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Health Disparities, Social Distancing, and Belonging in Pre- and Post-Covid-19 United States

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Abstract: This commentary explores the relationship between health disparities, social distancing, and belonging in the United States pre- and post-Covid 19. The author concludes that post-Covid-19 requires a radical re-visioning of society to address structural inequality that has heightened the vulnerability of some populations to Covid-19, which has, in turn, exacerbated the pre-existing vulnerabilities.

Keywords: *health disparities; HIV/AIDS; Covid-19; social justice.*

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Covid-19 has impacted almost everyone, whether infected with the virus or not. For some of those who have been infected, it has brought severe illness and the need for extended hospitalization and, for some, it has led to their demise (Centers for Disease Control and Prevention, 2020a). For almost everyone, it has brought social distancing and isolation (Centers for Disease Control and Prevention, 2020b), made visible with the increasing use of face masks; lockdowns, shelter-in-place, and stay-at-home orders (Gershman, 2020); an increase in internet orders for the essentials of living; a ban on mass gatherings; and a disruption of familiar rituals, including weddings and funerals. For many of those who have died in hospitals and even in their homes, it has meant for some dying alone, without the presence of their loved ones nearby and little possibility of even saying goodbyes.

What Covid-19 has also done is to direct attention again to already-existing health disparities; individuals and communities that were more vulnerable to Covid-19 have been made even more vulnerable because of Covid-19. In the United States, increasing evidence suggests that African Americans are not only disproportionately infected by Covid-19 but also have a higher mortality rate due to the disease (Eligon et al., 2020). The underlying medical conditions that render individuals at higher risk of Covid-19—obesity, diabetes, liver disease, chronic kidney disease—are more prevalent among African Americans (Cunningham et al., 2017). These disparities are often attributed to social determinants of health, including lesser access to health care, lack of adequate funds or insurance, and poorer quality health care (McFayden, 2009). Elimination of these inequities will presumably eventually lead to the diminution of these health disparities.

Many members of minority communities receive constant communications telling them in any number of ways that they do not belong in the society in which they reside including microaggressions and hate crimes. Structural violence to and in minority communities may be pervasive and unacknowledged, even when clearly visible: disproportionate rates of arrest and conviction for the same offenses in comparison with non-minority individuals; inexperienced teachers and inadequate school supplies and buildings in predominantly minority neighborhoods; factories that discharge dangerous particles into the air, toxic waste dumps whose chemicals seep into the water table; food establishments that lack fresh produce but have ample alcoholic and sugar-laden products. Indeed, "[t]he modern America of obesity, inactivity, depression, and loss of community has not 'happened' to us. We legislated, subsidized, and planned it this way" (Frumkin & Jacson, as cited by Mile High Connects, 2012, p. 62).

We have seen this before, this disproportionate impact of a disease on a minority population, one that was relegated to the fringes of the larger community. HIV/AIDS, initially believed in the U.S. to impact only homosexuals, was known at first as "the gay plague" and then GRID: gay-related immunodeficiency disorder. The "risk groups" were later expanded to include three additional categories of persons, two of which often existed outside of society's sphere of concern: Haitians and injection drug users (Lederer, 2000). Like Covid-19, susceptibility to disease was attributed to individual characteristics: the choice of sexual partner, the choice to use drugs. Structural factors that constrained individual choice—laws that prohibited and criminalized same-sex sexual relations, the unavailability of harm reduction measures or recovery services—remained ignored during the early years of the pandemic. Like Covid-19, the U.S. federal government looked the other way as increasing numbers of individuals became infected with HIV, acknowledging the epidemic only in response to mounting criticism (Horton, 2017). As with Covid-19, although many health care professionals were dedicated to their patients and others devoted their efforts to finding treatments, some refused to administer care, fleeing instead (Bilefsky, 2020; Gillon, 1987; Parachini, 1987). Individuals believed to be infected with Covid-19 have been asked to self-quarantine to avoid transmission of the infection to others. HIV/AIDS prompted calls for the involuntary quarantine of infected individuals, even as recently as 2017 (Sheridan, 2017).

What Covid-19 has done as well is to bring to the fore deeper issues that underlie even these identified determinants of health, forcing us to turn our attention to the concepts of valuation and belongingness, to ask: would such disparities exist if the populations and communities so disproportionately impacted were viewed and treated as though they belonged?

The social distancing demanded as a preventive response to Covid-19 stands as a metaphor for the structural and social space that has been created between those communities deemed sufficiently worthy to belong and those who are to be marginalized and pushed to the margins of our concern. Belongingness suggests social acceptance and being respected, supported, valued, and validated (Gailliot & Baumeister, 2007; Goodenow, 1993; Hagerty et al., 1992). Individuals need belongingness not only at the specific level, as in romantic or sexual relationship, kin relationships, and supportive friendships, but at a more general level as well, in the workplace and in communities (Leary & Cox 2008). Too little belongingness is harmful, having been found to be associated with lower levels of self-esteem (Gailliot

& Baumeister, 2007), higher levels of depression (McLaren et al., 2008), immune dysregulation (Jaremka & Sunami, 2018), and appetite dysregulation (Jaremka et al., 2014, 2015). Research suggests that the absence of belongingness in a particular sphere is unique and is not compensated for by the presence of belongingness in another sphere (Cockshaw et al., 2013).

What is needed post-Covid-19 is not a reopening, but a radical re-visioning of who we are and how we relate to each other. In re-visioning our world post-Covid 19, we must work to address the structural inequities that lead to the health care disparities and increasing vulnerabilities. It was possible for individuals to ignore the impact of HIV/AIDS if they were not a member of a health profession, were not infected, did not know anyone who was infected; it was all too easy for individuals to divide the world into US and THEM. Covid-19 has made clear that we are all interconnected in large and small ways and we are all impacted; it is no longer us and them but US.

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