

Socioeconomics, inequities, and Covid-19

Introduction

Coronavirus is a group of related RNA viruses that cause fast spreading, contagious diseases, that affect the respiratory tract system, proven to cause mild to life threatening effects. The most recent and most lethal variant COVID-19, the disease in which is caused by the SARS-CoV-2, a new strain of coronavirus which had not previously been identified within humans.

Since the first case of this variant was detected in Wuhan, China in December 2019, it has caused a fast spreading, uncontrollable outbreak of respiratory illness, subsequently spreading worldwide, placing the globe into an ongoing pandemic (Velavan and Meyer, 2020).

Evidence suggests that humans respond to this by activating an immune response that destroys the cells that are infected, the viruses have learnt to adapt and mutate in order to evade the immune system, which explains why individuals respond differently, affecting the more vulnerable individuals, namely those with chronic health conditions (Sewell, Agius, Stewart and Kendrick, 2020).

Social determinants of health are considered the circumstances in which individuals are born, live, grow up, work, and their age, inclusive of the health care and services available to them (Marmot, 2020). These determinants influence the inequities, the unfairness in society where people have more affluent choices, in this context, within the health service; causing unfair yet avoidable differences in the service received. Evidence shows that the lower the social economy, the poorer the health (Abrams and Szefer, 2020). Many social determinants of health, together with poverty and the physical environment, have a considerable effect on COVID-19 outcomes (Bambra, Riordan, Ford and Matthews, 2021). (Marmot 2012), highlights that though every society will have aspects of socio-economic inequity, striving for a society in which creates the foundations for everybody to have the same opportunities available to them will in time enable people to lead a life in which holds equal value and fairness. Evidence currently shows that physical and mental health is deteriorating, and the health inequities are widening. (Marmot, 2020). People from a higher socioeconomic background are more accustomed to opportunity, chances, and accessibility to health services too (Marmot, 2012).

“Health inequalities are not inevitable and can be significantly reduced, avoidable health inequalities are unfair and putting them right is a matter of social justice. There will be those who say that our recommendations cannot be afforded, particularly in the current economic

climate. We say that it is inaction that cannot be afforded, for the human and economic costs are too high (Marmot, 2012). ”

Discussion

Within the United Kingdom, minority ethnic groups, people living in areas of high social deprivation and those living in hardship reportedly have a higher rate of several underlying clinic risk factors, such as obesity, smoking, cancers, renal and cardiovascular disease, hypertension and asthma (Abrams and Szeffler, 2020). It is suggested that this inequality of surging rates of chronic conditions, within this group of people is due to the lack of access to services such as healthcare and day-to-day essentials such as food, water, and hygiene facilities, thus due to low income. Along with low-income occupations, often come adverse working conditions, such as long shift work associated with repetitive, low concentration jobs which can often cause increase risk of musculoskeletal disease, stress, and anxiety (Bambra, Riordan, Ford and Matthews, 2021).

In addition to the inequalities highlighted, individuals are said to be deprived of adequate sick leave protection, resulting in hesitancy to quarantine and subsequently exposing themselves to contamination risks, solely to avoid loss of earnings (Paremoer, Nandi, Serag and Baum, 2021). Evidence shows the factors in discussion surge the mortality of COVID-19 (Abrams and Szeffler, 2020). It is evidently suggested that low-income occupations such as health care, cleaning, and hospitality are all services that cannot be provided from home and therefore involve close proximity and direct contact with the community, exposing individuals to potential risk of infection. Along with low-income occupation are factors such as commuting on public transport to and from the workplace which is likely to increase the risk of transmission of COVID-19. Travelling on public transports is deemed higher risk due to the lack of ventilation and also the traffic of people travelling from different environments. Zhao et al (2020) explored evidence showing transmission rates of SARS CoV-2 on public transport versus travelling by domestic travel; it was found that there was 56.87% more risk of transmission on a train than if travelling by car. Evidence has shown that many infected by COVID-19 may be asymptomatic, therefore potentially unaware that they are carrying the virus and are therefore less likely to be as vigilant of their actions in preventing the spread (Yu and Yang, 2020), yet another influence in which inequality becomes apparent (Shadmi et al., 2020).

Throughout the pandemic, personal protective equipment has been paramount in order to protect against the virus, and to prevent the spread. It is evident that if an individual is not provided with the adequate personal protective equipment the transmission of the virus is often unavoidable

(WHO, 2021), although employers are accountable for the availability of this, within low paid occupations, the funds are not always readily available to provide staff with the necessary PPE, in addition to funding issues, shortage issues have risen therefore emphasising the need for prioritisation (WHO, 2021).

A significant factor within health inequalities is also a person's housing circumstance. Issues such as overcrowded living conditions and multigeneration living arrangements are components in which provide a more compact surface area wherein the virus can spread, posing significant challenges for households trying to control the spread of infection. As advised by the Government it has been compulsory that physical distancing measures, and self-isolation guidelines have been adhered to, having a profound impact on many people's daily lives. The situation becomes more inferior if the homes people are self-isolating in, do not have sufficient space, again highlighting the inequalities, in this example, that of a person's mental wellbeing (Lades, Laffan, Daly and Delaney, 2020). During these times, people have found being outdoors, in fresh air and having the space to exercise, highly beneficial for their wellbeing and mental health. Individuals living in high rise flats or built-up areas, however, may not have the luxury that of individuals living in the countryside with ample space around them do (Lades, Laffan, Daly and Delaney, 2020). In addition, some may have the fortune of having a spacious garden, which is believed to alleviate poor mental health and anxiety. Discriminating those who do not freely have this option (Shadmi et al., 2020). Furthermore, poor quality of living can often be associated with issues such as inadequate heating and damp which could cause weakness within the respiratory system, and over time result in respiratory diseases (Burström and Tao, 2020). Without the protection against diseases that affect the respiratory system, it is apparent those affected by housing inequalities are at higher risk of contraction of COVID 19 and consequently experiencing a poorer response and outcome (Patel et al., 2020).

Conclusion

Although it is not scientifically proven that these factors are the reason that people will contract COVID 19, it certainly highlights the inequalities in which would determine the protection they have against contraction, and additionally the care they will receive to determine their outcome if COVID19 is contracted. Everyone has lived or is living through this global pandemic and social determinants continue to have a bearing on how they are affected in different ways, this seems to be biased and unfair (Marmot, 2020). Going to a place of work to earn a living, returning home and utilising public transport, should not cause anyone to be at a disadvantage and are these are not sound enough reasons to enable change, and to implement improvement?

How people are affected differently by a pandemic should not be based on social determinants (Burström and Tao, 2020). Every person should be adequately provided with the correct personal protective equipment to complement their occupation and their day to day living within the vicissitudes the nation has been governed to live under. Passable protection and equality should be viewed as basic rights (Burström and Tao, 2020). The pandemic has indeed highlighted the unambiguous inequalities within our society and will expectedly continue to intensify them. (Marmot, 2020) said “The question we should ask is not, can we afford better health for the population of England, but what kind of society do we want?”.

With the pandemic still very much present, various funds have been found to see the nation through this adversity (Shadmi et al., 2020), is now the appropriate time to review this ongoing social equality and initiate change? There has never been a more appropriate time to address social inequities, the disparities experienced throughout this pandemic have not only presented new issues but continue to expose the disproportion embedded in our social system and within our health system. Life expectancy and mortality rates continue to follow history as being inconsistent between the population of the fortunate and the deprived. (Ahmed, Ahmed, Pissarides and Stiglitz, 2020).

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