Global health equity: COVID-19 highlights a need for ethical improvements

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During the COVID-19 pandemic, one of the earliest positives some asserted was COVID-19's status as an "equal-opportunity killer." The coronavirus does not distinguish between culture, race, class, or country and will infect everyone it can as opposed to diseases that typically infect the most vulnerable in our society. While the vulnerable population might be different based on geographical area, vulnerability typically intersects with socio-economic status and race. Despite the fact that everyone can be affected by this virus, people who are already economically and socially disadvantaged will suffer the pandemic's greatest burdens.[1] In the 1918 pandemic, in both wealthy and developing countries, disadvantaged groups (lower social classes and oppressed groups) had substantially higher mortality rates than more privileged groups.[2] Even in the absence of vaccines and antiviral medications, a pandemic has the potential to produce profound inequalities in burdens, both within and across countries.[3] These burdens affect morbidity and mortality which are dependent on the socio-economic status of the individual or community.

Social justice is concerned with how features of the social structure result in systematic inequalities and disadvantages in well-being. While social justice theories and their practical implications differ, all agree that there are some basic obligations to minimize or prevent harm to others, especially when the others are vulnerable to harm or injuries and the cost of doing so is not unreasonable. The rationale for social distancing during this pandemic is the same: take reasonable precautions to protect the public and especially the vulnerable. The principle of justice demands that we ensure fair distribution, not only of social benefits and opportunities, but also of burdens and risks. Although all countries must attend to the urgent concerns that affect their own citizens, none of us is exempt from moral obligations toward the world's vulnerable

population.[4] Already, the pandemic and the response, be it containment, suppression, or social distancing, are exposing class divides among and within countries.

The field of bioethics has not fully addressed global health equity or population health. As COVID-19 spreads in countries with high population densities like India, social distancing is challenging to implement.[5] We must be careful to ensure that responses account for local circumstances and cultural values to recognize differences between places and endeavor to protect the interests and rights of disadvantaged groups in this difficult period.

The recent statistics in the US show that we are not doing a good job of protecting these groups. For instance, ProPublica reports that the pandemic is already disproportionately affecting people with intellectual disabilities, the black community, and people with English language barriers.[6] In places like Washington and Alabama, pandemic preparedness plans discriminate against people with intellectual disabilities by designating them low priority when medical care is rationed. In Wisconsin, Chicago, and Detroit, the mortality rate for black people far exceeds the percentage of black people there. While black people are at higher risk of preexisting health conditions, we can do more to ensure our planning guidelines involve representatives of marginalized groups. In addition, social distancing as a response policy does not effectively address the people who must work during this time, and these are more likely to be vulnerable populations. A report from the Economic Policy Institute emphasizes, "Only 9.2 percent of workers in the lowest quartile of the wage distribution can telework, compared with 61.5 percent of workers in the highest quartile."[7]

The principles of beneficence and non-maleficence dictate that we must do the most good and avoid harm. In this case, the principles would require inclusion of disadvantaged groups in decisions as opposed to a one-size-fits-all response. Engaging these groups is in everyone's best interest as an effective response to a pandemic will require widespread cooperation throughout society with a range of government recommendations.[3] Disadvantaged groups have the best understanding of their own interests and priorities making them crucial in pandemic response policy. Involving these groups would also engender their trust and cooperation as they historically have sound, deep-rooted reasons for distrusting their governments. Secondly, more information and data need to be provided on these disparities including race-specific data on cases and deaths. Knowing which communities are most impacted allows public health officials to tailor their approach and work on overcoming the distrust these groups have had for government. Health officials in different countries can address inequities in health outcomes and testing that may emerge by focusing on marginalized communities as well. Ultimately, COVID-19 has shown that the field of bioethics should become more engaged in reducing global health inequities and that we must emphasize the importance of investing globally in emergency preparedness that will include protections for vulnerable groups during emergencies such as pandemics.

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