Perspective:
COVID-19

INCORPORATING HEALTH EQUITY AND COMMUNITY PERSPECTIVES DURING COVID-19: COMMONALITIES WITH CARDIOVASCULAR HEALTH EQUITY RESEARCH

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The COVID-19 pandemic is revealing the deeply entrenched structural inequities in health that exist in the United States. We draw parallels between the COVID-19 pandemic and our cardiovascular health equity research focused on physical activity and diabetes to highlight three common needs: 1) access to timely and disaggregated data; 2) how to integrate community-engaged approaches in telehealth; and 3) policy initiatives that explicitly integrate health equity and social justice principles and action. We suggest that a similar sense of urgency regarding COVID-19 should be applied to slow the burgeoning costs and suffering associated with cardiovascular disease overall and in marginalized communities specifically. We remain hopeful that the current crisis can serve as a guide for aligning our principles as a just and democratic society with a health agenda that explicitly recognizes that social inequities in health for some impacts all members of society. *Ethn Dis*. 2020;30(3):421-424; doi:10.18865/ed.30.3.421

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INTRODUCTION

Like the rest of the world, we are closely following the unfolding of the COVID-19 pandemic and are deeply affected by the growing death toll and morbidity the world is experiencing. We recognize that this is an unprecedented moment in history and acknowledge the suffering uniquely caused by this pandemic. Nevertheless, we take this moment to reflect on what the pandemic is revealing to us about the deeply entrenched US health inequities, which have a well-documented history and cut across disease areas.

In this commentary, we draw parallels between the COVID-19 pandemic and our cardiovascular health equity research focused on physical activity and diabetes to highlight three commonalities: 1) the need for access to timely and disaggregated data; 2) how to integrate community-engaged approaches in telehealth; and 3) implementing policies that explicitly integrate health equity and social justice principles and action. In the end, we are hopeful that the current crisis can serve as a guide for aligning our principles as a just and democratic society with a health agenda that explicitly recognizes that social inequities in health for some impacts all members of society.

TIMELY AND DISAGGREGATED DATA

The COVID-19 pandemic in the United States is slowly revealing how a lack of a health equity lens can make race/ethnicity and other markers of social exclusion invisible.[1] Preliminary evidence indicates large amounts of missing data by race/ethnicity; yet some states that have begun to disaggregate mortality data show a disproportionate burden of death for African American and Latinx communities. The lack of reporting COVID-19 deaths by race/ethnicity is surprising given that race/ethnicity is required on death certificates. As researchers interested in physical activity promotion, we have similarly encountered challenges in timely access and disaggregation of data for select exposures. For example, African American, Latinx, and other socially marginalized groups in the United States experience high levels of social disruption and firearm-related community violence.[2] Exposure to community-level firearm violence has been associated with poor health outcomes, including physical inactivity.[3] However, comprehensive data collection on firearms violence in the United States is severely lacking.

In 1996, Congress approved the Dickey Amendment that drastically cut federal funding for firearm violence prevention research and limited reporting of firearm outcomes to the general categories of 'accidental,' 'suicidal,' or 'violent crime.' Data on social determinants of health such as, concentrated poverty, unstable housing, and educational attainment, associated with these deaths are typically not reported. This lack of data on antecedent, structural barriers driving firearm use limits our understanding of its effect on physical activity adoption in communities experiencing this type of violence. Similarly, not linking structural-level data to COVID-19 has led to an emphasis on individual-level risk factors (ie, individuals not following stay-at-home orders during the COVID-19 pandemic) and reduced interpretations to behavioral factors as the sole explanation for the health of communities. As we continue to monitor COVID-19 and seek testing, treatment, and vaccine solutions, we must insist on a data collection system that consistently and reliably reports all health conditions by social determinants, particularly race/ethnicity.

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COMMUNITY-ENGAGED APPROACHES IN TELEHEALTH

Telehealth strategies are increasingly being used to screen and care for patients during the COVID-19 pandemic. However, prior to the pandemic, an emerging body of research suggested that telehealth and other forms of virtual connection could be effectively used for participant recruitment, data collection, and monitoring of patients enrolled in clinical research trials.[4,5] What has received relatively little attention is the effectiveness of these methods for reaching low-income and racially/ethnically diverse groups, particularly those who do not speak English well or solely rely on their cell phones for internet connectivity.[6] Moreover, there is a dearth of research examining if cutting-edge technologies can address the mistrust and apprehension some communities have regarding research and the health care system.[7]

Community-engaged research methods are grounded in a collaborative process of designing, implementing, and interpreting study findings.[8] As such, they overcome community mistrust and increase study participation and retention because they recognize that research teams are most effective when they reflect the racial/ethnic background and experiences of study participants. In doing so, these methods serve as a bridge between researchers and the communities for which research results are intended. In a local pilot diabetes study that we are conducting, we had to end in-person participant recruitment and data collection and are identifying culturally relevant, timely and virtual ways to connect with study participants. Given the potentially long-lasting effects of the COVID-19 pandemic, research is urgently needed to investigate approaches that simultaneously combine virtual recruitment and data collection methods as well as clinical care, coupled with community-engaged approaches rooted in health equity.

POLICIES, HEALTH EQUITY AND SOCIAL JUSTICE

In response to COVID-19, policies such as stay-at-home orders, school closures, work-from-home mandates, and travel bans have been implemented throughout the country. Policies such as these often have the largest and speediest impact on the public's health and remind us that political will drives broad-based public health action. In physical activity research, we have similarly seen how built environment policies and initiatives have created settings, ranging from neighborhoods to cities, where adults and children alike, can engage in more active living.[9] However, absent an explicit recognition of how structural barriers such as racism, residential segregation, immigrant policies, and economic opportunities influence health, policies can actually create or exacerbate health inequities.[10] Take COVID-19 as an example. Preliminary evidence suggests that some wealthier neighborhoods in the nation showed high rates of testing, likely due to increased access among more privileged individuals and not necessarily because of increased exposure or infection.[11] Conversely, lower income communities (eg, Queens, New York) are experiencing high death rates that are likely the result of low-wage service workers, the majority of whom are African American, Latinx or Asian American, not having the privilege to work from home. The health effects of COVID-19 across multiple social factors such as race/ethnicity, immigrant status, and work conditions are currently unknown. However, future research will likely show that the integration, or lack thereof, of health equity in policy initiatives influenced exposure, sickness and death resulting from COVID-19.

Conclusion

In summary, while the infectious nature of COVID-19 clearly poses immediate risks to populations, social inequities in cardiovascular health have marked and lasting effects on the social and economic well-being of the nation. In 2017, diabetes care alone cost the United States $327 billion in medical costs and lost work productivity.[12]

A similar level of urgency that we are seeing in response to the COVID-19 pandemic would be a strategic and well-spent investment on our part to slow the burgeoning costs and suffering associated with cardiovascular disease overall and in marginalized communities specifically. We suggest the use of the six principles for collaborating for equity and justice introduced by Wolff et al.[13] These six principles include: 1) Explicitly addressing issues of social and economic injustice and structural racism; 2) Employing a community development approach in which residents have equal power in determining the coalition's or collaborative's agenda and resource allocation; 3) Using community organizing as an intentional strategy and as a part of the process to build leadership and power; 4) Focusing on policy, systems, and structural change; 5) Building on the extensive community-engaged scholarship and research over the last four decades that show what works, that acknowledges complexities, and applies appropriate evaluation strategies; and 6) Constructing core functions for the collaborative based on equity and justice in order to build member ownership and leadership.

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These principles highlight the importance of addressing power, equity and justice while engaging communities in collaborative and transformative action. The challenge lies in if and how we will use the COVID-19 pandemic as a shining example of the possibility to create a society that ensures that all who call America home can lead healthful, fulfilling and dignified lives.

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