

Published: October 31, 2023

Citation: Muntaner C, Gunn V, et al., 2023. An Emerging Storm? Increased Health Inequities in the Context of Racialized Patriarchal Capitalism, Deaths of Despair and Covid-19, Medical Research Archives, [online] 11(10). <https://doi.org/10.18103/mra.v11i10.4414>

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DOI: <https://doi.org/10.18103/mra.v11i10.4414>

ISSN: 2375-1924

RESEARCH ARTICLE

An Emerging Storm? Increased Health Inequities in the Context of Racialized Patriarchal Capitalism, Deaths of Despair and Covid-19

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ABSTRACT

This article discusses the gradual increase in Deaths of Despair in the United States, followed by a reversal in the increased life expectancy trend for a subset of the population. This phenomenon is examined in the context of pronounced social and health inequities linked to globalization and capitalism as well as the overall negative implications of the COVID-19 pandemic and subsequent socio-economic crisis, all having the potential to further worsen health and social inequities in the US but also globally.

The development of effective and actionable solutions requires an in-depth understanding of the root causes linked to an overall decrease in population-level life expectancy. While focusing on the phenomenon of Death of Despair brings attention to the role of class in the creation of health inequities and increased mortality rates, this approach should be part of a larger examination of contributing factors. Scrutinizing the impact of other social location factors such as race, gender, age, sexual orientation and identity, migration, and citizenship status, along with their interaction is equally important. Research approaches that allow the stratification of analyses by population groups are needed to facilitate a better understanding of the observed decreases in population-level life expectancy. Such approaches require long-term and ongoing investments in research and the intentional collection of indicators that could reveal the breadth and depth of health and social inequities and the pathways through which they lead to increased mortality rates for various population groups. The sustained financial investment and efforts required to examine the causes of decreases in population-level life expectancy and to inform the implementation of protective policies that could reverse this trend have the potential to bring long-term societal dividends. An indirect outcome of the reduction of social and health inequities and the adoption of protective policies could be that individuals and populations regain their trust in social institutions and, as a result, enhance their active political participation through increased voter turnout and decreased political radicalization.

Keywords: social determinants of health, health inequities, structural systems of discrimination, excess mortality, public health, globalization, social and health politics

Introduction

This commentary article discusses the gradual increase in Deaths of Despair in the United States, in the context of pronounced social and health inequities linked to capitalism and the overall negative implications of the COVID-19 pandemic and subsequent socio-economic crisis. A case is made for the need to carefully consider the interplay of factors involved in the creation of health inequities to support the development of effective and actionable solutions.

As has happened in other wealthy countries¹ the COVID-19 pandemic has exacerbated existing health inequalities in the United States (US) as it has produced greater morbidity and mortality among the racialized working classes (Indigenous, Latinx, and Black Americans).² Yet the evidence of American exceptionalism³ is impressive, using a counterfactual approach. For instance, in the middle of the pandemic, if the US had managed mortality rates that mirrored the average of the other 21 wealthy nations (Australia, Canada, Japan, plus 18 countries from Europe), it could have avoided 1.1 million deaths.⁴ The current number of “excess deaths” in the US is also the largest since 1933, continuing an upward trend that started in the 1980s.⁴ Excess mortality is calculated by estimating the difference between anticipated and documented mortality in each period and has been used recurrently to gauge the COVID-19 pandemic’s mortality impact.^{5,6}

There is a characteristic, also unique to the US, among other wealthy nations that suggest the presence of *Deaths of Despair* (DoD)⁷⁻⁹ among the “excess death” rates: about half of these deaths occur before the age of 65, that is during working life. As defined by Case and Deaton, DoD refers to the rise in recent years of mortality from suicide, alcoholism, and drug overdoses, among working-class whites of working age^{7,10}. DoD appears to be mostly a US phenomenon since the same patterns have not been observed in Scotland, England, Wales, or Canada before or during the pandemic.^{8,11} Thus, the extent of premature mortality observed during the pandemic is particular to the US. The US excess death has been increasing since the 1980s, following a pattern like the DoD,⁷ so that between 1980 and 2021, the excess deaths reached a staggering 13.1 million. The conclusion of the Dowd et al (2022) study was that Scotland has suffered increases in drug-related mortality comparable to the US, while Canada and other UK constituent nations did not see dramatic increases questioning the utility of a generalized “deaths of despair” label.

Yet, contrary to the DoD afflicting mostly Whites, the excess deaths impact disproportionately Indigenous, Latinx, and Black Americans.^{2,4} Structural (i.e., political, economic, and cultural) racism,¹² rooted in White supremacy beliefs, creates and maintains the overall economic deprivation and political oppression affecting Black¹³ and other racialized communities. Dismantling structural racism must happen at the institutional level, including public health institutions.¹⁴ Yet, the overall US Liberal Welfare regime would need to be substantially reformed to provide health care, public health, social protection, and social determinants of health to eliminate racial and class health inequalities.¹⁵ To these longstanding social determinants of health in the US we need to add the low vaccination rates, unequal access to public health measures (e.g., masks and other protective equipment, social distancing), workplace safety regulations (stronger OSHA) and the inequities in these during the COVID-19 pandemic that affected disproportionately low-income and racialized communities.^{16,17}

Paglino et al conducted a study on excess mortality in US counties during the first two years of the pandemic.⁵ Using a Bayesian hierarchical model, they estimated monthly excess mortality in each county and compared it to official COVID-19 death counts. Their findings revealed that 23.7% of all excess deaths were not reported as COVID-19 deaths, and there were significant regional and temporal variations in reporting accuracy. The study also examined factors that influenced the differences between excess deaths and reported COVID-19 deaths, such as testing capacity, comorbidities, and demographic characteristics. It provided the first-ever monthly estimates of excess mortality rates for every US county during the first two years of the pandemic. Interestingly, between the first and second year of the COVID-19 pandemic in the US, excess deaths decreased in large metropolitan counties and increased in rural counties. The high excess death rates that initially affected large metropolitan areas in the Northeast and Mid-Atlantic regions began to shift to rural areas in the South and West as early as August 2020, with the sharpest increases occurring during the surge of the more contagious Delta variant in the spring and summer of 2021. So rural areas continued to experience a significant burden of excess deaths throughout the second year of the pandemic when vaccines were already available. The rural areas with the highest cumulative excess mortality by February 2022 were in the South and in the West.

Rural excess deaths can be explained by a failure of public health preparedness, policies and interventions to protect its populations, including counties without public health departments.¹⁸ Rural areas already suffered from health inequalities compared to metropolitan areas in major causes of mortality such as cardiovascular disease¹⁹ and Covid-19 exacerbated these inequities.²⁰ In addition, lack of public health infrastructure, misinformation, vaccine hesitancy or skepticism, opposition to the government that expanded to public health recommendations, and partisanship also played a role in rural-urban inequities.⁵ While for most rural communities, misinformation played a key role in vaccine hesitancy and increased mortality rates during the pandemic, racialized communities, including rural Black and Latinx American communities, suffered from a lack of access to health care, which constituted an important component of their excess in mortality rates. However, in Arizona, Indigenous people manifested high excess mortality despite access to vaccines, pointing to a range of other factors impacting health outcomes, besides vaccine access issues.

The specificity of Deaths of Despair

It appears that the DoD phenomenon is characteristic of the US in recent years because these epidemiological trends of alcoholism, overdose and suicide deaths have limited generalizability to other countries.¹¹ Several populations, including Indigenous, Black, Latinx, and working-class White Americans, account for the recent increase in mortality in the US, although with different trajectories, diseases and underlying causes.^{7,22} While some countries may exhibit patterns like the DoD (e.g., the Scottish opiate overdose epidemic) they do not necessarily reproduce the mortality triad and have different underlying causes.¹¹

Looking at social epidemiology as a social science helps accept the difficulty of generalizing a contextual, historical phenomenon like DoD²³ while simultaneously searching for regularities.²⁴ The hopelessness experienced by US middle-aged White American populations without a BA degree goes beyond the effects of being unemployed. After two centuries of social and health progress, this population experienced declining living standards destroying expectations of continued economic melioration and global leadership.²⁵ The resulting DoD bears some similarities to the anomie and alcoholism epidemic experienced by Russian workers with lower educational credentials after the sudden fall of the Soviet Union.²⁶

An emerging storm threatening to further worsen health and social inequities

The gradual increase in DoD in the US, followed by a reversal in the increased life expectancy trend for a subset of the population, along with pronounced social and health inequities linked to globalization and capitalism, as well as the overall negative implications of the COVID-19 pandemic and subsequent socio-economic crisis, all have potential to further worsen health and social inequities in the US but also globally. Consequently, these issues require close attention.

Examining the phenomenon of DoD is important because it brings attention to the role of class in the creation of health inequities and increased mortality rates. However, an in-depth understanding of the root causes linked to an overall decrease in population-level life expectancy—needed for the development of effective solutions—requires equal attention to the impact of other social location relations such as race, gender, age, sexual orientation and identity, migration, and citizenship status, and their interaction.²⁷

The complex consequences of globalization and the increasingly acknowledged failures of capitalism need further examination as they are linked to an upward redistribution of capital, a reconfiguration of forms of work, and weakening of social and health services and protections, all with negative implications for health outcomes, especially for population groups at increased risk of being affected by discrimination and oppression.

One approach is to consider DoD as fundamentally a Public Health problem rooted in the availability of cheap and addictive compounds such as Fentanyl. Prevention of overdoses due to toxicity combined with reduction of supply via intersectoral action and demand with Public Health interventions would reduce the number of DoD substantially. The anomie and the economic problems of the population, the root cause would not be affected, but fundamental mechanisms to translate “despair” into mortality would be prevented.

Last, but not least, the long-term impacts of the COVID-19 pandemic and the outcomes of response and recovery initiatives need further investigation.

Implications for research, policy, and politics

While the mechanisms impacting health outcomes and causing social and health inequities may differ among population groups, there are many

similarities in the lived experiences of groups who have been historically excluded from decision-making and denied access to resources that facilitate health. It is only through stratified analyses that researchers could better understand these lived experiences and grasp the breadth and depth of health and social inequities and the pathways through which they lead to increased mortality rates for various population groups. However, such analyses are not possible without consistent and long-term financial investments in research along with an intentional collection of indicators that allow the disaggregation of analyses by population group.

The research results could, in turn, be used to inform the adoption of both health and social policies that address the identified gaps and offer the needed protection for individuals and population groups. An indirect outcome of the adoption of protective

policies and the reduction of social and health inequities could be that individuals and populations regain their trust in social institutions and, as a result, enhance their active political participation through increased voter turnout and decreased political radicalization.

Conclusion

Achieving health equity requires complex approaches including the dismantling of structural systems of exploitation, domination, discrimination, oppression and adoption of protective health and social policies. Intersectoral and enduring action is required in the context of existing inequities linked to capitalist globalization, an increase in deaths from suicide, alcoholism, and drug overdoses, and a range of negative implications of the COVID-19 pandemic and subsequent socio-economic crisis, all of which have potential to further worsen health and social inequities in the US but also globally.

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