

Education

COVID-19: Health Inequities Exposed and How We Can Do Better

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Abstract

Description

If a fair and just healthcare system is the goal, then the COVID-19 pandemic proves America still has a long way to go in its effort to achieve health equity for all. Inequalities in the healthcare landscape have been amassing for decades. Lack of access to quality care, underfunded public health programs, and the rising cost of treatment are just a few of the proposed origins of systemic inequity—all of which were apparent long before COVID-19's arrival. Will observing these deep-seated issues under the lens of an ongoing pandemic shine a brighter light on these enduring disparities? More importantly, what can we, as healthcare providers, do to accelerate change?

Keywords

COVID-19; coronavirus infections/ethnology; healthcare disparities; health status disparities; United States/epidemiology; pandemics; minority health

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Introduction

COVID-19 has brought considerable hardship to communities across the country. “It has been deemed ‘the great equalizer’ in the fact that COVID-19 transcends wealth, fame, prestige, and age.”¹ Examination of recent data, however, suggests COVID-19 has disproportionately affected already marginalized populations, particularly ethnic and racial minorities, low-income populations, and residents of nursing homes and assisted living facilities. To understand why these groups bear the brunt of adverse health outcomes, we must be willing to scrutinize the longstanding health policies that allowed for such pervasive health disparities in the first place.² In that regard, the COVID-19 pandemic only exposed the cracks in a healthcare system already broken at its foundation.

Many of today's health disparities were brought to light decades ago, yet little has been done in the pursuit of health equity. The term health disparity is broadly defined by the U.S. Department of Health and Human Services (HHS) as the “systematic difference in

health between social groups.”³ Furthermore, HHS defines health equity as the “absence of disparities or avoidable differences among socioeconomic and demographic groups or geographic areas in health status and health outcomes such as disease, disability, or mortality.”³ Research has indicated that many of these injustices stem from the imbalanced distribution of economic, social, and environmental resources, both past and present.⁴

This inequity is illustrated by the response from health officials during the pandemic. Early recommendations to minimize the spread of COVID-19 included social distancing, early detection, and isolation of confirmed cases—three strategies that inadvertently harmed marginalized populations.¹ These groups are frequently single-income families who live in crowded conditions and rely on public transportation.⁵ Ethnic and minority populations are more likely to work in service industry jobs that lack sick leave and limit their ability to work from home.⁶ Furthermore, minority groups must often overcome language barriers, making it difficult

for them to obtain public health information, which in turn delays care.¹ On an even broader scale, the economic inequalities that marginalized groups already faced during pre-pandemic times, including housing instability, lack of access to education, food security, and unemployment, were only compounded by the policies put in place to curb COVID-19's spread.⁷

It should be no surprise that decades of unequal access to basic health, education, and economic needs, combined with public health programs that only further marginalize ethnic and racial minorities, have culminated in poor COVID-19-related health outcomes for these same populations.⁷ Furthermore, the pandemic demonstrated that our national public health response should not be so alienated from the community programs which house initiatives tailored to the needs of disenfranchised groups.⁸ The goal of health equity for all is complex and is going to require a systematic restructuring, but there is certainly much that we can do individually to hasten these changes.

We, as medical providers, must acknowledge the role that our profession played in the failure to support vulnerable populations, both before and during the pandemic. A lack of advocacy from our profession, inadvertent as it may have been, only perpetuated health inequity. We must do more to educate healthcare professionals on diversity, inclusion, implicit bias, health equity, and health policy. We must also increase recruitment and enrollment from marginalized groups into medical school, nursing school, research, and other health professions. Graduate medical education must prioritize public health so that our next generation of physicians are keenly aware of the current health inequities. Moreover, we cannot rely solely on those health professionals who come from marginalized groups to advocate for change while the rest sit by idly. It is up to the majority groups and leaders in their respective fields, health professionals included, to advocate for the minority, and galvanize others to do the same.

What can we do now to help accelerate change? Generate meaningful analysis of the pandemic data so that we can more appropriately address the unmet needs of our most vulnerable populations.⁹ Then, use this informa-

tion to construct more effective public health policies. There is room for focused political advocacy, but there is also much to be done at the ground level, in communities, and our own personal work environments. Urge the program leadership at your place of employment to make primary care more accessible to all populations, decreasing the comorbidities, which translate into inferior health outcomes, when the next pandemic arrives. Start a Diversity, Equity, and Inclusion program at your institution to educate healthcare workers on the implicit biases that drive poor health outcomes. Invite public health professionals to guest lecture on the current state of marginalized populations. Better yet, be advocates of change in your community by reaching out to and encouraging youth from ethnic and minority populations to pursue a career in the medical field. Undoubtedly, it will take more to upend the deeply entrenched systemic pitfalls that have led to the present state of healthcare, but as health professionals, we see the ramifications of a broken system daily. Can you think of anyone better to lead the charge?

It is a commonly held belief that our healthcare system is merely a "microcosm of American society, in which power and resources are not allocated fairly among races, sexes, or classes."⁷ It may seem as though COVID-19 has only solidified this rationale, but one could argue that a resounding response to the pandemic may be just what this country needs to gain equitable access to healthcare for all Americans, once and for all.

Conflicts of Interest

The authors declare they have no conflicts of interest.

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