Abstract: COVID-19 provides numerous opportunities for policy makers to consider matters of social equity in relation to the field of public health. Specifically, by reflecting on health disparities in relation to the disproportionate impact of COVID-19 on minority and historically underserved populations, we can leverage a needed discourse on health outcomes for many communities. Grounded in the social determinants of health conceptual framework, this essay explores the application of the disproportionate impact of COVID-19 to vulnerable populations and communities of color for a discussion of strategies for minimizing health disparities.

Much of the intellectual history of public administration over the past 50 years has been shaped by an evolving discourse on the notion of social equity. Following questions about structural and social inequalities in the late 1960s and early 1970s, we have witnessed a half-century of administrative considerations of issues of representation, inclusion, and distribution of resources as part of a broader exploration of enhanced quality of life for historically marginalized groups. Authors have presented examples of how social equity has come into cases focusing on challenges around developing a more just society (Frederickson 1990; Gooden 2017; Guy and McCandless 2012). We have witnessed societal equity applied in cases of environmental justice (Bowen and Wells 2002), deep economic inequalities (Valenzuela 2017), and racial profiling and police abuse (Ward 2002).

Our experiences with COVID-19 in the early months of 2020 provide a basis for considering numerous factors in the social equity arena—particularly as they pertain to public health concerns. Communities have been forced to wrestle with questions related to the encouragement of social distancing, determining who gets access to health services and needed protective supplies, and how to deal with the economic impact of the virus on different communities. Most directly, as data have been reported on disproportionate impacts on poor, minority, and vulnerable communities in terms of rates of infection and fatality, critical questions have been raised about how to address these disproportionate impacts in the long term. A central component of these questions related to disparate impact, particularly on communities of color, is whether COVID-19 provides a foundation from which to explore the challenges of responding to “nervous” areas of government (Gooden 2015).

This Viewpoint essay aims to identify ways to leverage discourse around COVID-19 into a social equity dialogue on addressing matters of health disparity. We suggest that the COVID-19 experience provides an opportunity to explore the social equity agenda and engage actors in explorations around addressing health disparities.

We begin with a brief discussion of notions of social equity. Instead of recapping the nearly 50-year history of an evolving concept that is grounded in notions of justice and fairness, we focus our brief section on a means of fostering discourse on the government response to those nervous areas pertaining to racial and health inequalities, especially at a time of pandemic. We then explore the intersection of the social determinants of health and health disparities.

Next, we examine the case of the Bronx, New York, which illustrates some of the intersections between community experiences with COVID-19, social determinants of health, and health disparities. This case, which draws on the thematic area explored, aims to illustrate the complexities that arise when health disparities and pandemic conditions such as those presented by COVID-19 interconnect. We close with a set of recommendations for exploring factors of social equity and health disparities drawing from our experiences with COVID-19.

Social Equity and Nervous Areas of Government
Susan Gooden’s (2015) proposition of the notion of nervous areas of government as a way of applying
social equity approaches provides a framework for encouraging administrators to reflect and ultimately act on difficult questions related to racial inequalities in communities. Specifically, how might we consider the roles that actors in the public sector have played in promoting some of these inequalities? In considering critical areas of inequality in these areas, it is important to consider how such notions apply to various policies in practice that have a negative impact on the lives of population segments. Gooden’s conceptualization provides a foundation for examining approaches that government agencies might apply to cases in which they choose to wrestle with the complexities of race, class, and other factors that often correlate with situations of marginality. The centrality of race in our examination of the disproportionate impacts of COVID-19 provides a foundation for applying concepts of social equity to some of the challenges caused by COVID-19 in communities of color.

The Social Determinants of Health and Health Disparities: Evolving Discourses

Notions of social determinants of health (SDH) and health disparities are closely linked concepts that explore core questions about the inequality of health realities in communities. SDH include factors such as economic status, race, and educational attainment and often correlate with disparities and inequities in health (Fraser 2013). These aspects have an early and profound impact on health status (Fraser 2013). The impact of these structural factors on health equity and well-being is mediated by behaviors and living conditions (Solar and Irwin 2010). Health equity, defined as “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically” (WHO 2005), is increasingly becoming a pressing public health issue. Health inequities are health differences that are socially produced, systematic across the population, and unfair (Whitehead and Dahlgren 2006). Social, economic, and environmental inequities can persist across generations, collectively limiting individuals’ future health and creating variations in the incidence and impact of many diseases (Brown, Smith, and Beasley 2013). Examples of SDH include income and income distribution, education, social safety networks, employment and working conditions, unemployment and job security, early childhood development, gender, race, food insecurity, housing, social exclusion, and access to health services (Mikkonen and Raphael 2010). Social inequities include but are not limited to differences stemming from race/ethnicity, access to educational opportunities, and socioeconomic status, which may lead to poor housing conditions, less awareness about access to health care, and inferior health outcomes.

When considering the chain of causation in health disparities, one must also consider upstream, midstream, and downstream factors. Schroeder (2007) estimates that only 10 percent of population health differences can be attributed to health care and points to upstream causes, factors that influence people’s underlying health, to explain the bulk of health outcome differences among large social groups defined by race/ethnicity, class, or country. Upstream factors also include gender, immigration status, and policies and programs by corporations, government agencies, and schools. Midstream factors include housing, land use, transportation, and residential segregation. Lastly, downstream factors include infectious disease, chronic disease, and health issues such as the emergence and impact of COVID-19. Traditionally, the medical field looked at health inequalities through an individual lens that was biological in nature. However, such an view represents only part of a needed and broader population approach (Koh et al. 2010). Expanding to an integrated, multilevel social determinants approach complements a focus on individual biology of disease with attention to social and economic factors, physical and social environment, and social and health policies (Berkman and Ichirō 2000; Durch, Bailey, and Stoto 1997; Krieger 2001). An integrated social determinants approach provides varied and complementary lenses through which to view and address health disparities (Koh et al. 2010).

Health disparities are frequently associated with social inequities in communities. According to the National Institutes of Health, “Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States” (Krieger 2005, 7). Health disparities occur by race/ethnicity, sex, socioeconomic status, and sexual orientation, with inequities in screening, incidence, treatment, and mortality across a number of diseases and conditions, including cancer, diabetes, cardiovascular disease, infant mortality, and HIV/AIDS (Gehlert et al. 2008). Although a host of hereditary and individual behavioral factors are linked to health outcomes, we now understand that social circumstances and environmental factors place minority groups at a distinct disadvantage in health and disease (Gehlert et al. 2008). The history of America has laid the foundation for the health disparities that we face today.

Any historical accounting of health disparities has to be examined through the lens of power, politics, and racism within the United States (Hogan et al. 2012). The social effects of historical inequity are evident in poor health outcomes among African Americans. In the United States, we must consider the historical and current effects of structural racism, which include a complex interplay of intergenerational poverty, lack of economic opportunity, income disparities, cultural isolation, and chronic stress (Christopher and Simpson 2014). Health disparities have their roots in structural and social inequalities embedded in the nation’s political, economic, and social climate (Hogan et al. 2012). From the period of the civil rights era and even now in contemporary society, African Americans, for example, still experience disparate health status and access to health services as a result of institutional racism and bias. That African American people experienced various forms of racism—from low-level interpersonal prejudice to lynching—by the majority population for nearly four centuries on an unmitigated basis should prove to be the basis for aggressively pursuing remedies to the sequelae as manifested in chronic health conditions, access to care, and other inequities (Hogan et al. 2012).

In 1985, the U.S. Department of Health and Human Services (HHS) released the Secretary’s Task Force Report on Black and Minority Health, also known as the Heckler Report. Completed under HHS Secretary Margaret Heckler, the report cited vast differentials between health indicators in minority and nonminority communities. The report leveraged federal activity on building institutional infrastructures related to minority public health concerns. The report served as one of the critical studies at a federal level pointing to many of the differences in health between
population groups in the United States (National Library of Medicine 1986).

In the decades since the release of the Heckler Report, several agencies at the federal level have explored the persistence of health disparities and supported the development of strategies for addressing them. Central to these efforts has been the Healthy People Initiative—a multidecade effort aimed at exploring strategies for minimizing health disparities between various population groups in the United States. Healthy People established 10-year targets for the improvement of public health goals. In the first of these, Healthy People 2000, goals were established to reduce health disparities between populations in the United States. The next report, Healthy People 2010, focused on the elimination of health disparities. Healthy People 2020 established a goal of achieving health equity, eliminating disparities, and improving the health of all population groups (CDC 2013).

COVID-19 and Disparate Impact

The advent of COVID-19 in the early months of 2020 sounded alarms around the disparate impacts that the virus was having on communities of color throughout the nation. Early reports from across the United States pointed to some of the disparate realities that were occurring. In early April, for example, it was reported that while African American residents made up 29 percent of Chicago’s population, 72 percent of the city’s residents who had died from COVID-19 were African American (Moore 2020). In New York, by mid-April, the New York Times (2020) indicated that Hispanics, at 34 percent of the COVID-19 deaths in the city, made up the population with the highest death rate. A report from the Centers for Disease Control and Prevention (CDC) released around the same time indicated similar disproportionalities in a COVID-19 sample, noting that in a catchment of 580 hospitalized COVID-19 patients with race/ethnicity data, approximately 45 percent were white, 33 percent were African American, and 8 percent were Hispanic, suggesting a disproportionate impact of COVID-19 in minority communities (Garg et al. 2020).

In a letter addressed to HHS Secretary Alex Azar in late March 2020, several members of Congress called on his department “to monitor and address racial disparities in our nation’s response to the coronavirus disease 2019 (COVID-19) public health emergency” (U.S. Congress 2020). The letter pointed to many concerns from a broad public health perspective related to underlying factors associated with community susceptibility in the face of COVID-19. According to the authors of the letter, enhancing the racial data collected on COVID-19 infections and fatality rates would improve strategies for determining responses that considered the disparate impact on minority communities across the nation. As an extension of matters noted in the letter, on April 14, 2020, Representatives Ayanna Pressley, Lauren Underwood, Robin Kelly, Karen Bass, and others introduced the Equitable Data Collection and Disclosure on COVID-19 Act.

This act called for the establishment of a standardized repository for race/ethnicity data related to COVID-19 and the establishment of a commission on health equity during the COVID-19 public health emergency. Underscored in the act were several themes that provided deeper illustrations of some of the initial challenges that many communities were beginning to confront related to the disparate impact of COVID-19—particularly in many historically underserved communities of color. The movement of COVID-19 across the nation yielded a narrative of challenges within communities of color related to the outbreaks. Race/ethnicity and class operate simultaneously, each exerting its own burden on health (Kawachi, Daniels, and Robinson 2005). To understand the disparate impact of COVID-19 in the United States, health inequity has to be analyzed through many different lenses.

Early data on the risks associated with increasing rates of COVID-19 suggest that people with higher rates of chronic health conditions such as diabetes and high blood pressure are at a greater risk of fatality and morbidity due to the virus. This issue parallels a general concern related to a broader impact on communities struggling with higher rates of these chronic conditions. Many of the conditions identified thus far have had a high prevalence in communities of color. Using CDC data, McKinsey & Company (2020, 7) affirmed that “Black Americans are on average about 30 percent more likely to have [chronic] health conditions that exacerbate the effects of COVID-19, including cardiovascular disease, asthma, diabetes, chronic kidney disease, hypertension, and obesity.” Furthermore, “Black Americans have more existing medical issues, less access to health care, and are more likely to work in unstable jobs—all factors that have made the coronavirus pandemic disproportionately hurt blacks more” (Levenson 2020).

Disparity in access to and affordability of care is another critical issue that has surfaced in relation to COVID-19. This area of concern focuses on access to quality care in many underinvested communities and access to insurance for members of such communities. In 2010, the enactment of the Patient Protection and Affordable Care Act significantly reduced the number of uninsured people in the nation—and had a particular impact on reducing the number of uninsured people from underrepresented communities. As the impact of care provision for COVID-19 is increasingly felt in communities across the nation, further exploration of ensuring access to care for wider segments of the population is an area for continued examination.

Case: Access to Care, Chronic Health Conditions, and COVID-19 in the Bronx, New York

The Bronx, one of New York City’s five boroughs, was selected as our case study for examining health disparities in relation to COVID-19, because of several sociodemographic and health factors and because it is one of the communities that was most heavily impacted by COVID-19 in the early months of the pandemic. The Bronx is located in the state’s poorest congressional district, has the highest number of people of color (Santiago 2019), and “has long been plagued by underlying illnesses now associated with an increased vulnerability to COVID-19, such as respiratory problems, diabetes and heart disease” (Simon and Ebbs 2020). According to the New York City Department of Health and Mental Hygiene, in 2018, 30 percent of residents in the Bronx identified as non-Hispanic black (tied with Brooklyn), 56 percent as Hispanic or Latino, and 9 percent as white (the highest and lowest percentage among the five boroughs, respectively). Compared with the city’s four other boroughs, the Bronx had the lowest public high school graduation rate in 2013–2014 (68 percent); the highest percentage of adults with no health insurance (37 percent); and the second highest rate of poverty (27 percent; only Brooklyn was higher at 28 percent). As the pandemic progressed, the spread of COVID-19 increased in the Bronx, which was the first area in the United States to experience a significant wave of cases and fatalities. The Bronx is also home to some of the most vulnerable populations in the nation, including the elderly, those with pre-existing health conditions, and those living in poverty. As such, the Bronx is an ideal case study for examining health disparities in relation to COVID-19.
aged 25 and older who had not earned a high school diploma or GED (29 percent); the lowest percentage of adults aged 25 and older who had obtained an educational degree above a high school diploma (26 percent); the highest percentage of people living below 100 percent of the city’s calculated poverty threshold (25 percent); and the highest unemployment rate (13 percent) (NYCDOHMH 2018). Among adults, the Bronx also fares the worse of all boroughs in several key health indicators. The borough has the lowest percentage of residents who self-reported their health as “excellent,” “very good,” or “good” (73 percent); only 70 percent reported participating in any physical activity in the last 30 days (tied with Queens as the lowest); just 83 percent of residents reported eating one or more servings of fruits and/or vegetables in the past day; and life expectancy is only 80.9 years (NYCDOHMH 2018). With respect to other health outcomes among adults, the Bronx has the highest rates of daily sugary drink consumption (32 percent), obesity (32 percent), diabetes (16 percent), hypertension (36 percent), new HIV diagnoses (35.7/100,000), and new hepatitis C reports (99/100,000) (NYCDOHMH 2018). Lastly, the Bronx has the highest percentage of adults who reported not getting needed medical care at least once in the past 12 months (12 percent); the highest rate of avoidable hospitalizations among adults (2,091/100,000); and the second-highest percentage of adults who reported not having health insurance coverage (NYCDOHMH 2018).

In December 2019, the City of New York announced that it had enrolled more than 10,000 residents of the Bronx in NYC Care, a no-cost and low-cost initiative to provide health care access for New York residents who are not eligible or cannot afford insurance. Through this initiative, the city recognized that access to health care services, a main tenet of SDH, has the potential to improve social equity outcomes in one of the city’s most vulnerable boroughs. Addressing SDH is important for improving health and reducing long-standing disparities in health and health care (Artiga and Hinton 2018). Within three months of the launch of NYC Care, the Bronx found itself in the middle of the COVID-19 pandemic. The introduction of this pandemic further illustrates the need for approaches that improve overall health and promote equity while diminishing long-standing health disparities.

Living conditions are another facet of the SDH framework, and environments that have long been abandoned, such as the Bronx, will continue to negatively impact poor health outcomes among residents. Along with “lower-than-average life expectancy . . . those infected with coronavirus die at a rate three times higher than those who live just a river away in Manhattan” (Olumhense and Choi 2020); the borough ranks last among the state’s 62 counties (Robert Wood Johnson Foundation 2020). “While the number of confirmed infections in the borough is in line with its 17 percent share of the city population, the stakes for anyone who contracts the virus are far higher in the Bronx than anywhere else in the city” (Olumhense and Choi 2020). Ensuring that equitable access to care in a community that was already dealing with this challenge prior to COVID-19 is a pressing issue.

Recommendations

A social equity framework provides a foundation for exploring questions related to why COVID-19 has had a disparate impact on communities of color in the United States. Social equity notions should be applied to public health concerns—particularly in crisis and pandemic situations. We propose five recommendations for framing an examination of how social equity factors, considered in the context of COVID-19, might frame a set of strategies. These recommendations provide insights and evidence for practice for public administrators to consider in a COVID-19 setting and well after a pandemic or public health crisis ends.

**Recommendation 1: Build Continuous Dialogue on the Role of the Administrative State in Reinforcing Issues Underscoring Critical Health Disparities**

The concept of nervous areas of government, particularly when applied to matters of race and inequality, is critical for consideration by administrators and others in the public sector. The areas of health disparity brought to light as a result of COVID-19 frame notions of consideration as we reflect on nervous areas of government—particularly when we consider historical inequalities that link to notions of race and socioeconomic in societies. Public administrators play an important role in effecting change as it relates to health disparities in vulnerable and underserved communities. Before implementing changes that impact the health of minority communities, public servants must reflect on the long-standing inequities and underlying factors that underscore health disparities and adverse conditions. These changes have to be examined through the SDH framework, and policy makers must consider the intersectionality of race, power, and politics that is ingrained within the United States.

**Recommendation 2: Enhance Monitoring Mechanisms of Health Disparities**

Government actors at the federal, state, and local levels must engage in continued monitoring of health indicators, with a particular focus on monitoring changes in health disparities. Such monitoring could provide a road map for how to allocate resources for rapid response needs for COVID-19 outbreaks (and future broad-scale public health needs) and provide evidence for implementing changes in policies and practices. Provisions to ensure data collection (as illustrated in the letter to HHS Secretary Alex Azar by members of Congress), public reporting, stakeholder leadership, and public accountability are crucial to ensure success and remedy continuing patterns of neglect.

**Recommendation 3: Focus on Investment in Addressing Health Needs at the Local Level**

COVID-19 has pointed to public health infrastructure needs in many low-income communities. Through the process of charting where services are available, as well as mapping COVID-19 incidence and death rates, we can develop important correlations showing where there has been notable underinvestment in local health infrastructure. To address gaps in infrastructure, a focused strategy should be formed to encourage the development of a better understanding of how actors in the public sector might partner with those in the private and nonprofit sectors to consider a reallocation of resources to address health care infrastructure gaps. By enhancing opportunities for encouraging investment in the local health infrastructure of communities, we can identify strategies for addressing the systematic health care gaps that might exist in various settings.
Recommendation 4: Include Strategies to Further Advance Issues of Access to Care
The issue of access to care for people in historically underinvested communities has long been a challenge in public health. To improve access to care for historically marginalized populations, state and local health departments should guarantee equal access to high-quality care opportunities. Ensuring such access entails implementing strategies to manage costs for the uninsured and underinsured in communities and ensuring local presence of services.

Recommendation 5: Enhance Community Health Worker Infrastructure
A critical component of a local health care infrastructure is the human capital for understanding and responding to local health care needs. Local health departments should train community health workers to provide health education, build trust in health care systems, and offer psychosocial support to residents of historically underinvested communities. While usually implemented in low- and middle-income countries, community health workers have proved effective in improving access to care for vulnerable populations.

Conclusion: Framing a Conversation on Health Disparities and COVID-19
COVID-19 has health implications that intersect with social equity concerns. Public administrators should use this as an opportunity to frame an intergovernmental and intersectoral dialogue around the integration of social equity and long-term public health infrastructure needs of communities. Reflection on the lessons of COVID-19, with an emphasis on the disproportionate impact on communities of color will help frame discussion and long-term activity on the issue of broader health disparities and strategies for continuing to address them.

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