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Global Disparity and Solidarity in a Pandemic

by ANITA HO and IULIA DASCALU

One of the recurring phrases we hear in the current pandemic is that “Covid-19 does not discriminate.” The ravaging global transmission reveals that SARS-CoV-2 knows no racial, ethnic, gender, or national borders. Nonetheless, the complex web of social determinants of health, such as poverty and living conditions, can lead to unequal risk of Covid-19 exposure and inequitable access to care. Moreover, how we respond to the pandemic may exacerbate the burden of infection and mortality among certain populations at home and abroad.

While the domestic effect of structural racism and other social vulnerabilities on Covid-19 mortality in the United States has received some attention, there has been much less discussion (with some notable exceptions¹) of how structural global inequalities will further exacerbate Covid-related health disparity across the world. This may be partially due to the delayed availability of accurate and comparable data from overwhelmed systems, particularly in low- and middle-income countries (LMICs). However, early methods to procure and develop treatments and vaccines by some high-income countries (HICs) reflect ongoing protectionist and nationalistic attitudes that can systemically exclude access for people in regions with weaker health systems. What’s needed is a global coordinated effort, based on the principle of solidarity, to foster equitable health care access.

As no drugs have been approved to treat or prevent the new coronavirus, major efforts are under way in the scientific community to find effective treatments and vaccines. As of April 25, 2020, at least 864 trials related to Covid-19 have been registered to test more than 133 therapeutics.² In March, the World Health Organization launched the Solidarity Trial, a global randomized control “megatrial” of four of the most promising treatments thus far: remdesivir, lopinavir/ritonavir, lopinavir/ritonavir combined with interferon-beta, and hydroxychloroquine or chloroquine. As

of April 8, 2020, over ninety countries are participating in this megatrial.³ However, the name Solidarity notwithstanding, African countries are currently underrepresented in it. Delays in securing supplies and expertise further complicate effort for LMICs that are conducting their own trials.⁴

Given that many of the medications being used in these clinical trials are approved for other conditions, the ethical procurement and supply distribution is of utmost global health concern. A reported supply shortage of hydroxychloroquine and chloroquine has already affected five million lupus patients, who depend on this medication to manage their symptoms and prevent potentially life-threatening organ damage.⁵ The drugs were originally approved, moreover, for preventing and treating malaria. While their use has decreased over time due to the emergence of resistant malarial species in many countries, the drugs are still recommended by the Centers for Disease Control and Prevention as the treatments of choice for uncomplicated cases of malaria acquired in Central America, Haiti, the Dominican Republic, and most of the Middle East.⁶ This redistribution of life-saving medications is therefore alarming for countries that have high disease burdens and fragile health care systems. In 2018, the WHO reported an estimated 228 million cases of malaria worldwide,⁷ with most of the cases and deaths occurring in LMICs. As the Covid-19 pandemic has further lessened health resources in LMICs, the WHO recently warned that the number of deaths caused by malaria in sub-Saharan Africa could double to 769,000 this year.

Wealthy countries have been focusing narrowly on their own needs. For example, there has been a significant spike in demand for chloroquine and hydroxychloroquine because of clinical trials testing their efficacy for Covid-19 treatment and because some health systems in HICs (including the United States, France, Italy, and Israel) have provided emergency approval for the drugs’ use. Despite the lack of robust efficacy evidence, some HICs continue to stockpile in the hope of positive clinical trial results, with the United States announcing in early April that the country

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The principle of solidarity may serve as a means to guide systematic planning that can harmonize national and international responses to facilitate medical and nonmedical countermeasures to the virus.

had amassed 29 million doses of hydroxychloroquine.⁸ As multinational pharmaceutical companies pledged additional tens of millions of doses to the United States, an Australian businessman reportedly purchased over 30 million doses of hydroxychloroquine for the Australian National Medical Stockpile.⁹ As early promising results of another drug, remdesivir, prompted its manufacturer to donate its entire stockpile to the U.S. federal government, other countries may lag in benefiting from Covid-19 research advances.

HICs, in addition to stockpiling their own resources, may forcefully divert resources away from LMICs. Recently, the United States secured its hydroxychloroquine supply from India by threatening to retaliate against bans on export of the drug.¹⁰ Two-thirds of the pharmaceuticals used by global health organizations to combat HIV, tuberculosis, malaria, and tropical diseases are sourced from India.¹¹ With significant strain already being placed on the drug supply chain by the Covid-19 pandemic, additional demands from nations like the United States may threaten the supply of these key medications to LMICs.

Work is also under way to develop a vaccine for SARS-CoV-2, and there are concerns about the feasibility of supplying and distributing a vaccine to billions of people around the world. LMICs may not have the infrastructure to produce or deliver enough of the vaccine for their entire population in a short time. Their supply may therefore depend on manufacturing by HICs, differential pricing for LMICs that cannot otherwise afford the high-cost vaccines, or compulsory licensing for production of generic versions. However, since LMICs are underrepresented in clinical trial efforts, there are also concerns that socioeconomic determinants, such as health care infrastructure, access to water, food security, climate, and geography will not be adequately considered in vaccine trials, which may compromise the efficacy of produced vaccines for different regions. Moreover, HICs may prioritize distribution of a vaccine to their own population before exporting it globally, as happened in the H1N1 epidemic. Australia delayed export of the H1N1 vaccine to other countries until its projected domestic needs were met, while Canada and the United States abstained from providing vaccines to LMICs altogether in fear of shortages within their own countries.¹² If an effective vaccine is developed against SARS-CoV-2, this type of protectionist behavior by HICs would inevitably further disadvantage LMICs, leading to greater Covid-19 disease burden and mortality in parts of the world that already endure disproportionate health and socioeconomic burdens.

Facing a new virus that does not discriminate, we need a true international commitment to the principle of solidarity—highlighting our common vulnerability, our interconnectedness and interdependency, yet recognizing ongoing health inequities.¹³ The principle of solidarity may serve as a means to guide systematic planning that can harmonize national and international responses to facilitate medical and nonmedical countermeasures.¹⁴ For example, co-contributing expertise to collect, analyze, and model international data may help the global community to understand differential risk factors for Covid-19 and mitigation needs.¹⁵ Once clinical data regarding potential treatments and vaccines are available, coordinated development and needs-based distribution systems to prevent disproportionate stockpiling may help to ensure access to vaccines at a basic level in LMICs. For example, experienced global health and public-private alliances such as Coalition for Epidemic Preparedness Foundation and Gavi, the Vaccine Alliance (both founded by the Gates Foundation), may help to work with local governments and private entities to evaluate Covid-19 needs and coordinate and distribute supplies accordingly.

No nation is isolated or self-sufficient in combatting this pandemic. If HICs' strategies halt the critical medication and vaccine supply lines, people fortunate to have been treated or vaccinated in HICs may still be at risk of infection from unprotected populations.¹⁶ Collaborative and coordinated responses that ensure the protection of the world's more fragile regions promote the good of all. More importantly, a truly nondiscriminatory approach requires that wealthy nations correct the myopic attention to the needs of their own countries at the exclusion of those of LMICs.

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Duties toward Patients with Psychiatric Illness

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The Covid-19 pandemic is exacerbating long-standing problems within society and health care in the United States. One among them is the protection and treatment of vulnerable psychiatric populations. Psychiatric patients have significantly increased risks of suicide, sudden cardiac death, all-cause mortality, and being victims of violence.¹ Those with psychiatric illness receive poor medical care, and a diagnosis of schizophrenia reduces life expectancy by approximately fifteen years.² Additional stigma, lack of reimbursement parity for psychiatric conditions, and a shortage of mental health workers further contribute to their vulnerability.

Patients with severe and persistent mental illness are often less able to advocate for themselves as a function of their symptomatology.³ Disorganized speech, inappropriate affect, ambivalence about treatment, and difficulty trusting

providers may lead to poor communication and misunderstandings. Comorbid substance use may further complicate their conditions and care. Neurocognitive impairments and negative symptoms such as lack of motivation, poor judgment, and impaired executive function may limit their ability to navigate a complex health care system. Many patients with severe and persistent mental illness face additional barriers, including poverty, marginal housing, and food insecurity, and the many challenges that come with any of these factors.

The U.S. health care system is attempting to improve health care access during the pandemic, and its primary strategy has been a rapid expansion of telehealth. The therapeutic potential for telehealth services for mental health care may create new outpatient treatment options for some populations. Tele-mental health care offers both monitoring and delivery of intensive treatment outside of the hospital and is easily scalable. However, the efficacy has yet to be demonstrated, and it may not reach the most vulnerable populations due to lack of Internet access and technological

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