THE REEDE SCHOLARS, INC.

CALL FOR ACTION:

Policies needed to protect the poor and working poor during a pandemic

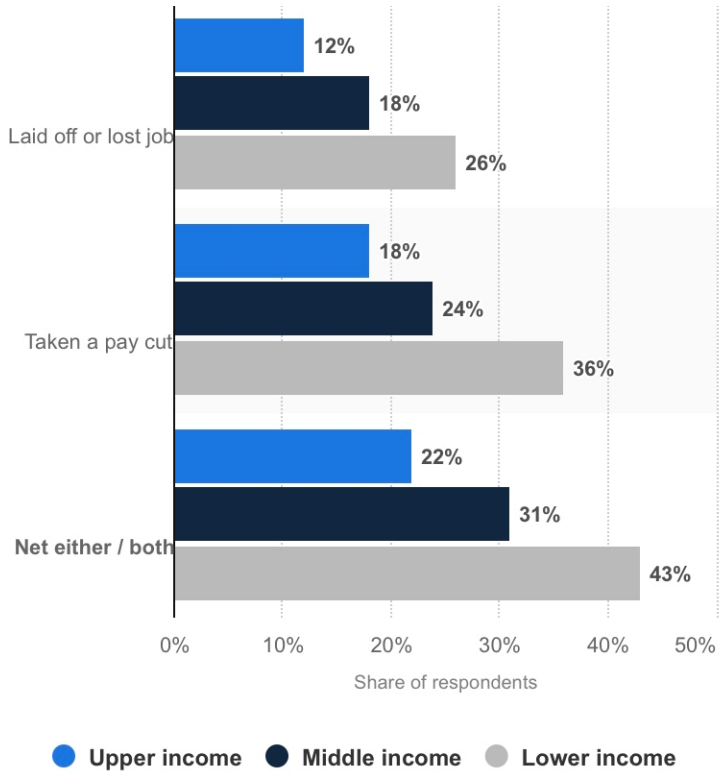
The COVID-19 pandemic has illuminated, once again, the glaring disparities between poor, working poor, and non-poor Americans. While the coronavirus strikes without regard to age, gender, economic status, sexual orientation, employment status, or geographical location, the poor and working poor are most vulnerable for excess morbidity and mortality. Poor and working poor in this context are surrogate terms for underserved communities, low-wage earners, marginalized populations, and groups suffering health, economic, and social justice disparities.

Among the poor and working poor, women and racial/ethnic minority/minoritized groups, i.e. persons of African decent, Latinx, and Native and indigenous groups, are disproportionally represented when compared to their numbers within the US population. Furthermore, the poor and working poor are disproportionately affected by chronic conditions including hypertension, diabetes, and obesity. People with these chronic conditions are at higher risk for severe illness from Covid-19. For these reasons, we are recommending proven public health measures targeting poor and working poor people, to assure they are able to return to jobs as soon as possible based on available scientific information.

When a communicable disease outbreak begins, such as Covid-19, the ideal response is for public health officials to begin testing for it early. Testing allows for quick identification of positive cases, quick treatment for positive people, and immediate isolation to prevent spread. Contact tracing, while tedious, helps identify anyone who came in contact with infected people so they too can be treated and quarantined. Early testing also identifies asymptomatic carriers. Lastly, testing is important in the bigger public health picture on mitigation efforts, helping investigators characterize the prevalence, spread and contagiousness of the disease.

Poor and working poor are more likely to have more than one contact as multi-person households are the norm. Under conditions where poor workers are forced to stay home, positive cases have the potential to be sicker, as well as, spread to family members while living in crowded conditions.

Graph 1: **Share of the U.S. adults with someone in household who has lost a job or taken a pay cut as a result of the Covid-19 outbreak in March 2020, by income group – Statista 2020**



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An estimated 53 million people - 44% of all U.S. workers ages 18 to 64 - are low-wage workers (including those in retail sales, cooks, janitors, sanitation, food and beverage servers, caregivers for children and adults, and patient care assistants). More than half (56%) are in their prime working years of 25-50, and this age group is the most likely to be raising children (43%). Women are more likely than men to be among the working poor. Additionally, Blacks and Latinx individuals continue to be about twice as likely as Whites and Asians to be among the working poor.

Essential low-wage workers include those who continue to work in grocery stores and gas stations, prepare food at restaurants, and are janitorial staff in hospitals. Unless they are completely isolated, they are continually exposed to COVID-19 at work (from co-workers and customers) and potentially during their commute, especially without adequate PPE. Due to this, they could carry and expose the virus to their co-workers and customers, or they could be exposed and contract the virus. Therefore, there is a need not only for more PPE, but also more widespread testing, so workers will know if they have the virus and are at risk of exposing those with whom they are in contact.

The categories of essential versus nonessential — or skilled versus unskilled — were never as clear as their common usage implied. The pandemic illustrates the vulnerability and the necessity of low-wage workers. As the pandemic rearranges American life, possibly for good, it should also force a reckoning that the way we think about labor and work must evolve and change. Indeed, the most important public health workers may be sanitation workers.

When the economy reopens, low-wage earners, hit hardest by this pandemic, may be slow to return (many will not return) due to excess morbidity and mortality. As the coronavirus pandemic ravages the American public, unsurprisingly, poor communities are emerging as hot spots for COVID-19.[3] Vulnerable groups already besieged by more illnesses and fewer resources, will invariably experience high incidence, greater morbidity, and higher mortality than non-poor, more affluent Americans.

The Reede Scholars, Inc. - https://reedescholars.org/ - is a culturally, socially, politically, and professionally diverse group of health professionals and alumni of Harvard's Minority Health Policy Fellowship Program (MHPF). Our combined talents, training, and skills promoting health equity are vast. We are recommending specific actions be enacted immediately in order to lessen the burden of COVID-19 on all essential workers. It is a certainty that the American economy cannot recovery without them.

Policy recommendations at federal, state, and local levels

Poor and working poor are not a homogenous group. Racial and ethnic minorities are more likely to suffer health disparities, low socioeconomic status, and toxic living environments. Poor and working poor whites are less likely to confront bias in health care and be denied lifesaving procedures. Latinx and Native Americans have higher prevalence of diabetes. Hence, public health interventions must be culturally, age-specific, and specific to urban populations, rural areas, Latinx communities, Native American communities, and employers doing business within these communities, i.e. local grocers, hair and nail salons, laundromats/cleaners, churches, and food vendors. Messaging must be easily and readily comprehensible, internet friendly, and utilize social platforms, where appropriate. Trust in the messenger is a building block to trust in the message.

Policies must include interprofessional collaborative health care, including oral and behavioral health providers. Oral physicians (dentists) are a valuable resource that could be utilized for triage with teledentistry and to broaden the scope of testing within their offices. Mental and behavioral health physicians can expect greater need for services; these encounters could also include Covid-19 testing. Testing should be available during maternal and child health visits.

Additionally, community workers, social workers, promotors, and health educators must have a voice in planning, implementing, and evaluating these recommendations. The U.S. National Public Health Services Corp should be part of the team approach, dispatched with the necessary resources, to reach our poor and working poor.

Recommendation 1*:*

Immediately direct testing sites, state health departments, and state agencies to collect the following data for all persons who test positive for COVID-19:

a) ***Detailed Demographic Data:*** *Include race and ethnicity, age, gender, geographic location, and socioeconomic status.*
Note: *Geographic location should include not only a patient's county or zip code but more detailed community-level data to reflect the patient's community.*

b) ***Morbidity Data****: Incidence (by race and ethnicity and socioeconomic status), emergency department use, ventilator use, hospitalization, and comorbidities, (i.e., diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), obesity, and cardiovascular disease).*

c) ***Mortality Data***
NOTE: *May consider the development of a standardized data collection system.*

Recommendation 2:

Provide COVID-19 test sites that are accessible, available, and appropriate for poor and working poor persons. Test sites must be located where poor and working poor people reside, are employed, and where they gather, to include drive thru testing services, mobile medical vans, and in medical and dental offices.

a) Testing*: Must be available at times convenient for target audience, i.e., early mornings, mid-day, and evenings. Tests must prioritize those with chronic ailments, multi-person households, and all essential workers.*

b) Tracing of COVID-19: *Positive contacts must be adequate and expedient to prevent spread in highly dense settings, such as nursing homes, prisons, shelters, homeless sites, densely populated communities, i.e., row houses, public housing, college campuses. Ongoing surveillance that is culturally sensitive must be continued in poor and near poor communities, and work sites of essential workers.*

c) Coverage for Testing: *Prohibit cost-sharing for diagnostic testing and prior authorizations for testing. Provide Medicaid coverage of testing for uninsured residents.*

Recommendation 3*:*

Increase promotion of and expand access to telemedicine and teledentistry.

Recommendation 4*:*

Maintain funding levels for education (no cuts).

These recommendations and all resulting policies must be accompanied with appropriate funding and widespread communication to all departments and agencies involved at state and local levels. Funding is critical for outreach, health care for persons with chronic ailments, home visits, housing, persons located in food deserts, internet access for school age children to limit educational disruption, resource poor communities, and Native American reservations.

Conclusion

The period between the disease outbreak and the time it takes to mobilize resources is referred to as the 'gap'. Within this chasm, people are becoming sick and some will die. The challenge is to mobilize faster in order to save as many lives as possible, and to assure disadvantaged persons are afforded maximum public health protections. It has been remarked that COVID-19 is the "great equalizer" of health challenges. However, with recent data released detailing the demographics of confirmed cases, significant disparities in outcomes were revealed - demonstrating that COVID-19 has in fact been the great tester of inequities.

If there is to be an economic recovery, federal and state initiatives are needed to protect essential workers who are the producers of consumer goods and providers of *essential* services. To ensure a viable and productive workforce post coronavirus, deliberate, population specific policies must be developed, implemented, and evaluated to ensure the most vulnerable are cared for and protected. To enable holistic and equitable health for every citizen, intentional action needs to happen to address the underlying disparities in health and healthcare outcomes. An amplified commitment from healthcare delivery (providers and healthcare systems) must include investing resources to improve person-centered access to care, investing in social needs infrastructure, education, and training in cultural humility, accelerating quality of care for persons with chronic conditions/behavioral and mental health concerns, and addressing unconscious bias and social racism.

Adoption of the recommendations outlined above will go a long way to protect the nation's poor and working poor. It is not only the time to recognize their contributions; it is also the time to value their essential contributions.

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