COVID-19: Politics, Inequalities, and Pandemic

Health Equity, Social Policy, and Promoting Recovery from COVID-19

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Abstract The COVID-19 pandemic has revealed starkly and publicly the close interconnections between social and economic equality, health equity, and population health. To better understand what social policies would best promote population health, economic recovery, and preparedness for future pandemics, one must look both upstream and abroad for inspiration. In this article, the author argues for a suite of near-term and longer-term interventions, including universal health insurance and paid sick leave; upgraded wage insurance policies; tax reform; investments in parental leave, childcare, and education; and upgraded government record systems. Policies that equalize the distribution of the social determinants of health and promote social solidarity also will improve population health and economic performance and allow everyone to confront future pandemics more successfully.

Keywords COVID-19, health equity, inequality, population health

The COVID-19 pandemic has revealed starkly and publicly the close interconnections between social and economic equality, health equity, and population health. Social epidemiologists and health policy experts have long understood that social policies can contribute to health equity by reducing inequalities in the distribution of the social determinants of health (SDOH). The pandemic has made it more obvious to the public and to policy makers that well-designed social policies are essential to good population health. To better understand what social policies would best promote population health, health equity, and preparedness for future pandemics, we must look both upstream and abroad for inspiration.

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What Do We Currently Know (and Not Know) about the Link between COVID-19, Social Policy, and Health Equity?

Social policies that reduce inequalities in the distribution of a variety of SDOH, from access to medical care to transportation networks to workplace safety to income security, shape health inequalities across a wide variety of health outcomes (Berkman and Kawachi 2000). Unequal health outcomes for groups defined by socioeconomic status, race or ethnicity, and gender, among others, result when these groups have different endowments (on average) of both downstream social determinants and upstream or fundamental causes (Link and Phelan 1995). This is because social determinants pattern both exposure to risks or protective factors and the effects of these exposures on health. COVID-19 is no exception.

Particularly in the early phases of the pandemic, protective factors such as access to accurate information about the importance of hand washing and social distancing and the ability to stay home from work or order groceries for delivery were stratified by income and education (Reeves and Rothwell 2020). Exposure to risks has also been socially patterned throughout the pandemic. Exposure to the virus that causes COVID-19 is much higher among people working in "essential" jobs (Lu 2020). While some of these jobs, such as physicians and nurses, are well-paid and occupied by relatively high-status individuals, far more are not: hospital orderlies and cafeteria workers, nursing home aides, city bus drivers, sanitation workers, grocery store clerks, and meat packers are among the lowest-paid workers in our society, are disproportionately women and members of racial/ethnic minority groups, and not only must go to work but also are less likely than their higher-status managers and coworkers to have access to personal protective equipment on the job (North 2020). Unsurprisingly, infection and death rates are particularly high among these groups of workers (CDC 2020).

Past social policies shape socioeconomic stratification, which in turn not only patterns exposure to protective and risk factors but also affects whether and how exposure is translated into health outcomes. For example, high levels of air pollution, which are disproportionately found in lower-income and predominantly minority communities, appear to cause higher mortality from COVID-19 (Wu et al. 2020). Similarly, people with preexisting conditions such as diabetes, cardiovascular disease, and asthma are more likely to become seriously ill or die from COVID-19, but these conditions are not distributed at random in society. The strong social

gradient and intersecting racial/ethnic disparities in these kinds of chronic conditions means that minority and low-income people have been overrepresented in the COVID-19 infection and death counts so far (Garg 2020).

The best available data on infection and death rates from COVID-19 suggest that there is substantial variation in the impact of the disease not only within countries, states/regions, and localities but also between them. It is tempting to use these data as evidence to explain how public policy—different government responses to the pandemic itself as well as prior policy patterns, including social policy—affects population health and health equity. The problem is that the best available data right now are not very good. Lack of widespread testing in many localities, highly variable criteria for counting deaths as resulting from COVID-19, and a failure on the part of many governments to collect systematic information on the race/ethnicity and socioeconomic status of affected people means that current information about the impact of the pandemic is radically incomplete and noncomparable across political units.

This means we ought to be careful about claiming causal connections between variation in social policies and variations in infection or death rates, especially given the likelihood of unobserved heterogeneity across units that may be associated with both the character of social policies and the (reported) incidence of COVID-19. Nevertheless, it is worth keeping in mind that there *may* be a causal link between robust, equalizing social policies in the past and how countries, subnational regions, and/or localities are experiencing the pandemic today. It is even more important to use what we know about the links between social policy, health equity, and population health to mitigate the effects of the pandemic in the short term, encourage an equitable exit from the pandemic in the medium term, and prepare for future pandemics.

Social Policies to Contain the Epidemic and Minimize Inequality

In the short term, social policies are needed to help us contain the epidemic effectively, prevent recurrent waves of infection, and minimize mortality. Some of these policies are obvious and have already been extensively discussed or even (partially) implemented: Paid sick leave and some form of income replacement for missed hours are needed to allow workers who are ill to stay home and avoid infecting coworkers and the public. (I will address in the next section what I think the most helpful forms of income

replacement would be.) Universal access to affordable health care is a must if people who become ill are to seek timely care for both COVID-19 and other emergent or preexisting conditions, control underlying conditions that would worsen prognosis in the event of a COVID-19 infection, and avoid spreading illness in their families and communities. The millions of American workers who have lost employer-sponsored health care along with their jobs, or who are unable to purchase insurance due to loss of income, must be offered in a timely manner and for as long as the pandemic continues an affordable, comprehensive form of insurance for the medical bills they would incur if they were to seek care. Effective mental health care coverage (including but not limited to actual parity in coverage of mental health treatment among those lucky enough to be insured) is also needed to prevent loss of (quality of) life due to the psychological stress of pandemic-related social and economic disruption (Pfefferbaum and North 2020). Finally, income and nutrition supports are needed to prevent the poorest members of our society from suffering physical harm from exposure or hunger at a time when earnings are reduced and savings depleted. Thirty percent of American adults reported reducing their spending on food in the early weeks of the pandemic, and one quarter experienced food insecurity (Waxman 2020). Conditions are likely to worsen, especially if school-based nutrition programs remain disrupted.

Social Policies for an Equitable Exit from the Pandemic

Within the next year to eighteen months, one hopes, we will move beyond the immediate need to contain the spread of infection and sustain life in pandemic conditions, and into a phase of recovery. As we exit from the pandemic, creating the conditions for a healthy and equitable recovery will require us to deploy social policies that shape the upstream social determinants of health. Because economic recovery is necessary to sustain such social policies over the long term, it is worth considering not only what we can do to promote population health and equity but also which social policies are likely to support a sustainable economic recovery.

Promoting Population Health via Social Policy

Many of the same policies that are needed to protect health during a pandemic are also needed to ensure population health and health equity over the longer term. Universal access to affordable, timely, and appropriate health care that is not conditional on employment; real behavioral and

mental health parity; and paid sick leave for all workers are critical reforms that are needed well beyond the current crisis situation. The precise effects of the pandemic on the politics of health care reform are difficult to predict. However, it seems likely that some major reforms are likely to occur, including the possible expansion of Medicare and Medicaid to new groups of beneficiaries, and/or introduction of some form of "public option." As reforms to the health care system are undertaken, expanded behavioral and mental health care surveillance and treatment should be prioritized to counteract the likely long-term consequences of mass trauma stemming from extended confinement and loss of life and livelihood during the pandemic (Galea, Merchant, and Lurie 2020). Finally, the US must introduce a more robust form of sickness benefit, that is, insurance against short-term income losses sustained due to illness, disease, or injury. The current system of disability insurance plus workers' compensation is inadequate and results in unnecessary hardship, reduced productivity, and the spread of infection when workers cannot afford to stay home when they are sick or injured.

While health care and other protections for people who are already sick are important, still greater benefits for population health and health equity can be gained by considering social policies that act on more distal social determinants of health. For example, direct government provision of housing, zoning policies, rental subsidies, and regulation of consumer credit could all be deployed to ensure access to safe, affordable housing, which is a major social determinant of health (Taylor n.d.). Similarly, more stringent regulation of environmental hazards could help to reduce the overall burden of disease in the primarily poor and minority communities that are exposed to them (see, e.g., Rowangould 2013).

But perhaps most critical for the US context are social and labor market policies aimed at reducing our very high levels of poverty and inequality, and with them the morbidity and mortality associated with both absolute and relative low socioeconomic status (Pickett and Wilkinson 2015). Universal Basic Income (UBI) programs have received growing attention on both the left and the right in US politics (Murray 2006; Stern and Kravitz 2016). If set at a high enough level to support even the neediest households, UBI holds some promise as a tool for reducing poverty and making social policy more efficient. Universalism is a desirable feature in social policy design, as it prevents stigmatization of recipients, reduces administrative burden on both individuals and the state, and generates higher levels of political support than targeted programs do (Esping-Andersen 1990; Herd and Moynihan 2019; Skocpol 1991). However, it seems very unlikely that

in the US context there would be political support for UBI payments that are high enough to meet the multiple needs of poor individuals (Kearney and Mogstad n.d.).

Precisely because poverty is so often comorbid with multiple other adverse conditions (e.g., disability, single-parenthood, divorce, poor labor market conditions, insecure housing), a broader scope of support is needed than the $500 to $1000 per month proposed by many domestic advocates of UBI. Fortunately, many other kinds of policies are effective in alleviating poverty—as is amply evidenced by the fact that other rich democracies have rates of poverty among children and working-age adults much lower than ours (Smeeding 2006). From job guarantees, living wage ordinances, and advanced maintenance (child support) directives to protections for organizing and broadening the tax base, there are many things we could do to reduce poverty. And any of these would help promote population health and health equity, since resource poverty is a key upstream social determinant of health.

Large gains in population health overall are also likely to come from policies that reduce income inequality (Pickett and Wilkinson 2015). Despite high rates of poverty, the bulk of the US population falls in the middle of the income distribution rather than at the very low end, and health status rises across the full social gradient, not only when one goes from being poor to not poor. This means that policies that reduce inequality, and not just poverty, have an important role to play in ensuring that our emergence from the pandemic is equitable and healthy. Fair taxation of capital gains and wealth and raising the level of income on which social insurance contributions are levied would generate revenue and so reduce the need for austerity in social spending, and would allow us to shift the burden of taxation away from those with incomes near the middle of the income distribution and toward those with the highest earnings and wealth. Along with greater public support for health care and education, this would free up resources for middle-class people and allow them to live less-stressed, healthier lives.

Policies That Are Good for Health Equity Are Also Good for Promoting Economic Recovery

Any set of postpandemic social policies that hopes to promote population health and health equity must also contribute to economic growth, as a thriving economy is necessary to generate employment, income, and tax revenues—all of which are necessary to ensure individual and societal well-being. High levels of social protection are generally compatible with

economic performance, but certain types of social policies are particularly valuable for promoting economic dynamism (Atkinson 1996). I will focus here on four aspects of social policy—income protection policies, support for families, investment in public education, and administrative systems reform—in which the US lags significantly behind our OECD (Organization for Economic Cooperation and Development) peers, and that have significant implications for both economic performance and health.

The COVID-19 pandemic has revealed stark deficiencies in our policies for protecting both workers and firms during crises in which there is major disruption to employment. Recovery from the pandemic is likely to continue to be characterized by significant disruptions to employment across multiple sectors of the economy. Yet our unemployment insurance system, which is significantly less generous than in most other rich democracies, is administratively cumbersome and difficult to access, delivers benefits that are often inadequate to maintaining household consumption during prolonged periods of unemployment, and does not protect all workers (OECD n.d.). Unemployment benefits are critical "social shock absorbers" because they allow households to have adequate income to consume, without which consumption-based economies falter. However, other forms of wage protection, such as the wage insurance or *kurzarbeit* systems used in Germany and Denmark, may be even more valuable during the recovery from COVID-19. Such programs protect not only workers' ability to consume but also employers' ability to rehire quickly and without loss of firm-specific skills (Thelen 2014). Emergency support for small businesses to retain salaried workers during the pandemic has been a welcome relief to many firms and workers, and should be regularized and expanded to support economic recovery.

Another area in which the US currently lags and that will be needed to promote economic recovery is support for families with young children. The US is unique among rich democracies, and nearly unique in the world, in lacking paid leave policies to support mothers after the birth of a child. Paid maternal leave protects the health of very young children and their mothers, and, if structured correctly, also facilitates the reentry of mothers into the workforce. Most rich democracies also now have leave policies that support fathers in taking time off to care for young children, which encourages mothers' reemployment and fathers' engagement with children, both of which promote longer-term gains for household earnings and child well-being (Hegewisch and Gornick 2011). Affordable, high-quality childcare and early childhood education are also critical for parents' ability to return to work after the birth of a child as well as for child development

and subsequent earning potential (Heckman et al. 2010; Morrissey 2019). The US performs remarkably poorly in international comparisons of the availability and quality of affordable childcare (Chzhen, Gromada, and Rees 2019). Making society work better for parents with young children can help boost the employment and earnings of both caregivers and parents, which are necessary for economic recovery in the medium term, and is an important long-term investment in the health and productivity of our future workforce.

Wise investment in public education at all levels will also help foster the productivity gains and high employment levels that are necessary for a complete recovery from the pandemic. US educational outcomes for K–12 students lag behind those in other rich democracies, with poor results driven by the very large disparities in achievement between high- and low-performing students (NCES n.d.). Current spending by states and localities on primary and secondary education has remained fairly steady since the mid-1990s, but the distribution of funding across districts within many states has become markedly less progressive during this period (Urban Institute 2017). Student achievement is exceptionally strongly correlated with socioeconomic status in the US, with the result that the educational opportunities that are critical for ensuring both health and economic prosperity will be limited unless states and localities commit to more equitable funding of primary and secondary education (Conti, Heckman, and Urzua 2010).

Since its peak in the late 1970s, and accelerating since the mid-2000s, both federal and state spending on upper-secondary (vocational and technical) and tertiary education has declined as a share of GDP. Robust vocational education and training programs are regarded by many scholars and European policy makers as engines of both economic growth and social inclusion (European Ministers of Vocational Education and Training, the European Social Partners, and the European Commission 2008; Thelen 2014), while strong public investment in mass tertiary education facilitates the emergence of economies characterized by relatively low earnings inequality and a larger role for high-productivity manufacturing (Ansell and Gingrich 2013). The COVID-19 pandemic has disrupted higher education. Faculty and staff employed at public institutions have been furloughed, and private colleges and universities already struggling with declining enrollments before the crisis are likely to lay off teaching staff permanently (Carlson and Galbally 2020; Kelderman 2020). Without public investment in upper secondary and tertiary education, our nation's capacity to educate productive workers will suffer, with consequences for both economic recovery and health equity.

A final area of desperately needed interventions in US social policy concerns our antiquated informational and benefits delivery infrastructure. Well before the pandemic, lax government regulation of commercial systems resulted in excessive administrative costs and substandard care in the health sector, where electronic medical records lack interoperability. Government systems that do not speak to one another impose further administrative burdens on individuals, who must repeatedly prove their eligibility for means-tested programs and often forego benefits as a result (Herd and Moynihan 2019). The troubled rollout of state health insurance exchanges under the Affordable Care Act a decade ago illustrated vividly how difficult it is to introduce policy innovations when separate government systems for recording data about income, benefits eligibility, and enrollment are housed on obsolete computer systems with limited connectivity across government departments and US states (Timberg and Sun 2013). During the COVID-19 pandemic, fragile records systems have delayed processing of claims for unemployment insurance payments, resulting in severe hardship (McGreevy and Christensen 2020; Nirappil and Simon 2020). Without substantial reforms to government records systems, it will be extraordinarily difficult to launch and maintain the robust system of immunization, testing, and contact tracing needed to ensure safe restarting of economic activity (Watson et al. 2020).

Social Policy, Health Equity, and Preparing for the Next Pandemic

Global climate change and mass movement of populations means that the current novel pandemic is unlikely to be the last one we face (Settele et al. 2020). If we get the social policy response to COVID-19 right, however, the very same policies we use now to promote health equity and a robust economic recovery will also help prepare us for the next pandemic. Universal access to health care, paid sick leave, and insurance against lost wages will help slow the spread of novel illnesses. Better administrative systems will help us track and respond more effectively to new challenges. Perhaps most importantly, the enhanced sense of social solidarity and trust that stems from strong systems of social protection also protects our health.

At both the individual and societal level, higher levels of social trust are associated with better health outcomes (Barefoot et al. 1998; Giordano, Björk, and Lindström 2012). Generous public social programs in turn are associated with higher levels of social and political trust (Cammett, Lynch, and Bilev 2015; Kumlin and Rothstein 2005), with some research demonstrating a causal relationship flowing from welfare states to trust (Brewer,

Oh, and Sharma 2014). In pandemic situations, individuals are more likely to cooperate with rules issued by trusted leaders (Prati, Pietrantoni, and Zani 2011). Investing in social welfare systems that promote social cohesion and trust in government are thus not only good for population health, equity, and economic recovery but also essential for our survival.

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