

# Elites can take care of themselves — Comment on *COVID-19: the rude awakening for the political elite in low-income and middle-income countries*

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Political and economic forces, both internal and external to low-income and middle-income countries (LMICs), have shaped the health and well-being of people across much of the Global South. Like in other regions of the world, corruption for private gain, including in health systems, has impeded the development of a welfare state and has thus cost lives in Latin America.<sup>1</sup> It may be true that political (and we add economic) elites have the ability to receive the best possible care outside their countries, nevertheless, COVID-19 has definitely not diminished privileges locally.<sup>2</sup> In fact, while they would previously seek high-end medical attention in the USA or Spain, today, in countries such as Ecuador, these elites might be just as catered for at home. Even in the midst of the pandemic, they are able to secure medical resources that are not available for everyone, for instance, through private health or prepaid care insurance companies offering a range of services from basic to five-star' services, depending on the customer's ability to pay.

After the major port province, Guayas, became the first COVID-19 epicentre in Ecuador in mid-March, it was widely reported in the media that its elites forced their hand to continue as usual when it was widely known that the virus was circulating. In addition to migrants returning from countries such as Spain to visit family, gatherings with recently arrived vacationers became another likely source of contagion not only among attending elites but also service workers catering to these events. Some of these families even skipped mandatory quarantine from a luxury hotel using a private doctor's note during national lockdown after landing back from Europe.<sup>3</sup>

## Summary box

- ▶ The COVID-19 pandemic has exacerbated pre-existing inequities in low-income and middle-income countries without robust universal health coverage, placing marginalised and vulnerable populations at higher risk.
- ▶ Access to healthcare has been limited in Ecuador, where more than 8000 excess deaths were registered in April, while supplies and services are available through private insurance or out-of-pocket payments.
- ▶ Political and economic elites may also avoid restrictions and profit from the emergency, making evident that vulnerability to the disease cannot be reduced to biological risk.
- ▶ We must continue to make the case for responsible health governance and a greater share of financing by the elites for universal primary care to be accessible regardless of ability to pay.

Concurrently, the emergency was already exacerbating pre-existing inequities in the healthcare system and broader society in Ecuador. At the beginning of the pandemic, public hospitals had only about 20 intensive care units per million people compared with twice as many in Costa Rica, and an oxygen tank could cost US\$240 in a country where the average minimum wage is US\$400. Moreover, private hospitals and clinics located primarily in the three major cities in Ecuador (Guayaquil, Quito, Cuenca) have more intensive care beds than public facilities. Accessing them and staying as many days as may be required to be treated for COVID-19 demand being able to make large out-of-pocket payments or to have high-end health insurance, or both.

If anything, it has become increasingly evident that the burden of COVID-19 is felt very differently along class, race and gender in LMICs, similarly to high-income

countries like the USA or the UK. On one hand, non-communicable diseases (eg, cardiovascular disease) have a disproportionate impact on marginalised populations,<sup>4</sup> further impoverishing them in a vicious cycle that influences the impact of COVID-19, not the least because these comorbidities place them at greater risk. On the other hand, in the absence of a proven treatment or vaccine, physical distancing, a key preventive measure, plays largely differently in these populations. Shelter-in-place measures are challenging for families living in crowded conditions in multigenerational homes and, frequently, domestic violence, while working members have little opportunity to work or find work remotely. According to the most recent WHO report, 2.1 billion people do not have safe drinking water at home and 4.5 billion lack proper sanitation. Washing hands periodically, another recommended measure, can be an impossible luxury for families that must ration water for more essential needs (eg, cooking and drinking).

When the pandemic disrupted livelihoods across the globe, political and economic elites retreated to their large primary residences, second (or third) homes, with enough space and resources to shelter comfortably in place, or avoided quarantine without major consequences. For others, properly isolating and caring for oneself or other often vulnerable family members with COVID-19, especially in single-room households, may be more difficult or outright impossible. Even once infected, as has been the case for a number of elected officials, the prognosis is much different. From news reports, we know that most of them have or are in the process of recovering from the disease, having had the 'good fortune' of getting tested early and procured the best possible care at their disposal. Conversely, that is not the reality of much of the population in LMICs, as shortages of testing are commonplace, except if, like in Ecuador, one is able to pay up to US\$120 to a private laboratory.

As an example, official figures show that rural parishes in the Metropolitan District of Quito, the capital city of Ecuador, have only 1.7 health personnel per 1000 people but urban areas have 5 per 1000. Tumbaco, one of the rural parishes with the highest number of confirmed COVID-19 cases in Quito, had 62 cases in about 60 000 people on June 1; in contrast, the urban parish Ponceano, with roughly the same population, had only six cases. While Ponceano is at the top quartile of health results, Tumbaco is at the bottom quartile, when in Ecuador the urban poverty rate is 17.2% and the rural, 41.8%.

COVID-19 has pulled up the curtain on the extent of outstanding societal and healthcare challenges. While the biological susceptibility to infection may be generalised, the economic and social susceptibilities are by no means equitably distributed across the population. The contention that elites in LMICs 'have no other choice but to experience the same weak and ill-equipped

health system that they perpetuated'<sup>2</sup> actually feels like a slap in the face for countries that do not have a robust universal health system, such as Costa Rica,<sup>5</sup> because this can mean the difference between life and death, between a healthy future or dire health consequences. Correspondingly, the pandemic has revealed other inequities across many LMICs: unemployment is soaring and quality online education during school closures is an option only for the higher echelons of society—and we are not even fathoming the return to crowded classrooms with limited sanitary resources.

In Ecuador, private companies have profited immensely from the state through external provision of services and supplies, when more cost-effective investments should have been made at the primary care level—where the pandemic response is more likely to succeed. Further, during the pandemic at least 23 cases of corruption in public hospital purchases have been identified by the National Anti-Corruption Commission. Precisely because it is the case that more unequal LMICs are 'showing their true colours',<sup>2</sup> we must continue to make the case for equity-based responsible governance and investing in health systems, expanding quality and timely health coverage to all segments of the population, instead of drawing a smokescreen by depicting the elites as vulnerable. Even if we focused solely on internet connectivity together with health literacy or even literacy in general as a leverage for improved outcomes, elites do not need to travel far to be better off. They already have continuous access to knowledge and may be better able to discriminate it from misinformation and apply it to their well-being.

It is a testament to the impact of inequality during the pandemic that political elites can make the news more predominantly than individuals whose lives have been devastated by COVID-19. Only in the Guayas province, not considering population growth, in April 2020 there were 8838 more deaths than in April 2019, which registered only 180 more deaths than in April 2018. Biological risk of contracting an infectious or any other disease must never be equated with social and economic vulnerability. On the contrary, biological risk alone cannot account for the real toll COVID-19 will claim on the vast majority of LMICs populations.

Ultimately, a progressive framework must guide social and healthcare policy, so that lower-income people across LMICs can readily access health promotion, disease prevention and curative care services during the COVID-19 pandemic and beyond. Moreover, we must require the elites to contribute a larger share of financing quality universal primary healthcare systems that care for all regardless of ability to pay. This approach entails also moving away from a hospital-based industrial complex model that only further enriches the elites, many times through obscure business arrangements.

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