



# COVID-19: The Challenge of Disadvantaged Groups and their Access to Care

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## Dear Editor,

A novel coronavirus called COVID-19 was first detected in Wuhan, China, in late 2019. Since then, it has been spreading relentlessly around the world and has developed into a pandemic.<sup>1-3</sup> In a concerted effort, many countries have deployed and mobilized all their resources to stem the spread of the virus, provide their patients with optimal care, and minimize its impacts on healthcare institutions, social service sectors, and the economy.<sup>3</sup>

One key element in avoiding or minimizing serious outbreaks is ensuring that people, in particular the disadvantaged, have access to adequate healthcare.<sup>4,5</sup> As the socially and economically disadvantaged groups have to face challenges in terms of geographic accessibility of healthcare services, unsuitable services from a cultural perspective, financial restrictions, low levels of health knowledge, and language constraints, which hamper their efficient utilization of health services, they are especially vulnerable to this disease.<sup>6,7</sup> Add to the list their unawareness of the currently available health resources and lower levels of competency to be covered by health insurance, which limits their access to proper health services even more.<sup>6</sup> Homeless people, scavengers, disabled individuals, those without an official identity card or documents, refugees and illegal immigrants are more likely to adopt a cavalier attitude toward their medical needs and health. If history is any guide and current reports about epidemics are to be trusted, one thing is a given: poverty, social inequality, and an imbalance in the distribution of health services provide fertile ground for the easy spread of the virus, culminating in tragic mortality and morbidity rates.<sup>8</sup> Racial and socioeconomic disparities in an emergency like the COVID-19 outbreak significantly determine both the course of a disease but also who is to be hit the hardest.<sup>8</sup>

Yet, to date, studies on underprivileged social groups are scarce to directly investigate the differential effects of disease outbreaks on them. It is clearly evident that there is no equitable response to COVID-19.<sup>9</sup> This is despite the common knowledge that governments are not likely to

stop, even slow down, the transmission of the COVID-19 virus, prevent deaths, and mitigate economic impacts without taking care of the health of these vulnerable groups.

In this regards, generally, there are different strategies for health systems to reduce inequalities in access to health care. For instance, the European Social Policy Network (ESPN) analyzed reports of 35 ESPN countries and provided main recommendations to them to guarantee better access to healthcare. It included sufficient public funding for health systems, improving health coverage, protecting individuals from user charges, increasing the availability of health services, avoiding financial support of voluntary health insurance scheme and targeting vulnerable groups.<sup>10</sup>

In the current crisis, considering the economic impacts of the COVID-19 pandemic on individuals, particularly those in low-income groups, the first and foremost option to guarantee access to COVID care is targeting and protecting disadvantaged people from user charges.

In Iran, although many attempts have been made by policy makers to manage the COVID-19, more policy attention is required across the society to overcome the outbreak, save more lives and also assure equitable access to care.<sup>11</sup> One such area is vulnerable groups. In this way, one of policies adopted by the Iranian government and healthcare system is ensuring that all individuals, particularly the disadvantaged, have equal access to healthcare. More specifically, there were two policy options:

## 1. Providing Poor Patients with Healthcare Services Related to COVID-19 for Free

In this scenario, suspicious cases, even those with no official identity documents and basic insurance, are admitted to hospitals and treated for free. This would encourage more and more disadvantaged individuals to seek healthcare. According to the statement by the Ministry of Health and Medical Education (MOHME) in public hospitals, the average out-of-pocket payment by

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patients in a general ward and for ICU care is 2 000 000 and 4 500 000 Iranian Rials, respectively.<sup>12</sup> Considering the admission rates of 85% and 15% for public and private hospitals in COVID-19 patients, 20% rate of ICU admission and also fourfold ratio of private to public health expenditure, if COVID-19 patients pay nothing for all hospitalization care, the additional financial burden imposed on the government for 100 000 patients will amount to 360 billion Iranian Rials in total for those admissions, approximately – of course, after deducing subsidies and insurance costs.

## 2. Providing Poor Patients with Healthcare Services Related to COVID-19 by Case-by-Case Assessment

If we assume this scenario and free user charge for disadvantaged groups through by case-by-case assessment through hospital assistance departments (*Madad-kari*), a sharp decrease would be almost inevitable in homeless people, refugees and illegal individuals seeking healthcare services. Assuming R-Zero value range-attack rate between a minimum of 1.4 to maximum of 4, as often these groups live in crowded places with low levels of hygiene, the virus spread can be wild. In this case, between 1.4 to 4 people may be infected and the imposed cost will be higher. Moreover, uninsured people who seek healthcare from private hospitals will be faced with astronomic expenses as a result of banning them from referring to the private sector. So, even in case the capacity of government hospitals is filled, the payer would not accept the charges of referral to the private sector. If they refer, they will be faced with exorbitant costs; if they wait, they could infect others, particularly family members.

In brief, although determining required resources and the rate of transmission call for epidemiological simulations, thorough estimations, and more empirical research, given the high transmission rate of this disease, we believe that if the Iranian healthcare system or any other healthcare system, for that matter, goes by the first scenario, governments can save much more compared to the case-by-case scenario. Adopting the first scenario can also go a long way toward mitigating social inequality. Therefore, providing financial protection for the underprivileged is not only a sound economic decision, but it is also ethical and helps address the outbreak more adequately. Although this recommendation can be applied to the current outbreak of COVID-19, it does not have to stop there; governments can benefit from this policy in future outbreaks of infectious diseases.

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## Authors' Contribution

MZ, LZ, and NM: participated in the conception and design of the study. MZ and NM: had contributed to the acquired data. LZ, NM and AR: were drafted the manuscript. NM, LZ, and KB.L: had revised the manuscript critically for important intellectual content. All authors read and approved the final manuscript.

## Conflict of Interest Disclosures

The authors declare that they have no conflict of interest regarding the publication of this study.

## Ethical Statement

Ethics approval was not required for this study.

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