



Promoting Health Equity in the COVID-19 Era

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As members of the Diversity and Inclusion Task Force on behalf of the Society of Gynecologic Oncology (SGO), we raise alarm and concern regarding recent reports of systemic health inequity during the COVID-19 pandemic. We strive to increase awareness of these critical issues as they pertain to gynecologic oncology patients, caregivers and providers. Across the country, this pandemic is exacerbating existing societal biases and longstanding inequities in health care that SGO is committed to addressing as part of our mission. While coronavirus does not discriminate, dangerous and familiar disparities, myths and biases are revealed and amplified during this global health crisis. As practitioners, researchers, educators and community health leaders, we must address these issues actively and transparently.

Health Equity

Equity is defined as fairness and justice. Health equity exists only when people have an equal opportunity to be healthy. When defined structures or systems limit a person's ability to be healthy, health inequities and disparities persist. Marginalized and chronically under-resourced communities are plagued by health inequity. Additionally, institutional and individual health care provider implicit biases may further exaggerate these health inequities [1]. Inequity and discrimination as well as implicit and explicit bias are antithetical to our society's aspirations and are condemned by SGO.

COVID-19 and Health Care Disparities

Emerging data suggests that the COVID-19 pandemic has disproportionately affected many minority and marginalized populations in the United States (U.S.). For health care disparities experts in the field and those caring for vulnerable populations, this is not surprising [2]. While news of elderly and immunocompromised patients from other countries led to a focus on elderly, frail, older, assumed white populations, reporting in the U.S. has also revealed the COVID-19 impact in our communities by race, ethnicity and socio-economic variables.

The trends in disparate infection rates, outcomes and higher mortality are now being reported across the country [3]. On April 3, 2020, ProPublica reported, in Milwaukee County, WI, 81% of the deaths from COVID-19 were Black residents despite Black people comprising only 26% of that county [4,5]. The Detroit News reported on April 2 that thus far, at least 40% of deaths attributed to COVID-19 in Michigan are Black residents, a percentage that far exceeds the proportion of African Americans in the Detroit region and state [4,6].

More community-based local data mirrors this trend. For example, the Third District in Kansas City, which has a high percentage of households with poverty and whose residents are 60% Black, have reported to have higher COVID-19 infection rates than neighboring districts [7]. In addition, more recent reporting in Chelsea, MA, Chicago, IL, and San Francisco, CA, has revealed local hot spots of COVID-19 among LatinX and immigrant communities [8, 9]. Specific populations including those in nursing facilities, incarcerated people and the homeless have unique risks. Homeless populations are among the most vulnerable to infection with COVID-19.

Unhoused people disproportionately suffer from chronic illnesses including cancer and “social distancing” is nearly impossible among this population [10,11]. One model using pre COVID-19 health data from Los Angeles, CA, and New York City (NYC) assumes potential 40% infection rates among homeless and estimates 4.3% of the nationwide homeless population (~21,295) would require hospitalization [12]. Finally, data from rural populations has been more limited but concern about health care system capacity that has already demonstrated strain in cancer care delivery will become increasingly relevant [13].

Complexity of COVID-19-Related Health Care Disparities

Often blame for this disparity in outcomes is shifted to underlying comorbid conditions such as hypertension, chronic lung disease, asthma, diabetes and obesity as COVID-19 risk factors, with an attitude that increased deaths are inevitable and there is “nothing to be done.” In gynecologic oncology, we are familiar with complex comorbid conditions irrespective of race/ethnicity and how these can adversely affect cancer care. Now, we must apply our active management skills to best consider how COVID-19 risks can be mitigated for patients instead of accepting these risks as inevitable.

While comorbidities are contributory, other structural concerns surrounding COVID-19 are also important. Although current data is lacking on specific demographics of testing, there is concern that minority groups and/or marginalized communities may have disproportionately less access to testing. Health care providers’ implicit racial bias could also influence their decision about who receives a diagnostic coronavirus test or triage. In New York, factors such as resource allocation, geographic location and public versus private hospital systems have influenced access to necessary supplies and COVID-19 testing. As a result, state legislation was rapidly implemented to better pool resources to address these disparities [14,15,16].

Steps to “flatten the curve” and “shelter in place” also come with their own set of racial and economic inherent biases. We must understand there is a stark difference in who has the “privilege” to work and stay at home [4]. Many white-collar workers have broadband internet and computers which enable them to easily work from home, while many from poorer neighborhoods do not have this luxury. Many lower wage jobs deemed essential are done by racial minority and marginalized populations. It is often more difficult to practice social distancing in these circumstances and these individuals have therefore a higher risk for contracting COVID-19. The novel coronavirus affects them because they are more exposed, more fragile and more ill.

Lessons on Disparities from Frontline Regions

The granular statistics from the front lines of the COVID-19 pandemic in the U.S. are even more concerning. As providers, we must learn from these data and act to protect our own vulnerable patients and communities in diverse gynecologic oncology practices in urban, rural and suburban settings. NYC has emerged as one of the epicenters of the coronavirus outbreak, with the highest number of COVID-19 cases (104,410) and deaths (6,898) nationwide as of April 12, 2020. Data regarding the racial breakdown of NYC COVID-19 demographic data was not initially available, but it was clear by ZIP code that certain communities were harder hit [14]. As of April 3, 2020, the highest case counts by ZIP codes ranged from 409 to 1245 cases and are concentrated in parts of Brooklyn, Queens and the Bronx, specifically in lower income communities of color [15].

Recent preliminary data from the city’s Health Department as of April 8 has confirmed clear racial disparities in NYC among both Hispanic and Black communities despite only representing 29% and 22% of NYC population, respectively. Blacks and Latinos were found twice as likely to die of COVID-19 as compared to Whites. (Hispanic 22/100,000, Black 20/100,000, White 10/100,000 and Asian 8/100,000) [17]. In NYC, the

concept of social distancing and lockdown for many in immigrant and underserved communities has not yet been feasible. Many continue to work and are considered “essential” as health care workers, city employees, delivery personnel and service workers logically leading to higher spread and later presentation to hospitals for treatment.

In Louisiana, as of April 12, 2020, there have been 20,595 cases of COVID-19 in all 64 parishes with 840 deaths. Black patients comprise 70.48% of COVID-19 deaths in Louisiana while Black people make up only 30% of the state’s population. Of the COVID-19 deaths in Louisiana, 66% had hypertension, 43% had diabetes, 25% had chronic kidney disease, 23% had cardiac disease, 14% had pulmonary disease, 11% had neurologic disease and 10% had cancer [18]. Additionally, the social ramifications of these losses were even more poignantly described in New Orleans including the inability to conduct traditional jazz funerals or second lines due to social distancing, leaving the community with an additional sense of loss [19].

In Chicago, which has a much smaller Black population than New Orleans, 2,102 Black Chicagoans had been diagnosed with COVID-19 as of April 8, 2020, 52% of those with positive tests and 70% of Chicago residents dying from the coronavirus were African Americans, when the city’s African-American population is 29% [20,21]. The challenges for the local homeless populations have only gotten worse. Shelters are full, closed or too fraught with COVID-19 transmission risk due to crowded conditions. Common places to find safe shelter or bathrooms such as libraries, gyms, fast food restaurants are also closed. Shelters or traditional soup kitchens are also more limited due to decreasing availability of employees or volunteers [10,11].

Bias Towards Asian and Asian American Communities Due to the COVID-19 Pandemic

Another critical consideration is how the COVID-19 pandemic has affected the diverse Asian and Asian-American communities throughout this country. A rise in the incidence of verbal, physical and violent attacks against Asian Americans has been reported throughout the U.S. Promotion of hateful rhetoric like labeling SARS-COV-2 virus the “Chinese Virus” has resulted in increasing anti-Asian sentiments and individual bigotry [22]. Americans of Asian descent need to know they will be protected not just from COVID-19 but also from violence, harassment and discrimination that they may encounter on a day-to-day basis. About 20% of the nation’s front-line health care workers are immigrants, representing many countries in Asia. In 2018, the Association of American Medical Colleges reported that 17% of doctors practicing in the U.S. were of Asian descent. The virus of hate puts Asians and Asian American members within our own gynecologic oncology community and the patients they serve in double jeopardy, which cannot not be tolerated [23]. SGO—like many leading medical organizations, including the American College of Surgeons—condemns such bias and bigotry and encourages reporting of any such incidences [24].

A Call to Action and the Role of the Gynecologic Oncology Provider

We conclude this statement with a call to action. SGO advocates for the continued support of all our patients and health care personnel providing cancer care during this turbulent time. Care delivery should be performed without the specter of discrimination, racism, implicit or explicit bias and should factor in the social determinants of health in order to identify focused solutions. First, to be successful, organizations must acknowledge and know the historical context, cycles, systems and structures that make minority and underserved communities at risk. Creating social capital by training and positioning community advocates and leaders in key positions is necessary to foster meaningful community shared governance to respond to this crisis and to promote long term health equity.

Second, we must continue to lead at the local, state and national policy levels to advocate for improved and

equitable health care access and quality including better access to health care insurance for all. Despite the Affordable Care Act's original intent to expand coverage to near universalism, about 3 million Americans remain uninsured due to a gap in coverage caused in part by failure of some states to implement Medicaid expansion [25,26]. In the non-expansion states, over half of low-income Americans who were uninsured in 2010 remain without access to affordable coverage. These Americans fall in the so-called coverage gap: they are not poor enough to qualify for traditional Medicaid and yet do not earn enough to qualify for subsidies on the exchange. We must advocate for closing this glaring loophole in coverage, which disproportionately affects underserved patients. This effort will be even more necessary as more patients will be left financially vulnerable due to the COVID-19 crisis. We must continue to acknowledge that many of the people we care for with gynecologic cancer are affected by these structural inequities and many more will be adversely affected by the financial and social strain that COVID-19 will place on them and their communities.

As practitioners involved in gynecologic cancer care, we should continue to have frank conversations with our patients with regards to COVID-19 symptoms as well as questions about changing financial concerns, safe home environments, access to care, food and housing. We should collaborate with our medical colleagues to actively manage ongoing comorbid conditions for our patients as these may influence treatment options for cancer during the pandemic and worsen outcomes related to both. We must continue to partner with our colleagues in social work and local and national advocacy organizations many of which have quickly adapted to the crisis and are providing online resources for groups and individuals. This crisis should create new opportunities for collaborations with community organizations that can be integrated to better serve our patients now and into the future. Many patient advocates are well positioned to help lead these efforts. Just as our routine workflows have been altered, we must think outside of our current care delivery models and be both bold and creative.

Finally, both individual physicians and health care systems must prioritize respectfully assessing and addressing goals of cancer and social determinants of health including economic stability, physical environment, education and access to healthy food that might limit patients' ability to comply with public health recommendations, affect our recommended treatments and influence their outcomes. Specifically, meaningful community engagement at the level of the individual providers and our health care systems should be prioritized as we realize that we must partner to both better understand local needs and to address them in sustainable ways. It is imperative to harness our energy to research and develop ways to diminish the glaring heightened impact of health care disparities and discrimination the pandemic has brought to the forefront.

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