Emerging US Socioeconomic and Health Disparities in the COVID-19 Pandemic: A Scoping Review

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Abstract

The coronavirus disease 2019 (COVID-19) emerged as a pandemic in late March 2020, with cases escalating in the US. (1) Health disparities, caused by underlying low socioeconomic factors,(2) are heightened in the current COVID-19 pandemic and response. These health disparities are especially evident for disenfranchised populations like low-income, Black and Hispanic, and incarcerated communities. This scoping review was conducted to provide an overview of the evidence that highlights the need for public health policies sensitive to socioeconomic and health disparities in the US. First, the review provides evidence suggesting that low-income earners, Blacks and Hispanics, and incarcerated populations are among those with the greatest risk for COVID-19 due to underlying disparities. Second, it contains a review of the research that suggests these populations also have a decreased ability to adhere to social-distancing directives. The results suggest that there is an increased burden and exposure to COVID-19 among the poor, Blacks and Hispanics and incarcerated, and that these populations are less able to follow social-distancing guidelines. Overall, new policies should challenge existing socioeconomic and health disparities by addressing economic security, housing security, criminal justice, and healthcare access. Therefore, the current COVID-19 pandemic response needs to be part of a larger effort to combat health and socioeconomic inequity in the US.

Introduction:

COVID-19 is a respiratory disease, caused by the SARS-CoV-2 virus, that transmits from person-to-person through small droplets released from breathing, sneezing, and coughing.(3) The symptoms of COVID-19 are generally mild; however, a small percentage of infected individuals can develop more serious symptoms such as pneumonia, often leading to fatal consequences.(4) As of April 2020, the number of COVID-19 cases surpassed 2 million globally, with almost every country reporting infection worldwide.(5) In the United States (US), the country with the greatest number of COVID-19 cases globally, evidence is emerging that health disparities linked to pre-existing socioeconomic disparities are highly associated with the disease infection and the ability to practice “social-distancing”.

Social-distancing has been adopted as the primary emergency response to COVID-19 in the United States during the pandemic. The Center for Disease Control and Prevention (CDC) has issued voluntary guidance to “stay at home” and “away from people” as much as possible by staying 6 feet apart from others.(6) However, there have been broader “shelter-in-place” orders in multiple communities, cities, and counties across the US.(6) This social-distancing policy was declared by Executive Order in almost all states as of March 2020(7) and it is among the most aggressive emergency response strategies in the wake of the pandemic. This policy necessitates the termination of any unnecessary travel outside the home environment including the closures of schools, workplaces, places of worship, and any other locations where people are most likely to congregate in groups.(6) Exceptions to the policy have included getting groceries, obtaining medications, completing home maintenance work,

working “essential” jobs, and doing exercises.(6) Models by the CDC suggest that the transmission of the SARS-CoV-2 infection rate, without this type of mitigation, would be more than 60% of the US population,(8) thus highlighting the importance of adhering to the social-distancing orders across the nation.

During a pandemic, the consequences of current health and socioeconomic disparities among various ethnic/racial groups, income levels, and social classes are heightened. Underlying social determinants of health drive unequal disease burden during outbreaks, reflecting existing discriminatory social, political, and historical systematic structures. Consequently, these factors accumulate over lifetimes and generations, worsening illness for disadvantaged populations. (9) Poverty, unstable and/or overcrowded living conditions, lack of community resources, poor education, and inaccessible healthcare services are some of the underlying socioeconomic factors prevalent among disenfranchised, Black and Hispanic communities, and incarcerated populations. Across cities and states in the US, low-income earners are less able to cope with COVID-19 illness and are more likely to die.(10) Blacks and Hispanics account for a disproportionate amount of cases and fatalities related to the novel disease,(11-13) while prison and jail systems have reported an alarming increase in COVID-19 cases and deaths.(14) These populations exemplify how certain groups in the US are more vulnerable to exposure and suffer greater consequences because of COVID-19 than other groups.(15)

Concerns for health disparities in the COVID-19 pandemic reach beyond fatalities and infection rates. Social distancing directives are critical to decreasing transmission of the SARS-CoV-2 virus but impose disproportionate social and economic

challenges to vulnerable populations.(16) Certain groups are not privileged with income security and safe housing to work or remain at home for extended periods of time,(16) and a study has found unequal social distancing across various demographic groups.(17) This raises serious concerns for ensuring equitable public health policies that protect vulnerable populations.

The objectives for this scoping review paper are: (1) synthesize relevant evidence that low-income, Black and Hispanic, and incarcerated populations have increased risk for COVID-19 due to existing socioeconomic and health disparities, and (2) present evidence that these populations also experience a decreased ability to adhere to social-distancing guidelines because of these underlying disparities. The paper suggests policy reforms can address socioeconomic and health disparities through emphasis of economic security, housing security, criminal justice, and healthcare access. Ultimately, transformative solutions will only be achieved in the US if equitable response efforts are part of a larger systematic effort.

Methods:

A scoping review approach was used to include a wider range of evidence beyond traditional peer-reviewed articles. Newly emerging data, press accounts, and interviews related to the research topic of COVID-19 health disparities were summarized. The scoping review was conducted between March and May 2020 by the reviewer O.E. Peer-reviewed academic articles were found through databases like Google Scholar and PubMed. Articles were included if they described the landscape of the COVID-19 pandemic within the United States and related COVID-19 health

disparities. In total, seventy-two peer-reviewed articles, news articles, editorials and working papers were reviewed.

Press accounts such as newspaper articles and editorials supplemented peer-reviewed articles. Press accounts were found through reporting outlets circulated through list servers like *The Spirit of 1848*.(18) The rest were found through scanning different news reports and Google searches. Finally, interviews were conducted to contribute qualitative and thematic discussion in this scoping review. Interviews were 30 minutes in total and held over the phone or through video conferencing applications like Zoom. The interviewees were three academic and professional leaders within the fields of bioethics, equitable health policy and incarceration issues. Interview questions were open-ended [supplemental data] and formatted to promote broad discussion on health and socioeconomic disparities among low-income, Black and Hispanic and incarcerated populations. IRB approval was not required as human participants were not used for the review.

Review of the Evidence

1.Populations at a Higher Risk for COVID-19

1.1 Low-Income Populations: Low-income earners in this scoping review include populations that work in service and care industries, vulnerable families (such as single-parent households and families with individuals with disabilities) and persons experiencing homelessness. These populations were frequently cited as having a greater risk for COVID-19. For service and care industry workers like personal care aides, home health aides, first responders, teachers, cashiers and fast-food workers,

their risk of COVID-19 infection is greater compared to workers in other industries.(19,20) US workers who are janitors, housekeepers, and maids, must be physically present to carry out their work duties and have increased vulnerability to COVID-19.(21) Evidence also suggests that these workplaces often involve duties that require close contact with other people, making COVID-19 highly transmittable. The outbreak at the Smithfield meatpacking plant in South Dakota exemplifies the increased risk of contracting COVID-19 in close-contact settings.(22) Workers of meat and poultry processing plants typically stand in close proximity, unable to mitigate the exposure to others.(23) Furthermore, thousands of meat workers and their close contacts in the Midwest and Great Plains have tested positive for COVID-19.(19)

Evidence from the review suggests that people experiencing homelessness are also at an increased risk for contracting COVID-19.(24,25) Furthermore, there is greater potential financial and healthcare impact for government systems if transmission within this population is not mitigated.(26) In the US, there are approximately 570,000 individuals who experience homelessness on a single night.(27) Evidence reports that people experiencing homelessness face greater health challenges compared to other people in the US, (25,26,28) like mental health problems,(29) substance abuse,(29) and decreased access to healthcare services.(30) Services for people experiencing homelessness are often in facilities and institutions that involve a high congregation of people in limited spaces.(31) Furthermore, encampments, where many people experiencing homelessness live, are characterized by the decreased spacing between each person. Therefore, the transmission and severity of the COVID-19 disease in these settings is great, underscoring the vulnerability of this population. (25)

1.2 Black and Hispanic Populations: Epidemic disease disproportionately affects minority populations.(32) Exacerbated by current health and socioeconomic disparities, COVID-19 shows similar trends of Black and Hispanic populations being at a higher risk for disease than other ethnic groups.(33-36) Blacks in the US disproportionately suffer from heart disease,(37) diabetes,(38) kidney disease,(39) HIV,(33) respiratory disease,(40) and other serious medical conditions, increasing the number of immunocompromised and leading to more cases of COVID-19.(41) Similarly, Hispanic populations also face increased rates of underlying medical conditions that can increase their vulnerability to COVID-19 transmission.(11) These health disparities stem from underlying and pre-existing socioeconomic and social determinants of health factors that have played a substantial role over generations to culminate into medical conditions.(33) COVID-19 has been reported two times more fatal among Blacks and Hispanics compared to White counterparts in New York.(12) The city of Chicago and the state of Louisiana have both reported that Black patients account for 70% of COVID-19 mortalities although they only make up one-third of the total population in these regions.(13) At Massachusetts General Hospital, it has been estimated that 35-40% of patients are Latino, representing a 400% greater representation of COVID-19 patients for this ethnic population.(42)

African Americans and Hispanics, along with other ethnic/racial minorities, are likely to live in disinvested communities with a history of not trusting healthcare settings.(43) The Tuskegee Syphilis experiment, is an example of where this distrust stems from. Researchers had unethically withheld syphilis treatment from African American populations.(44) Similarly, Hispanics have also faced similar distrust for the

US healthcare system from previous historical occurrences.(45) Consequently, both populations experience reduced healthcare-seeking behaviors that increase disease and worsen underlying health conditions.(45) Furthermore, poor health outcomes are heightened by the higher rates of underinsurance and uninsurance among Black and Hispanic people.(46) Because COVID-19 is a highly transmittable respiratory illness, underlying socioeconomic disparities like overcrowding and poor living conditions that are frequent among these groups make airborne transmission easier.(11) Lastly, as many Blacks and Hispanics work in lower-paying service industries like hospitality, fast food restaurants, and home care, they have increased potential exposure to the virus due to elevated human contact.(11) Thus, the evidence exemplifies the stark contrast in COVID-19 related poor health outcomes between Black and Hispanic populations and their White counterparts in the US.

1.3 Incarcerated Populations: The American justice system currently holds approximately 2.1 million individuals across 5,000 prisons, jails, and detention facilities (47) with 415, 000 correctional officers serving this population daily. (48) The ability and ease of transmission in incarcerated settings are increased by underlying factors. Over half of the population is reported to have at least one chronic disease(49) and many are over the age of 60 years.(50) Almost every state prison system in the US has reported escalating COVID-19 infections, with more than 23,100 cases and 238 deaths among inmates and staff nationwide.(19) The Cook County jail system in Chicago, Illinois has reported an overwhelming 800+ cases of COVID-19 infections among staff and inmates.(51) Additionally, in April 2020, the CDC reported that among 37 jurisdictions

reporting confirmed cases of COVID-19, 86% reported at least one confirmed case on-site.(14)

There is a historical and disproportionate level of illness in jails and prison systems in the US. Correctional environments have often been described as overcrowded, dirty and mismanaged. (48) The dangers of exposure to the virus are very high because physical contact between inmates and staff is unavoidable. Interviews with current inmates have revealed that there is a lack of access to resources like hygiene essentials, continued sharing of showers, toilets, and tables, limited testing available only to those presenting with fever, and improper social distancing measures in jails and prisons.(51) Furthermore, past and present discriminatory mass incarceration of vulnerable populations in the US has resulted in certain groups disproportionately serving time in the US prison and jail system.(52) Thus, Blacks and Hispanics and other individuals with a low-socioeconomic status are among those most widely represented in inmate populations.(50,52) These inmates are marginalized in society, facing underlying physical and mental health concerns.(50,53) Research suggests that these underlying socioeconomic factors contribute to the increased risk of contracting COVID-19, especially in a tightly closed environment.(50) Most importantly, jail workers can introduce COVID-19 into incarceration systems from surrounding communities and become reinfected when returning to these communities, producing a bidirectional transmission exposure flow.(50) Therefore, evidence strongly suggests that populations involved in criminal systems are disproportionately vulnerable to COVID-19.

2. Review of the Evidence: Challenges of Social Distancing

2.1 Low- income populations: The evidence from the scoping review points to low-income populations being less able to adhere to social distancing directives implemented in numerous cities, counties and states across the nation.(54) Social-distancing exacerbates the inability of low-income populations, like those in the service and care industries, to tolerate workplace closures and/or reduced working hours.(23) Not only are incomes needed but remote work may not be an option for these respective sites. The consequences of lost income can be disastrous for a population that already faces economic and social challenges in the midst of a pandemic. (10)

Many low-income families are supported by low-paying workplaces. (55) These workplaces involve close contact and thus low-income families have increased exposure to illness. Low-income families, such as single-parent households, also tend to live on very tight budgets, with overdue bills, unstable housing, poor health care, and unsteady employment.(55) Parents in low-income households experience a dual burden of stress as a result of social distancing: they have a greater need to continue earning an income regardless of social-distancing imperatives, and have extra challenges related to childcare and coordinating home-schooling.(56) Evidence shows that school closures are especially burdensome for lower-income and single-parent households whose children may depend on the school setting for daily nutritional intake.(57) Additionally, at-home schooling is a challenge to navigate for families with limited access to computers and the Internet.(56) This affects the education of many already disadvantaged children, who will continue to fall even further behind in the education system.(56,58) Finally, parents of children with special needs are especially affected by social distancing directives.(59) Services normally provided by educational and other

private caregiver institutions are likely closed due to social-distancing guidelines.(59) This loss of support along with mounting financial pressures and juggling remote work, or the loss of work, creates extreme stress for parents and caregivers caring for special needs children.

Social-distancing directives orders are difficult to follow for populations experiencing homelessness. If shelters are available, they are often crowded and/or have decreased their accessibility to comply with government social-distancing policies.(31) Adequate hygiene and sanitary resources such as the means to wash hands are limited, again exemplifying the decreased ability to adhere to safe and healthier regulations.(25,31) A shortage of personal protective equipment (PPE) results in not every worker being able to protect themselves, increasing exposure and transmission risks.(25) This population also faces underlying social, health and economic factors that delay testing and treatment that can improve health outcomes.(31) In conclusion, the social and economic disparities faced by low-income populations influence the ability to effectively adhere to social-distancing policies and “stay-at-home” orders.

2.2 Black and Hispanic Populations: Within Black and Hispanic populations across the US, there is a decreased ability to practice social-distancing (7) due to underlying socioeconomic factors. Minority populations living in integrated communities are characterized by high population density, lack of healthcare infrastructure and resources, higher crime rates, and poorer access to community services. (11) Consequently, these populations face adverse outcomes in mental health, social, and

financial institutions and often intense social stigma and discriminatory practices. The evidence in this review suggests that high poverty rates among Blacks and Hispanics contribute to the inability to tolerate lost income from workplace closures or reduced hours. This makes exposure likely as individuals may feel pressure to continue working to provide financially. (11) Blacks and Hispanics are among the most impoverished ethnic/racial demographics in the US, making the effects of social distancing greatest in these communities.

2.3 Incarcerated Populations: Evidence from the review suggests that the high level of turnover, close living quarters, and limited medical supplies in jail and prison systems across the US makes COVID-19 transmission prevention nearly impossible and social-distancing policies equally difficult to implement.(50) The Federal Bureau of Prisons has released guidance memos to ensure population safety under incarceration by restricting visitors to prisons, limiting staff travel, and increasing COVID-19 screening.(47) Additional guidance and policies have also been implemented at the state and local levels to mitigate the COVID-19 spread. In some jurisdictions, individuals who do not pose an immediate threat have been sent back into the communities to reduce jail and prison populations.(60) In Ohio, courts have ordered the release of inmates with increased COVID-19 complication risks.(61) While in San Francisco, the district attorney has directed that pretrial releases for misdemeanors and or drug-related felony cases be granted by prosecutors if the individual does not pose an immediate threat to society.(62) Reports show that in Maine, courts have vacated over 12,000 outstanding unpaid fine warrants and fees to reduce people entering jail systems(63)

while some communities have even lowered the number of arrests for low-level crimes.(60) Challenges associated with social-distancing exist within a disenfranchised population in confined spaces. However, it further exemplifies the difficulties of adhering to social- distancing in overcrowded jail and prison systems. (64)

Discussion:

1. Strengths and Limitations

This scoping review provides a descriptive overview of the available research related to COVID-19 health disparities, through a discussion of underlying socioeconomic disparities. A broad range of data was used, that included non-traditional, non peer-reviewed, working papers and news articles. However, this permitted a wider range of evidence and a broader analysis of perspectives and literature that included working papers and editorials.

2. Recommendations

The evidence in this scoping review suggests that certain populations are at a higher risk of COVID-19 and also have a decreased ability to practice social-distancing due to underlying socioeconomic and health disparities in the US. In this context, the COVID-19 pandemic exposes the consequences of inequitable policies and practices within the US healthcare system and other systematic structures. Public health policies need to address underlying socioeconomic and health disparities, and provide community-oriented transformative solutions that challenge the current conditions that promote health inequity. There are four key areas that need to be integrated into current

and future public health policy reforms: economic security, housing security, criminal justice, and healthcare access. (65)

2.1 Economic Security: Economic instability is prevalent among the reported groups who are disproportionately affected by the COVID-19 pandemic in the US. Economic security needs to be integrated into policy reforms to ensure an economic focus on health equity and the health of populations, not just monetary profit. First, there needs to be an expanded coverage for unemployment, income support, childcare support and paid leave. The extension of paid sick leave during the pandemic grants workers the ability to transition to time-off for health reasons.(23,65) Paid sick leave legislation should be expanded federally to protect businesses with over 500 employers, less than 50 employers, and gig workers.(65) State unemployment insurance should be expanded, protecting workers who lose their work and eliminating waiting periods for benefits.(65) This would ensure job security and increased adherence to health-seeking behaviors among populations. Lastly, it is very important that direct stimulus payments to low-income populations are continued until the economy resumes, benefiting low-income populations disproportionately impacted by COVID-19 and beyond.

Childcare and family support need to be prioritized during emergency public health policies through the expansion of eligibility criteria and financial bolstering of Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and the Special Supplemental Nutrition for Women, Infants and Children (WIC).(65) For low-income families and those caring for children and persons with disabilities, it is important that this supplemental support is provided to increase

adherence to social-distancing. It is recommended that state and local policymakers consider providing childcare assistance to families, especially those considered essential workers and are affected by school and childcare closures.(66) Fortunately, some regions, like the states of Colorado and Massachusetts, have confronted these challenges through initiatives that provide emergency childcare services for frontline health and essential workers.(67,68) Similarly, Chicago and other cities have also allowed daycare centers to provide childcare services for essential workers.(69) Consequently, policymakers should promote an available and well-funded childcare and social service workforce so that recommendations are effective.

2.2 Housing Security: Housing insecurity is repeatedly highlighted as a socioeconomic factor contributing to the current health disparities that are exacerbated during the Covid-19 pandemic.(25,26) Reformed policies should ensure that all people are able to have safe and affordable housing, preventing debilitating debt incurrence, increasing social distancing adherence and protecting both homeowners and renters.(65) Vacant residences like hotels and college dormitories should be used to house those experiencing homelessness.(25,26) This can be further expanded to provide shelter for those experiencing domestic abuse, reentry into communities after incarceration, and unhealthy/overcrowded housing.(65) In some regions, local capacities have opened unused hotels and dorms to address the challenge of social distancing in often overcrowded shelter facilities.(70) Such a response should be mandated nationwide and uniformly to improve health outcomes for the homeless, (26,31) poor and needy. Adequate housing can decrease in overcrowding and

unhygienic living conditions to ensure low disease transmission within the current pandemic and in the future. (26) Policies supporting low-income populations should be included. These include the cancellation of payment requirements and the suspension of rate increases during COVID-19 and for later health crises and emergencies. (65) Most importantly, there is a need to provide adequate hygiene resources to vulnerable populations, increase healthcare visits and COVID-19 testing. (26)

2.3 Criminal Justice System: Evidence from the review shows that incarcerated populations experience a high degree of health and socioeconomic disparities during COVID-19. Policies related to the justice system should protect the incarcerated populations and limit entry into incarceration. (65) First, individuals who do not pose a risk to society, by predetermined threat level analysis, should be released, decreasing the incarceration population size. This has already been issued in various states and jurisdictions;(71) however, a more unified response across the nation is warranted. Policymakers need to consider the implications of socioeconomic and health disparities. Jurisdictions should ‘decarcerate’ vulnerable populations such as those who are older, pregnant, have chronic illness or disabilities or are primary caregivers. (65) Policymakers need to ensure that those who are incarcerated have access to medical care by suspending medical co-pays (65) and increasing medical care access. Throughout the US, there need to be a coordinated approach to protecting the incarcerated by ensuring federally mandated medical resources such as masks and hygiene materials are accessible to inmates and staff in these settings. (65)

Although limitations to visitors are important to decrease the spread of COVID-19 in incarcerated populations, social interaction is still important for mental health and overall well-being. Maximizing technology like video-chatting and telephone use is an important strategy to enable the continued well-being of inmates. Policies should ensure that incarcerated people and their families should not have to pay for phone services use.(65) In Tennessee Shelby County and Pennsylvania Department of Corrections, officials have already made efforts to allow access to phone calls and video chats by waiving and reducing fees for inmates.(72,73) Moreover, nationwide guidance and policies will increase the feasibility of using technology in this way. Lastly, policies should be committed to ensuring sound community reentry programs that provide resources and support for individuals to navigate health access after release to ensure continued health outcomes.

2.4 Healthcare Access: A Public Health Disparities Geocoding Project reported that the highest-burden of COVID-19 was among those with disadvantaged socioeconomic status in New York.(74) Similarly, higher rates of COVID-19 were observed among communities of poverty than more advantaged populations.(74) There is an immediate need for the expansion of testing and treatment while amplifying PPE demands of essential workers during the current COVID-19 pandemic. This response attempts to resolve health disparities associated with COVID-19 within the US, protecting and covering the health needs of vulnerable populations. Universal access to testing, treatment and healthcare facilities is critical to effective solutions.

Underinsured and uninsured individuals should have access to care through expanded Medicaid and Medicare coverage in the US.(65) This will address and eliminate some of the barriers to healthcare access for low-income, Blacks and Hispanics and newly released populations. During COVID-19 clinical care, health care resource allocation should not deny care based on socioeconomic status and race. It is worth mentioning that Blacks and Hispanics could face resource access disparities. This is because the scoring system that determines resource allocation may give lower predictive values of survivability to these populations based on pre-existing conditions.(75) Thus, ensuring equitable policies, that are cognizant of the underlying factors that lead to disproportionate health outcomes across Blacks and Hispanics, will aid in eliminating this disparity.

Employers of all workplaces should instate policies that grant workers the right to self-quarantine and seek medical care under compensation as a measure to protect themselves and their families from COVID-19.(10,23) In workplaces where close contact with others makes social distancing harder to achieve, research suggests that policies should require more frequent and aggressive disinfection of work areas and/or changes to work shifts to decrease close contact among staff.(23) This could occur through the expansion of sanitation and hygiene centers and enforced social distancing.(23) Moreover, employed individuals who are 65 years and older, the highest age group at risk for COVID-19 infection, should be provided compensated “shelter-in-place” by the federal government to ensure a unified health response.(23)

Requiring hospital systems, states, and health departments to track COVID-19 by race/ethnicity, socioeconomic status, geography and occupation permits resource

distribution that is evidence-based and equitable for vulnerable populations.(65) For Blacks and Hispanics dealing with COVID-19, reformed policies can then address specific racial disparities that accompany communities of color to ensure solutions and resources are provided.(76) Racially-stratified surveillance that monitors and addresses disparities is key to an effective national response.

Conclusion:

This review suggests that vulnerable populations like low income, Black and Hispanic, and incarcerated populations are at a higher risk for COVID-19 infection and severity. Evidence also points to these populations being less likely to practice social-distancing due to poor social determinants of health. It is important that public health emergency responses account for underlying socioeconomic and health disparities. Recommended policy reforms should focus on integrating economic security, housing security, criminal justice systems and healthcare access. This grants improved and equitable health outcomes for the vulnerable in the US.

Populations that are disproportionately affected by COVID-19 extend beyond the low-income, Blacks and Hispanics and incarcerated populations highlighted in this review. Inequity is a fundamental basis for any health disparity; thus, the current COVID-19 response needs to be part of a larger effort to combat inequity in the US and not just momentarily for the current pandemic. To address inequity within the United States, there needs to be a strengthened and integrated public health system that addresses underlying socioeconomic and health disparities.

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Supplemental Data: Raw Interview Questions and Responses

Margie Schaps, MPH
Executive Director
Health & Medicine Policy Research Group

1. What are the reasons for current disparities of COVID-19?
    - Death rates higher among AA; of non-white populations
    - Chicago: AA tend to live in communities that are least disinvested in; history of not trusting the healthcare system
        - Likely more delay in seeking healthcare
        - Live in communities that have less access to healthcare resources
        - AA: in less good health conditions going into COVID
        - Obesity rates, disease rates are a lot worse
        - Disinvested in these communities
            - Frontline workers- disproportionately exposed and exposing other people
    - Incarceration
        - Getting people out of prisons
        - Increasing older populations-pose little risk for re-committing crimes
        - At least 3% have dementia
        - First get older people out
        - There have been efforts and work has been done
        - Isolation: every prisoner is either positive or potentially positive
        - Exposure rates are high and staff
        - Close quarters

2. How do you think hospital policies are or can account for the racial disparities currently being seen with COVID-19 infection?
    - More community-based hospitals less resourced- disparity
    - Resources to treat this disease

3. Do you think the social-distancing policies are equitable to all populations in Chicago and diverse populations in the United States?
    - Luxury for the rich
    - Crowding is less able to
    - Denser quarters
    - City of Chicago→ better use of hotels, McCormick place can be use
    - Dormitories in colleges for the homeless
        - Should be explored

Dr. Kelly Michelson- Clinical Perspective
Center for Bioethics, NU

1. How are the current policies being made- hospital-based? Accounting for vulnerable populations?
    - Complicated process- a pediatrician at Lurie

- Involved in discussion for Lurie; more tangentially for related for NM and resource allocation across Chicago area
- "Stay at home"- bioethics to share in their respective hospitals- conversations sharing about what each policy (e.g. ventilators allocation)
- People aren't starting from scratch
    - E.g. ventilator allocation- a lot of thought into and concrete suggestion into how to implement a strategy with a bioethical input
    - Because of another global crisis we've seen
    - Every life is valuable
    - Utilitarian perspective: trying to save as many lives as possible: sometimes difficult decisions need to be made
    - Multi-Tiered approach- first line: save as many people- is there a process that someone would be likely to survive

2. It's becoming more evident that certain populations are especially impacted by COVID-19. What is your experience with this?

- canceling clinics to promote social distancing means that some will go without needed medical care.
- Certain groups of people are further disadvantaged when it comes to ventilator schemes
- Because of higher comorbidity
- 2 ways: 1 of the first levels for who gets a ventilator is often will this person will survive
    - Risk of survival;
    - Second tier: we need to consider people with comorbidity or limited lifespan
        - The idea of saving as many life years as possible
        - Score about surviving
        - Saving life cycles prioritizes younger people
    - A lot of subtle inequalities about each tier
        - The score that predicts mortality may make score low by factors that are unrelated to getting COVID-19
            - Populations that have health disparities it's almost as if they come below based on this scoring system
- Some argue that certain populations should have some type of cushion or prioritizations because they come from a community with health disparities
    - For ventilators should we support that person because they already disfranchised
- Another argument: in this time of crisis: our society needs to reframe- we can't heal the wounds of society in the middle of a crisis
    - These inequities can't be solved during a pandemic- cannot make up for the years of inequities
- Who decides?
    - Protocols take away the decision from the bedside and made very objective

Another thing that has been challenging- each hospital has been working separately (ventilator allocation)

- Individual policies
- Some states have implemented guidelines
- Illinois has not done that, and every hospital has a different policy
- One person might be chosen in one hospital and not at another- that has an enormous impact for things like public trust; “hospital shopping”; resources allocation across the city- want to distribute resources according to the populations

3. How do you think hospital policies are or can account for the racial disparities currently being seen with COVID-19 infection?
    - Not aware of any policies that indirectly or directly advantages or disadvantages any incarcerated individuals
    - Important subtleties that do disadvantaged
    - Disadvantaged because of confinement
        - Risk of infection is higher than the population potentially
        - Would take one person asymptomatic but infected and create a burden on the whole facility
    - We are privileged to be at home and make decisions t be careful- don’ have all those choices
    - Disadvantaged before they get to the hospital

4. Palliative care preparedness in the US during COVID-19
    - Very important because we need to focus on this
    - Make sure that people continue to get care
    - A very big part of this conversation
    - Advanced directives and helping people understand that there may be situations that you might not want to be on a ventilator
    - People who might not want to be on a ventilator in other situations
    - Medication shortages- for ppl who need good palliative ace for those not going on ventilators
    - Not an expert on GH → don’t know; challenge for having the actual medications

Rashonda Johnson- Reentry Program Manager MSW

- **Partners: AIDS foundations of Chi; Christian community center; transforming reentry services; legal counsel for health justice; Cermak health services**

1. It’s becoming more evident that certain populations, specifically those in incarceration settings, are especially impacted by COVID-19. What are the concerns here and how can we work in PH to mitigate these problems?
    - Not enough testing in the general public- issue with accessing tests; the administration within the jail and don’t want to test- if positive it can cause hysteria
    - Other piece is that if they tested, are there any resources to treat?

        - More people to be aware of with nothing to do about it→ apprehension to do testing within facilities because there is no ways to really do isolation
        - Cause a ruffling within staff concern with staff not coming in
    - Different theories for not testing
    - Some people do not believe they deserve that right to good healthcare
    - "Good prison health is good community health": will go back to the community- the community is at a higher risk
        - Even prior to COVID-19
        - Now see that it's more important
        - State level: anyone who hasn't committed 'big' crimes- now being released; also, pregnant mothers
    - Community risk
    - As a network: trying to share resource- very small percent of a larger problem

2. How do you think the social-distancing policies are not equitable to individuals in incarcerated settings?
    - Jail or prison- set up differently
    - Cook county jail- 9 different divisions each operating the building
    - Each division is very different
    - Open floor division
    - Social distancing is not possible
    - But other divisions where there are 2 per room
    - If moving from open to rooms→ can start overcrowding
        - Hesitancy to test because then have to quarantine→ how do you do this
    - May have to assign correctional worker to monitor with those isolated→ cannot do this with less employees
    - Suspect why we are seeing rise in cases; hard to social distance and with staff

3. Many jail and prison systems in the US are releasing inmates to mitigate COVID-19 risks, how are these people being supported during reentry in the face of the pandemic, if they are being supported?
    - Great that people are being released; but seeing that a lot of people who are just released into a completely new setting during the pandemic- shell shock
    - Seeing housing scarce now a lot of facilities are not taking new clients because they don't want to risk this
    - A Lot of issues with general resources→ organizations where they could see case managers are closed
        - May still be offering services, etc.…
    - Not aware of any collective resources; some partners though are looking for ways to service these clients- e.g. purchasing sim cards to speak to case managers, etc.… accessibility of consistent phones
    - Hotels and motels are seeing decrease in occupants

        - Discounted rates to programs that want to house individuals for short term housing
    - Lack of familial support because of fear→ increasing testing will help with this
    - Vouchers to clients

4. How should we be handing COVID-19 outbreaks in prison and jail systems?
    - Need to come up with strategies to decrease the spread
    - Don't know what that is looking like
        - Guess that they move those with it into one place
    - Older populations who are incarcerated
    - Issue is testing: more testing before releasing individuals
    - If they do have it; working with orgs to get a place to quarantine; health services
        - Help with being able to stay with family members and halfway house, etc.…
    - Telehealth services while incarcerated about symptoms and when released
    - Cook county: staff were testing for fever- do more preventative measures while incarcerated
    - Doing more education: a lot of people don't know
        - Staff not being transparent with inmates; hysteria
        - Increase education with prisons and jails and communities that receive these people- decrease stigma

    - Working with landlords with resources