

THOUGHT LEADERSHIP CONVERSATION

What Has the Pandemic Revealed About Health Equity and Where Do We Go From Here?

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INTRODUCTION

The COVID-19 pandemic has thrown into sharp relief long-standing inequities in the American healthcare system. Black and brown communities have experienced a disproportionate number of coronavirus cases and deaths. For example, at the height of the pandemic in New York City, age-adjusted mortality rates for Blacks and Latinos were double those of whites and Asians. The pandemic's economic devastation has been unevenly experienced as well. In a national survey conducted in July and August of 2020, 72% of Latino, 60% of Black, and 55% of Native American people reported they were experiencing serious financial problems. In contrast, 37% of Asian and 36% of white people said the same.

The Schwartz Center for Compassionate Healthcare convened a panel of physicians who have dedicated their careers to addressing the inequities embedded in the U.S. healthcare system. Panelists discussed how social determinants and structural racism have led to unequal morbidity and mortality among people of color during the pandemic. They also discussed ways to dismantle these inequities by rebuilding the social safety net, examining long-held assumptions about race, and redefining what a thriving country means.

Among the major themes that emerged from the discussion:

- The social determinants of health (the conditions in which people live and work) have always played a major role in poorer health outcomes for people of color—and the pandemic has put a spotlight on this fact.
- Understanding why health inequities exist requires examining root causes.
- Rebuilding the social safety net, expanding access to quality healthcare, and rethinking fundamental assumptions about race are important first steps toward a more equitable system.
- Americans need to be convinced that a thriving country is one in which all citizens prosper.

OPENING REMARKS

Matt Herndon, JD

Chief Executive Officer, The Schwartz Center for Compassionate Healthcare

Beth Lown, MD

Chief Medical Officer, The Schwartz Center for Compassionate Healthcare

Associate Professor of Medicine, Harvard Medical School Department of Medicine, Mount Auburn Hospital

MODERATOR

Sandro Galea, MD, MPH, DrPH

Dean and Robert A. Knox Professor, Boston University School of Public Health

PANELISTS

Mary T. Bassett, MD, MPH

Director, François-Xavier Bagnoud Center for Health and Human Rights at Harvard University

Thea James, MD

Vice President of Mission and Associate Chief Medical Officer, Boston Medical Center

Associate Professor of Emergency Medicine and Director of the Violence Intervention Advocacy Program, Boston Medical Center

Christopher S. Lathan, MD, MS, MPH

Faculty Director for Cancer Care Equity, Dana-Farber Cancer Institute

Medical Director, Dana-Farber Cancer Institute at St. Elizabeth's Medical Center

Associate Medical Director, Dana-Farber Cancer Institute Network Assistant Professor of Medicine, Harvard Medical School

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THE DOUBLE WHAMMY

Mary Bassett, MD, director of Harvard University's François-Xavier Bagnoud Center for Health and Human Rights, began the discussion talking about what top infectious disease expert Anthony Fauci, MD, called the "double whammy" impact of COVID-19 on Black and Latino communities. First, people of color have a higher risk of exposure because they're more likely to live in crowded conditions, work front-line jobs, and lack paid sick leave—the social determinants of health. "And then there's the likelihood that once you get COVID, you will have an adverse outcome... because of the way in which these communities interact with the healthcare delivery system. Unfortunately, there are people who think that this is okay, that it's Black and Brown people who are dying, and that's not us," said Dr. Bassett.

The healthcare system, and doctors specifically, have historically ignored the social determinants of health, according to Thea James, MD, vice president of mission and associate chief medical officer at Boston Medical Center. "We treat disease, not what's making people sick," she said. "Imagine walking along the stream and seeing children floating down the stream with broken arms. We have stood there, pulled them out, and fixed their broken arms for decades. But until you go upstream, you really don't get to understand what's driving this, where it is coming from."

In recent years, healthcare has begun to recognize the social determinants of health, but too often the system continues to set up patients for failure, commented Chris Lathan, MD, Dana-Farber's faculty director for cancer care equity. "We don't take into account that you have an hourly job, that when you take time off from work you don't get paid, and then we punish you for it. You didn't show up for your appointment, but we didn't call you and speak to you in your language. We don't consider that you may not have any minutes left on your phone plan or your phone number changed because now you're on a different plan."

COVID-19 policies are one more example of this lack of patient-centered care, added Dr. Lathan, citing cultures where healthcare decisions may be made by someone other than the patient. "Think about our hospital visitor policies, which are understandably made to protect people. But in certain Black communities, for example, the decision-maker may be a woman—the male patient's sister, spouse, daughter—and they're not allowed to be present. We have to do a better job of reaching out to connect with these decision makers." Another inequity he has observed during the pandemic is that patients of color from the hardest hit communities are showing up for treatment with more advanced cancers. "This is one of the sequelae of COVID, you lose job and then you lose your health insurance."

THE U.S. BLACK-WHITE WEALTH GAP

The median net worth of a white household is 10 times greater than that of a Black household—\$171,000 vs. \$17,100. In Greater Boston, the median net worth of Black households was \$8 versus \$247,500 for white households, according to a [2015 study](#) by the Federal Reserve Bank of Boston.

On average, homes in majority Black neighborhoods [are valued at \\$48,000 less](#) than comparable homes in white neighborhoods.

Controlling for education, experience and location, as of 2015, [the average hourly wage of a Black man was 22% less than his white counterpart](#). [Black women earned on average 11.7 % less than their white peers](#).

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UPSTREAM CAUSES

Panelists discussed the history of the structural racism at the core of health inequities, beginning with 250 years of enslavement of African Americans, followed by 90 years of Jim Crow, 60 years of “separate but equal” doctrine, and more than 35 years of racist housing policy. Said Dr. Lathan: “Any discussion must include root causes, how we got here; otherwise, we are at risk of recreating the same structural systems that got us to where we are right now.”

Dr. James spoke about how the New Deal opened new pathways to wealth-building. But policies like redlining, which discouraged investment in Black neighborhoods, left African Americans out of these reforms. “It’s a very, very clear correlation to what we’re seeing now with COVID,” said Dr. James. “The people and the communities that were behind those red lines are the exact same communities where COVID cases and deaths have been the highest.”

Dr. Bassett, who, with Dr. Galea, co-authored an opinion piece in The New England Journal of Medicine arguing for reparations as a public health intervention to reduce health disparities, said policy can only go so far: “The only solution is to acknowledge that these rectifications are not going to happen simply through policy. They’re going to require an examination of financial instruments to rectify the gap...The wealth gap is insurmountable and it’s resulted in the loss of life we’re seeing during this pandemic.” (See “The Black-White Wealth Gap” box on page 3.)

REMEDIES FOR DISPARITIES OF HEALTH AND WEALTH

Dr. Galea asked the panelists what is the one thing they would want the federal government to do to address the health equity gap. Dr. James said the U.S. needs a new definition of a thriving country, one that emphasizes equity and the ability of all people to achieve at their highest levels. “And with this would be an examination and dismantling of all of the policies—healthcare, education, housing—that prevent this from happening,” said Dr. James.

Dr. Bassett said that rebuilding the social safety net is critical, pointing to other industrialized countries, specifically in Western Europe, whose responses to the pandemic have been more effective than those of the U.S, thanks to their generous state benefits. “These countries have national health systems with universal access, they guarantee a living wage, provide paid sick leave.” She added that the purchasing power of the U.S. federal minimum wage peaked in 1968 at \$1.60/hour, which translates to \$12/hour in today’s dollars. And reforming the tax system, so the richest Americans and corporations shoulder a fairer share of the burden, is imperative, she and Dr. Lathan agreed.

Dr. Bassett also said that society needs to rethink long-held assumptions, including that race is an immutable category that alone can explain the differences in health and economic outcomes for people of color. “Crowded housing, low-wage jobs, and lack of health

DISPARITIES IN MORBIDITY AND MORTALITY BASED ON RACE, ETHNICITY, AND INCOME

Greater wealth has always been a predictor of a longer life and the life expectancy gap has grown over time. For men born in 1930, those in the top 20% income bracket could expect to live 5.1 years longer than those in the lowest 20%. Among men born in 1960, the life expectancy gap expanded to 12.7 years.

Infant mortality rates for Native Americans and Alaska Natives are 60% higher than those of whites.

12.6% of African American children had asthma in 2017, compared to 7.7% of non-Hispanic white children.

African Americans have the highest mortality rate for all cancers combined and for most major cancers compared with any other racial and ethnic group.

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insurance and access to high-quality care... these are the reasons we see these differences, not innate ability,” Dr. Bassett asserted.

Dr. Lathan proposed expanding access to quality healthcare as a good place to start leveling the playing field, “using whichever mechanism we can do it with,” he said. “Even with the Affordable Care Act, we have states that have not expanded it. And then you look at the outcomes in these states and see differences in cancer survivorship. These differences affect all populations, but especially Black and Brown communities and poor people in general.” (See “Disparities in Morbidity and Mortality Based on Race, Ethnicity, and Income” box on page 4.)

THE ARGUMENT FOR EQUITY

Dr. Galea asked panelists how they would convince the richest 20 percent of Americans — which roughly correlates to those with four-year college degrees — that it’s in their interest to promote health equity.

“Power concedes nothing without a demand. It never did and it never will,” responded Dr. Bassett, quoting abolitionist Frederick Douglass. But wealth doesn’t provide inherent protection from a disease like coronavirus, and she pointed to the fact that COVID-19 penetrated even the rarefied environment of the White House. “I hope that people see that we have to respond with social solidarity,” said Dr. Bassett. “Whether people will embrace that is not so clear, especially in our highly polarized environment.”

Dr. James returned to the misconception many people have about innate differences among races: “We have to dismantle the beliefs people have about why, for example, COVID disproportionately affects one group of people versus another,” she said. “But these ideas go beyond COVID. At the root is the belief that people of color are somewhere innately inferior.” Even the most well-meaning people, those who would never consider themselves racists, harbor some of these notions, she added.

Dr. Lathan said that convincing the wealthy and powerful that they should care about the disenfranchised will require making people recognize the good that comes from ensuring everyone prospers. “Our society is only as good as our safety net structure,” he said, offering the example of the New Deal, which helped poor and unemployed Americans recover from the Great Depression. “These types of reforms are not un-American. They propelled the United States forward, except that racism prevented one particular group from benefiting.”

THE ROLE OF THE PRIVATE SECTOR

Dr. Galea concluded the discussion by asking what role the private sector can play in narrowing the health outcomes gaps across class and racial lines. Dr. James said that multi-sector partnerships, which



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address the root causes of poor health outcomes, are one important solution. Her hospital, Boston Medical Center, is part of the The Boston Opportunity System Collaborative, which leveraged a \$5 million award from JPMorgan Chase to create affordable housing in several Boston neighborhoods. The money also is used to train Black and Latinx residents for careers in healthcare, technology, and biotech, then connects them with jobs. “This is a great example of medicine beginning to get at the root causes that lead to bad health,” said Dr. James.

Dr. Basset underlined the importance of social movements. “The public health and medical community must become more outspoken, as we have watched this income inequality escalate. We need to speak out against it.”

Finally, Dr. Lathan spoke about capitalism as a “double-edged sword.” “As a system, it can be used to perpetuate income inequality, but it can also be, with the help of regulation, used to redistribute resources and contribute to the safety net,” he commented. He went on to talk about corporate responsibility. “Their successes are built on the backs of labor and publicly funded infrastructure, like roads...They have a responsibility, just like individual citizens, to contribute to the betterment of our society.”

CONCLUSION

Dr. Galea ended the session by emphasizing one thread that ran through the conversation: “This is the moment to change how we talk about these issues...how we talk about health equity. We change things by having these conversations, by being public about it.”

RECOMMENDED READING FROM THE PANELISTS

Articles

[How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities](#)

[Structural Racism and Health Inequities in the USA: Evidence and Interventions](#)

[Why Your Doctor Should Care About Social Justice](#)

[Unequal Treatment](#)

Books

“An American Health Dilemma: A Medical History of African Americans and the Problem of Race: Beginnings to 1900” by W. M. Byrd and L. A. Clayton

“The Health Gap: The Challenge of an Unequal World” by Michael Marmot

“Well: What We Need to Talk About When We Talk About Health” by Sandro Galea, MD

“Random Family: Love, Drugs, Trouble, and Coming of Age in the Bronx” by Adrian Nicole LeBlanc