COVID-19 and Health Disparities:
Insights from Key Informant Interviews

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Roadmap

- Opening parable
- COVID disparities
- Measures that can help
- Questions and discussion

An opening parable

- Dr. James Mahoney was for decades a critical care physician at University Hospital in Brooklyn, NY

- Dr. Mahoney became infected with COVID-19, and requiring care in his hospital's under-resourced ICU

"In a desperate effort to save his life, his colleagues loaded him onto an ambulance and rushed him to Tisch Hospital, a wealthier institution with a sophisticated blood oxygenation machine that University Hospital did not possess. Five colleagues, a kind of honor guard, followed the ambulance as it rode from Brooklyn to Manhattan. They escorted him to the hospital and were with him, at his bedside, when he died" (NYT)

Epidemiological Disparities & Social Determinants of COVID-19

- Income/race/ethnic disparities in COVID hospitalization
- Low-income Americans--higher prevalence of comorbidities
- Immigrants are 15% of U.S. labor force--70% are essential workers
- Contact tracing fails to win trust of communities and is often ineffective

Disparities in intensity & proficiency of care

- Nursing homes and long-term settings--at least 40% of current COVID-19 fatalities
  - More than 850 staff deaths--one of the most dangerous occupations in America
  - Critical factors--COVID prevalence in communities
- ICU and critical care
  - COVID-19 patients admitted to hospitals with fewer than 50 ICU beds display significantly higher mortality

Aligning clinical excellence with community benefit

- Advantages of regionalization underscored but not brought to light by the COVID pandemic.
- Prone positioning and other best practices linked to reducing disparities

  “It’s not just the machine….Obviously that’s a necessary condition, but it's by no means sufficient to provide excellent ARDS care. Where that comes from is from having awesome ICU nurses and this team of doctors and respiratory therapists and the whole infrastructure.”

- Organizational barriers and incentives in receiving & referring hospitals
- Revenue streams and COVID supports poorly targeted to hardest-hit facilities

Expanded, politically durable public health funding model

- Funds required for aggressive COVID response ($75B annually) are…
  - Large by standards of public health (5x CDC annual budget)
  - Small by standards of medical care (1 week's expenditure)
- Current funding models discourage state and federal public health spending at the margin
  - Medicaid FMAP offers better model
- Create geographically and ideologically diverse coalition to defend public health investments
- Mobilize public health and social services workforce

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Q&A

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