety long term. The economic policies described above can provide protection from income loss leading to a housing crisis. Additionally, strengthening existing laws regarding safe housing, for example, the recently proposed Lead Safe Housing Act (Durbin, 2019), can provide protection for the health and safety of those who are in insecure housing, particularly those in low-income housing.

Lastly, the public health emergency highlighted the need for accessible and affordable mental health services. The mental health consequences of the public health emergency will not end when the emergency ends. Mental health services are already difficult to access for many, particularly mental health coverage. Well-trained service providers who understand trauma are needed in increased numbers. Coverage for mental healthcare increased under PPACA but is still unavailable for those who remain uninsured, a disproportionate number of which are people in marginalized groups. Policies which increase funding for services and training are critically needed.

The temporary legislative, regulatory and funding changes proposed and implemented as the coronavirus crisis continues to highlight that what all is possible when the political will exists. Many of the temporary changes were implementations of policies which have been advocated for years by those working for healthcare access, disability rights, prisoner rights, mental health and addiction reform, and other areas of social and community change. At this moment, the USA must choose to act on what communities have been calling for by implementing lasting changes.

## **Implications for Community and Social Development Practice Post-pandemic**

Just as public health focuses on primary prevention when possible, social development models seek to change the structure to prevent the problems rather than deal with the results of a poor system (Mapp, 2014). Coronavirus-related disparities have created an opportunity to advocate where people, even those not normally impacted, are aware of the real and unnecessary products of an unjust system. In this environment, using the public awareness that has been created, local-level community groups can work together to push for policies which may have been presented before but may now be presented to power structures which are better educated and able to hear from a new point of view.

Pawar (2014) outlines seven concepts and variables to be examined in social development approaches—existing conditions, goals, values, processes, strategies and levels and dimensions. Coronavirus and the governmental response provided



more awareness of the existing conditions in health disparities on a national scale. The government implemented, though in a time-limited manner, some of the policy goals of national and local advocacy groups. In the post-pandemic USA, local and national social service agencies and social and community development groups can examine what values led the government to make these changes, and use the lessons learned to strategically develop goals which will positively impact social determinants of health for the long term.

‘Community and social development’ efforts in the post-pandemic USA can be informed by a ‘health justice framework’ (Benfer, 2015; Tobin-Tyler & Teitelbaum, 2018). The health justice framework begins with these assumptions:

1. There is no across-the-board right to health, healthcare services or health insurance in the USA.
2. Social factors play a critical role in individual and population health.
3. Wealth equals health, and the USA currently faces historically high levels of economic inequality.
4. Society is too willing to medicalize social needs and criminalize social deficiencies.

(Tobin-Tyler & Teitelbaum, 2018, p. 15)

The framework recommends goals across economic, societal and cultural, environmental, and social dimensions. Dimensions which have all been implicated in the coronavirus response and are found in other social and community development models. The framework acknowledges the neoliberal ideology present in much of the policymaking structures in the USA, a framework that ‘is often deaf to the dignity and needs of vulnerable populations’ (Tobin-Tyler & Teitelbaum, 2018, Chapter 7). The framework explicitly endorses not simply a leader speaking on behalf of a marginalized group but skills that empower and support people to advocate on their own behalf.

[I]t is worth reiterating that policy advocacy that is done in a vacuum—that is, without engaging the community affected—is not only less effective in making lasting change, it is also less likely to fundamentally challenge the power structures that drive disempowerment of vulnerable populations. Health and legal professionals have much to offer (knowledge, expertise, experience and passion) in advocating for health justice. But it is important to keep in mind that advocacy must be driven by listening to the daily concerns and experiences of patients and constituents and working to not only change systems and policies affecting their health but also to challenge the systems that keep their voices from being heard. (Tobin-Tyler & Teitelbaum, 2018, Chapter 7)

The health justice framework proposes work at multiple levels. It includes recommendations for individual, institutional and policy advocacy. The framework outlines mechanisms for working at the local, state and federal level. It is built on the belief that much of the important work is done in local communities and through local policies. This is particularly important given the political realities of a highly partisan federal government in the USA, where much policy work is unable to move forward at the present time.

It will be important for social and community development efforts to involve those who have led efforts in the time of the pandemic rather than creating whole new and duplicative movements. Community-led groups have been key in creating solutions for problems ignored in the formal policy process during this crisis. As housing insecurity increased and the laws continue to be insufficient, rent strikes are on the rise (Action Network, 2020; Gabbatt, 2020; Housing Justice for All, 2020). HCWs organised to stage protests to force action to provide PPE (Lang, 2020). Prisoners staged hunger strikes and protests regarding the lack of medical treatment and protection from coronavirus (Jaafari & Taylor, 2020). Working alongside those who have already been doing the work can amplify progress already made and lead to further progress.

## Conclusions

Health disparities and inequities did not begin with coronavirus and will not end in the post-pandemic USA. Social and community development efforts which value health justice and concentrate on social determinants of health can provide needed policies and programmes, for a more equitable US health system. The coronavirus response provided needed policy change for more equity during the crisis. Post-pandemic work must make the long lasting changes and build upon their foundation for further US health justice and equity.

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