

# Covid-19 pandemic and the social determinants of health

**Lauren Paremoer and colleagues** call for action to create a fairer and more sustainable post-covid world

**T**he covid-19 pandemic has exposed the longstanding structural drivers of health inequities, such as precarious and adverse working conditions, growing economic disparities, and anti-democratic political processes and institutions. These important determinants of health have interlinked with class, ethnicity, gender, education level, and other factors during covid-19 to exacerbate existing social vulnerabilities in society.

Numerous warnings of the dangers of inequity have emerged over the past decades. The Alma Ata declaration convincingly argued that “health for all” could be achieved only through a New International Economic Order and people’s participation in decisions affecting their community’s health.<sup>1</sup> These principles were affirmed in the report of the Commission on the Social Determinants of Health<sup>2</sup> and the 2008 *World Health Report*.<sup>3</sup> The commission proposed “tackling the inequitable distribution of power, money, and resources” that drive systematic inequalities in health outcomes, and improving daily living conditions especially

for those in vulnerable circumstances.<sup>2</sup> Historically, the social determinants of health agenda has been influential in highlighting and reducing inequities,<sup>4,5</sup> and in relation to covid-19, academics and activists have called for a social determinants of health approach.<sup>6,7</sup>

From a social determinants of health perspective, global economic trends create enduring health hazards. These trends include the ballooning debt burden of low and middle income countries (LMICs), interpretations of the Trade-Related Intellectual Property Rights (TRIPs) agreement that undermine equitable access to medical technologies, and the pressure from the International Monetary Fund (IMF) on borrowers to implement austerity policies. These processes entrench the commercialisation of healthcare and constrain implementation of policies to reduce inequalities between and within countries. Additionally, the marginalisation of certain groups because of ethnicity, race, caste, migrant status, gender, class, or nature and conditions of work, for example, continues to undermine health.

Understanding what a post-covid world could look like necessitates an examination of key structural determinants that have contributed to the disproportionate effects of the covid-19 pandemic on marginalised and other groups, beyond the proximate drivers of the current crisis. Interventions to tackle systematically reproduced conditions of vulnerability would contribute towards a fairer and more sustainable world.

## **Precarious work and adverse working conditions**

The covid-19 pandemic has highlighted that precarious work and exploitative and adverse working conditions intersect with multiple factors, including ethnicity, migrant status, class, and gender, to influence which population groups are most exposed to covid-19 infection. People in precarious forms of work have limited access to sick leave and healthcare services and their often low wages mean they

cannot afford sufficient quality food, water and sanitation, and housing. They may also be hesitant to quarantine when they have covid-19 because they cannot afford to lose income and are unable to work from home. For example, major covid-19 outbreaks have occurred among meat workers globally.<sup>8</sup> Working conditions in slaughterhouses are hazardous to health even without a pandemic,<sup>9</sup> and covid-19 intensifies existing health risks. The physical configuration of slaughterhouses and communal housing and transport make social distancing near impossible.<sup>8</sup> Some workers’ immigration status makes them reluctant to join unions or challenge exploitative practices.<sup>10,11</sup>

In the US, people of colour make up 60% of warehouse and delivery workers and 74% of cleaning services workers.<sup>12</sup> Partly as a result of this, ethnic minorities have been over-represented among covid-19 cases and deaths.<sup>13</sup> A similar pattern has been seen in the UK, where the death rate from covid-19 is twice as high in black communities as in white communities.<sup>14</sup> The more severe effect of covid-19 among people in precarious work is starkly illustrated in India, where lockdown caused migrant workers to lose their income and forced their return to home villages. One estimate suggests at least 971 deaths occurred among migrant workers and their families because of starvation, financial distress, injury, suicide, police brutality, and lack of access to medical care.<sup>15</sup>

Globally, women constitute 70% of those employed in health and social work. They are often engaged in lower status and poorly paid frontline worker positions and are at a greater risk of covid-19 because of their working conditions, especially in LMICs.<sup>16</sup> For example, community health workers have undertaken covid-19 surveillance, contact tracing, and monitoring quarantine and isolation, along with their regular tasks.<sup>17-19</sup> Their work subsidises the public health system<sup>16</sup> yet they are paid irregularly and inadequately, and often do not have adequate personal protective equipment.<sup>17-19</sup>

## **KEY MESSAGES**

- The covid-19 pandemic has affected groups that face discrimination and historical injustices hardest
- Poor and exploitative working and living conditions have increased health risks and enabled inequitable distribution of income
- Support systems that should have been geared to respond to this crisis proved inadequate
- Many (mainly authoritarian) governments have used the pandemic to further undermine civil and human rights and promote extractivism
- A post-covid world must ensure equity, social justice, solidarity, and a shift in the balance of power and resources to people living in poverty and otherwise marginalised

Nearly 40% of employed women worldwide work in sectors that were hit the hardest during the pandemic, leading to a loss or reduction of their incomes.<sup>16 20</sup> These include the informal sector, arts, entertainment, and domestic services. The International Labour Organisation estimates that as of 4 June 2020, 55 million or 72.3% of domestic workers were at risk of losing their jobs, of whom 67.3% were migrant workers and therefore at higher risk.<sup>16</sup> From April 2019 to April 2020 women's employment fell by more than 16% even in Canada, Colombia, and the United States. Women are also estimated to be doing three quarters of the unpaid care work that has resulted from the closure of schools and childcare services during covid-19 and the increased care needs among older people.<sup>21</sup>

**Growing economic inequality and inadequate social protections**

The pandemic continues to widen income and wealth inequalities worldwide. The world's richest five billionaires enjoyed a 59% increase in their combined wealth between March and September 2020<sup>22</sup> at a time of higher global levels of unemployment, poverty, and debt.<sup>16</sup> Around 435 million women and girls will be living on less than \$1.90 (£1.40; €1.60) a day in 2021, with 47 million in poverty as a result of covid-19.<sup>20</sup> These growing economic inequalities are underpinned by weak regulatory control in financial and commercial markets, illicit financial flows, regressive taxation policies, and the increasing influence of transnational corporations in shaping national economies.

These increases in private wealth have corresponded to decreases in social wage (the goods, services, and payments that the state provides to all residents as a basic right). Combined with the commodification of food, land, seeds, and essential services, austerity policies that have reduced social protection measures have had a devastating effect on vulnerable groups and, during the pandemic, increasingly on the middle class. Social protection measures introduced during the pandemic, such as tax relief, cash transfers, unemployment benefits, and food and nutrition assistance, have mostly been inadequate as they have excluded or been inaccessible to those who need them the most, such as informal workers, migrants, young people, and displaced and indigenous populations.<sup>23</sup> An 82% increase in hunger levels is predicted as a result of the pandemic,<sup>24</sup> and the number of people facing acute food

insecurity is expected to double, especially in countries affected by conflict, climate change, and economic crisis.<sup>21</sup>

The pandemic is also being exploited to intensify extractivist approaches to economic development. For example, in India covid-19 was used an excuse to reduce time for public consultation to push through weak environmental protection laws,<sup>25</sup> and in the US the extractive industry is exploiting the pandemic by lobbying the government to suspend fuel efficiency standards and environmental laws.<sup>26</sup>

**Restrictive measures and anti-democratic political processes**

Control measures to contain the pandemic have disproportionately affected women and girls. Restrictions on freedom of movement have severely disrupted sexual and reproductive health services<sup>27</sup> and could lead to an estimated seven million unintended pregnancies and thousands of deaths from unsafe abortions and complicated births globally.<sup>27</sup> Lockdowns have also led to a worldwide increase in domestic and sexual violence, especially affecting women from indigenous, migrant, or refugee backgrounds, women with disabilities, and those living in conflict settings.<sup>28</sup>

Some governments have used covid-19 to introduce anti-democratic measures such as closing down courts, increasing surveillance, and passing emergency laws that are repressive.<sup>29</sup> The UN special rapporteur on freedom of expression has raised concerns about the introduction of measures in Belarus, Cambodia, China, Iran, Egypt, India, Myanmar, and Turkey that restrict the free flow of information related to the pandemic and punish those distributing it.<sup>30</sup> Numerous governments have also introduced surveillance measures (mostly digital) to track covid-19 transmission that in future could be used to monitor other activities, including political dissent.<sup>31</sup>

While governments have used public health to justify restrictive regulations, they have not introduced regulatory measures on the private health sector that could increase access to covid-19 treatments, vaccines, medical technologies, and healthcare facilities. Such measures include prices regulation, prioritisation of production of covid related treatments, and the introduction of progressive solidarity taxes. The pandemic has brought to the fore the negative consequences of fragile and commercialised or profit driven health systems, especially for vulnerable groups already experiencing inequitable

access to healthcare.<sup>32 33</sup> For example, in Australia, by the end of July 2020 there were five deaths in public care homes for older people compared with 900 deaths in privatised homes.<sup>34</sup>

**Building a fairer post-covid 19 world**

Covid-19 has crystallised the need to address the “toxic combination of poor social policies, unfair economics, and bad politics [that are] responsible for much of health inequity.”<sup>32</sup> Countering this requires building solidarity to realise health for all. Since the Commission on Social Determinants for Health report, criticism of the unequal distribution of resources, power, and money has intensified.<sup>35</sup> We suggest six measures (box 1) to enable a more just and sustainable world following the covid-19 pandemic.

Policies and interventions to tackle vulnerability in living and employment conditions are critical. These include social protection programmes to reduce poverty and safeguard livelihoods, including for informal workers. Decent work conditions will protect paid and unpaid workers from health threats, including covid-19. Governments should institutionalise policies that value the contribution of social reproduction work, and compensate people (mostly women) for the unpaid social reproduction work they do on a daily basis. The conditions of health and social care workers can be improved with the provision of formal contracts, decent wages, and non-exploitative working conditions. More broadly, the interdependence of reproductive and productive work should be recognised through institutionalising measures such as childcare and breastfeeding facilities at workplaces, paid parental leave, occupational health facilities, and subsidised healthy meals at work.

Governments could also reverse rapidly growing inequities by implementing progressive taxation, including wealth taxes.<sup>36</sup> This would increase their ability to fund the public sector, including health and social services. Other measures include strengthening government administrative capacities to monitor and tax international financial flows.<sup>37</sup> IMF requirements for austerity measures in countries given loans for covid-19 should also be lifted as they undermine national governments' policy autonomy and may lead to a lost development decade.<sup>38</sup>

Initiatives for progressive social change should also be implemented, including affirmative action in education,

**Box 1: Measures to move towards a just and sustainable post-covid world**

- *Design and implement policies to remove vulnerability in living and employment conditions*—eg, public housing add ;? private rental controls; mandate against long term casual employment add ;? introduce progressive labour laws, universal employment guarantee programmes, universal basic income programmes, social security pensions, childcare at workplace, parental leave, and school meals
- *Implement progressive taxation and regulate illicit financial flows*—eg, national taxation policies that ensure high income earners pay most tax and making corporations pay tax in the countries they operate
- *Implement policies to address structural racism and discrimination against religious, ethnic, racial, and sexual minorities*—eg, establish national anti-discrimination organisations, workplace unconscious bias and anti-racism training; pass laws to prohibit racist attacks and discrimination; and implement affirmative action laws and policies
- *Strengthen public sector provision of healthcare and stop further healthcare privatisation and commercialisation*—eg, increase health budgets to at least 5% of GDP, finance the public health system to provide services rather than outsource, increase resources to areas and communities that are currently underserved, regulate private providers
- *Invest in human resources for health, including community health workers and those trained in public health infectious disease control*—eg, implement fair wages for all health workers, reduce use of short term contracts, train and recruit health workers from the local area to ensure retention
- *Democratise decision making about healthcare services and medical technologies at community, national, and global levels*—eg, include the community (especially those most affected) and people’s representatives in decision making structures, monitor and take action on possible conflicts of interest in health governance structures, implement laws supporting freedom of the press

employment, and political representation; laws against discrimination; and support for communities to build their capacities to organise against anti-democratic measures, inequalities, and racism.<sup>39</sup> This includes the implementation of laws and policies to ensure access to healthcare services is based on medical need rather than on ability to pay or social status and that services are tailored to recipients’ cultural, linguistic, and religious requirements.

Access to healthcare also remains hampered as the healthcare and pharmaceutical industries seek profits in a way that makes it unaffordable for many. Commercialisation is continuing under the guise of promoting universal health coverage, and in some countries, such as the UK, as a rationale for institutionalising an efficient response to covid-19.<sup>40</sup> Governments should instead work towards institutionalising and financing universal coverage through progressive taxation schemes and provide primary healthcare and services to everyone as conceptualised in the Alma Ata declaration<sup>41</sup> and by the Commission on Social Determinants of Health. Furthermore, the capacity and efficacy of the public sector as a provider of healthcare, especially to people from marginalised groups, should be strengthened, including by recruiting and training adequate numbers of health

workers and providing fair wages, social protection, and a conducive working environment.

Defending the principle that people have a right to participate in decisions about their health and in processes affecting it, including economic processes, is central to building solidarity for health for all. This means resisting global and national health governance processes that privilege organisations not subject to democratic oversight. For example, the privatisation of global health governance gives stakeholders with huge financial resources—such as philanthropic foundations, commercial consulting firms, and drug companies who are beholden to shareholders or governing boards — disproportionate power to define health priorities and solutions. Democratically elected governments are best placed to demand and support action on the social and economic determinants of health to prevent and manage future pandemics.<sup>42</sup>

The erosion of national autonomy is also echoed in international agreements such as TRIPS, which the most powerful states in the World Trade Organisation are interpreting in a manner that undermines equitable access to covid-19 medical technologies.<sup>43</sup> If global governance for health is to be meaningful, international trade agreements must promote the

public good rather than defend private interests. The pandemic also reiterates the urgent need for the binding instrument on transnational corporations and human rights that is currently being negotiated within the United Nations.

In conclusion, the covid-19 pandemic has exposed the health effects of long-standing social inequities and that vulnerability to disease is shaped by labour market structures, lack of social protection, and anti-democratic processes. The effect of these structural inequities on populations is mediated by intersecting social dimensions, including occupation, class, ethnicity, race, citizenship status, and gender. The pandemic has highlighted the unequal distribution of power and resources, and people are also using this moment to challenge these inequalities anew. Governments and the international community must take responsibility for rebuilding social protection and solidarity to protect populations from future health challenges, while civil society and social movements also have a role in holding decision makers to account.

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