COVID-19: A Mirror to Our Flaws

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The COVID-19 pandemic has illuminated many painful truths in our state. This commentary addresses some of them, including racism, lack of universal health care access, and defunded public health infrastructure, from the perspective of a local county health department medical director. We have an opportunity to fundamentally improve North Carolinians' collective health, but only if we are willing to reckon with past and current failings.

Introduction

The COVID-19 pandemic has brought into glaring focus many societal ills and failings in our country and right here in North Carolina. We must tackle them head-on if we have any hope of improving the current situation and preventing the next pandemic's worst outcomes. We often discuss social determinants of health within public health circles, but this pandemic has laid bare what negative outcomes transpire when a state does not have a robust safety net and has not dealt with racism and xenophobia. As a county health department medical director, I bear witness to these issues playing out right here in our state. Public health as a discipline prides itself on going upstream. Let's go upstream and find the root causes of devastating COVID-19 outcomes.

Racism and Xenophobia

COVID-19 has revealed American racism on multiple levels. There is the racism toward those of Asian descent, as if being of a certain ethnicity conveys some sort of propensity toward contagion. There is also the systemic racism that results in the disparate impacts of the virus on communities of color.

From the outset, the novel coronavirus has been tied to anti-Chinese and broader anti-Asian rhetoric. Stop AAPI Hate, a coalition formed to track Anti-Asian sentiment during the pandemic, documents over 2,500 separate incidents of racist verbal and physical assaults on Asians and Asian Americans nationally from March through August 2020 [1]. The Orange County Health Department heard from members of our Asian American community about their own personal experiences, and early on attempted to highlight the dangers of racism and xenophobia that this virus brought. Even some 11 months deep into this pandemic, we continue to hear politicians strategically refer to this as the "China virus" in order to stoke anti-Asian sentiments and deflect our own shortcomings in this fight.

The racial disparities of COVID-19 infections and mortality are also illustrative of a deep structural racism that has been woven into the fabric of our society. In North Carolina, as of September 29, people identifying as Hispanic make up 34% of infections [2] despite being less than 10% of the population [3], and people identifying as Black comprise 30% of deaths [2] but are only 22% of the state's population [3]. Acknowledging that COVID-19 disproportionately affects people of color is not enough—we must examine the root causes of that disparity.

Scientists have struggled to find the long-hypothesized genetic differences that would account for racial health disparities in the United States ever since the completion of the Human Genome Project in 2003. On the contrary, a systemic review regarding cardiovascular disease, the leading cause of death disparity between whites and Blacks, failed to find any genetic explanation [4]. Discrimination and inequality, not genetics, are at the root of these disparities. Socioeconomic status and education/health literacy are often cited as explanations for these disparities, and yet any disparities in those areas are often themselves examples of systemic racism. These superficial explanations also fail to consider the clear evidence that racial health disparities persist even when controlled for other factors like socioeconomic status and education. For instance, Black college graduate women are more likely to die from pregnancy-related reasons than white women who did not finish high school [5]. Black and brown skin is not a risk factor for worse outcomes of this virus; exposure to racism is.

These disparities are based on the data we have, and yet even that needs to be examined. In North Carolina, 21% of racial demographics and 33% of ethnic demographics are missing from the reported COVID-19 cases [2], and even those that are reported may be assumptions from the health care provider that have not been confirmed with patients. Undervaluing the collection of these data may also be linked

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to underrepresentation of Black and brown epidemiologists, public health officials, and medical professionals making decisions regarding what data are collected.

Lack of Health Care Access

North Carolina has one of the highest rates of uninsured people in the country, with only eight states having worse coverage [6]. Not coincidentally, we are also one of the few states that has refused to accept Medicaid expansion [6]. We have over 1.1 million uninsured people in our state [6]. This is a public health nightmare.

Stemming the tide of COVID-19 hinges upon the early detection and isolation of cases. The federal government recognized this problem and attempted to solve it by ensuring funds for uninsured people's COVID-19 tests and care [7]. While this is helpful, it is a temporary measure. It also doesn't address the needs of sick patients who are COVID-19 negative but require treatment for myriad conditions such as pneumonia and exacerbation of chronic obstructive pulmonary disease (COPD). Symptoms of COPD and bacterial pneumonia are often indistinguishable from those of COVID-19. Under the current paradigm, ironically, symptomatic people who seek care have to hope for a COVID-19 diagnosis, otherwise any necessary treatments may not be covered. North Carolinians without access to health care are disincentivized from seeking care by the threat of financial ruin. This can lead to delays and worsening medical conditions. Once they do experience a hospital admission, uninsured nonelderly patients have much higher rates of bankruptcy [8].

Our current health care system in this country, in which insurance status is tied closely to job status, was born out of World War II wage-setting and consequent desire to attract workers with a different type of compensation [9]. It is long past time for us to come up with a better system. Many workers no longer stay with one company for a career; in fact, on average people hold 12.3 different jobs in their lifetime [10]. And now, hardworking North Carolinians are desperately afraid of losing their jobs during this economic crisis brought on by the COVID-19 pandemic, not just because of the lack of a paycheck but because it can mean losing their access to health care. Recent studies suggest approximately 257,000 North Carolinians lost their health insurance due to job loss during the first six months of the pandemic [11]. North Carolina has actively chosen not to expand Medicaid, despite the opportunity to cover (pre-COVID-19) more than 600,000 more residents [12]. This only exacerbates the public health COVID-19 crisis.

Defunding Public Health

The feeling I have had many times in attempting to address all the public health needs regarding COVID-19 is of extracting blood from a stone. State funding for public health in North Carolina has decreased 28%, adjusted for inflation, between 2008 and 2018, a foreboding fact leading up to this global pandemic [13]. North Carolina ranks 43rd in the country for public health spending as of 2016 [14]. Local health departments have lost 14% (1,368) of individual staff since 2007 [15]. While I am incredibly proud of our team at the Orange County Health Department, we have to acknowledge that we have been squeaking by with a small team working countless overtime hours in order to try to stay above water. Keeping up with case investigations and contact tracing has been a challenge for many counties, and while the state public health department has been able to supplement local efforts, at some points local counties became dozens or hundreds of cases behind. What good is case investigation and contact tracing if it occurs weeks after the initial positive result?

Lack of Workers' Protections

A cornerstone of communicable disease management is isolating those infected and quarantining those exposed. This has been the backbone of successful responses to COVID-19 in other countries, like Vietnam [16]. Unfortunately, however, many workers in North Carolina live paycheck to paycheck and without robust benefits. They do not have many protections to ensure they can comply with isolation or quarantine. We need people with even the mildest symptoms of COVID-19 to stay out of work, especially public-facing work like retail or health care, until receiving test results. This is a much more difficult request when people fear going without hourly pay needed for food for their family or rent, or even losing their jobs if they call out of work. This issue is even more dire when a worker is identified as a close COVID-19 contact and needs to be quarantined for up to 14 days. That can be half a month's wages. Many North Carolina workers don't even make a living wage, meaning that in the best of times working a 40-hour-a-week job does not even meet the minimum requirements to afford housing, food, and other essentials for living.

Forcing sick or exposed workers to choose between protecting their coworkers and the public by staying out of work and having enough money to cover rent and food is not a sustainable societal system. COVID-19 has painfully demonstrated that. A quarantine period shouldn't financially ruin anyone.

And now, as an economic crisis deepens and many are without jobs at all, this is even more incentive for those still fortunate enough to hold jobs to avoid "causing a problem" by reporting their isolation or quarantine status to their employer. The Families First Coronavirus Response Act is a step in the right direction of ensuring paid leave to some workers for COVID-19-related absences, but we need to do more.

Child Care Costs and Food Insecurity

The widely utilized nonpharmaceutical intervention of temporarily closing K-12 schools was taken in order to stem the growing transmission threat of COVID-19. Closing the

schools made it abundantly clear that the public-school system serves many functions in addition to education, with child care and food provision being two of the most critical. Many working parents struggle to pay for child care, and many children rely on school to provide at least one hot meal a day. (In North Carolina, 55.7% of children qualify for free or reduced-price lunch [17].) Things don't need to be this way. We need to take this opportunity to tackle the exorbitant costs of child care as well as issues of food insecurity (tied closely to the lack of living wage for many).

Conclusion

This is not an exhaustive list of societal or systemic issues that COVID-19 has pushed to the forefront. Anti-intellectualism, politicization of basic public health interventions like masking, and anti-vaccine efforts are just a few other examples this brief commentary did not touch upon. As in any crisis, the experience is painful but it can also illuminate opportunities and accelerate progress. For instance, we have already seen meaningful and quick adoption of telehealth as an alternative to traditional health care provision.

It is incumbent upon all public health and medical practitioners to take a step back and analyze the systems and policies that have brought us to this place. We must think broadly, invest in public health, and be willing to dismantle toxic systems to get ourselves out of this pandemic as well as prevent the next. The time to reckon with our shortcomings is now. NCMJ

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