Addressing health inequities re-illuminated by the COVID-19 pandemic: How can nursing respond?

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Abstract

The coronavirus disease 2019 mortality rate among Black adults in the U.S. is double that of other racial and ethnic groups. The current pandemic is re-illuminating health inequities that are pervasive in our society and reflected in our health system. This creative controversy describes critical conversations needed within nursing to acknowledge the contribution of structural racism to health equity. We recommend implementing structural competency into nursing education and prioritizing nursing research and policies focused on health equity and community-based interventions.

KEYWORDS
COVID-19, health equity, nursing, racism

1 | INTRODUCTION

The first half of 2020 has ushered the work of nurses to the forefront as we confront one of the deadliest pandemics of the 21st century. Much of the conversation has centered on nursing responsibilities within the hospital, and the dire need for protective equipment that permits nurses to provide critical, life-saving care to the community. We contend other critical and creative conversations are needed within nursing to address how and why the coronavirus disease 2019 (COVID-19) pandemic is illuminating pervasive inequities in the health care system. This requires a critical race lens to understand the structural components underlying our present-day system, and creativity to move nursing forward beyond a description of the problems, to actionable steps.

Longstanding patterns of health inequities observed with other chronic (e.g., asthma, hypertension) and communicable (e.g., H1N1 influenza) diseases are not surprisingly also occurring amidst the COVID-19 pandemic. The COVID-19 mortality rate for Black adults was double that of any other group in early April 2020 and this disproportionate rate of death persisted into August 2020. The startling, but sadly, not surprising inequities re-illuminated during the COVID-19 pandemic are not new, rather are a result of distal factors (e.g., structural racism), and proximal explanatory factors related more directly to the healthcare system (see Figure 1). To clarify, proximal factors are those social contributors to health which have direct effect on health while distal and intermediate contributors both directly and indirectly influence health outcomes. Early in the pandemic, the high mortality of Black adults may have been proximally related to the insufficient access to testing in communities of color, but this is difficult to ascertain as initially, only two states, (Illinois and Kansas), released disaggregated testing data by race and ethnicity. Initial pre-screening for testing was largely based on a history of international travel, and people of color presenting with symptoms, were least likely to check this box, and therefore were not tested. Also, many of the initial testing sites were drive-up testing only, excluding people relying on public transportation. Social and economic level factors are intermediate contributors to the health inequities re-illuminated by COVID-19. People of color are disproportionately represented in entry level jobs, such as grocery clerks and fast food workers, which are deemed as essential services. Despite their essential nature, many of these workers earn low wages and lack access to affordable insurance benefits. Under the light of COVID-19, we see that people of color comprise 41% of front line jobs, 1 out of 3 live in low income families, have small children at home, or care for an elderly family member, making social distancing difficult. This is not unlike what occurred during the
H1N1 pandemic which similarly illustrated that people of color simply cannot afford to socially distance given their socioeconomic and structural constraints. These trends were even suggested before the H1N1 pandemic in a national survey of the public’s response to possible community-based pandemic interventions. As Dr. Oni Blackstock notes, the inability to social distance may be considered a new social determinant of health. These same factors have contributed to disparities for decades, and are magnified in the time of COVID-19.

2 | CRITICAL CONVERSATIONS

The distal contributors to the inequitable distribution of death and disease in the U.S are more insidious but critically important. Much attention has been given to social contributors to health, for example, housing, employment, limited access to health care, but to understand these social contributors, and to make progress in eliminating health inequities, we need to understand the historical contexts, which are rooted in structural racism. Structural racism refers to how societies and systems foster housing, credit, employment, media, healthcare, and criminal justice discrimination based on race. Using housing as an exemplar, racist redlining laws prevented Black adults from purchasing homes for years, and housing is a leading way families build and pass on wealth. This wealth gap translates to more people of color experiencing cyclical poverty, having a vulnerable insurance status (e.g., uninsured, high deductible insurance plans), in low wage jobs, and living in hyper-segregated communities. Although the legal enforcement of these laws ended in 1948, some remain on the books, and discriminatory lending practices towards Black and Latinx individuals continue (see 2015 HUD case for a recent example: https://archives.hud.gov/news/2015/pr15-064b.cfm).

Addressing the root of the problem, structural racism, is imperative for action to occur. Without recognition of the historical problem, our intervention and policy efforts are band-aid solutions.

Nursing’s meta paradigm lends itself well to incorporating structural factors into nursing curriculum as it focuses on the relationship between the person/community, the environment, and nursing practices which influence the health experience. Yet, not many health professions curriculums include content on structural racism as a baseline contributor to health and its distillations, such as implicit bias. With a rich body of literature documenting the associations between implicit bias, and lower quality of care, patient-provider relationships, and poor health outcomes, these issues affect nurses and their ability to provide care. To provide competent, contextually appropriate care, nursing’s awareness of the root causes of these disparities is critical for nurses to stimulate creative, action focused conversations.

3 | CREATIVE CONVERSATIONS

In the new normal that will follow the COVID-19 pandemic, there will be many discussions about what nursing can learn from this, and what we need to do differently. We assert that as part of the discussion, nursing can seize this opportunity to creatively address racial and ethnic inequities through education, research, and policy. The ideas we share are not exhaustive, but merely an attempt to stimulate conversation.

3.1 | Education

Nursing programs could be the intervention point to increase awareness of implicit bias before independent practice. We believe this extends to structural racism content as well. Nursing programs should augment cultural competence or cultural humility program outcomes with structural competency. Structural competency is a means of understanding the institutional forces and social conditions leading to poor health and lack of access to care, and provides a broader context for understanding social contributors to health.
Other health disciplines have begun to include a focus on structural contributors to health, but only one study in nursing has piloted a similar curriculum innovation. A structural competency requirement would present a more accurate portrait of the factors affecting health, correct the tendency to “blame” patients for their current situation, and in the era of precision health, could stimulate robust conversations on how social and structural factors intersect with biology (i.e., epigenetic changes). Thoughtful consistent exposure using a leveled approach to strategically integrate content on racism, health equity, and bias throughout nursing or health professions curricula is needed across the academic continuum (didactic, clinical, and simulation), and should be a priority for nursing education research.

Another way nursing educators can respond is through policy education. The American Association of Colleges of Nursing essentials require the inclusion of policy education and competencies in nursing curricula at the graduate level, but research suggests policy education in nursing curricula does not result in policy engagement among graduate nursing students. Future education research could identify best practices for integrating policy content across the nursing continuum, and action steps for translating education to action. From a structural competency lens, policy content linking social contributors to health with policies that may not be typically viewed as health policies, such as minimum wage, could help nurses identify structural forces that influence individual health.

Nurses are primed to lead health promotion policy initiatives, such as ones addressing the wealth and education gap in the U.S. which sustains health inequities by reinforcing the status quo. Advocating for an increase in minimum wage is a health promotion initiative, and course assignments involving writing and submitting op-eds for publishing, attending legislative days, volunteering with local, state, or national advocacy groups could all be integrated into policy education for nurses. Undergraduate nursing students can be introduced to payment structures and systems to build an understanding of the complex barriers which limit access to care. For graduate level nursing students, this curriculum can expand to include education on state licensure regulations and health insurance payment structures (private or commercial vs. Medicare or Medicaid). The COVID-19 pandemic presents a unique opportunity for nursing students to explore the rise in telehealth necessitated by COVID-19, the effect of state level regulations on reimbursement for telehealth visits, and how these policy decisions impact access to telehealth services for people of color. Engaging a structural competency lens informs how a rise in telehealth could exacerbate disparities. A 2018 U.S. Department of Education report found that 22% of Black adults lacked foundational computer skills (i.e., digital literacy) compared with 11% of their White counterparts. Reasons for this disparity could be associated with educational attainment, employment status, and unequal distribution of access to high-speed internet, just to name a few, and all can be connected back to the groundwater problem of racism. A structural competency lens creates an opportunity for a more rigorous analysis of existing policies, and challenges nurses to identify health and equity implications in all proposed solutions.

### 3.2 Research

In the post-pandemic world, nurse researchers can also address many of the inequities re-illuminated by the current pandemic. As noted by Yancy, higher morbidity and mortality from COVID-19 among the Black population may also be driven by a disproportionate prevalence of asthma, heart disease, hypertension, diabetes, and obesity. Nurse researchers can prioritize interventions with ambulatory monitoring of blood pressure, improved medication management, and of paramount importance, addressing the role of stress in the social environment (e.g., racism, sexism) as a critical risk factor for hypertension and heart disease. Nurse researcher, Regina Conway-Phillips, has piloted an intervention to address the stress of racism on the cardiovascular health of Black women, and more similar work is needed. A 2019 article urges clinicians to appreciate that weight gain and obesity are often the manifestations of food related coping. Consequently, advice from clinicians may be less effective without tools and interventions to address the underlying proximal, intermediate and distal contributors to health behavior and coping. Nursing science must embrace our community health origins and fund community based nursing research on par with funding of research focused on acute care nursing practices. Moreover, clinical translation of this type of research is imperative to significantly and effectively address social and structural factors at the community level.

With the rise of telehealth services related to COVID-19, research is needed to understand best practices for patient-nurse communication in the telehealth environment, and nuanced ways which implicit and explicit biases may influence telehealth care. Many Black patients will dress in their best attire for a healthcare visit to “earn” the respect of the provider, but could be embarrassed to reveal their housing situation in a video visit. Other areas of research include health services research to address access to care, communication strategies for disseminating key health promotion education, and prioritizing funding for interventions focused on the social contributors to health, and scaling health-related interventions that show the most promise.

### 3.3 Policy

To uproot disparities, policy adaptations are required to move from the current reactive, illness model to a proactive, wellness, and chronic care model. Nurse researchers and DNP prepared clinical leadership can partner to design and test new care delivery models that leverage the community based public health nursing models heralded by Lillian Wald. Nurse-led community-based implementation of models like the chronic care model has shown promise in mitigating risk factors in the development and management of
diseases which disproportionately affect people of color.\textsuperscript{28,29} However, the scaling and sustainability of nurse-led community-based interventions are dependent on creating health policies that reflect their benefit on patient outcomes and therefore supply funding mechanisms for community-based programs and workers.\textsuperscript{30,31}

Many low-to-middle income countries can serve as policy exemplars in the establishment of evidence-based community health models.\textsuperscript{32,33} For example, the use of community health workers to address mental health disparities is promising. Models from low-to-middle income countries have demonstrated success with providing evidence based treatment in areas of high need, by deploying trained community health workers.\textsuperscript{32} Existing mental health disparities in the U.S. may be exacerbated by grief related to the higher mortality rates from COVID-19 in communities of color, the absence of typical grief rituals, and greater economic hardships due to lower family income. Nurse researchers can create and test evidence based mental health treatment delivered by community health workers and propose policy reforms to fund reimbursement for these innovative delivery models. Nurse researchers are poised to conduct and advocate for policy research and reforms related to community-based provisions of care.

4 | CONCLUSION

The long-standing health inequities have persisted for far too long, and the pattern of communities of color experiencing high morbidity and mortality from novel infectious diseases is sadly quite predictable.\textsuperscript{34} In this year of the nurse and midwife the impact of nursing is on display more than ever. While nursing has given enormously to the effort to combat this pandemic, we must simultaneously begin and continue conversations about how nursing can respond to the undeniable, structural inadequacies resulting in unnecessary disease and deaths of people of color. The COVID-19 pandemic has again demonstrated that health and policy are not independent of each other and can lead to catastrophic outcomes when policy does not address the needs of those at the margins.

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