Health Equity

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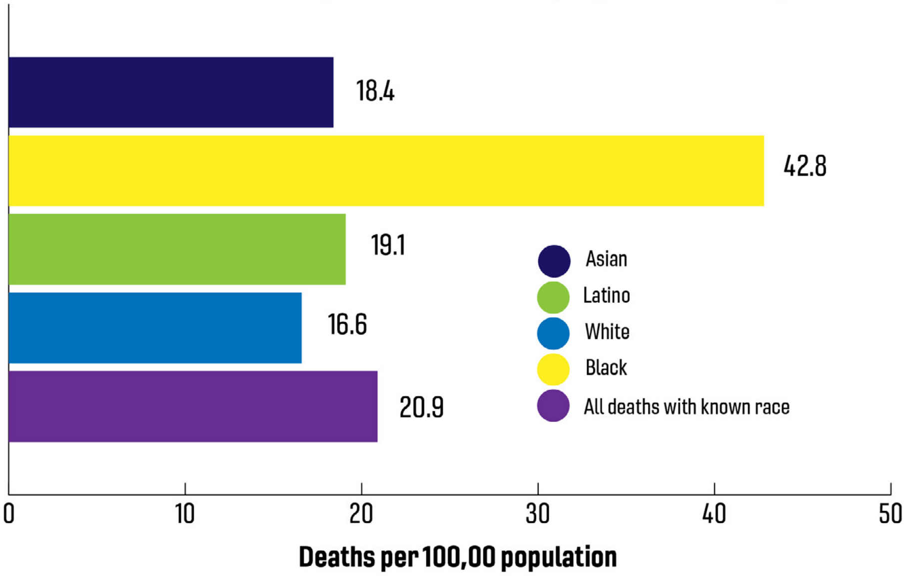
Prepared by:
Shari Barkin, MD, Kecia Carroll, MD, Velma McBride Murry, PhD, Melissa McPheeters, PhD, Adriana Bialostozky, MD, and Neely Williams, M.Div., along with
Health Policy & Public Health COVID-19 Advisory Panel
Department of Health Policy
Vanderbilt School of Medicine

Addressing the COVID-19 Health Equity Chasm

In cities all across the country, ranging from New York to Nashville, COVID-19 cases and deaths are over-represented in racial/ethnic minority populations, including Blacks/African Americans and Latinos.

COVID-19 Deaths per 100,000 population by race, U.S.



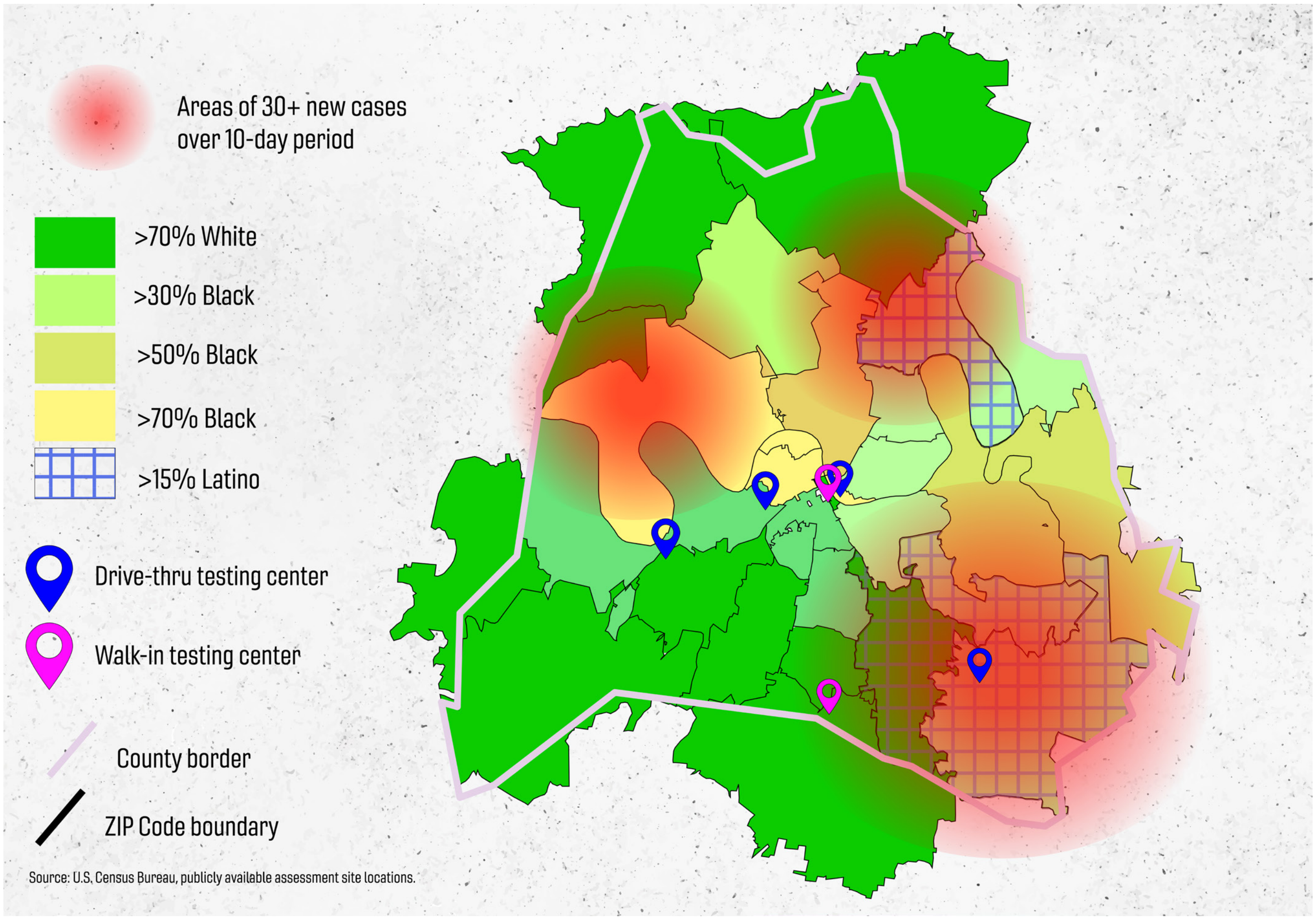
Source: APM Research Lab, COVID-19 Deaths By Race and Ethnicity in the U.S., May 2020. https:/www.apmresearchlab.org/covid/deaths-by-race

For example, in Tennessee, Blacks/African-Americans make up only 17% of the population, but comprise 32% of COVID-19 related deaths. The reasons are multifactorial. The U.S. Centers for Disease Control and Prevention (CDC) point to living conditions, work circumstances, and underlying health conditions fueled by pre-existing economic, social, and educational inequities. Racial/ethnic minorities are more likely to have low incomes, lack health insurance, live in dense, crowded, multigenerational homes and disproportionately constitute the "essential" workforce, with jobs that often do not have the option of working from home. It is a privilege to continue to have a livelihood while staying in a home that allows for physical distancing.

In addition, structural racism is a driver of these inequities that not only contribute to increased prevalence of underlying health conditions that increase the risk for poor COVID-19 outcomes, such as hypertension, but also engenders mistrust that create barriers to health care. These circumstances, colletively lead to decreased utilization of and delayed access to health care services.

Figure 2

As an example this graphic illustrates the relationship among the location of ethnic/racial minority populations, publicly run assessment sites, and the highest concentration of reported cases, using a 10-day period ending May 10, 2020 in Davidson County.



Source: U.S. Census Bureau, publicly available assessment site locations.

A commitment to eradicating health inequities requires a system-level shift to disrupt policies and processes that perpetuate inequities. **Although we cannot fully address the complexities described above, in the short term, we must take real and concrete steps toward achieving social justice and parity.**

We offer three concrete and achievable activities to achieve this goal. They are to: 1) rigorously collect accurate data to understand, describe, and make definitive conclusions about the scope and impact of inequities in this pandemic; 2) immediately commit to enhancing access to COVID-19 testing and health care for everyone, and 3) build trust by engaging communities that have been marginalized to become active participants in the promotion of health equity to create a unified community response to the pandemic.

Rigorous Data Collection

It is not possible to solve a problem that is not known. Currently, data on the impact of the pandemic on race and ethnicity are incomplete or missing in up to 30% of COVID-19 positive cases. This affects our understanding at both the testing and health care provision levels. Comprehensive needs assessments, designed to include racial/ethnic minorities, are essential to understand underlying conditions that increase risk of infection, including housing, employment, language barriers, immigration, and access to food and medical care.

State and local health departments must immediately commit to collecting and publicly posting de-identified data on racial/ethnic minority populations and COVID-19 testing and outcomes, including mortality, ***taking into account the percent of the population these groups represent as a percentage of the number of cases and deaths.*** Assuring that data are secure and patient privacy is respected are essential. Where there are significant disparities, departments of health should be accountable for proposing and implementing data collection approaches to ensure an accurate and comprehensive understanding of testing and health care access.

Access to Testing and Care

In Tennessee, data are unavailable or missing on race and ethnicity for persons who are tested overall and those who test negative, which makes it difficult to assess whether testing is truly available to everyone. Many test sites operate in facilities that are not easily accessible by public transportation or at convenient times when many individuals are not at work. ***Testing should occur in locations trusted by community members and offered at a time when individuals can use them.***

The Tennessee COVID-19 Cases that are not yet linked or have unknown race or ethnicity.

Race

28%

Ethnicity

36%

Departments of Health should confirm that tests are affordable, including free testing for those who are uninsured, and easily accessible to people who satisfy local testing criteria, allowing inclusion of individuals who live in crowded housing and in neighborhoods with the highest concentrations of cases. Furthermore, as medical care shifts to telemedicine, lack of access to technology and broadband internet, and technological literacy are becoming barriers to care. Programs must be established immediately to help individuals navigate these challenges in accessing medical care. New creative solutions that provide access to the internet for all populations are urgently needed.

Trust and Community Engagement

Finally, both prior points are predicated on trust in the system of data collection, testing access, and healthcare delivery. Without trust, transparency, and community engagement, it is impossible to identify and implement solutions that are appropriate, science-based, and tailored to specific community needs. We should foster and sustain collaborative partnerships between internal partners (key community gatekeepers, long-term residents in communities; community health workers, pastors/religious leaders) and external stakeholders (local and state health departments, community organizations and community-engaged academic researchers and clinicians).

Organizations and services working in diverse communities should have comparably diverse staff and be trained in cultural and racial sensitivity. The acquisition of such skills will reduce the likelihood that individuals from racial/ethnic minority populations will avoid seeking care due to fear of discrimination, fear of affecting their immigrant status or even deportation and help ensure that they receive equitable treatment when they seek care. In addition, the collection of accurate and complete data, maintained in a secure manner that adheres to privacy laws and regulations, will build trust and inform the development of evidence-based strategies to tackle these COVID-19 inequities.

Notes: Strategies for combating the spread of COVID-19 and their likely effectiveness, a review of models for forecasting the spread and severity of COVID-19, and other topics will be the subject of additional working papers. The views expressed are those of the advisory group and do not necessarily reflect the views of Vanderbilt University School of Medicine or Vanderbilt University Medical Center. Please see vumc.org/health-policy/covid-19-advisory-memos for those papers.