BLUE PAPER RESEARCH GRANT:

HEALTH DISPARITIES & HEALTH EQUITY

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ABSTRACT

Martin Luther King Jr. once said, "Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane."[1] This paper explores why health disparities and inequities exist in healthcare, and how where you live, your protected class and your status as an incarcerated person can impact the quality of healthcare you receive, or if you receive it at all. Especially during a worldwide pandemic, the idea of health disparities and inequities comes to the forefront. The Center for Disease Control (CDC) has stated that "Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19."[2] It goes on to suggest five factors which contribute to this disparity in risk: discrimination, healthcare access and utilization, occupation, wealth gaps in education and income,, and housing.[3] While the CDC suggests these as factors that apply to racial disparities in COVID-19 outcomes, these factors also tend to be applicable to members of other protected classes, such as persons with disabilities and the elderly. However, the most important factor is where a person lives – that factor is likely to be related to all the other risk factors. This research focuses on how where you live and the systematic inequities informing that location affect the quality of healthcare you receive. It then discusses how those factors relate to COVID-19 and the burden of infection on marginalized populations.

[1] Dr. Martin Luther King Jr., Second National Convention of the Medical Committee for Human Rights (March 26, 1966).
[2] Center for Disease Control, *Health Equity Considerations and Racial and Ethnic Minority Groups*, CDC (Jul. 24, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.
[3] *Id*.

WHERE YOU LIVE

INTRODUCTION

There are many factors which affect disparities in an individual's overall health and healthcare. These barriers include race and ethnicity, socioeconomic status, and perhaps most impactful, a person's geographic location. A person's geographic location can not only affect a person's access to healthcare services, but can also directly affect his or her quality of health through myriad factors. A healthcare or health disparity is a difference in the likelihood of negative health outcomes, specifically, "differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care."[4] These disparities have been shown to exist more frequently among different population groups which "may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, and geographic area of residence."[5] Researchers Stratton, Hynes, and Nepaul point out that these disparities "refer to those *avoidable differences* in health that result from cumulative social disadvantages.(emphasis added)"[6]

These protected classes tend to inform one's geographic location, or in other words, where one lives. Not only may one's protected class inform one's geographic location and by proxy his or her socioeconomic status, but in many cases one's geographic location is directly related to socioeconomic status. In a recently conducted study, researchers looked at the spread of influenza and concluded that those with lower socioeconomic status (SES) disproportionately bear the burden of infection; "The lower an individual's socioeconomic position, the higher their risk of poor health in low, middle, and high-income settings alike."[7] The researchers go on to claim that "health disparities are expressed geographically […] The association between health and socioeconomic prosperity has a long history in the epidemiological literature."[8]

In looking at data about the spread of influenza, as well as the link between health and socioeconomic prosperity, it is easy to analogize this data to the COVID-19 pandemic and make the assertion that those with lower SES have and will continue to bear the burden of transmission of the virus. This has not only been demonstrated in the infection rates as will be discussed below, but by healthcare inequities in testing sites. One study asserts, "reduced geographic access to SARS-CoV-2 testing sites is associated with sociodemographic factors that, in turn, are

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[4] Alison Stratton, et. al., Issue Brief: Defining Health Disparities, Hartford, CT: Connecticut Department of Public Health, 1, 2 (Summer 2007).
[5] *Id.*
[6] *Id.*
[7] Casey M. Zipfel & Shweta Bansall, Health inequities in influenza transmission and surveillance, 1,1 (Aug. 4, 2020) https://www.medrxiv.org/content/10.1101/2020.03.30.20048017v2.full.pdf.
[8] *Id.*

linked to poor structural access to care and health outcomes."[9] Essentially, because of 'where you live' and systemic disparate healthcare access, you may not have access to testing for the virus and thus may be more likely to become infected, transmit, or die from the virus due to lack of treatment.

PRACTICAL APPLICATION & REAL LIFE EXAMPLES OF HEALTHCARE DISPARITIES AS IT RELATES TO PROTECTED CLASS

RACE & COLOR

Racial segregation has always been a part of American history but took a more subtle and pernicious turn with the introduction of the government-sponsored practice of redlining. Redlining is the "practice of withholding mortgage credit from an entire neighborhood," and by proxy segregating the neighborhood into mostly Black people and People of Color.[10] During the same period the Home Owners Loan Corporation (HOLC), "evaluated neighborhoods for loan viability" by assessing "residential neighborhoods to record their upkeep, and to make note of who lived there.[11] Neighborhoods with high scores were considered better bets for mortgages."[12] These grading systems effectively segregated neighborhoods into mostly Black and other people of color, and removed the funding that was essential to improving the neighborhoods.[13][14] This practice was made illegal by the Fair Housing Act of 1968, but at that point the damage was already done.

In his research, Dr. Cato Laurencin points out that "A significant proportion of the Black population (at least one-third) resides within only a few cities and towns in Connecticut (a state that has over 150 cities and towns)." [15] People who, "live in close communities," are at

[9] Benjamin Rader, et. al., *Geographic access to United States SARS-CoV-2 testing sites highlights healthcare disparities and may bias transmission estimates*, Journal of Travel Medicine, 1, 3 (May 12, 2020).
[10] Amy C. Kantor & John D. Nystuen, De Facto Redlining a Geographic View, 58, Economic Geography, 309, 309 (1982) (discussing the practice of redlining as a way to exclude minorities from home ownership in certain neighborhoods).
[11]Susan Campbell, *What Redlining Did to Connecticut's Impoverished Neighborhoods,* WNPR (Apr. 19, 2016), https://www.npr.org/post/what-redlining-did-connecticuts-impoverished-neighborhoods.
[12] *Id*.
[13] *Id*; John Kimble, Insuring Inequality: The Role of the FHA in the Urban Ghettoization of African Americans, 32, Law & Social Inquiry, 399, 399 (2007) (discussing how the FHA segregated American neighborhoods based on race).
[14] James W. Loewen, Sundown Towns: A Hidden Dimension of American Racism vii (The New Press 2018) (2018).
[15] Cato T. Laurencin & Aneesah McClinton, The COVID-19 Pandemic: a Call to Action to Identify and Address Racial and Ethnic Disparities, 7 Racial and Ethnic Health Disparities 398, 399 (2020) (discussing how the distribution of racial minorities in Connecticut towns and cities exacerbates health disparities).

substantial increased risk for "an infectious agent […] to spread amongst [these] group[s] due to proximity."[16]

The median wealth of a Black American household is $11,030. The median for white households is $134,230. (*See Image 1*). Studies have shown that those in lower income communities do not have the same access to quality healthcare.[17] In fact, "Poor neighborhood conditions may put children at risk for developmental delays, teen parenthood, and academic failure, resulting in long-term implications throughout life . Factors such as access to healthy foods and the safety of the environment will determine a neighborhood's influence on the residents' health."[18]

Dr. Laurencin's research suggests that "[t]he culmination of Blacks maintaining greater disease burden, higher poverty rates, limited health care access, higher rates of jobs in service industries where they are less able to work from home with a subsequent increased exposure risk, and the unfolding spread of the virus in cities with larger Black populations is a forewarning that if disregarded may constitute imprudent action."[19]

In the time of the COVID-19 pandemic, when healthcare and especially quality healthcare is essential, "historical patterns of discrimination and neighborhood segregation surely exacerbate" healthcare disparities. [20] This is supported by the Center for Disease Control's (CDC) data which suggests that Black people are dying at a rate 2.5 times that of Whites.[21] Dr. Laurencin calls Connecticut "a microcosm of America," as demonstrated by population breakdown.[22] Citing the U.S. Census, Laurencin states, "the state is comprised of 66.5% White, 12% Black, 4.9% Asian, 0.6% American Indian/Alaska Native, and 16.5% Hispanic/Latinx."[23] Despite Black people, for instance, accounting for just over 12% of the total population, they constitute 19% of coronavirus cases and 15% of coronavirus related deaths.

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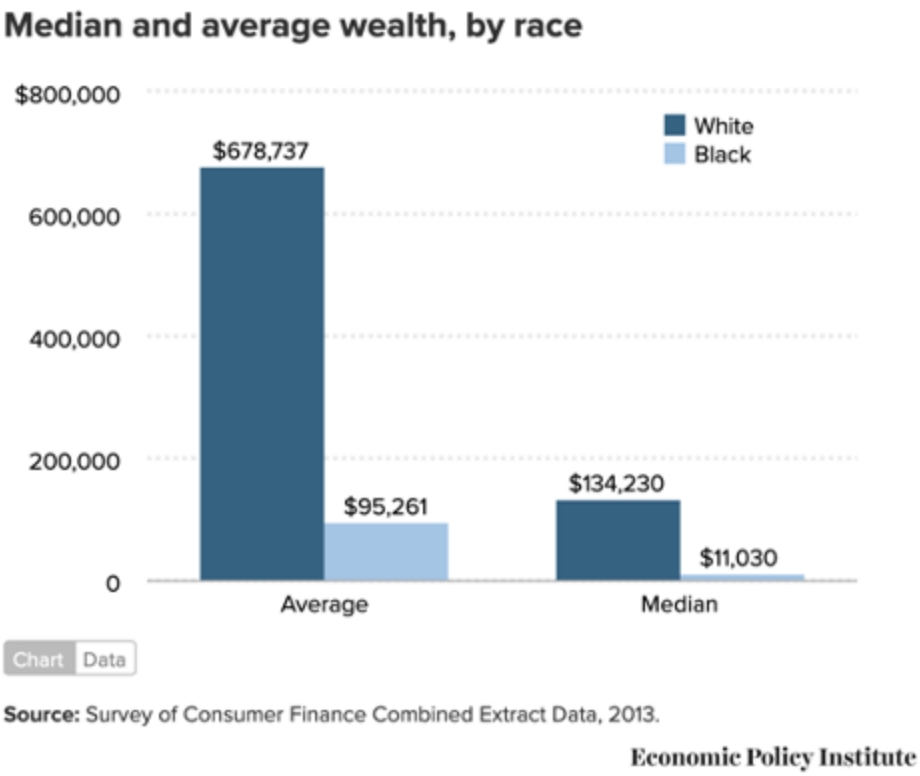
[16] *Id*.
[17] Amitabh Chandra, Who You Are and Where You Live: Race and the Geography of Healthcare, 47, Medical Care, 135, 136 (Feb. 2009).
[18] Institute of Medicine, *The Impact of Geography on Health Disparities in the United States: Different Perspectives in* Challenges and Successes in Reducing Health Disparities: Workshop Summary 7, 7 (Jennifer A. Cohen, Rapporteur 2007) (2008)
[19] Laurencin & McClinton, *supra* at 399.
[20] See D. R. Williams & C. Collins, Racial residential segregation: a fundamental cause of racial disparities in health, 116 Public Health Rep. 404, 404 (2001); See Also D.R. Williams & P.B. Jackson, Social Sources of Racial Disparities in Health, 24 Health Affairs 325, 325 (2005).
[21] COVID-19 Data Tracker.
[22] Laurencin & McClinton, *supra* at 399.
[23] *Id*.



(Image 1)

DISABILITY & AGE

Evidence of COVID-19 fatalities has shown not only that a disproportionate number of Black people and People of Color have died from the pandemic, but also that a disproportionate number of the elderly and those with disabilities have died as well. The data has demonstrated that in Connecticut, over 10,000 cases were reported in long-term care facilities, such as nursing homes, and of those, over 3,000 resulted in death; this makes up 21% of all reported cases in Connecticut, and 73% of Connecticut's deaths.[24] While only 6% of those over the age of 65 live in facilities which place them in close proximity with each other, such as long-term care facilities or nursing homes, "about 13% to 20% of people with developmental disabilities live in such settings."[25] As a result of the increased likelihood of a preexisting health condition, those who have intellectual disabilities are at higher risk for contracting COVID-19; that risk is compounded by what is, in many cases, their necessary living situation. The same is true of the elderly who are also higher risk and more likely to live in densely populated convalescent homes.

[24] KFF, State Data and Policy Actions to Address Coronavirus (2020).
[25] Joseph Shapiro, COVID-19 Infections And Deaths Are Higher Among Those With Intellectual Disabilities, NPR (Jun. 9, 2020 at 5:00 AM) (https://www.npr.org/2020/06/09/872401607/covid-19-infections-and-deaths-are-higher-among-those-with-intellectual-disabili).

NATIONAL ORIGIN

COVID-19 has compounded fair housing issues both medically (i.e. underlying health conditions and/or perceived disability) as well as based on national origin or perceived national origin protected under state and federal discrimination laws.[26] This has had a major impact on individuals whose national origin or perceived national origin is of Asian descent. The coronavirus has been widely perceived as originating from a market in Wuhan, China, causing a rapid slew of hate crimes against Asian people across the nation.[27] Since March, the organization Stop AAPI Hate has received 1,843 reports of anti-Asian discrimination due to COVID-19 including reports of incidents in Connecticut[28] In one incident, a Chinese food restaurant in Seymour, Connecticut received racist death threats from an unknown caller who threatened to shoot the owners and blamed people of Chinese descent for the pandemic.[29] In addition to the verbal and physical violence enacted against this group, Asian Americans have also been impacted financially by the xenophobia stemming from COVID-19. Prior to the nationwide shutdown of certain dining services, "restaurants across Boston's Chinatown have seen up to an 80% drop in business"[30] demonstrating the multifaceted consequences of the misinformation and paranoia about the virus. Although the U.S. Department of Health and Human Services, the Office for Civil Rights and other departments released statements condemning racist attacks against Asian Americans, as well as guidelines reasserting protections for this group, it is not enough to thwart the increased discrimination Asian people are now subjected to in employment and housing opportunities.

MASS INCARCERATION

INTRODUCTION

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[26] For example, see Title VIII, Conn. Gen. Stat. § 46a-64c et seq.

[27] Asian hate crimes: Attacks fueled by COVID-19, racism threaten Asians (usatoday.com)

[28]Press Release, Chinese for Affirmative Action & Asian Pacific Policy & Planning Council, In Six Weeks, STOP AAPI HATE Receives Over 1700 Incident Reports of Verbal Harassment, Shunning and Physical Assaults (May 13, 2020) (http://www.asianpacificpolicyandplanningcouncil.org/wp-content/uploads/Press_Release_5_13_20.pdf).

[29] Eugene Driscoll, *Update: Racist Death Threats Lodged Against Seymour Restaurant*, Valley Independent Sentinial (Apr. 5, 2020) (https://valley.newhavenindependent.org/archives/entry/update_racist_death_threats_lodged_against_seymour_restaurant/).

[30]Press Release, United States Commission on Human Rights, The U.S. Commission on Civil Rights Expresses Concern Over Growing Anti-Asian Racism and Xenophobia Amid the COVID-19 Outbreak 1, 2 (Mar. 20, 2020) (https://www.usccr.gov/press/2020/03-20-Racism-and-Coronavirus-Stmt.pdf).

Among the groups disproportionately at risk for contracting and dying of coronavirus is the prison population. Where an individual lives and their protected class has a large impact on their chances of being incarcerated and therefore denied quality access to healthcare. In his research, Dr. Laurencin that policing, and racial profiling as a part of policing, have culminated in a public health crisis which has exacerbated health disparities.[31] The mass incarceration of Black and Brown people is a direct result of increased policing, which is based in large part on where a person lives. Before the pandemic there were several long standing injustices defining America's system of mass incarceration, however, the ongoing pandemic has further exploited these shortcomings, impacting inmates in a manner that can only be described as unnecessarily cruel and inhumane.

A CLOSER EXAMINATION ON RACIAL DISPARITY & DISABILITY IN PRISONS AS IT RELATES TO HEALTHCARE ACCESS

RACIAL DISPARITY

The United States has one of the largest criminal justice systems in the world, detaining roughly 22 percent of the world's prisoners despite only representing 4.4 percent of the world's population.[32] In 2015 alone, over 6.7 million individuals were under some form of correctional control in the U.S.[33] This staggering statistic is made worse when considering the racial disparity that defines the American criminal justice system. African Americans are more likely than any other race to be arrested, convicted and to experience lengthy prison sentences.[34] According to the Sentencing Project, African American adults are 5.9 times more likely to be incarcerated than Whites.[35] The prevailing racial statistic is that one of every three Black men can expect to go to prison in their life time compared to one in six Latinos and one in every 17 White men.[36] It should be noted that racial disparities among women exist as well but remain less substantial compared to men.

A large factor as to why and how Black Americans are incarcerated at disproportionate rates involves the ways in which African American communities are policed. While many people would like to believe the cause for such disparity lies in the linkage between race and crime, the issue actually stems from the consequences of concentrated urban poverty. As previously stated, the *de facto* segregation of America's neighborhoods causes a concentration of Black and impoverished individuals. Unfortunately, the focus is placed on the high rate of Black crimes rather than the fact that communities of color are disproportionately victims of crimes and the

[31] Cato T. Laurencin & Joanne M. Walker, Racial Profiling Is a Public Health and Health Disparities Issue, 7 Journal of Racial and Ethnic Health Disparities 393, 393 (2020).
[32] Roy Walmsley, World Prison Population List, International Centre for Prison Studies (10 ed. 2013) (Nov. 21, 2013).
[33] The Sentencing Project, Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System, 1 (Mar. 2018).
[34] *Id*.
[35] *Id*.
[36] *Id*.

prevalence of racial bias in the criminal justice system.[37] In an effort to prove their ability to be "hard on crime," politicians have implemented policing policies such as "Broken Windows," "Stop and frisk," and the infamous "War on Drugs" which has done nothing more than prosecute African Americans for being Black and poor.[38] According to the ACLU, in 2010, African Americans "were 3.7 times more likely to be arrested for marijuana possession than Whites,"[39] although their rate of marijuana usage was comparable. This disparity is further demonstrated in the fact that "although African Americans and Latinos comprise 29% of the U.S. population, they make up 59% of the U.S. prison population"[40] (figure 1).

Figure 1

Race/Ethnicity	% of US population	% of U.S. incarcerated population	National incarceration rate (per 100,000)
White (non-Hispanic)	64%	39%	450 per 100,000
Hispanic	16%	19%	831 per 100,000
Black	13%	40%	2,306 per 100,000

The racial and ethnic make-up of incarcerated populations is dramatically different from that of the U.S. as a whole.
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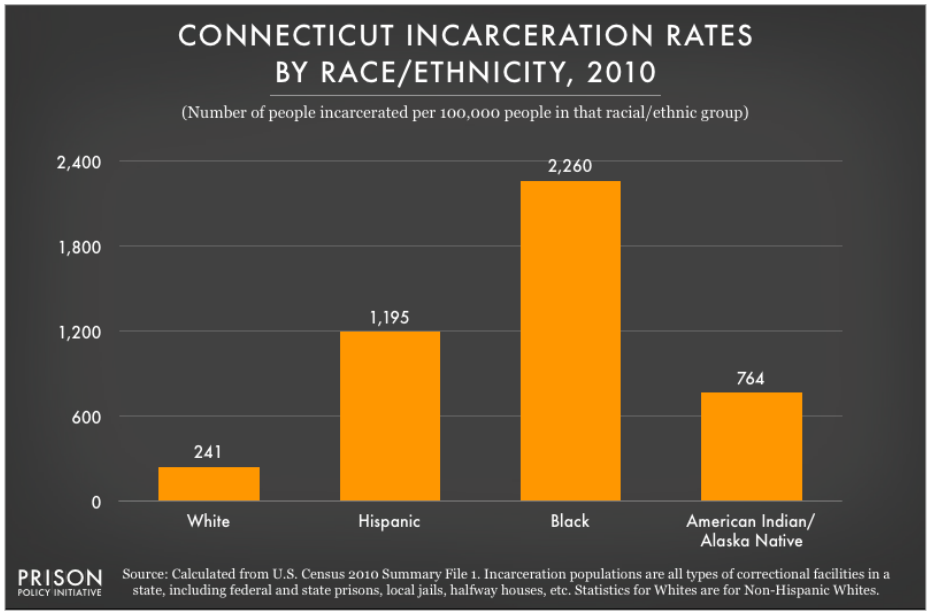
RACIAL DISPARITY IN CONNECTICUT PRISONS

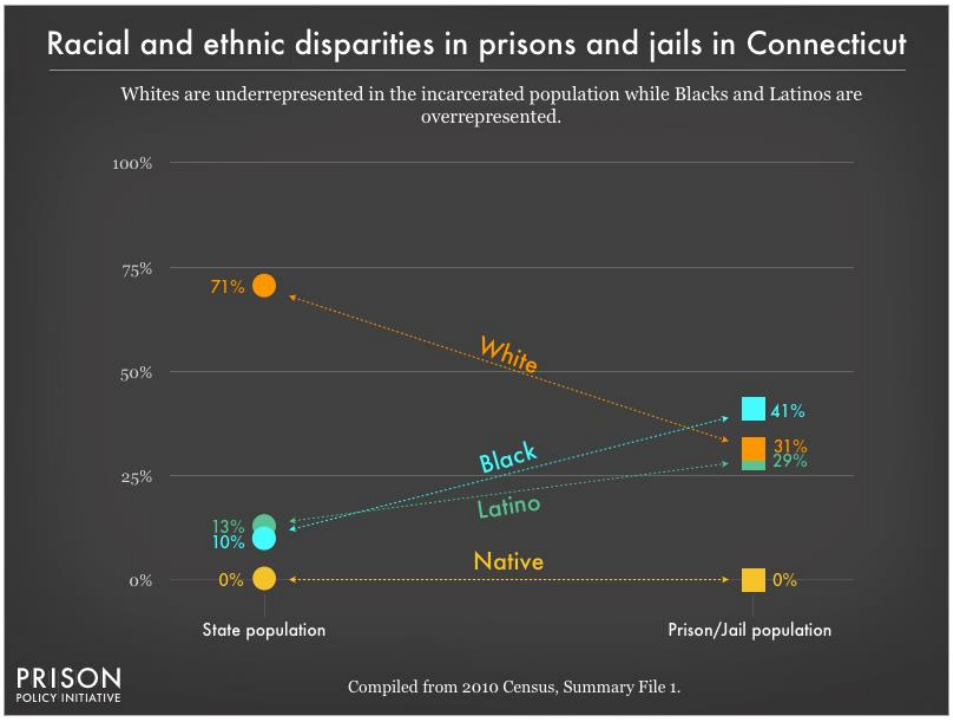
Connecticut's incarceration rate has dramatically increased over the last 40 years with a "[current] incarceration rate of 468 per 100,000 people."[41] Connecticut's incarceration system reflects many of the racial disparities seen on the national level. Black people are incarcerated at a disproportionate rate in comparison to other races as represented by figure 2. Furthermore, when compared to the total state population the disparity is even clearer. While Whites represent 71% of Connecticut's population, they only represent 31% of inmates. Comparatively, African Americans represent 10% of the state population but 41% of Connecticut inmates (figure 3).

Figure 2

[37] *Id*. at 2-3.
[38] *Id*. at 3.
[39] *Id*. at 4.
[40] *Id*. at 6.
[41] Prison Policy Initiative, Connecticut Profile (2020) (https://www.prisonpolicy.org/profiles/CT.html).



[Figure 3]



DISABILITY

People in prison are disproportionately more likely to have and develop chronic health problems such as diabetes, high blood pressure, HIV, as well as issues with substance abuse and

mental health.[42] Prisoners with pre-existing health conditions may have their health needs ignored or neglected and others may develop health problems while in prison due to unhealthy and unhygienic prison conditions as well as poor control of infectious diseases.[43] Prisons are considered to be breeding grounds for HIV/AIDS, tuberculosis (TB) and other infectious diseases with 15% of jail inmates and 22% of prisoners reported having tuberculosis, Hepatitis B and C, HIV/AIDS, or other STDs, compared to only 5% of the general population.[44]A study conducted by the National Center for Biotechnology Information (NCBI) found that "many inmates with a serious chronic physical illness fail to receive care while incarcerated." [45] This becomes a more pressing issue when considering that "nearly 2.3 million US inmates [...] must rely on their jailers for healthcare."[46] Despite healthcare in prisons being low-quality and difficult to access, it can also be expensive.[47] Most prisons charge incarcerated people a co-pay for doctor visits.[48]

COVID & HEALTHCARE IN CONNECTICUT PRISONS

Because prisons are structured to force inmates to live in close knit, controlled communities, viral infections are common among inmates, making a severe outbreak of COVID-19 within prisons imminent. From the start of the outbreak to June 22, 2020, over 570 incarcerated people and over 50 correctional staff in the United States were documented as having died due to the coronavirus.[49] Some of the largest outbreaks have been in dense correctional facilities where social distancing is impossible, sanitation is poor and medical

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[42] Nicholas Freudenberg, Jails, prisons, and the health of urban populations: A review of the impact of the correctional system on community health, 78 Journal of Urban Health 214, 217-21 (Jun. 2001).

[43] Glen Ellis, *Examining health care in U.S. prisons*, The Philadelphia Tribune, Mar. 25, 2017 (https://www.phillytrib.com/news/examining-health-care-in-u-s-prisons/article_43520055-789e-52a9-aed5-eaf1c75c7c36.html).

[44] NAACP, Criminal Justice Fact Sheet (2020) (https://www.naacp.org/criminal-justice-fact-sheet/).

[45] Andrew P. Wilper et. al., The Health and Health Care of US Prisoners: Results of a Nationwide Survey, 99 American Journal of Public Health 666, 666 (2009) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661478/).

[46] *Id*.

[47] Prison Policy Initiative, Public Health, *supra*.

[48] Ellis, *supra*.; See also Prison Policy Initiative, Public Health (2020) (https://www.prisonpolicy.org/health.html).

[49] Emily Widra & Dylan Hayre, Failing Grades: States' Responses to COVID-19 in Jails & Prisons, Prison Policy Initiative (Jun. 25, 2020) (https://www.prisonpolicy.org/reports/failing_grades.html).

resources are scarce.[50] The NAACP has reported that five of the largest known clusters of COVID-19 virus are within correction institutions.[51] Public health experts have warned that prisons and jails would become "petri dishes where, once inside, COVID-19 would spread rapidly and then boomerang back out to the surrounding communities with greater force than ever before."[52] Nationally there are more than 68,000 identified prison inmate cases of Covid-19.[53]

Within the state of Connecticut, as of April 22, 2020, the CDOC had reported 303 COVID cases among inmates and 222 cases among correctional staff.[54] Lack of concern for the improvement of healthcare for inmates during COVID is also threatening the health of healthcare workers and correctional staff who have reported that they're struggling due to lack of protective equipment. In an interview with Yale Daily News, Brett Davidson, founder and co-director of the Connecticut Bail Fund said that the correction facilities "are filthy" and that there is "no possibility for social distancing."[55] Shared spaces in correction facilities have intensified as breeding grounds for the virus making a simple trip to the bathroom or shower an opportunity for transmission. Furthermore, a correctional officer at Cheshire Correctional Institution told Yale Daily News that inter-facility transfers were still occurring with an inmate being transferred to Cheshire despite a fever of 102 degrees.[56] Furthermore, inmates are expected to purchase sanitary and hygiene supplies from the prison commissary unless their account is below $5.00.[57] Hand sanitizer itself can be considered contraband in some prisons due to its alcohol base.[58] However, even if the alcohol base could be removed, the CDC recommends an alcohol content of at least 60 percent to effectively combat COVID-19.[59] Necessary cleaning equipment such as bleach, also tends to be in short supply in prisons.[60]

Understaffing has been a persistent issue among healthcare workers in correction facilities. In a fiscal analysis published last March by the CDOC it was stated that the department had 309 nurses on staff for 12,320 inmates and one doctor or physician for every 579 inmates.[61] It is common for prisons to be short staffed or for medical staff to be diverted to care for COVID patients, leaving other inmates with medical needs unattended. Nurses are also often expected to

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[50] *Id*.
[51] NAACP, *supra*.
[52] Widra & Hayre, *supra*.
[53] NAACP, *supra*.
[54]Mira Shoaib, *UP CLOSE: Prisons hit by a pandemic*, Yale Daily News (Apr. 22, 2020) (http://features.yaledailynews.com/blog/2020/04/22/up-close-prisons-hit-by-a-pandemic/).
[55] *Id*.
[56] *Id*.
[57] *Id*.
[58] *Id*.
[59] *Id*.
[60] *Id*.
[61] *Id*.

work back to back shifts without relief for meals or breaks while their medical supplies are worn and limited.

SOLUTIONS

As a solution to the consequences of the outbreaks in prisons, many political leaders have taken the step to accelerate the release of prisoners in order to reduce the prison population. Governor Lamont and CDOC Commissioner Cook stated in a press briefing in April that the prison population had dropped by 727 people since March. However, this does not solve the issues that persist within the institution. The CDOC eventually began transferring all inmates who positive for COVID to an isolation unit at the Norther Correctional Institution in Somers, Connecticut.[62] However, for an institution that tactically uses solitary confinement as the highest level of punishment, this cannot be deemed as an adequate treatment for infected inmates. Last year, the Allard K. Lowenstein International Human Rights Clinic at Yale Law School even wrote a letter to the United Nations Special Rapporteur on Torture, to convince them to declare the DOC's use of isolation as torture under international law.[63] The Yale clinic found the condition of isolation cells at Northern to be "unsanitary beyond what could be expected in a lower security prison documenting the use of in-cell restraints and negligence that have led to individuals trapped in cells covered in their own bodily fluids."[64] Furthermore, it was stated that the CDOC is not permitting COVID-19 positive inmates in Northern to shower during their quarantine.[65]

CONCLUSION

An individual's access to healthcare not only impacts the length of a person's life, but the overall quality of that life. A person's race, national origin, ability or socioeconomic status should not determine their right live. However, during the current pandemic we are witnessing just that. An individual's protected class is the single largest determinate of where one lives and therefore their access to healthcare services. Race, national origin, disability and socioeconomic status are often barriers to accessing adequate healthcare services. Due to the structural inequities that exist, Black people, people of color, immigrants, persons with disabilities and people with low income are all at greater risk to become infected by the virus with higher fatality rates

Geographic location can also determine a person's likelihood of incarceration, especially for people of color. Urban, low-income neighborhoods highly populated with people of color tend to be heavily policed, creating a great racial disparity within the prison system. Many of the practices within prisons work to not only actively neglect the pre-existing health conditions of inmates but also to create a number of new detrimental physical and mental health issues. With the outbreak of COVID, the injustices within the prison system pave the way for the intensification of inhumane treatment of inmates who are disproportionately Black and poor.

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[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*

Despite efforts made on both a national and state level to make vital resources and services more accessible, people are still being infected and killed by the virus due to the immutable traits they possess. The disparate impact of these structural discriminatory practices will continue unless intervention occurs. However, acknowledgement of the systems of inequity that existed before COVID is essential to fully understanding the severe threat it poses to marginalized communities during the pandemic.