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# EXECUTIVE SUMMARY

The outbreak of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection (COVID-19) created disruptions in the world economy by adversely impacting the health and economic conditions of the individuals. Once the individuals are infected with Covid-19, the individual needs to be hospitalized and given proper care so that he/she recovers from the infection symptoms. Covid-19 is found to lay negative outcomes on the individuals that are suffering from comorbidities such as hypertension, diabetes, and obesity. Despite all these issues, Covid-19 has also created health disparity among the different social groups that are living in the US. The ethnic and marginalized groups such as American Indian, Black, and Hispanic that are residing in the US face health disparities owing to differences in socioeconomic status; ethnicity; occupation/employment; neighborhood; social support/social capital/social cohesion/social norm; and gender & sexuality factors. The health disparity conditions lay adverse implications on the ethnic and marginalized communities and reduce their standard of living to low levels. It creates social disparities and increases food insecurity conditions among the minority groups. Therefore, the study recommends the introduction of federal COVID-19 legislation so that there will be readdressing of the gaps and promotion of public health education. It is also recommended that equitable care models must be developed in the US which will help in strengthening the existing healthcare systems in the US. It will encourage the patients to reach the healthcare organization and consent for treatment and medical processes effectively. Apart from this, all communities must be encouraged to take the Covid-19 vaccination so that there will be a reduction in the spread of Covid-19 infection and improve the health standards of the individuals.

# INTRODUCTION

Coronavirus pandemic attack has not only adversely impacted the health and economic conditions of the individuals but also created health disparities in the social workings. The survey conducted by public health officials highlights the emergence of social, ethnic, and economic disparity among the Black People, American Indians, and other nationals. The mortality rate of the indigenous population is 5 to 7 times more in Arizona and New Mexico as compared to other populations**.[[1]](#footnote-1)** On the other hand, the report published by California statistics state that 74% of the Latino Americans belonging to the age group of 35-49 years are infected by Covid-19, while Los Angeles County report stated that poor communities experienced 3 times higher risks of morality as compared to wealthier groups. Additionally, discriminatory policies and systemic inequalities practiced by governing bodies lead to unequal distribution of resources and disparate healthcare provisions. It adversely impacts the unilateral growth of all communities and lays negative implications of sustainable healthcare promotion**.[[2]](#footnote-2)** The present report highlights the health disparities issues that emerged in the Covid -19 pandemic and focus on improving equity in health by addressing the specific social determinants of health. The implications of social determinants of health that contribute towards disparities in health during the Covid 19 pandemic will also be discussed in the report.

# LITERATURE REVIEW

## Socioeconomic Status

The ethnic and social minority status in the developed countries such as the United States (US) is inextricably linked with socioeconomic groups that have low earning power. It includes American Indian, Black, and Hispanic populations that reside in more crowded locations in the US. The minority groups live in the multigenerational household and often share accommodation with essential workers. As a result, these communities are highly exposed to vulnerable conditions and face higher risks of Covid-19 infection. The survey conducted by the Epic Health Research Network and the Kaiser Family Foundation specifies that 30.4 Hispanic patients followed by 24.6 Black patients, 15.9 Asian patients, and 7.4 White patients were hospitalized against every 10000 individuals. The death rates against every 10000 individuals were recorded to be 5.6 among Hispanic patients followed by 5.6 Black patients, 4.3 Asian patients, and 2.3 White patients.[[3]](#footnote-3)

## Ethnicity

Due to the higher spreading rate of Covid-19 and the presence of chronic medical comorbidities, the marginalized population is at higher risks of hospitalization. The prevalence of comorbidities such as hypertension, diabetes, and obesity is high among the marginal groups because of which Covid-19 infection lays adverse outcomes on the patients. Additionally, the ethnic minority groups have poor access to healthcare because which they receive medication and treatment in the later stages of Covid-19 illness which increases mortality risks adversely. Moreover, the individuals that are illegally residing in the US also avoid accessing healthcare facilities in fear of deportation. The low-income American Indian, Black, and Hispanic populations do not private vehicles and use public transport for commutation. Most of the minority groups live with essential workers and more likely to be prone to communicable diseases such as coronavirus 2 (SARS-CoV-2) infections.[[4]](#footnote-4)

## Occupation/Employment

The marginal communities are engaged in low-income professional tasks such as construction workers, store clerks, nursing aides, transit staff, and others that cannot be executed remotely. As a result, the minority groups are often engaged with essential tasks and increasingly exposed to risks of Covid-19 infection. Moreover, occupational disparities are practiced in the US which gives rise to healthcare disparities in Covid -19 pandemic. For example, the Hispanic groups in the US were denied access to healthcare facilities since the onset of the Covid-19 pandemic.[[5]](#footnote-5)

## Neighborhood

The individuals illegally residing in the US also avoid accessing healthcare facilities in fear of deportation. It increases the risks of Covid-19 infection among the immigrants and illegal residents and creates health disparities. The low-income American Indian, Black, and Hispanic populations do not private vehicles and use public transport for commutation. Most of the minority groups live with essential workers and more likely to be prone to communicable diseases such as coronavirus 2 (SARS-CoV-2) infections. Additionally, in some cultures, it is common for households to live together and share belongings with family members. This type of family culture leads to exposure of elderly people to susceptible diseases and increases the risks of Covid-19 infection.[[6]](#footnote-6)

## Social Support/Social Capital/Social Cohesion/Social Norm

The racial or ethnic minority communities are the most vulnerable groups in the US to experience Covid-19 adverse outcomes. The major reason behind it is that these groups do not have healthcare insurance and are exposed to high risks of comorbidities. The marginal communities belong to low-income status, reside in a violent neighborhood, and highly dependent on low-funded healthcare organizations for medical support and healthcare facilities. Moreover, lack of awareness about health-related knowledge also creates disparities in health in the Covid-19 pandemic. Most of the patients that belong to ethnic groups are not proficient in the English language and have limited healthcare literacy which leads to worse health outcomes.[[7]](#footnote-7) The fact is supported by the study which was conducted by Alsan et al.[[8]](#footnote-8) The study included 830 Black men and 3759 White men and found that Black men had little or no knowledge about the healthcare system practiced in the US. The Black men also lacked learning about symptoms of Covid-19 infection and treatment or medication that must be taken to get cured. Therefore, it can be said that healthcare information is not uniformly perceived by all groups in the US resulting in health disparities.

## Gender & Sexuality

To examine the impact of gender and sexuality on health disparity in Covid-19 pandemic conditions. To analyze this, the study included a survey that was conducted by the Italian National Institute of Health and found that amongst 23188 deaths in Italy owing to Covid-19, 70% were males. On the other hand, the survey reports of the National Center for Health Statistics revealed that amongst 37308 deaths occurred in the US owing to Covid-19, 59% were males. Similar trends of males death percentages have been recorded by other countries such as China and South Korea. The males are more likely to suffer from Covid-19 infection because of the presence of testosterone hormones. These hormones reduce the efficacy of the immune function and increase susceptibility to infectious diseases in males. On the other hand, estrogen hormones are found among females that help in enhancing innate and adaptive responses to immune function. As a result, the females show faster clearance and develop greater efficacy from the vaccine.[[9]](#footnote-9)

# DISCUSSION

Based on the above insights, it can be said that though there is no disparity in the provision of healthcare facilities to individuals by the governing agencies disparities do exists owing to socioeconomic status; ethnicity; occupation/employment; neighborhood; social support/social capital/social cohesion/social norm; and gender & sexuality factors. Due to the presence of differences between different living groups such as White, American Indian, Black, and Hispanic populations, there is differentiation in the socioeconomic and living opportunity levels. For example, when the Covid-19 pandemic struck the US, 17.6% Black and 33.1% Hispanic individuals lost their jobs as compared to 14.2% White population. About 40 million and more individuals applied for unemployment benefits in which the Black and Hispanic community individuals topped the list. About 6 in every 10 Hispanic working group adults were forced to live with someone who neither has a job nor income. It has degraded the living conditions of the minority communities and many of them are facing issues related to food insecurity. These challenges lay a detrimental impact on the health outcomes and lead to disparities. Therefore, it can be said that the onset of the Covid-19 pandemic has engraved the situation of disparity in the US as previously, it only existed in socioeconomic status, ethnicity, and racial regimes but now it has extended its roots to the health sector also.

# CONCLUSION AND RECOMMENDATIONS

The Covid-19 pandemic has created disruptions in the economic workings and laying a negative impact on the healthcare domain by creating health disparities. Though disparities based on socioeconomic status, ethnicity, and race are not new in the US, the occurrence of Covid-19 has introduced a new kind of disparity in the US known as a health disparity. It adversely impacts the Black, Hispanic, and American Indian communities in the US and reduces their standard of living to low levels. Therefore, reformative measures must be introduced by the governing agency so that there is the elimination of ill-practices from the social realms. It includes the introduction of federal COVID-19 legislation so that there will be readdressing of the gaps and promotion of public health education.

The other measure that can be implemented by the US government agency is related to increased investment in safety-net hospitals and community healthcare centers. By enhancing the capabilities of the safety net hospitals and community healthcare centers, there will be an increase in the efficiency of the medical staff to serve the minority, low-income, and undocumented immigrant communities that are residing in the US. Additionally, establishing equitable care models will also help in strengthening the existing healthcare systems in the US. It will encourage the patients to reach the healthcare organization and consent for treatment and medical processes effectively. It also includes implementing an inclusive approach and developing a multidisciplinary team so that people belonging to all groups feel comfortable seeking medical care. The efficiency of the medical centers could also be enhanced by introducing an approved encrypted free platform so that it becomes easy for the healthcare staff and patients to communicate with each other. By using a universally accepted encryption-free platform, the interaction could be established with the patients beyond conventional call limitations. It will help in breaking barriers to access to healthcare and encourage minority groups to seek healthcare facilities.

Apart from this, the trusted community voices from different fields such as sports, entertainment, and media can be included to promote and encourage individuals to take Covid-19 vaccination. By taking vaccination against Covid-19, the propensity of all groups to get infected with the corona virus will get reduced. Addressing social determinants of health is another measure that would help in eliminating health disparity in the US. It includes a healthcare system that screens the patients to meet their social needs of food, housing, and legal assistance. Through an aligned healthcare system, there will be addressing of health as well as socio-economic needs of the patients. It will encourage the patients to connect to the healthcare organization and receive health as well as socio-economic support from them.

# REFERENCES

Alsan M, Stantcheva S, Yang D, Cutler D. Disparities in coronavirus 2019 reported incidence, knowledge, and behavior among US adults. JAMA network open. 2020 Jun 1;3(6):e2012403-.

Gangopadhyaya A, Karpman M, Aarons J. As the COVID-19 recession extended into the summer of 2020, more than 3 million adults lost employer-sponsored health insurance coverage and 2 million became uninsured. Washington, DC: Urban Institue and the Robert Wood Johnson Foundation. 2020 Sep.

Ghanchi H, Patchana T, Wiginton IV J, Browne JD, Ohno A, Farahmandian R, Duong J, Cortez V, Miulli DE. Racial Disparity Amongst Stroke Patients During the Coronavirus Disease 2019 Pandemic. Cureus. 2020 Sep;12(9).

Gonzalez D, Karpman M, Kenney GM, Zuckerman S. Hispanic adults in families with noncitizens disproportionately feel the economic fallout from COVID-19. Washington, DC: Urban Institute. 2020 May.

Kurtzleben D. Job losses higher among people of color during coronavirus pandemic. NPR, April. 2020;22.

McCormack G, Avery C, Spitzer AK, Chandra A. Economic vulnerability of households with essential workers. Jama. 2020 Jul 28;324(4):388-90.

Rubin-Miller L, Alban C, Artiga S, Sullivan S. COVID-19 racial disparities in testing, infection, hospitalization, and death: analysis of epic patient data. Kff. Org. 2020.

Spagnolo PA, Manson JE, Joffe H. Sex and gender differences in health: what the COVID-19 pandemic can teach us.

Yehia BR, Winegar A, Fogel R, Fakih M, Ottenbacher A, Jesser C, Bufalino A, Huang RH, Cacchione J. Association of race with mortality among patients hospitalized with coronavirus disease 2019 (COVID-19) at 92 US hospitals. JAMA network open. 2020 Aug 3;3(8):e2018039-.

1. Kurtzleben D. Job losses higher among people of color during coronavirus pandemic. NPR, April. 2020;22. [↑](#footnote-ref-1)
2. Gonzalez D, Karpman M, Kenney GM, Zuckerman S. Hispanic adults in families with noncitizens disproportionately feel the economic fallout from COVID-19. Washington, DC: Urban Institute. 2020 May. [↑](#footnote-ref-2)
3. Rubin-Miller L, Alban C, Artiga S, Sullivan S. COVID-19 racial disparities in testing, infection, hospitalization, and death: analysis of epic patient data. Kff. Org. 2020. [↑](#footnote-ref-3)
4. Ghanchi H, Patchana T, Wiginton IV J, Browne JD, Ohno A, Farahmandian R, Duong J, Cortez V, Miulli DE. Racial Disparity Amongst Stroke Patients During the Coronavirus Disease 2019 Pandemic. Cureus. 2020 Sep;12(9). [↑](#footnote-ref-4)
5. McCormack G, Avery C, Spitzer AK, Chandra A. Economic vulnerability of households with essential workers. Jama. 2020 Jul 28;324(4):388-90. [↑](#footnote-ref-5)
6. Gangopadhyaya A, Karpman M, Aarons J. As the COVID-19 recession extended into the summer of 2020, more than 3 million adults lost employer-sponsored health insurance coverage and 2 million became uninsured. Washington, DC: Urban Institue and the Robert Wood Johnson Foundation. 2020 Sep. [↑](#footnote-ref-6)
7. Yehia BR, Winegar A, Fogel R, Fakih M, Ottenbacher A, Jesser C, Bufalino A, Huang RH, Cacchione J. Association of race with mortality among patients hospitalized with coronavirus disease 2019 (COVID-19) at 92 US hospitals. JAMA network open. 2020 Aug 3;3(8):e2018039-. [↑](#footnote-ref-7)
8. Alsan M, Stantcheva S, Yang D, Cutler D. Disparities in coronavirus 2019 reported incidence, knowledge, and behavior among US adults. JAMA network open. 2020 Jun 1;3(6):e2012403-. [↑](#footnote-ref-8)
9. Spagnolo PA, Manson JE, Joffe H. Sex and gender differences in health: what the COVID-19 pandemic can teach us. [↑](#footnote-ref-9)