

Short Takes: COVID 19 and Health Equity

Prepared by Kay Johnson, Maxine Hayes, Charles Bruner, InCK Marks, April 15, 2020

The COVID 19 response has often been described as a war. Wars always have casualties and it's not only soldiers we lose, but innocent women and children. Pre COVID 19 we were making strides in applying what we know is true: The Science of Early Child Development. Early Childhood is the foundation upon which successful societies are built. Disparities in opportunities to be healthy over the life course start early (even prior to conception). Post COVID 19, let us make sure our policies protect those very wise investments. Budget is policy. The ramifications of the economic impact of COVID 19 will be felt for many years to come. Our leaders today—the president, Congress, governors, mayors and county officials—are making budget decisions now that need to assure that sacrifices made for the war against COVID 19 will not be on the backs of mothers and children, particularly people of color. Historically, we have made mistakes like this but let us not repeat them again. To respond to the disgraceful disparities in the COVID 19 crisis, we must use data for action and transform health care, beginning in the early childhood years and continuing throughout life, not just measure the gap in disease and death rates.

It has been 35 years since the US Department of Health and Human Services (HHS) released the *Report of the Secretary's Task Force on Black and Minority Health*, including Volume VI on Infant Mortality and Low Birthweight.¹ The overall report recommendations emphasized minority health initiatives which would use outreach and education, answer questions through research and data, and develop new strategies to minimize health inequities. HHS Secretary Margaret Heckler said: *"It can--it should--mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health."* Of course, it was hardly the end of health disparities. While advances in health care continued, the "shadow" has remained. The high costs for coverage and care, cuts to the safety net, and unequal treatment for people of color within and beyond the health system sometimes have lengthened this shadow.

Over the three decades, public health agencies have measured and monitored continuing disparities in maternal, infant, and child health, including sometimes widening gaps in maternal and infant morbidity and mortality. For children of color who survive their first year of life, a substantial share will have inadequate access to quality health care, early education, income, and other family supports. We have for too long accepted different health objectives or rates of progress for different racial/ethnic groups.

Many have proposed better approaches for setting goals, measuring what happens, and using data for action.

At the same time, as Nancy Krieger and others remind us, the data are never neutral.² The numbers are biased by many factors and through many processes. Measures are set and data are collected in the context of socio-political values, frameworks, and assumptions that may have racial, class, or gender bias embedded.

The COVID 19 pandemic dramatically highlights our failure to reduce disparities and improve the health of African Americans, as well as to measure access and outcomes by race/ethnicity.^{3 4} The minimum that must be done immediately is to collect and report such data, which about half of states are doing.⁵ Such action falls, however, into a category of too little, too late. We must begin in the early years of childhood to change the conditions of life that lead to chronic conditions and poor health among adults.

For decades and now, too many public health leaders emphasize the health-related behaviors of people of color as central drivers of the disparities in maternal and child health. This persistent emphasis on behaviors implies that compromised outcomes are the fault of certain individuals or groups rather than primarily attributing outcomes to the social, political, and care systems that are in truth the central drivers of health outcomes.

Currently, we see some promising efforts and change, with growing emphasis on ensuring equity, rather than just measuring disparities. The national discussion on maternal and child health—led by champions from federal agencies, professional organizations, academic institutions, and communities—is now grounded in a focus on the role of racism, rather than race or behavior, as a key driver in disparate outcomes. The role of social determinants of health—such as racism, poverty, and unequal treatment in health, housing, and employment—is more often discussed and also is influencing public health and medicine approaches more widely. For example, in setting the framework for the Healthy People 2020 National Health Objectives, HHS for the first time articulated an overarching goal related to social determinants.^{6 7} Yet much remains to be done beyond measurement.

The COVID 19 crisis highlights the inequities experienced by African American children and their families. Families having babies and caring for young children are vulnerable in the COVID 19 pandemic, less from the virus itself than from the changes in the world around them. The poorest census tracts also: 1) are rich in young children, 2) have the least realized social, physical, educational, and economic capital, and 3) are highly racially segregated and separated from sources of economic opportunity.⁸ These neighborhoods are disproportionately home to children of color, with nearly one in four being African American. Many of the adults in the poorest census tracts are disconnected from the workforce, or, in the COVID 19 emergency, many are forced to continue working outside their homes as frontline, essential workers in hospitals, grocery stores, child care centers, and other duty.

Our nation must take the essential first step to end disparities and assure equity by starting in early childhood to transform lifelong trajectories for health and well-being. Research and professional guidelines such as *Bright Futures*⁹ point to a need to transform health care beginning with young children. We need more high performing medical homes¹⁰ that emphasize: 1) promotion, prevention, and healthy development, 2) family-centered and meaningful family engagement, and 3) connections to other services in the community that support health and well-being.¹¹ In addition to providing high quality medical care, child health practitioners are being called upon to identify and respond to social

determinants of health, including economic, social, and psychological factors. Changing the culture of children's primary care will require transformation in practice, measurement, and financing.¹² Most important, transforming child health care will require a culture of practice without bias and with emphasis on equity and long-range outcomes, not short-term costs.

The impacts of racism in America, both historical and current, are profound. It may or may not be immediately reflected in how infants and toddlers themselves are treated when they do experience the outside world, but it definitely is reflected in the stresses and strains their parents experience from structural racism. We know that high levels of maternal stress during pregnancy impact the fetus's own immunology and health—and that African American women in particular often experience high levels of stress because of the discrimination they experience. We also know that young children of color are most likely to live in families directly experiencing racism, marginalization, and other barriers presented by society. Some of these are historic and vestiges of prior direct discrimination, as reflected in higher parental poverty rates and less formal education. Others, however, these reflect ongoing cultural insensitivity in interactions with others in society, including from those in the health care system.

The health system has a responsibility not only to be “nondiscriminatory” and “unbiased” in its response to young children and their families. It also needs to recognize the impacts of both historical and current racism on their lives and seek to rectify those. This starts with valuing, rather than demeaning, those placed at the margins of society. As expressed by Dr. Paul Farmer, this involves embracing the three tenets of liberation theology – a preferential option for the poor, an imperative against structure violence, and empowerment.¹³

Our current efforts to transform health care must lean toward a focus on listening to and engaging families, particularly women of color in communities with concentration of risk.¹⁴ Research and practice should be informed by those with lived experience of how larger socio-political factors such as racism and public policies such as Medicaid eligibility affect their life course, families, and communities.¹⁵

A renewed alarm has been sounded in the COVID 19 emergency. The disproportionate deaths among African American adults underscores the unacceptable disparities in health status by race and ethnicity. Such disparities begin before birth and worsen over the life course.¹⁶ This all points to the urgency of **using data for action and health care transformation** beginning in the early childhood years and continuing throughout life, not just measuring the gap in rates of disease and death.

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