

# COVID-19 response

Addressing health and health care disparities



## COVID-19: Disparities at the forefront

The COVID-19 public health crisis has shone a spotlight on health-related disparities, highlighting the critical need to address the roots underlying these inequities.

With a goal of improving public health, Optum Serve leverages its foundation in data, analytics and multidisciplinary approaches to assess and evaluate why health disparities occur and how they can be addressed to drive better health outcomes across all populations. Emerging data on race and ethnicity patterns indicate that minority communities in the United States bear a disproportionate burden of adverse outcomes.

As of June 2020:

- Black individuals (non-Hispanic/Latinx) experience age-adjusted COVID-19 hospitalization rates approximately five times greater than white individuals (non-Hispanic/Latinx), while Hispanic/Latinx individuals and Native American individuals (non-Hispanic/Latinx) experience four times greater rates.<sup>1</sup>
- Black individuals (non-Hispanic/Latinx) die from COVID-19 at a rate more than 1.5 times higher than their population share.<sup>2</sup>
- More than 60% of nursing homes where a quarter or more of the residents are Black or Hispanic/Latinx have reported at least one COVID-19 case.<sup>3</sup> This is double the rate of facilities where both racial/ethnic groups make up less than 5% of the nursing home.

Inequalities in COVID-19 spread and outcomes reinforce the widely recognized correlation between social determinants of health (SDOH) and health outcomes. Disproportionate impacts of COVID-19 for racial and ethnic minorities stem from increased risk of transmission, increased risk of severe symptoms and mortality, and reduced access to care.



## What are disparities?

Disparities are inequalities in opportunity and outcomes that cannot be explained solely by individual choices. They are driven by factors including race/ethnicity, gender identity, sexual orientation, age, location and socio-economic status. These factors can intersect with, compound and moderate one another.

**Health disparity** refers to a higher burden of illness, injury, disability or mortality experienced disproportionately by one group relative to another.

**Health care disparity** refers to the difference between groups in insurance coverage, or in the access to use or quality of care.

## Increased risk of transmission

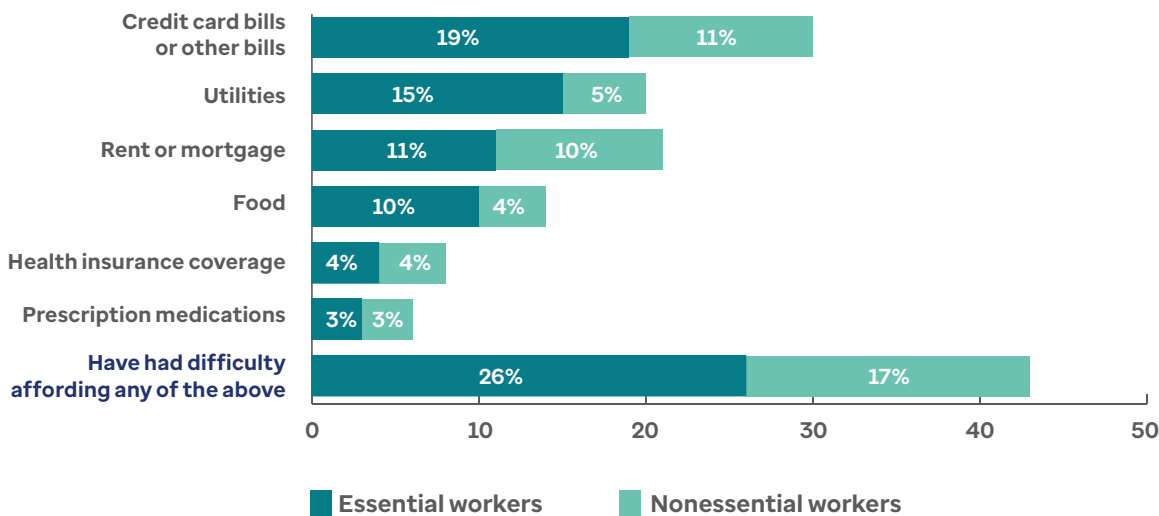
The nature of COVID-19 transmission leaves some individuals at greater risk than others, particularly those whose living situations or employment requires regular face-to-face contact with others, especially in close quarters.

### Low-wage essential workers

- Non-white workers disproportionately represent the essential workforce in health care, retail and transportation that regularly faces exposure to the public.<sup>4,5</sup> In 2019, people of color (individuals who do not self-identify as white) made up the majority of essential workers in food and agriculture (50%) and in industrial, commercial, residential facilities and services (53%).<sup>6</sup>
- Essential workers with low incomes often cannot stay home due to limited access to paid leave and the need to maintain sufficient income to afford necessities such as food, housing and health care.<sup>7</sup> They are also more likely to use public transit, where they have limited ability to maintain social distancing.<sup>8</sup>

## One in four essential workers report having difficulties affording basic household expenses

The chart below displays the percentages of individuals who responded to the Kaiser Family Foundation Health Tracking Poll<sup>9</sup> who say they or any other adult in their household has had problems affording, or fallen behind on payments for, each of the following as a result of COVID-19:



**NOTE:** Essential workers are those who say they are required to work outside of their home. Nonessential workers are workers who maintain their employment and are not required to work outside their home.

## Older adults and persons with disabilities

- Older adults and persons with disabilities in nursing facilities face an increased risk of community transmission due to high-density living arrangements and the rotation of staff across care sites. Residents also face more severe outcomes due to underlying health conditions.
- As of June 26, 2020, 43% of U.S. pandemic fatalities occurred among nursing home residents or staff.<sup>10</sup>

## Persons experiencing homelessness

- Individuals experiencing homelessness face rapid community transmission due to crowding in shelters and the lack of options for self-isolation for the unsheltered. For example, one in three individuals experiencing homelessness in Boston tested positive for COVID-19 as of May 2020.<sup>11</sup> Other shelters across the U.S. have reported rapid spread.
- People of color comprise a disproportionate share of the homeless population compared to the general population, and are among the most vulnerable to COVID-19. Black, Hispanic/Latinx and Native American individuals represented 40%, 22% and 3% of the 2019 homeless population, respectively, but represent smaller proportions of the general population (13%, 19% and 1%, respectively).<sup>12,13</sup>

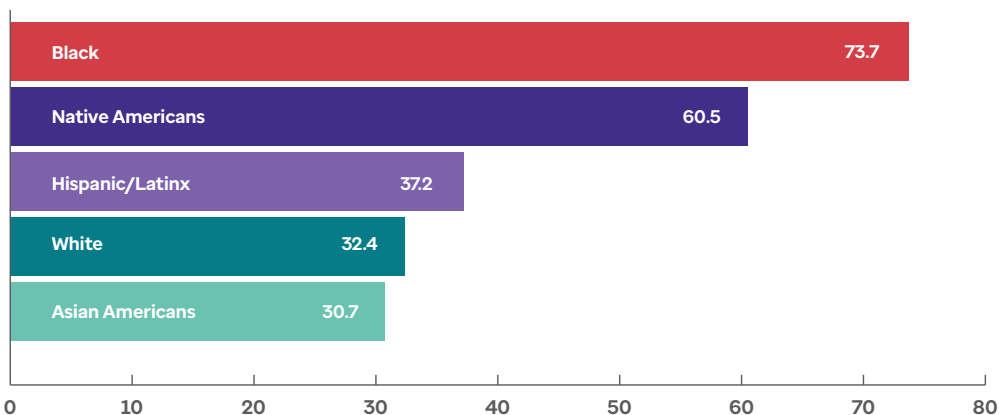
## Increased risk of severe symptoms and mortality

Individuals with underlying health conditions, such as lung disease, heart conditions, obesity, diabetes, as well as those immunocompromised, experience increased risk for severe symptoms of and mortality related to COVID-19. People at greater risk for severe symptoms due to chronic, underlying health problems include those suffering from food insecurity, those living in poverty, and certain racial and ethnic minorities.<sup>14,15</sup>

### Pre-existing chronic conditions

COVID-19 patients with an underlying condition have hospitalization rates six times higher<sup>16</sup> than those with no underlying condition, and rates of mortality 12 times higher. Non-Hispanic/Latinx Black, Hispanic/Latinx, and Native American individuals' higher rates of obesity, diabetes, hypertension, asthma and cancer contribute to a heightened risk for severe symptoms and death from COVID-19.<sup>17</sup> In addition, underlying conditions, such as diabetes, heart disease and HIV/AIDS occur among individuals experiencing homelessness at rates between three and six times that of the general population.<sup>18</sup>

**COVID-19 mortality rate per 100,000 by race/ethnicity<sup>19</sup>**  
(current as of July 21, 2020)



## Food insecurity

Due to the rapid increase in unemployment during the public health emergency, increasing numbers of individuals are experiencing food insecurity – a risk factor for chronic conditions. Households below 185% of the federal poverty line experience nutritional gaps at 2.6 times the national average.<sup>20</sup> By the end of April 2020, more than one in five households in the United States, and two in five households with mothers whose children were 12 and under, experienced food insecurity.<sup>21</sup>

Even before COVID-19, Black (non-Hispanic/Latinx) and Hispanic/Latinx individuals experienced food insecurity at 1.9 and 1.5 times the national average, respectively.<sup>22</sup> Food insecurity among older adults (age 65 and older) was increasing pre-COVID-19, heightening their risk for health complications due to poor nutrition as well as severe symptoms from COVID-19.<sup>23</sup>

## Reduced access to care

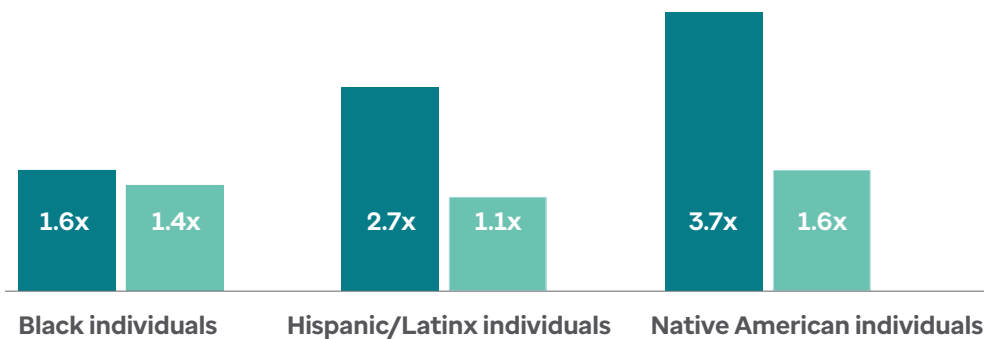
Uneven access to health care results from factors including differences in health insurance coverage, provider availability, affordability and quality of care for low-income families, people of color and rural communities.

- In 2018, employer-provided insurance covered nearly 60% of all non-elderly (age 64 and younger) individuals in the U.S., while employer-sponsored insurance coverage remained lower for Black individuals (46%), Hispanic/ Latinx individuals (41%), and Native American individuals (36%).<sup>24</sup>
- At the end of April 2020, the U.S. unemployment rate had risen to nearly 15%, over four times the rate at the end of January 2020.<sup>25,26</sup> Those who experience job losses also risk losing employer-based health insurance coverage, impacting the ability to afford and seek care. While Medicaid coverage mitigates some coverage losses, eligibility requirements vary by state, and individuals in states that did not expand Medicaid coverage under the Affordable Care Act may be at a relative disadvantage.
- Members of low-income households and those without insurance have historically been more likely to delay seeking care and filling prescriptions due to cost, and report greater difficulties in receiving care<sup>27</sup> – potentially resulting in exacerbated chronic conditions prior to COVID-19 and poor care outcomes.



Following the outbreak of COVID-19 in the U.S., nearly **1 in 5 children did not have enough to eat**<sup>28</sup>

## Racial and ethnic disparities in insurance coverage and inability to seek care due to cost<sup>29</sup>



- Likelihood of not being insured, compared to White individuals
- Likelihood of not seeking medical care due to cost, compared to White individuals

## Going forward

Curbing the spread and impact of COVID-19 through testing, vaccination and support for economic and social recovery requires strategies reflective of the myriad dimensions of health equity, including: race/ethnicity, language and literacy, age, gender identity and sexual orientation, rurality, disability status, family structure, residential arrangement, occupation and comorbidities. Optum Serve has deep analytical capabilities, as well as strong policy research expertise to help government leaders make informed decisions in order to deliver consistent and quality care across the populations they serve. The approaches below, proposed by Optum Serve as a path forward to address COVID-19 health disparities, can assist leaders in their efforts to tailor strategies to specific geographic areas and populations.

### **Leverage cross-sector partnerships**

Working across local, state and federal health and social service partners allows for a “whole person” approach to care and recognizes the deep impacts of food, education, employment and housing needs on health care outcomes. Successful cross-sector partnerships prioritize collaboration with and engagement of community members and leaders as well as trusted social service organizations, community-based organizations, health care providers and public health care programs such as Medicaid and the state Children’s Health Insurance Program. While in some communities these partnerships may be well-established, other communities may need to build this capability.

### **Strengthen data collection, use and sharing**

Reliable and timely data are key to assessing disparities, community-specific needs and the impact of related interventions. The U.S. Department of Health and Human Services required in June 2020 that laboratories reporting COVID-19 test results also collect demographic data including race, ethnicity, age and sex, to allow for assessment of equitable access to testing and the burden of infection on vulnerable groups. In addition to collecting data on race and ethnicity, it is also critical to collect and leverage individual-level data on social determinants of health, to inform public health initiatives and to connect individuals with needed resources. Although an increasing number of organizations are collecting SDOH data, there is a lack of consistency and standardization, and community-level data may need to be employed to support allocation and appropriate focus of resources.

### **Ensure practical and targeted information from trusted sources**

Communities across the nation are continually receiving information about COVID-19 from a variety of sources, and this information may be incomplete, untested or factually incorrect. Culturally competent information from trusted messengers combats communication and trust gaps and ensures cultural relevance. Public messaging sometimes emphasizes strategies that individuals cannot easily practice if they are experiencing homelessness, living in congregate settings or working in public-facing jobs. Nuanced and practical messaging at appropriate health literacy levels is key.

### **Invest in community health workers**

Community health workers are in a unique position to address health care disparities related to COVID-19, given their connection to and understanding of the communities they serve, and their ability to reach community residents where they live, eat, play, work and worship. These workers are valued partners in testing and contact-tracing initiatives, home-based COVID-19 treatment supports, and referral programs for health care and social services. Dedicating resources to training, sufficient personal protective equipment and user-friendly technologies will be critical to their effective deployment.

### **Use learning systems to accelerate results**

In mass emergencies, the best solutions often emerge from local ingenuity. Learning systems, including action groups and innovation networks, accelerate results by rapidly surfacing and spreading successful practices. The most effective learning systems draw on insights from multiple fields including improvement science, community organizing, dissemination and implementation, and adult learning to mobilize health care organizations, community-based organizations (CBOs) and other partners around shared goals. Addressing disparities should be included as a goal in learning systems to address COVID-19.

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### **Learn more at:**

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