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Coronavirus Disease Discriminates. Our Health Care Doesn't Have To | Opinion

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Are we really all in this together? It is true that until December 2019, no human had encountered the 2019 novel coronavirus, and so none of us was immune. It is also true that political and national boundaries have not halted the spread of this contagion throughout the world. But it is just as true that COVID-19 has washed away any veneer of equal opportunity or equal risk in the population.

The "pre-existing health conditions" that put a person at risk of severe disease and death from COVID-19 are over-represented in communities of color and poor communities as a result of long-term disinvestment and neglect. And now our country's delayed response to the looming pandemic has resulted in unprecedented and under-resourced demands on our health care system. It has raised the specter of health care providers having to make decisions in real time, at the bedside, of who will receive life-saving treatment and who will not.

These decisions used to be made from a distance by our insurance companies, economic system and legally structured racial residential segregation. Now, they will seem personal and real in a whole new way.

Health equity is assurance of the conditions for optimal health for all people. It is a process, not a magical outcome. As we navigate through the immediate health, economic and social demands of the COVID-19 pandemic, three principles for achieving health equity can provide us with both a moral and practical compass: valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need.

These principles can serve as a framework for evaluating current and proposed policy solutions, as well as a checklist for identifying gaps in policy where no solutions have yet been suggested. They can also be the basis for decision-making at the health care provider level.

How can we operationalize these principles for our response to the COVID-19 pandemic?

Valuing All Individuals and Populations Equally

We need to consider how to reach all communities with our life-saving messages of social distancing, frequent hand-washing, stay-at-home orders and symptoms of COVID-19. And we need to enable all individuals to take up these practices. We need to value those who are detained in jails, prisons and immigration detention centers, as well as those who are unhoused, as much as we value people living in senior communities. We need to anticipate all of the needs that exist.

And we have to be bold in imagining solutions to the issues raised when we decide to value all individuals and populations equally. For example, the decarceration of jailed, imprisoned and detained people who pose little risk to society and are at high risk of death from COVID-19 due to their age or underlying health status. And connection to community resources to support these returning citizens. Or the housing of previously unhoused individuals in available vacant properties. Or at least providing hand-washing stations and opening public restrooms for their use.

At the policy level, the most important way to value all individuals and populations equally is by looking at who is at the decision-making table and who is not, what is on the agenda and what is not. When any of us is at a decision-making table, we need to look around and ask, "Who is not here who has an interest in this proceeding?" And then our job is not just to represent the interests of the missing parties, although that may

be a necessary short-term strategy. Our job is to create space for them at the table.

Even now, when Congress is working on the fourth COVID-19 rescue plan for the nation, we need to ensure that all voices can be heard in the deliberations. In the short term, that may be active solicitation of citizen input by our elected representatives. In the long term, that may take overturning Citizens United.

Communities of color should not be "sacrifice zones" with regard to the COVID-19 response. One wonders about the decision to disembark infected persons from the Diamond Princess cruise ship in Oakland Bay rather than in San Francisco Bay, noting that Oakland has a much higher population of color. Or about the decision to convert Carney Hospital in the Dorchester neighborhood of Boston to be the country's first hospital devoted to the care of COVID-19 patients, depriving that predominantly black neighborhood of access to other medical services and possibly increasing the risk of infection in the area.

Certainly, the since-abandoned policy proposal to provide lower one-time cash payments to Americans with lower incomes was the opposite of valuing all individuals and populations equally.

At the bedside, decisions about the allocation of life-saving treatments should not be done by the medical professionals directly involved in the patient's care. It is too easy for implicit bias about relative worth based on race or ethnicity, class, gender, language, disability or other characteristics to manifest itself in decision-making when a provider is tired or stressed. If patient prioritization will instead be done by a hospital ethics board, the composition of that board also needs to be examined for balance along axes of difference and power, and community input into the criteria and processes for decision-making should be rapidly sought.

If we really want to value all individuals and populations equally, should we use a lottery system for allocation of scarce resources? At least structured inequity and subjective valuation would be taken out of the decision-making. This is a provocative suggestion. But perhaps the threat of a fair system in which all people would have equal chances at life would stimulate a more rapid production and distribution of life-saving health resources, solving the issue of scarcity.

COVID-19 is washing away any veneer of equal opportunity or risk, writes Dr. Camara Phyllis Jones.ILLUSTRATION BY ALEX FINE; PHOTO BY FS PRODUCTIONS/GETTY

Recognizing and Rectifying Historical Injustices

The principle manifestation of historical injustices during the crisis of the COVID-19 pandemic is how segregation of resources and risks, societal devaluation, and environmental hazards and degradation are

written into the bodies of people of color and poor people. The greater health burden borne by these people may not only predispose them to more severe manifestations of the virus itself, but may also disadvantage them in any ethical protocol established for the rationing of scarce health resources. That would be wrong. It would be counter to the health equity principle of recognizing and rectifying historical injustices, putting at double jeopardy those who already bear the brunt of chronic assaults to health. Instead, this principle should lead to the provision of more ventilators and health services in populations with higher pre-existing health burdens.

Recognizing and rectifying historical injustices also necessitates collection and disaggregation of data on coronavirus testing, diagnosis, treatment, and outcome by "race" and ethnicity so that the impacts of those historical injustices can be recognized and addressed.

In the longer term, attention by policymakers to the history of each problem to be solved will always provide useful insight into effective solutions. Understanding how a knot got tied will always help in untying the knot. The United States population is notoriously ahistorical, thinking that the present is disconnected from the past and that the current distribution of advantage and disadvantage is just a happenstance. The long-term application of this principle will involve the large-scale teaching of our full histories as a nation and a commitment to apologize and make reparations for past injustices, recognizing that they continue to have present-day impacts.

Providing Resources According to Need

This is perhaps the easiest of the three principles to understand but often the hardest to implement. It takes a tremendous amount of political will. The first step is to establish a metric of need on which there is wide consensus. In the context of the COVID-19 pandemic, it might be the number of diagnosed cases or indicators of the trajectory of the epidemic (including doubling time and basic reproduction number) in a given jurisdiction. It might include projected number of deaths, projected demands on the health care system, current health system capacity or current levels of resources in an area.

Once a metric of need is established and agreed upon, it would then seem simple to take all available resources and distribute them according to that metric of need. However, even in the clear current situation of New York, topping out these measures of need all around, there is not a rapid deployment of national resources to the city. Other jurisdictions are holding on to theirs because of projected need in a few weeks. And the federal government is slow in using its full power to rapidly commission and deploy resources to areas of need. Instead of conducting targeted and fluid mobilization as the pandemic moves across the nation, there appears to be a stance of disbelief and paralysis at the scope of the need.

As often happens, people (and political jurisdictions) never compare themselves to those who have less than what they have. They always compare themselves to those who have more, so they always feel needy. A pre-established metric of need should solve that. But perhaps strong community pressure is also required.

This pandemic will not end in days or weeks. It could be a year, maybe 18 months. By then, the world will have faced immeasurable loss in terms of life. And economies will need to get back into gear. But maybe the lesson that we are all human and all vulnerable will have sunken through to those who feel better than, or removed from, or insulated from the conditions of others.

It is my hope that these three principles for achieving health equity will be useful in guiding decision-making during these treacherous times. But looking forward, I also hope that they will provide a guide for how we value and treat one another as we build a better, new normal after COVID-19.

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The views expressed in this article are the writer's own.