Health Inequities and Vulnerable Populations in Pandemics

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Objectives: Learners in this track will be able to:

1. Discuss the systemic, structural, sociocultural, and political factors that drive inequities in exposure, diagnosis, and treatment during pandemics.

2. Identify strategies to enhance risk communication, prevent/limit disease transmission, facilitate timely diagnosis and treatment, and enhance the quality of care among impacted populations during pandemics.

3. Understand policy-level, community-led, and safety-net efforts to mitigate and prevent pandemic inequities locally, regionally, and more broadly.

4. Use newly learned knowledge and strategies to improve pandemic preparedness and develop more equitable approaches to prevention and treatment during pandemics.
Health Inequities and Vulnerable Populations in Pandemics

Outline of today’s presentation:

1. What are health inequities and what are the drivers of health inequity?
2. Who is most vulnerable (impacted) during a pandemic?
3. How can we prevent/limit disease transmission, facilitate timely diagnosis and treatment, and enhance the quality of care among impacted populations during pandemics?
4. What policy and systems-level efforts could mitigate and prevent pandemic inequities?
Health Equity…

…is achieved when every person has the opportunity to achieve their full potential for health.
What about the differences in health outcomes between different populations?

**Health Disparities:**
Any differences in health outcomes between groups of people.

Ex: Seniors have a higher risk of cancer as compared to younger populations.

**Health Inequities:**
Any systemic, avoidable, unfair and unjust differences in health outcomes.

Ex:

Davidson County Infant Mortality Rate by Maternal Race (2016)
Equity and Equality: What’s the difference?

**Equity** involves understanding the varying needs of people, providing the **appropriate resources**, and removing barriers to using those resources to enjoy full, healthy lives.

**Equality** aims to provide everyone the **same resources** to enjoy full, healthy lives.

Like equity, equality aims to promote fairness and justice, but equality can only work if everyone starts from the same place and needs the same resources.
Equity and Equality: What’s the difference?

**Equity**
- People are given the right tools to succeed.
- All people have access to the same resources.

**Equality**
- People are treated the same.
- All people are given the same amount, without regard to their needs.
What creates Health Inequities?

*Perception:*
- Poor individual choices
- (Only) a lack of access to health care

*Reality:*
Historical and current policies have affected (and continue to affect) specific communities’ environments, access to opportunity and resources to thrive.
Determinants of Health: Identity, Social Status and Place

The Geography of Upward Mobility in the United States
Chances of Reaching the Top Fifth Starting from the Bottom Fifth by Metro Area

Note: Green = More Upward Mobility, Red = Less Upward Mobility
Source: The Equality of Opportunity Project

Opportunity Insights April 2018

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What determines health?

**Socioeconomic Factors**
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

50% can be traced back to your zip code!

**Physical Environment**

**Health Behaviors**
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Only 20% include those moments in a healthcare environment

**Health Care**
- Access to Care
- Quality of Care

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Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)
Social Determinants of Health

Factors that influence health that aren’t an individual’s biology, genetics, or behaviors.

Social Determinants of Health are the conditions where we live, learn, work, worship and play – they impact our health.

They can be influenced and changed.
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Why are Some People More Vulnerable (Impacted) in a Pandemic?

- **Physiology/Pathophysiology**: age, comorbidities, health status
- **Social, Economic, Political, and Cultural Factors**: such as race, ethnicity, language spoken, socioeconomic status, housing quality, employment, paid leave
- **Combination of the above**: age, comorbidities combined with social and economic deprivation will likely increase risk, disease burden and mortality
THE LIVES & LIVELIHOODS OF MANY IN THE LGBTQ COMMUNITY ARE AT RISK AMIDST COVID-19 CRISIS

Coronavirus spike on Navajo Nation raises alarms

Esmeralda Bermudez @BermudezNMS

California farmworkers provide more than 1/3 of the country’s vegetables & 2/3 of its fruits. Workers are considered “essential” but many are undocumented, lack health insurance & don’t qualify for federal COVID-19 relief. Here are the challenges they face.

For Homeless People, Covid-19 Is Horror on Top of Horror

Early Data Shows African Americans Have Contracted and Died of Coronavirus at an Alarming Rate —...

propublica.org

Social Position
Class, Geography, Race
Policy Context

Causes of Disparities
Distal
- Population Structure (crowding)
- Access to Clean Water & Sanitation
- Ability to Stay Away from Work
- Psychological Stress
- Nutritional Status
- Access to health providers, insurance
- Quality of healthcare available to patient

Proximal
- Assortative mixing
- Hand-washing Behavior
- Social Distancing Behavior
- Inflammation & Immune Function
- Vaccination Behavior
- Healthcare utilization (uncontrolled chronic conditions)
- Treatment options offered and availed

Differential Exposure
Transmission
Differential Susceptibility & Differential Disease Severity
Unequal levels of illness & death
Differential Consequences after Disease has Developed

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COVID-19 Active Cases

Includes active, recovered, and deceased
People in Poverty
By Census Tract

Davidson Co. 16.9%
Tennessee 16.7%
United States 14.6%

Percent in Poverty

Race and Racism + COVID-19


• NPR. “The Coronavirus Doesn't Discriminate, But U.S. Health Care Showing Familiar Biases”: 
  https://www.npr.org/sections/health-shots/2020/04/02/825730141/the-coronavirus-doesnt-discriminate-but-u-s-health-care-showing-familiar-biases
'Anti-Asian racism has come roaring back with Covid-19': Cathy Park Hong on being Asian American

Crystal Hana Kim

The Minority Feelings author talks about stereotypes in the wake of the coronavirus and being inspired by Richard Pryor

As an Asian American who grew up in what was once a very white and predominantly Italian neighborhood in S. Brooklyn where anti-asian attitudes were and still are a big issue, I can tell you there's no amount of virtue signaling of "Americanness" one can perform to curb racism.

12:30 PM · 4/2/20 · Twitter Web App

Jie Jenny Zou @jiejennyzou

Replying to @jiejennyzou

I've never understood the "assimilation" argument, especially now. When it comes to racism and bigotry, why is the onus always placed on the aggrieved group to prove their innocence and/or value?
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COVID-19 Health Equity Workstream - Leader: Wilkins

1. **Effective Risk Communication**
   - Goals/Objectives: Effectively communicate risks and prevention strategies to:
     - Patients and families from a range of backgrounds with varying levels of health literacy and limited English proficiency
     - VUMC employees, including roles outside of patient care such as dietary, maintenance, and environmental services

2. **Equitable Testing and Surveillance**
   - Goals/Objectives: Provide/facilitate timely testing to all with symptoms including those with conditions and from backgrounds at higher risk
   - Report aggregate test results by key demographics including age, gender, and race/ethnicity

3. **Equitable Healthcare (ED and Hospital)**
   - Goals/Objectives: Provide high quality care that does not vary due to race/ethnicity, gender, SES
   - Effectively communicate post-discharge plans and facilitate transitions of care
   - Report aggregate outcomes by key demographics including age, gender, and race/ethnicity

4. **Broad Implementation of Telehealth**
   - Goals/Objectives: Effectively use telehealth to provide care for those with limited health literacy, limited English proficiency, and varying levels of trust.
   - Increase adoption of telehealth among racial/ethnic minorities, patients with limited resources, and people living in rural communities

At-risk groups: racial/ethnic minorities, limited health literacy, Limited English Proficiency, rural communities, older adults, low SES, essential workers

Underlying assumptions: 1) Disparities will be compounded for subgroups with existing health inequities; 2) These disparities can be mitigated and addressed

Goal: Facilitate clinical research participation by groups impacted by and at-risk for the COVID-19.
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Panel Discussion: Where can we create equity?

Systemic
“My community”

Institutional
“My organization”

Individual
“Me”
Remember that equity is a state where outcomes cannot be predicted based on membership in a social identity group.

Equity is an ongoing process of intentional action to change the structural and institutional policies and practices in partnership with those most directly affected by them.
Questions/Feedback?

Thank you!

The Office of Health Equity
https://www.vumc.org/healthequity