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Policy and law changes to address healthcare inequities for minority populations during COVID-19

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Introduction

While other countries have begun to see a flattening of the Severe Acute Respiratory Syndrome – Coronavirus-2 (SARS-CoV-2) curve, the United States continues to see a rise in cases, with approximately 7.4 million confirmed cases to date [1]. Even more worrisome, various news articles have begun to shed light on the healthcare inequities that have become increasingly more transparent during this crisis [2–4]. The current literature shows that during this coronavirus disease-2019 (COVID-19) pandemic, viral transmission has disproportionately affected Black, American Indian/Alaska Native, Latinx, Asian-American, and the Pacific Islander communities [5]. More specifically, in states such as Chicago and Louisiana, African Americans experience at least a 50% higher total death count as compared to their White counterparts. In states such as New York, the deaths per 100,000 for African Americans has been around double that of Whites since the beginning of the crisis [6–8]. A recent study from the *New England Journal of Medicine* has shown that 76.9% of patients hospitalized with COVID-19 and 70.6% of those who died were Black, despite the fact that only 31% of the Ochsner Health Population in the state is African American [9]. Healthcare in Alabama has highlighted similar glaring issues. An increasing number of White Americans are being infected with COVID-19, but African Americans continue to represent a higher percentage of total COVID-19-associated deaths [10]. Interestingly, fewer African Americans have been infected with COVID-19 in Alabama, but a higher mortality rate exists even for African Americans who were found to have no other underlying medical conditions [10]. Based on the COVID Racial Data Tracker, which measures data from the District of Columbia and 41 states, the Latinx community has been disproportionately testing positive as well. In 30 states, the rates have been around double that of non-minority

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populations, and over four times the rate in eight alternate states [11]. The American Indian community, specifically the Navajo Nation, has accounted for 60% of cases in New Mexico, while only comprising 9% of the total population [12]. The pandemic has brought healthcare inequities that have existed for decades to the forefront of policy conversations—there are steps that can be taken in both the short and long-term to address the needs of these vulnerable populations.

Etiology of Increasing Disease Burden on Minority Populations

In order to bring about change to the healthcare system, a thorough understanding of the etiology of healthcare inequality is required. While there are several factors that make certain minority populations more susceptible to pandemics and infections during pandemics, the first reason has to do with a complex entity specific to the minority populations themselves—pre-existing conditions. African Americans have a longstanding history of increased rates of hypertension, obesity, diabetes, and chronic kidney disease [13–15]. The second factor, particularly impacted by pandemics, is the inability to reasonably maintain social distancing due to socioeconomic status. Minority populations have been over-represented in prisons and homeless shelters, where social distancing isn't feasible. The data also show that minority populations are more likely to live in dense housing, where individual units are close together, laundry can only be done in communal areas, and the use of custodial services to maintain clean public areas is minimally utilized [16,17]. Certain minority groups, such as African Americans, are also more likely to have essential jobs such as bus drivers and custodians, which cannot be feasibly done through Zoom, Skype, and Google Chat [12]. While the above reasons may account for the increased proportion of infection rates among minority populations, they do not account for the increased mortality rates among minority individuals without pre-existing conditions. Though the United States strives for healthcare equality and aims for all patients who seek medical care to obtain similar quality of healthcare treatment, that is unfortunately not the case. Minority populations have higher uninsured rates, and thereby utilize high-quality hospitals, primary care offices, and electives ambulatory care services less often. When controlling for insurance status, African Americans continue to be referred for lower quality treatment plans compared to White patients—implicit physician biases is at the forefront of steering minority populations from ideal healthcare services [18–21]. African Americans have already been hesitant to utilize healthcare resources, as there is a longstanding history of unethical experimentation on the group in the United States. Physicians, having learned of this phenomenon, may begin to perceive the minority population as unwilling to adhere to physician directions as well as their White counterparts, resulting in mistrust and subpar patient-physician communication [22–25]. While implicit biases certainly play a role in exacerbating healthcare inequities, explicit biases play an equal role. Which neighborhoods are we setting up testing tents for COVID-19? Recent studies by a biotech data firm, Rubix Life Sciences, found that African Americans with symptoms such as cough and fever are less likely to be testing for COVID-19 than their White counterparts. The etiology of these healthcare inequalities is thus multifactorial and complex—however, there are simple measures that can be taken to advance healthcare in the fair and just direction.

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Improving Living Conditions

Improving inequalities in living conditions can play a significant role in mitigating healthcare disparities. For instance, in the Yonkers Housing Intervention in New York, half of the housing residents were randomly selected to be moved to better housing. Two years later, those who were moved reported better health and economic outcomes compared to those who were not chosen and thereby stayed in existing housing [26]. In response to racial health disparities, the American Medical Association (AMA) has also begun partnering with hospitals, community health centers, and social organizations in Chicago in a 6-million-dollar pact called West Side United, with the intent of sparking economic growth in areas of Chicago's west side [12]. Similar investments pacts need to be made by the AMA or other organizations to help close the health equity gaps that are only widened by adverse living conditions. Additionally, increasing preventative screenings and treatment in underserved neighborhoods can also contribute to narrowing the racial inequality gap in healthcare. For example, a colorectal cancer initiative in Delaware in 2002 reimbursed colonoscopies for uninsured residents with household incomes up to 250% of the poverty level. By 2009, the rate of screening increased by 54% for Blacks, and the racial gap in screening was virtually eliminated. The program even resulted in a net cost savings [26]. Equalizing access to healthcare services, at the very least in terms of access to preventative screening and disease testing, can be instrumental in reducing racial gaps in healthcare outcomes.

Addressing Implicit/Explicit Biases

In terms of addressing implicit and explicit biases held by healthcare physicians, education on the effects of structural racism on healthcare outcomes needs to be advanced. On an organizational level, hospitals and other healthcare organizations can implement trainings and initiatives aimed at educating their employees. For example, in 2019, the AMA created the Center for Health Equity (CHE), an initiative aiming to integrate health equity into the practice and organizational performance of the AMA [12]. The AMA also launched "Accelerating Change in Medical Education" in 2013, an initiative representing one-fifth of allopathic and osteopathic medical schools that aims to educate future physicians on social determinants of health [12]. While this is a great start, it needs to be expanded to incorporate a much larger percentage of medical schools. Furthermore, this education needs to be expanded not only to medical residencies, but also to the entirety of the healthcare system, including nurses, nurse practitioners, and physician assistants. An example of this approach is found in the anti-racism training that was incorporated into staff professional development with the Racial Justice and Health Equity Initiative created by the Boston Public Health Commission [27]. Additionally, professional education needs to dedicate more time to professionals who focus on the intersections between racism and health, including social epidemiologists, medial anthropologists, and social scientists [27]. On a more individual level, healthcare professionals need to be made aware of the unconscious biases they hold. One study had medical school admissions committee members take an Implicit Association Test (IAT). Over two-thirds of the participants felt that taking the test would help them reduce their unconscious biases. Furthermore, when conducting interviews in the following admissions cycle, almost half stated that they remembered their IAT results, and 21% admitted that knowledge of the biases they found from their IAT results

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impacted some of their decisions. These results could be applied to healthcare training in the hopes that similarly, future healthcare professionals would also become more aware of the implicit biases they hold and remember them when treating future patients [28]. Furthermore, individuals can be taught about proven strategies to reduce prejudices, such as counter-stereotype imaging—a mental exercise in which the individual thinks of examples of people who defy the stereotypes in question, and stereotype replacement—where biased thoughts are recognized and replaced with non-prejudicial responses [26].

Data Collection

Finally, additional research and improvements in data collection are needed to reduce healthcare disparities. Legislation such as the "Equitable Data Collection and Disclosure on COVID-19 Act of 2020" should be enacted, requiring racial and ethnic patient outcome data, including testing, treatment, and fatality rates, to be reported to Congress [12]. A call for research on how racism contributes to health outcomes is also needed. The majority of empirical research on racial discrimination and health focuses on interpersonal racism or the stress of perceived unfair treatment. While this research is important, significantly fewer studies have been published on the effects of structural or systemic racism's effects on healthcare outcomes. In a search from the Web of Science, when the word "race" was searched with "health", "disease", "medicine", or "public health", almost 50,000 articles were returned, compared to 2,000 when "race" was replaced with "racial discrimination" or "racism" [27]. Without accurate knowledge of the effects, ailments have on various groups, as obtained through data collected from hospitals and medical literature, the most effective remedies cannot be implemented successfully.

Conclusion

It is clear that systemic racism and ingrained biases have and continue to negatively affect patient outcomes for many minority groups. Pandemics like COVID-19 only make these healthcare disparities even more apparent. While the issue of reducing the gap in quality of healthcare is complex and research on the relationship between racism and healthcare outcomes is relatively limited, many potential solutions show promise. By addressing one of the root causes of health problems, living and economic conditions, the barriers faced by many minority groups in gaining access to healthcare can be reduced. Training in hospitals via educating employees on the effects of these healthcare disparities and by making employees aware of implicit biases they hold and strategies to combat them is also essential in improving patient outcomes. Finally, whether through legislation or calls to action for additional research, more data is needed on the specifics of how different minority groups are impacted by disease both in the case of pandemics like COVID-19, and in other hospital encounters. While the effects of racism on healthcare are a result of longstanding historical biases and will therefore take time to combat, there are many steps that can be taken today.

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