

Introduction: Investigating Dimensions of Pandemic Inequity Requires a Multidisciplinary Approach

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When the coronavirus emerged in the United States in early 2020, reassuring early platitudes suggested that “we are all in this together” and “COVID-19 is an equal opportunity killer” (see, e.g., Blow 2020; Reuters 2020). These platitudes quickly became exposed as such, however, as evidence demonstrating the unequal reach and consequences of the pandemic accumulated. Data on the epidemiologic impact—combined with the everyday experiences of the most affected groups in the United States—continue to reinforce the reality that this pandemic is inequitable in almost every imaginable dimension. According to March 2021 data from the Color of Coronavirus project, the highest overall rates of death are among Indigenous Americans (256 deaths per 100,000), followed by Black Americans (180 deaths per 100,000); once accounting for age, Pacific Islanders and Latinos have the highest mortality rates (APM 2021). Coronavirus-related concern is also unequally distributed by race, with only 17% of white respondents to a Pew survey in late 2020 saying they were very concerned about getting COVID-19, while 37% of Hispanic and 36% of Black respondents reported the same (Pew 2020). Furthermore, 71% of Black respondents in the same poll reported they knew someone who had been hospitalized or died as a result of COVID-19, compared to 49% of white respondents (Pew 2020). Higher viral exposure through high-risk workplaces (e.g., meatpacking), living in crowded housing conditions (including long-term care and carceral settings), and inability to work from home—combined with heightened vulnerability to more serious illness because of chronic conditions borne from compounded risks of structural

racism—underscores the fundamental contribution of social and economic conditions at both the individual and community levels (Bailey and Moon 2020; Karmaker, Lantz, and Tipirneni 2021; Rollston and Galea 2020).

While these descriptive data confirm the highly unequal impact of the pandemic, a comprehensive understanding of how these inequities came to be requires a multidisciplinary approach. It is necessary to not only engage with the epidemiological issues of disease distribution but also examine the politics and policy that contribute to inequities and that could alternatively be mobilized to promote health equity. The six studies in this special issue of the *Journal of Health Politics, Policy and Law* do just that. Each article engages with the politics of inequality, demonstrating how inequality in the incidence and impact of COVID-19 was built on fundamentally unequal social, economic, and political structures in the United States and reproduced during the course of the pandemic in 2020. Using the lenses of law, political science, disability rights, and health policy, the authors contribute new insights into the politics at the center of pandemic inequality.

In the first article of this special issue, Sarah Rosenbaum, Morgan Handley, Rebecca Morris, and Maria Casoni present a case study of four ostensibly race-neutral health care policy decisions made by the Trump administration during the COVID-19 pandemic. They demonstrate that each of these policy choices exacerbated racial inequality and perpetuated structural racism. As a remedy for the future, they argue that equity must be at the center of health policy making—what they describe as an “equity-mindful” approach—which would incorporate a formal health equity assessment into the policy-making process. They suggest that such a policy-making strategy is consistent with US civil rights law, and alongside a fuller retrospective analysis of how policies in 2020 contributed to pandemic inequality, constitutes critical steps toward ameliorating structural inequities.

Consistent with Rosenbaum and colleagues’ call for deeper retrospective policy evaluation, Colleen M. Grogan, Michael K. Gusmano, and Yu-An Lin analyze one of the four case studies that the previous piece highlighted, the distribution of CARES Act provider relief funds to hospitals. They evaluate the distributional schemes that the US Department of Health and Human Services applied based on two key metrics: percent of outpatient revenue (measuring those hospitals likely to suffer most from revenue losses during the early phase of COVID-19) and days of cash on hand (measuring financial vulnerability of the hospital). Based on this analysis, they conclude that the CARES Act funds enriched hospitals that were already better resourced pre-pandemic. Their article situates the CARES

Act policy response within the already bifurcated structure of the American hospital system, providing a useful narrative history of how reliance on private capital contributed to hospital stratification into “haves” and “have-nots” long before the pandemic’s arrival in the United States in 2020.

While the CARES Act comprises a set of policies developed with the principal objective of providing relief from COVID-19–related burdens (on hospitals, other businesses, and the general public), Michael W. Sances and Andrea Louise Campbell’s study examines whether and how existing (i.e., pre-COVID) state-level policies buffered the impact of COVID-19 on mental health. Continuing the theme established in Rosenbaum and colleagues’ article, Sances and Campbell apply a structural racism lens to examine the racialized impacts of the pandemic and how existing inequalities in availability of safety-net policies (including unemployment benefits, paid sick leave, and Medicaid expansion) reinforced COVID-19–related inequality. The authors find significant consequences of the pandemic on mental health, with heightened mental distress among people of color. They further demonstrate that the effects of losing employment on mental health was offset by living in a state with a more generous safety net, illuminating the deleterious consequences of the differences in generosity across state contexts.

The next two articles offer deeper dives into two critically important—and often neglected in studies of health equity—populations: people with disabilities, and those living in carceral settings. Ari Ne’eman, Michael Ashley Stein, Zackary D. Berger, and Doron Dorfman conduct an analysis of change over time in state crisis standard of care (CSC) policies, policies that establish guidelines for triage of scarce resources. They first present a normative analysis about a set of five allocation criteria within CSC plans, suggesting which criteria promote disability rights and which are legally problematic according to disability rights law. Then they apply a rubric to code 58 CSC policies from 35 states to produce an index score reflecting degree of alignment with disability rights policy preferences. They find evidence that revisions to CSC policies over time increasingly align with disability rights and thus may reflect the influence of disability activism in public policy making. Their study presents questions for future inquiry about how the process of influence around bioethics issues happens in policy making.

Matthew G. T. Denney and Ramon Garibaldo Valdez examine the impact of COVID-19 within prisons, jails, and migrant detention centers. They first document how compounded racial vulnerability and specific policy choices contributed to the spread of COVID-19 in carceral institutions. They next ask how the general public would respond if they knew about the racial

inequalities and poor health conditions within these facilities, using a survey-based experiment. While their results generally depict a public uninterested in the plight of people in these institutions, they suggest that providing information about racial disparities may lead to increased public support for decarceration.

In the final article of this special issue, Katherine Carman, Anita Chandra, Carolyn Miller, Christopher Nelson, and Jhacova Williams present a less optimistic view about the potential of public awareness of racial disparities to translate into meaningful change in policy support. They leverage panel data from 2018 and 2020 to examine changes in awareness of health inequity over time. Despite high attention among public health professionals and at least some mass media outlets to the types of inequities embodied by COVID-19, Carman and colleagues' article suggests that these ideas have not been disseminated into the general public in ways that could meaningfully shift their understanding of health inequity. While 60% of respondents to their summer 2020 survey believed (correctly) that people of color face more health impacts of COVID-19 than whites, these views were more common among respondents of color than white respondents, and among those who acknowledged in 2018 that people of color faced health care inequities. The authors suggest that this finding signifies that beliefs about health inequities are unlikely to shift in a major way in response to information from news reporting, for instance, about the relationship between structural racism and health outcomes—whether COVID-19 or other health conditions. However, the authors do observe a significant shift in the share of the public that perceives that the government has an obligation to ensure access to health care, suggesting some broad public recognition that the government has a role in reducing health inequities, even if not necessarily framed with that specific objective.

Taken together, the articles in this special issue are a powerful argument for the importance of multidisciplinary analysis of health politics, policy, and law for understanding health equity. High-quality epidemiologic and demographic approaches to health equity are essential for revealing the inequalities in exposures, susceptibilities, and outcomes generated by COVID-19. Indeed, surveillance data in 2021 demonstrate striking inequities in vaccination rates by race, with Black and Hispanic people receiving lower shares of vaccinations compared to their share of the population (Ndugga et al. 2021). But an understanding of the upstream political, policy, and legal contexts that have shaped these and other population health outcomes is equally important, especially if we want to identify levers for change that operate at the collective or structural level.

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