Historical racial and ethnic health inequities account for disproportionate COVID-19 impact

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Health care disparities in historically disadvantaged communities like the Navajo Nation are worsened by the pandemic. Credit: ATS

A new Viewpoint piece published online in the *Annals of the American Thoracic Society* examines the ways in which COVID-19 disproportionately impacts historically disadvantaged communities of color in the United States, and how baseline inequalities in our health system are amplified by the pandemic. The authors also discuss potential solutions.

In "COVID-19 Racial/Ethnic Inequities in Acute Care and Critical Illness Survivorship," Ann-Marcia Tukpah, MD, MPH, Division of Pulmonary and Critical Care Medicine, Brigham and Women's Hospital and co-authors discuss how the legacies of structural racism, unequal resource investment and systems that perpetuate health disparities disproportionately impact individuals from the African American, Latinx, and Navajo Nation communities.

"We hope to draw attention to the effect of the COVID-19 pandemic on pre-existing health care disparities and inequities, with a focus on long-term care access," said Dr. Tukpah. "We also hope to spark discussion of how individual clinicians and health care systems can mitigate disparities, while recognizing the ultimate need for changes in health policy."

People in communities of color often have sub-par clinical care experiences, such as little to no access to specialty care physicians, and differences in rates of diagnostic testing. In many states, resources for COVID-19 treatment are allocated based on probability of survival.

These states rely on Crisis Standards of Care (CSCs) to prioritize treatment. "Some states with developed CSCs that consider comorbidities may not rely on validated comorbidity indices, such as the Charlson Comorbidity Index," the authors state. "Instead, vague language like 'major conditions with death likely within five years' are used. This sort of vague language opens the door to implicit biases playing a prominent role in decision making regarding resource allocation."

The broader question is whether basing care decisions on whether someone has comorbidities may lead to denial of lifesaving care to racial and ethnic minorities, as members of these groups may have these comorbid health conditions. The authors point out, "These groups tend to have poorer access to care and more comorbidities—such as Type 2 diabetes and chronic kidney disease— at baseline. In addition, it is unclear whether a low chance of five-year survival should dictate whether certain resources are provided, as a person's number of accomplishments, amount of quality family time, and contributions to society can be significant during these five years. Ultimately, even our best prediction models do not have 100 percent

accuracy. There will likely be no complete way to mitigate/eradicate disparities in triage and care allocation, but input by represented stakeholders and a process integrating equity and justice principles will be important."

Solutions to address these inequalities include implementing a racial or socioeconomic correction factor. Since priority scoring processes are subject to implicit bias, and may lack adequate representation of affected individuals, training is essential in order to ascertain ethical and equity values. Hospital triage and ethics committees need to communicate and monitor one another.

The authors state: "As pulmonologists and intensivists, applying an equity lens to our health care delivery, we are concerned by a COVID-19 cycle: In general, racial/ethnic minority patients have higher rates of public-facing occupations, suffer more from vulnerable conditions/chronic medical problems and have less insurance coverage. They also face higher rates of infection. If ethnic and racial minority patients present for acute care delivery and comorbidities are considered in their access to scarce resources, they may not be able to access potentially life-saving interventions. If they are then COVID-19 survivors, they face greater challenges to recovery, from logistical destination issues (access to long-term care) to symptom resolution or progression (because of the underlying chronic conditions or other patient-specific or care-related factors). Therefore, we want to continue to ask: How do we break this risk cycle?"

With concerns of a second surge of COVID-19 during the upcoming influenza season, preparing for both acute and post-acute/survivorship care in the most equitable and ethical manner is critical. "Given that about half of insurance coverage is through employer-based plans coupled with now high rates of unemployment, there are significant concerns about exacerbating already existing access disparities," said Dr. Tukpah. "Various public policies might be considered. Robust data should be collected about transfer rates for post-acute destinations and outcomes. Support for funding to expand available facilities (including specialized post-acute treatment facilities), provision of coverage mechanisms for unemployed patients (similar to the CARES Act condition for uninsured patients) and development of frameworks that recognize the challenges a surge can create for discharge destinations will be important initial considerations. There is already active discussion about possible state and federal acute care protections in the literature and we hope this will be extended to the post-acute setting."

She concluded, "Empowering people and communities (with information and tools) to engage in their own health care outcomes is also critical to how we deliver health care. Additionally, individual physicians can be advocates for improved care, quality and delivery—from recognizing implicit bias to contributing to coordinated accessible care, to leading change within their health care systems."

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