

Class and Race Inequality, Health, and COVID-19

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The demographic data collected and reported in the media for sickness and mortality rates due to COVID-19 has focused on age and to a certain extent gender. While mass hardship from unemployment has been widely reported, we have heard little about sickness or mortality rates by class or race for the coronavirus. There is nonetheless, clear evidence that class and race, and health and disease in general are closely linked. It is very likely therefore that sickness, recovery, and mortality rates for the Coronavirus pandemic will closely mirror class divides within countries and between rich and poor countries. Individual and household incomes, which reflects the class structure in a general way will be a key factor in how different classes experience the pandemic and its aftermath. Workers and the poor and people of color will likely suffer at greater rates than more privileged class and racial groups.

Sociologists, social epidemiologists and other researchers have long noted the close connections between class, race, and health. However, the two cases for which most data have been reported on COVID-19, China and Italy, gives us little guide to class or race in the current crisis because data on incomes or other measures of class have either not been collected or not have been released, and both are countries without the type of stratified racial structure as the US. While the virus spreads through human contact via close interaction with people and infected surfaces ignoring class distinctions, patterns of those who do become ill, their recovery rates and those who die will very likely be connected to social class. More research may very likely reveal a clear class divide in China and Italy. We can expect clear social epidemiological patterns along race as well as class lines in the US as the epidemic unfolds. We can see the connections between class structure and class inequality on the one hand, and health and illness rates on the other, by comparing data on income with data on measures of health such as infant mortality and life expectancy. These are general estimates in part because income is an imperfect measure of social class.

Increasing Class Divide

Over the last few decades, income inequality in the United States has sharply increased. While this has obviously created increasing hardship, especially for the lower levels of the eighty percent of the wage-earning population that experienced a reduction of their slice of the national income since the 1980s, the increasing gap between the top and the bottom income strata is *itself* a further aggravating factor in the degradation of quality of life measures such as those associated with health and illness. Sociologists like Richard Wilkinson argue that it is the *degree of inequality* in a society more than GDP that most determines measures of human well-being (Wilkinson, 1996; (Wilkinson and Pickett, 2008). Researchers often use the Gini coefficient to measure inequality across countries. It calculates income inequality on a scale of 0-1; a society with complete equality would have a score of 0.0, and one with complete inequality, that is, with *all* wealth going to top strata would score 1.0. The US currently scores .49, the greatest overall income inequality among the world's global north countries (China scores .55, Italy scores .33).

Since the 1990s, the one to twenty percent has taken increasing percentages of total income and wealth in the US. This is due to tax breaks to upper income strata, declining rates of unionization, neo-liberal deregulation, and continued gains in labor productivity, almost all of which have accrued to capitalist profit rather than higher wages. At the same time, wages and salaries have stagnated for at least three fifths of the income earning population since at least the 1990s.

Income data collected by the federal government divides the wage-earning population into twenty percent segments, often referred to as the "fifths", which show percentages of total income for each segment. Speaking generally, since the 1990s the percentage taken by the top 20% of wage earners has grown precipitously, the bottom two have shrunk, and the middle has stagnated. Workers can roughly be said to occupy the first three fifths of the income ladder. The lowest fifth received 4.3% of all total income in 1980 and 3.6% in 2000. The Occupy Wall street movement called attention to class inequality by focusing on the 1%. The 1% have indeed gobbled an increasingly huge percent of income-17% and wealth, 34% in recent years. But the top ten and top twenty percent have increased their share of wages wealth as well. The top fifth took 43.7 % of all salary and wages paid in 1980. By 2000, their share increased to 49.6%, and by 2010 slightly more to just over 51%. At that point the most substantial gains went to the top one percent.

Let's take a quick look at the bottom strata of the income hierarchy, those occupying the bottom fifth, especially its lowest earning levels. Poverty is calculated by the U.S. government on the basis of food and other living costs in relation to income (a very faulty formula that vastly underestimates true food and living costs). Currently, the poverty line is around \$25,000 for a family of four. The official poverty rate in the US is currently around 12%, or about 36 million people. A more reasonable estimate would be around 25-30% (25% would represent 88.5 million people). Many of these are children or retired people who would not be in the labor force. There are also millions barely above the poverty line whose actual life conditions resemble those under the poverty line, but yet who do not count as such in government statistics and do not qualify for public assistance. For those that do qualify, assistance payments have been slashed by successive waves of "welfare reform" from Clinton's deep cuts in the 1990s to the latest round of cuts announced by the Trump government just before the pandemic hit the US. Among the working age poor are long term or intermittently unemployed workers, while many others are low wage workers in fast food or retail, members of the informal economy, or "gig" workers. Many of these low-wage workers earn less than the poverty line and have no sick days, pension, or health insurance. Although Obama care added millions to the ranks of the uninsured around 20 million remained uninsured.

Class and Health

Against the backdrop of this quick look at the U.S. class structure, we can take a look at health data in relation to class. Overall, the middle and upper-class self-report good and excellent health in far

greater percentages than lower income strata. According to a report by the Center for Society and Health, “(p)oor adults are almost five times as likely to report being in fair or poor health as adults with family incomes at or above 400 percent of the federal poverty level . . . and they are more than three times as likely to have activity limitations due to chronic illness . . . Low-income American adults also have higher rates of heart disease, diabetes, stroke, and other chronic disorders than wealthier Americans (Woolf et al, 2015).

Health in a society can be measured by looking at several factors such as infant mortality, life expectancy, obesity rates, and more, not to mention multiple mental health factors. Here we take a brief look at two of these, infant mortality rates, and life expectancy, (both of which correlate with many other factors). Studies published as early as 1901 in York, England showed clear patterns linking class distinctions, living conditions, and infant mortality. A study conducted in York, England that collected data on infant mortality rates from three distinct working-class populations. The three groups differed according to living conditions and income with the poorest living in the most cramped and crowded conditions.

The infant mortality rate was highest at 247 per 1,000 live births in the poorest areas, 184 per 1,000, and in the highest, 173. The study noted that the infant mortality rate among servants living in the cleanest and least crowded neighborhoods and homes was 94. Research on 21st century populations reveals the same correlations. According to a study published in 2001, “In England and Wales infant mortality in 2000 was 3.7 per 1,000 among infants born to fathers in the top social class and 8.1 among those born into the bottom class. Among single mothers, the rate was 7.6. . . ” (National Statistics, 2001).

Life expectancy is also a prime measure of overall health in a population. Globally, the average life expectancy is 72 years according to the World Health Organization (WHO.) All of the countries with the longest life expectancies are in the global north with Japan and Hong Kong at the top with 84 plus, while all of the countries with the shortest are in the global south. Average life expectancy in the Central African Republic is 52.8 years.

In the US,” (a)mong men born in 1960, those in the top income quintile could expect to live 12.7 years longer than men in the bottom income quintile” according to a report by the non-partisan Congressional Research Service (Isaacs and Choudary,2017). All of this suggests that in general (individual exceptions aside), the poorer one is, the worse health they can expect; while, the richer one is, the better health they can expect. There is even evidence that the top half of the one percent have better health than the bottom half of the one percent.

Race and Health

Race also correlates closely with health and disease but less so than class. African Americans have much lower life expectancy and higher infant mortality rates than whites. Overall life expectancy in the US is around 78 years. Most studies find a 4-5-year gap between whites and blacks in general. Black men live around nine years less on the average than white men. In the US, according to the Center for Disease Control (CDC) the infant mortality rate (percentage) (measured as the number of infants who do not survive until their first birthdays), for African Americans is 11.4%, while the rate for whites was 4.9%.

Part of the poor health picture of communities of color reflects the overlap of race and class among blacks, Latinx, Asians, and Native people, all of whom are overwhelmingly working class and overrepresented in the ranks of the poor. Blacks and Latinx according to standard data collection are three times more likely to live in poverty than whites (the poverty rate for blacks and Latinx has been around 25% for most of the past few years, as opposed to 8% for whites). Blacks have far

higher diabetes rates than whites, and diabetes puts one at a distinct risk for the coronavirus. Research has shown that the connection between race and health is weaker than the relationship between class and health. In other words, “. . . higher-income blacks, Hispanics, and Native Americans have better health than members of their groups with less income, and this income gradient appears to be more strongly tied to health than their race or ethnicity. (Urban Institute,2015).

The high incarceration rates among African Americans will also result in higher infection and mortality rates in the black community since prisons are hotbeds of communicable disease transmission and prison hospitals are much less equipped to handle a sudden influx of patients. The myriad ways that people of color experience cultural racism in their interactions with health care workers at all levels including with physicians will continue to aggravate conditions for people of color during this crisis. And, all of the problems associated with poverty, malnutrition, and inequality will likely be magnified in unsanitary, closely packed Immigrant detention centers.

Class, Race, and COVID-19

The particularities of coronavirus will accentuate class and racial differences. For example, although people of all classes use public transportation in big urban centers, working people are more likely in some areas to take public transportation and less likely to have the option of driving their own cars, making them more vulnerable to infection. The automobile ownership rate per household in Milwaukee’s poor black neighborhoods for example, is 20-30%, while it is 90% in the white and wealthier areas. An article in the March 30 *New York Times* suggested that the use of long-distance public transportation that people in sprawling Detroit use to get from crowded neighborhoods to work may be factor in the sudden spike in coronavirus infections in that heavily black, working class, and poor city. Drive-up testing will be less effective in cities and counties where larger shares of the population do not have access to vehicles.

Data on the relationship between class, occupation, and the ability to self-isolate and therefore stay safe, during the pandemic is already being assembled. Information on fifteen million smart phone holders’ movements reported in the *New York Times* online edition on April 3, shows a clear occupational and class divide (the *New York Times* article did not discuss sampling issues). “(A)cross America, many lower-income workers continue to move around, while those who make more money are staying home and limiting their exposure to the Coronavirus”. For example, “The wealthiest people, those in the top 10 percent of income, however, have limited their movement more than those in the bottom 10 percent of the same metro areas.”

According to a study by the Data Center, a research group in southeastern Louisiana, “(i)ncome and poverty measures can indicate the extent to which a community may be able to successfully adhere to COVID-19 mitigation measures (such as “stay at home” and “quarantine family members who are sick”). (Data Center, March 25, 2020).” Allison Plyer, The Data Center’s chief demographer told the New Orleans *Sun Herald* (April 3, 2020) that “(w)hen people live in poverty, they live in much closer quarters, with potentially four people in a one-bedroom house,” said “That means it’s very hard to quarantine. A major way the virus is spread is among family members.” On the other hand, middle-class white-collar workers on the other hand, often live in larger living spaces. During the 1990s, newly built home size jumped from 1,800 feet to 2,400 feet, giving more room to quarantine a sick household member (Frank, 2015). These homes were most likely bought by those in the upper reaches of the third and lower levels of the fourth fifth.

Being poor, a person of color, or both makes one more likely to be homeless, or to live in a homeless shelter in close quarters. The vast and sudden unemployment and low wages, particularly in high rent areas, increase the likelihood that people will live in crowded living spaces making maintaining

social distancing especially difficult. Living in close quarters during this stressful time is also putting women facing domestic violence at greater risk according to numerous sources that have documented a surge in violence against women and LGBTQ people specifically connected to the COVID-19 crisis (Guardian, April 3, 2020).

<https://www.theguardian.com/us-news/2020/apr/03/coronavirus-quarantine-abuse-domestic-violence>.

Likewise, blue collar workers often work in closer quarters than white collar workers (some “pink collar” jobs in jobs gender-typed occupations such as secretarial work have also been moved to remote, while others such as house cleaning work, have not). In the current situation large swaths of the work performed by white collar employees has moved to online in comfortable homes (highly paid physicians working with Coronavirus patients are an exception), while working class and most people of color work in blue color jobs that can’t be performed at home, which has led to unemployment for some and the prospect of working under dangerous conditions for others.

The digital divide puts many poorer and rural working people and people of color without access to internet or quality internet or computers, smart phones, tablets, etc. in danger of not receiving the best and most up to date health related information. It also compromises their ability to follow school work that has now been shifted to a remote online format, which will further aggravate educational inequalities along class and race lines. Twelve percent of all US households lack internet access according to the US census. Only 61% of all households in New Orleans, a city with an overall poverty rate of 23.8% (2018), and one of the worst hit by COVID-19 have broad band. Twenty percent have no internet connection whatsoever (Data Center, 2020).

According to the Data Center in Louisiana, early studies of morbidity rates in Wuhan, China “have identified high blood pressure, diabetes, . . . coronary heart disease, chronic obstructive pulmonary disease (COPD—often associated with smoking), chronic kidney disease, and cancer as pre-existing health conditions that may increase the likelihood of severe outcomes for people who get infected with COVID-19” (Data Center, 2020; Yang, 2020). African Americans, and to various extents low income people of all races, suffer from these. Approximately, one third of all African Americans in Detroit suffer from asthma and diabetes.

Education, which overlaps with class, though it is a somewhat independent factor in health, is another fault line of health and social inequality linked to class. Currently, 12% of the US population does not have a high school diploma and 65% do not have a college degree. While 32% of white adults have a college degree, as opposed to only sixteen percent of blacks and nine percent of Latinx.

Poverty, however measured, is usually accompanied by malnutrition which in turn has a negative effect on many if not all measures of health. It certainly affects infant mortality and ultimately life expectancy. Malnutrition, with its connection to class and race inequality could very well be a significant factor regarding Coronavirus. Even some of the guidelines for who to prioritize in case of ventilator shortages will reflect class and race inequalities. An article published on CNN online on March 27, reported on a letter that held that “patients with severe heart, lung, kidney or liver failure, severe trauma or burns, or terminal cancers may be ineligible for a ventilator or ICU care. These patients will instead receive “pain control and comfort measures.” These conditions are far more prevalent in lower income strata and communities of color.

Access to Health Care

The United States is the only country of the global north without a universal health care system.

In the US the poor and near poor are most likely not insured as most people in the US receive health

insurance at workplaces with over 250 employees, and workers of color are more likely to work in smaller businesses that do not offer insurance. Theoretically, unemployed, underemployed, and workers working in small businesses exempt from the ACA would qualify for Medicaid, but many are excluded in part because Medicaid has been cut and Republican governors have refused federal offers to expand it.

Since lack of regular access to health care compromises overall health and likely weakens the immune system, layers of the population without regular access to health care can be expected to be more susceptible to getting sick from the virus and to experience its worst effects.

Restricted access to health care would seem therefore to be a major reason for health inequalities along class lines, and certainly plays a big part in class and health disparities. However, sharp health inequalities exist in other highly stratified capitalist countries of the global north, all of whom have some sort of universal health system. It was recently reported In England, a country with universal health care and GINI index lower than the US (.35 as opposed to the United States's .49) but still substantial, that the high-income strata in England live *ten years longer* than working people and the poor. The reasons for this are multiple and cannot all be analyzed here, but the English example points to the great depth and breadth of the destructive nature of and deep unfairness of class inequality.

The lack of a universal health care system in the US is both an expression of the great class inequality in the United States and a cause for the poorer health of the working class and poor. But, the example of England with its ten-year life expectancy gap from rich to poor attests to the depth of inequality in the sharply stratified societies of contemporary neo-capitalism. All of this means that being poor, a person of color, and/or a wage earner is an occupational health hazard in “normal” times, and even worse in the current crisis, a deep indictment of neo-liberal capitalist society. The much-touted high-quality Italian health care system had been subject to neo-liberal style cuts to public health for years in ways that badly aggravated the COVID-19 crisis.

According to a recent article on the crisis in Italy:

Our health care system was ravaged by a decade of funding and provision cuts, leaving it a shadow of its former self. 37 billion euros were cut and more than 70,000 beds vanished into thin air. ICU beds amount today to just 5,090, while the Ministry of Health states 2,500 more ICU beds are needed to tackle the crisis. The beds to population ratio is currently 3.6/1000, down from 5.8/1000 in 1998. . . .

Last but not least here, as neoliberal cuts were being implemented, the system was increasingly fragmented into regional management, breaking up state management and hampering national funding system. This resulted in economically stronger areas getting more resources while weaker areas fell behind. Worse, in recent years, public financial support has flowed into a growing private health care system. Thus, the Italian healthcare system was not well equipped to respond to the crisis when it hit. Even after all this, the Italian health system's greatest strength lies in still being a single-payer system . . . (Zecca, 2020).

Similar deep budget cuts to public health systems have also happened in Britain, France and elsewhere in previously social democratic “cradle to grave” welfare states that are now overwhelmed with Coronavirus patients.

The deadly combination of deep social inequalities, structural health care inequality, and neo-liberal

cuts to the health care systems in the richest countries of the global north that the COVID-19 epidemic has revealed, powerfully underlines the necessity and timeliness of the central points of Bernie Sander's program in his presidential campaign: universal health care and a redistribution of wealth and income through progressive taxation of the 1, 10, and 20%. His proposal for free college education is also essential because as has been suggested here education is also closely linked to health.

While a social democratic program would address the twin problems of income inequality and lack of a universal health care system, the tight connections between class inequality and health outlined here show that it is the existence of class divisions and therefore class society itself that inevitably denies the majority of society the means to healthy lives. The class inequalities that the COVID-19 crisis will expose means that only the elimination of penury and the drastic shrinking of social inequality, conditions which can only occur under socialism, can provide safe and healthy lives for all of the planet's peoples.

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