The World Economic Forum reports the COVID-19 pandemic could push half a billion people in the world into poverty and financially impact millions more due to the 20% drop in income caused by the impending recession.1 This contagion is expected to exacerbate the inequities and disparities in health outcomes for older adults, persons in poor living environments, and residents of resource-poor rural communities across the United States. For the poor and disenfranchised, many social determinants of health (SDoH) are expected to worsen during the COVID-19 (the disease caused by SARS-CoV-2) pandemic and in its aftermath, namely, employment, housing, food, education, and health care. Public health professionals and policy makers need to proactively work with community partners to influence policies and other relevant sectors to ensure that health inequities do not intensify for the most vulnerable in our communities. The far-reaching impact of the COVID-19 pandemic is already being felt among population subgroups as a function of poverty, whether it is due to structural racial injustice, an inability to treat underlying chronic conditions due to increased health care burden and clinic closures, patients’ lack of access to critically needed health care, or a product of long-standing social injustices manifested mainly through food insecurity or job and income losses.2,3

Crosscutting Consequences of Worsening Social Determinants of Health

The intersectionality of race, ethnicity, socioeconomic status (SES), and rurality, coupled with poor health status due to comorbidities, is expected to isolate the most disadvantaged during the COVID-19 crisis.4 The tracking of COVID-19 cases by race in the United States reveals that black populations are disproportionately affected by this outbreak, with early data indicating they have higher rates of hospitalizations2 and are more likely to die from this disease than white populations.5 Higher rates among black communities not only can be attributed to initial misinformation of the outbreak but are also suggestive of more deep-rooted issues such as deteriorating SES, nonconformity to preventive practices when they contradict social or religious norms, and a long-standing distrust toward health care institutions.6

The risk of adverse consequences of COVID-19 will be significantly higher for older adults who are generally more likely to have comorbidities. Among patients with confirmed COVID-19 cases in 14 states during March 2020, the most common underlying chronic conditions were “obesity, hypertension, chronic lung disease, diabetes mellitus, and cardiovascular disease,” with 90% of COVID patients having at least one of these conditions.2 People with respiratory and other chronic conditions such as cardiovascular disease are at a higher risk of negative consequences of COVID-19. Since the novel coronavirus primarily affects the lungs, smokers are at a higher risk than nonsmokers.7 Guan and colleagues8 reported that 33% of the COVID-19–infected population in China that required intensive care/mechanical ventilation or had a clinical endpoint resulting in death comprised current or former smokers, although they only represented approximately 15% of the study population. This finding is particularly worrisome since African Americans are more susceptible to mortality resulting from smoking-related diseases than whites, although they typically smoke fewer cigarettes and start smoking at an older age.9

Author Affiliations: Departments of Health Policy & Management (Dr Shah) and Biostatistics, Epidemiology & Environmental Health Sciences (Dr Schwind), Jiann-Ping Hsu College of Public Health, Department of Health Sciences & Kinesiology, Waters College of Health Professions (Dr Shankar); and Department of Biology, College of Science and Mathematics (Dr Sittaramane), Georgia Southern University, Statesboro, Georgia.

The authors declare no conflicts of interest.

Correspondence: Gulzar H. Shah, PhD, MStat, MS, Jiann-Ping Hsu College of Public Health, Georgia Southern University, PO Box 8015, Statesboro, GA 30460 (gshah@georgiasouthern.edu).

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The risk of hospitalization also increased with age, as the highest rates of hospitalization were documented among older adults 65 years or older. This sobering statistic is also consequential to rural populations as more than 1 in 5 older Americans live in a small town or other rural area. Given roughly 60 million Americans live in rural areas, a focus on rural populations is also imperative when conceiving policy and interventions for mitigating the negative impacts of COVID-19. In the early parts of the COVID-19 pandemic in the United States, people living in urban counties made up most of the confirmed SARS-CoV-2 cases, whereas people living in rural counties represented a much smaller share. By the last week of March, 85% of the counties with zero confirmed cases were rural, seemingly indicating rural populations is also imperative when conceiving policy and interventions for mitigating the negative impacts of COVID-19. In the early parts of the COVID-19 pandemic in the United States, people living in urban counties made up most of the confirmed SARS-CoV-2 cases, whereas people living in rural counties represented a much smaller share. By the last week of March, 85% of the counties with zero confirmed cases were rural, seemingly indicating rural counties were somewhat advantaged with a low incidence of SARS-CoV-2 infections and COVID-19-specific deaths. However, as the spread of this infection increases, rural areas are predicted to be hit the hardest due to aging populations, unfavorable SES, and a lack of resources in key areas such as transportation, employment, health care capacity, public health infrastructure, and food security.

This pandemic may also impact food security, especially among rural populations. According to FAO (Food and Agriculture Organization of the United Nations), quarantines and disruptions in the food supply chain will adversely affect the poorest and the most vulnerable people. Furthermore, border closures and trade disturbances caused by the pandemic may limit the availability of and access to adequate and nutritious foods for many. Reports have indicated that transitory disruptions to the food supply have already begun with localized shortages occurring. In addition to the risk of the disease itself, children who depend on school meals for sustenance will be affected by the shelter-in-place regulations enforced in many states. Food insecurity will only worsen in the coming months as the agricultural sector is particularly impacted because of the COVID-19 pandemic. Food insecurity is closely related to job loss and homelessness due to lost income. A record 6.6 million unemployment claims were filed by Americans by the end of March due to job losses associated with the pandemic. Furthermore, minorities are losing jobs at a higher rate than other groups. A Pew Research Center survey conducted in March 2020 found that almost half (49%) of Hispanics reported that either they or someone in their household has lost a job or taken a pay cut or both as a result of the COVID outbreak compared with 33% of this occurring in all US adults. While mandates to work from home for nonessential personnel are in effect in many states, many workers may have lost their jobs because the nature of their job does not allow working remotely or they could not fulfill job requirements without access to high-speed Internet. Job loss will worsen the health of the homeless, which is known to adversely impact both physical and mental health outcomes.

Health disparities with respect to infectious diseases, such as HIV/AIDS and tuberculosis among homeless people, may have a ripple effect on the transmission, screening, testing, and care related to COVID-19, as it is estimated more than 21,000 homeless people may need to be hospitalized. New Challenges and Opportunities for Health Departments and Community Partners in Addressing Health Inequities

Behind these tragic, dark times of death, sickness, and economic downturn, there is indeed a silver lining of opportunity. The importance of public health services and partnerships is often invisible to community stakeholders until a major public health threat or crisis occurs. The COVID-19 pandemic has led all industries to recognize the need to build community and public health infrastructure to address emergencies of global concern. Many stakeholders across a variety of industries have been compelled to make public health decisions related to prevention, surveillance, and safety during the COVID-19 crisis to protect their workforce and other business interests.

State and local health departments must recall the devastating effects of the 2008 economic recession and the 2009 H1N1 influenza pandemic on the country’s infrastructure and be prepared to utilize similar strategies in doing more with very limited resources as we prepare to face the challenges of health inequities and the resulting disparities in the aftermath of COVID-19. The anticipated inequities concerning SDoH call for health departments to act as “chief health strategists” in order to collaboratively influence “Health in All Policies” for effectively addressing the critical health needs of their communities. These collaborative efforts would also provide an opportunity to promote the well-being of the most vulnerable, as well as address social justice issues. Through the involvement of other community stakeholders, public health professionals, and industry leaders, we will need to collaborate and create synergies to move policy makers into SDoH domains, such as housing, land-use planning, financial institutions and safety nets, and educational institutions, to make sure health disparities are not aggravated further due to COVID-19–related changes in process, infrastructure, and human habits.

To bounce back from the aftermath of COVID-19, public health departments should partner with...
References


