

How Can we Ensure a Socially Equitable Approach to Deconfinement during the COVID-19 Pandemic?

Series | COVID-19 & strategy response

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[This document is part of a series of discussion notes addressing fundamental questions about the COVID-19 crisis and response strategies. The works are based on the best scientific information available and may be updated as new information comes in.]

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Soon after the World Health Organization (WHO) recognised that the growing COVID-19 epidemic was becoming a pandemic, governments around the world swiftly imposed confinement and social distancing measures. Fewer than eight weeks later, many governments now face the daunting **challenge of transitioning from lockdown to deconfinement**, while avoiding massive resurgences of new COVID-19 cases and an economic situation that could become more devastating than the disease itself.

In addition to the morbidity and mortality directly caused by COVID-19, it is important to consider **economic and social consequences** arising from social distancing and isolation, unemployment, and psychological distress. Owing to a variety of socioeconomic determinants of health, certain populations are at greater risk of these consequences. Such **vulnerable populations** include low-income

and unemployed individuals, especially those in the informal sector, migrants and minority populations, homeless individuals, people who use drugs, and prisoners. Therefore, the crux of the deconfinement challenge is **ensuring social equity** (Box 1) while mitigating further health declines and resuscitating economies and health systems ●

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“Health inequities (...) reflects deep inequalities in wealth, power, and prestige between different individuals and groups, which have been clearly manifested during the COVID-19 pandemic.”

Box 1. Social Equity

The World Health Organization defines **equity** as “the **absence of avoidable or remediable differences among groups of people**, whether those groups are defined socially, economically, demographically, or geographically”¹. Social equity is defined as having fair access to resources and opportunities². **Health inequities are avoidable inequalities** among groups of individuals within and between societies. Social inequity manifests across a range of intersecting social categories including class, education, gender, age, ethnicity, disability, and geography. It reflects deep inequalities in wealth, power, and prestige between different individuals and groups³, which have been clearly manifested during the COVID-19 pandemic.

Responding to the economic distress caused by the pandemic, by 3 April 2020, 106 countries had introduced **new social protection measures**⁴. Most of these measures targeted businesses and salaried employees, neglecting individuals in the informal labour sector and undocumented persons. **Many vulnerable groups were not specifically considered** in the vast majority of countries. Of the 106 countries with social protection measures, only 15 reported to have enacted measures to protect children, 13 for the elderly, 13 for those with disabilities, seven for those with low incomes or in or near poverty, two for homeless persons, and one for migrants (See details for Spain in Box 2).

1. The Unequal Distribution of Adverse Effects of Confinement

“Public health institutions must ensure social equity by prioritising the needs of high-risk groups and actively ensuring the social circumstances necessary to protect their health.”

Under public health frameworks, large-scale confinement during an infectious disease outbreak is justified if deemed critical for public safety and if the infringement of free movement is proportional to the threat to the population. Nonetheless, **collective societal efforts** to mitigate the severity of a pandemic must be met with equal efforts from governing bodies through, for example, the provision of financial support, workplace accommodations, and mental health services. Public health institutions must also ensure social equity by prioritis-

ing the **needs of high-risk groups** and actively ensuring the social circumstances necessary to protect their health, well into the stage of deconfinement. To gradually and safely reintroduce greater social and economic activity, some COVID-19 deconfinement strategies support the progressive release of populations into society on the basis of their expected contribution to viral transmission and risk profile, as well as both RNA and serology tests^{5,6}. However, **this approach may be inequitable** due to possible scenarios such as

¹ World Health Organization. Equity. www.who.int/healthsystems/topics/equity/en (Accessed Apr 2020).

² Government of South Australia & World Health Organization. Progressing the Sustainable Development Goals through Health in All Policies: Case studies from around the world. Adelaide, AU: Government of South Australia 2017:63.

³ CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, CH: World Health Organization 2008:18.

⁴ Gentilini U, Almenfi M, Orton I. Social protection and jobs responses to COVID-19: A real-time review of country measures. “Living paper” version 3, 2020 April 3. http://www.ugogentilini.net/wp-content/uploads/2020/04/Country-social-protection-COVID-responses_April3-1.pdf (Accessed Apr 2020).

⁵ Rivers C, Martin E, Watson C, et al. Public Health Principles for a Phased Reopening During COVID-19: Guidance for Governors. Baltimore, MD: The Johns Hopkins Center for Health Security 2020:1-24.

⁶ Gilbert M, Dewatripont M, Muraile E, et al. Preparing for a responsible lockdown exit strategy [comment]. *Nat Med* 2020. <https://doi.org/10.1038/s41591-020-0871-y> (Accessed Apr 2020).

under-testing, changing testing criteria, and the potential exclusion of marginalised groups from testing⁷.

Indeed, there has been forced confinement in response to previous epidemics of infectious diseases, but following confinement, vulnerable groups experienced **stigma** and **poor health outcomes**. For example, unnecessary confinement or hospitalization for tuberculosis (TB) in the former Soviet Union worsened socioeconomic conditions and caused a resurgence in TB incidence. Similarly, the Canadian government's policy of allowing First Nations individuals to be forcibly removed for TB treatment in the 1940s through the 1960s failed to eliminate TB within the population and contributed to stigma and mistrust of the health system. In recent epidemics of SARS (beginning 2002), H1N1 (2009), MERS (2012) and Ebola (2013), dramatic headlines and fear-mongering have likewise contributed to stigmatising attitudes post-confinement⁸.

Notably, the COVID-19 pandemic has been associated with discrimination against migrants and people of colour, who already have higher risks of comorbidities (e.g. diabetes, hypertension, substance abuse, and psychological illnesses) and lower economic capital due to systemic discrimination and other structural factors⁹. COVID-19-related incidences of deportation and entry refusal for migrants, political speeches against foreigners, and racism towards minority groups further heighten their vulnerability¹⁰. In fact, research on China's deconfinement experience has found more severe psychological distress among migrants¹¹. Thus, a deconfinement strategy that is particularly attentive to social equity is necessary to prevent adverse health and social outcomes among such vulnerable groups ●

Box 2. Spain – Social Protection Measures under Strict Confinement

Spain announced the mobilisation of a **EUR 200 billion package to support companies, workers, and some vulnerable groups** following interruption of almost 350,000 employment contracts and is moving to establish a minimum income guarantee in May 2020. In addition to expanding unemployment and employee retention benefits, Spain set up new **mechanisms for social protection**. Vulnerable families (e.g. in or near poverty) receive income support as an unconditional cash transfer (via wire transfer, pre-loaded cards, or supermarket vouchers). To protect against food insecurity, the government also supports home deliveries and food distribution points and has barred the suspension of energy, gas, water, and telecommunication services for these families. Additional measures include homeless support services to deliver information about COVID-19 prevention, hygiene kits, and food as well as a contingency fund to cover social services for elderly adults. These measures may help mitigate stress and anxiety attributable to financial loss, yet early indications suggest that stringent confinement policies are contributing to **depression, anxiety, stress and post-traumatic stress disorder** among the general population, which are likely to **disproportionately impact vulnerable groups**.

⁷ García-Basteiro AL, Chaccour C, Guinovart C, et al. Monitoring the COVID-19 epidemic in the context of widespread local transmission. *Lancet Respir Med* Published Online First: 2 April 2020. doi:10.1016/S2213-2600(20)30162-4.

⁸ Brooks SK, Webster RK, Smith LE, et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet* 2020;395(10227):912-920.

⁹ Devakumar D, Shannon G, Bhopal SS, et al. Racism and discrimination in COVID-19 responses. *Lancet* 2020;395(10231):1194.

¹⁰ Kluge HHP, Jakab Z, Bartovic J, et al. Refugee and migrant health in the COVID-19 response. *Lancet* 2020;395(10232):1237-1239.

¹¹ Qiu J, Shen B, Zhao M, et al. A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: Implications and policy recommendations. *Gen Psychiatry* 2020;33(2).

2. Impacts of Economic Recession

“Previous recessions have also exacerbated inequities in wealth and health. For example, the 2002 United States recession saw white households earning 11 times more than Hispanic households and 14 times more than black households.”

A global recession, even greater than that following the 2008 financial crisis, is nearly inevitable given the severe effects of COVID-19 on the world’s major economies such as those of China, the United States and the European Union^{12,13}. During the financial crisis of 2008, many European countries experienced increases in **mental health disorders and suicides** linked to high unemployment and financial instability. Confinement may exacerbate the mental health effects of financial insecurity, especially for those with low incomes. During the 2003 SARS outbreak in Toronto, Canada, experiencing prolonged confinement and having a lower income were highly associated with post-traumatic stress and depressive symptoms following quarantine.

Previous recessions have also exacerbated inequities in wealth and health. For example, the 2002 United States recession saw white households earning 11 times more than Hispanic households and 14 times more than black households. This highlights the need for social safety net provisions that demonstrably offer **greater support for socially disadvantaged groups**¹⁴. For example, to counteract job dislocation as a result of the COVID-19 pandemic, the Canadian government has increased access to unemployment insurance and adopted the Canada Emergency Response Benefit plan. This provides Canadians with \$500 per week for up to 16 weeks and expands eligibility criteria to self-employed and contract workers, individuals caring for children at home due to school closures, and those caring for family members affected by COVID-19¹⁵. In the United States, taxpayers

earning less than US \$99,000 are eligible to receive a one-time payment of \$1,200 and an additional \$500 per child if their income is under \$75,000. However, the stimulus payment is unavailable to those outside formal tax and social systems and has been withheld from some citizens married to immigrants without social security numbers¹⁶. Moreover, this small payment is unlikely to adequately address the **long-term needs** of marginalised populations ●

¹² International Monetary Fund. World Economic Outlook: Chapter 1 The Great Lockdown. 2020 April 6. <https://www.imf.org/~media/Files/Publications/WEO/2020/April/English/text.ashx?la=en> (Accessed Apr 2020).

¹³ Loayza NV, Pennings S. Macroeconomic Policy in the Time of COVID-19: A Primer for Developing Countries. Research and Policy Briefs; no. 28. Washington, DC:World Bank Group 2020:2. <https://openknowledge.worldbank.org/handle/10986/33540> (Accessed Apr 2020).

¹⁴ McKee M, Stuckler D. If the world fails to protect the economy, COVID-19 will damage health not just now but also in the future [comment]. *Nat Med* 2020. <https://doi.org/10.1038/s41591-020-0863-y> (Accessed Apr 2020).

¹⁵ Lord P. Incentivising Employment during the COVID-19 Pandemic. *SSRN Electron J* 2020 Apr 16. doi:10.2139/ssrn.3573176. (accessed Apr 2020).

¹⁶ Jarvie J. These U.S. citizens won’t get coronavirus stimulus checks — because their spouses are immigrants [eNewspaper]. Los Angeles Times 2020 Apr 20. www.latimes.com/world-nation/story/2020-04-20/u-s-citizens-coronavirus-stimulus-checks-spouses-immigrants (Accessed Apr 2020).

3. Protecting Vulnerable Populations during Deconfinement

“Those experiencing financial hardship in countries without adequate financial and social protection schemes are likely to avoid health services, as are undocumented migrants due to fear of deportation.”

Those experiencing financial hardship in countries without adequate financial and social protection schemes are likely to avoid health services, as are undocumented migrants due to **fear of deportation**. Consequently, this may sustain COVID-19 transmission and leave such groups susceptible to worse health out-

comes and greater financial hardship. Governments should consider tools to involve affected communities, such as the ‘Nobody Left Outside’ service design checklist, published at the start of the pandemic (Figure 1) ●

Figure 1. Schematic Overview of Nobody Left Outside Service Design Checklist



Source: Lazarus et al. *BMJ Open* 2020;10:e035621.

4. Recommendations

“We propose some recommendations to governments to mitigate inequities during and following deconfinement.”

We propose the following recommendations to governments to mitigate inequities during and following deconfinement:

1. Ensure financial protection for vulnerable populations

Government financial protection measures should target specific vulnerable populations.

a) Ensure that healthcare costs are not catastrophic during and after deconfinement, particularly in countries with largely privatised health financing systems.

b) Prioritise universal basic income with progressive subsidies, expand social security and unemployment eligibility and benefits, and implement other pro-poor policies that protect against adverse health and socioeconomic consequences of confinement and loss of income through the deconfinement period and economic recession.

c) Make permanent social protection interventions introduced during the crisis to enable governments to sustainably address the underlying contributors to financial and health insecurity.

2. Strengthen primary healthcare

Governments should strengthen national and subnational primary health services, which can address prevention, treatment, rehabilitation, and palliative care needs at lower costs compared to specialised and complex health services. This can reduce demand on hospital resources and protect population health while easing financial pressures on health systems.

a) Facilitate outreach from general practitioners and other health providers to community leaders to disseminate relevant information to hard-to-reach populations.

b) Utilise primary healthcare providers and emergency departments to monitor the social determinants of health of vulnerable populations.

c) Scale up mental health outreach services to address domestic violence, anxiety, depression, post-traumatic stress disorder, and other stress-related conditions related to confinement and economic insecurity.

d) Expand telemedicine services to reduce the risk of COVID-19 transmission while ensuring access to necessary care.

3. Address the health needs of migrants and refugees

Governments should provide physical and psychological health support to documented and undocumented migrants and refugees.

a) Provide healthcare and testing and treatment for COVID-19 regardless of migrant status.

b) Provide essential information on COVID-19 to communities in their own languages.

4. Promote housing protection

Governments should promote housing affordability, limit evictions and halt the suspension of utility and telecommunication services.

a) Provide adequate and safe accommodation for people who are homeless, which can also decrease use of costly emergency services, including hospitals and emergency shelters.

5. Maintain and expand open and safe public spaces

Vulnerable populations are more likely to live and work in conditions that negatively impact their health. It is essential to preserve access to public spaces for social security, health, and well-being.

a) Prioritise safe public transport and options that integrate mobility and physical activity (i.e. walking and cycling) to reduce contact with other people in daily routine activities.

b) Continue to use schools and other community spaces as centres to promote food security.

Addressing these considerations in deconfinement planning and implementa-

tion **can safeguard vulnerable groups against further inequities and maintain health, social, and economic preparedness for future crises** ●

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- [ISGlobal online event: Socioeconomic impacts and communication in pandemics](#)
- [European Union April 2020 factsheet: A European roadmap to lifting coronavirus containment measures](#)
- [United Nations April 2020 policy brief: COVID-19 and human rights: we are all in this together](#)
- [El Colectivo LGTBI frente al COVID-19. Guía de recursos para hacer frente a la exclusión y a discriminaciones por orientación sexual e identidad de género durante la crisis por COVID-19 \(Ministry of Equality, Government of Spain\)](#)
- [More documents of the ISGlobal Series on the Strategy for Lifting COVID-19 Containment Measures](#)

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