SOCIETY OF BEHAVIORAL MEDICINE

POSITION STATEMENT:

Society of Behavioral Medicine Calls for Equitable Healthcare during COVID-19 Pandemic

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SUMMARY STATEMENT

A pandemic has no borders and should not disproportionately penalize vulnerable segments of the population. Addressing COVID-19 requires us to act swiftly, bridging geographic, social, and economic divisions, while increasing focus on those at greatest risk. The Society of Behavioral Medicine (SBM) urges research on disparities in COVID-19-related morbidity and mortality outcomes. We also urge policy actions to enable proactive remediation of healthcare disparities.

The COVID-19 pandemic is the greatest public health threat since the 1918 influenza outbreak.[1] According to the World Health Organization (WHO), as of April 22, 2020, the novel coronavirus pandemic has infected 2,471,136 people worldwide[2] including 776,907 United States (US) residents.[3] Worldwide, there have been 169,006 deaths[2] including 37,602 in the US.[3] Disturbingly, the vulnerable in our society are more impacted.

The unfolding COVID-19 pandemic has exacerbated existing health inequities in the US.[5,6,7,8,9,10] Evidence is mounting regarding racial/ethnic and socioeconomic (SES) inequities in COVID-19 testing, morbidity, and mortality.[6] For example, African Americans comprise of less than 50% of the populations of states such as Wisconsin, Louisiana, Michigan, and Illinois, yet currently account for as many as 70% of COVID-19 related deaths.[11] Yet, due to data inaccuracies, underreporting, and missing critical demographic data, a complete picture of the disparate racial/ethnic and socioeconomic (SES) realities of this pandemic is currently unavailable.[9,12,13,14,15,16]

Underrepresented racial/ethnic minorities, lower-income individuals, and essential workers (note: racial/ethnic minorities are overrepresented in the latter two groups) are at higher risk of contracting the virus and having worse outcomes, due in part, to disproportionately higher rates of underlying health conditions e.g., obesity, diabetes, hypertension, heart disease, respiratory disorders[17] that are associated with COVID-19 complications. Contributing factors of these existing disparities include systemic discrimination, inadequate access to quality healthcare including preventive care, and economic constraints that prevent the vulnerable segments of our society from being able to prioritize health. In the US, race is associated with lower SES[18] stemming from historic systemic racism (e.g., Jim Crow laws, redlining) that placed racial/ethnic minorities in unfavorable (e.g., more crowded and polluted) neighborhood environments and in lower-paying occupations.[19,20] For example, less than 20% of African Americans are able to work from home compared to nearly 30% of non-Latino Whites. African Americans may also be more likely to work in essential services such as food, delivery, and transportation.[21] These social and economic circumstances place vulnerable and marginalized populations at higher risk for COVID-19 infection, morbidity, and mortality.

Hence, SBM advocates for prioritization of the needs of these vulnerable and marginalized populations through research and policy development to promote virus suppression and mitigation of current inequities. These priorities can be advanced through more accurate and comprehensive demographic data collection,[14,22] more

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widespread health outreach and COVID-19 testing, especially in underserved African-American, Latino, and Native American communities,[23] more funded research on the ethnic and racial correlates of COVID-19 disease-related morbidity and mortality,[24] and additional financial resources to offset work and health-related losses. Public health messaging must be tailored to highly affected groups so there is equitable access to high-quality, relevant, and evidence-based information. Only such focused policy action, research, and investment will garner evidence to develop and enact effective, timely, and lifesaving prevention and intervention strategies and policies. Below we offer specific research recommendations and short and long-term policy recommendations.

RESEARCH RECOMMENDATIONS

1. There are currently no approved treatments for COVID-19. Clinical trials can produce high-quality data that can be used to assess potential therapies for treatment and prevention.[25] It is imperative that underrepresented racial/ethnic minorities who are routinely underrepresented in clinical trials, due in part to distrust of the healthcare system based on past systemic injustices and lack of available tools in non-English languages, be fairly represented but not exploited. Best practices for informed consent and safe, humane research still apply.
2. Current data collection of positive test results for COVID-19 for individuals at home, hospitals or in intensive care units is often delayed or inadequate.[26] Accuracy of COVID-19 testing, incidence, and prevalence data needs to be improved and reported by race/ethnicity. Individuals with COVID-19 who reside in aggregate living facilities should also be included in state-level counts of affected patients and outcomes.
3. There is the potential to widen existing health disparities through conflicting and inadequate public health messaging. Attention to COVID-19 messaging and health literacy must be addressed given existing gaps in knowledge as well as concern and awareness among those who are economically disadvantaged and are from underrepresented racial/ethnic minority groups.[27]
4. Increased research is needed regarding the potential for COVID-19 stigma on already vulnerable populations and how COVID-19 intersects with race/ethnicity, income, immigration status, quality housing, access to care, and health status.[28]

POLICY RECOMMENDATIONS

Short-Term Recommendations

1. To address disparities in Internet broadband availability[29] and target gaps in Internet access due to the COVID-related closures of schools, businesses, and libraries[30] local, state, and federal governments should provide free and widely available internet access and education. This will increase opportunities for occupational telecommuting and promote access to medical telehealth services.[31]
2. To promote internet utilization, free or low-cost computers or tablets, and access to training on how to use these devices, should be made available to under-or unemployed individuals. Internet access is also critical for individuals with chronic illness who are implementing social distancing but need continuity of care to manage their pre-existing chronic conditions via telehealth services.
3. To better protect the health of essential "front line" employees, OSHA should conduct inspections to ensure that employers implement COVID-related safety policies and practices, such as the provision of effective PPE for all essential employees.[32]
4. Employers should offer flexible benefits to employees and caregivers should they acquire COVID-19 or need to care for a member of their household that has tested positive.
5. To increase the insurance coverage of unemployed or underemployed individuals, facilitate timely access to healthcare, and promote mitigation of the spread of the disease, per recommendations of the American Hospital Association[33] and the Alliance of Community Health Plans (2020), the ACA HealthCare.gov website, and insurance marketplace enrollment options, should be immediately reopened for uninsured people and remain open indefinitely.
6. Bias should be eliminated from treatment qualification algorithms.[34] Accurate, standardized, and comprehensive demographic data collection, which taps race/ethnicity, should be built into intake and follow-up of all medical and contact tracing procedures.[14,22]
7. All COVID-19-related diagnostic, preventive (e.g. vaccinations when available), and, treatment expenses should be automatically covered or reimbursed in full as per Brooking Institute recommendations.[35]

Intermediate and Long-Term Systemic Recommendations

1. Congress should prioritize the funding, development, and implementation of widespread affordable, accessible, culturally sensitive, multilingual, and systematic health-related outreach, education,[27] COVID-19 testing, and treatment specifically targeting underrepresented and marginalized groups.
2. Congress should restore funding and/or the equivalent of expected patient reimbursements to community-centric health delivery systems such as local hospitals, Community Based Health Clinics [CBHC], family practices[36,37,38,39] and School-Based Health Clinics (SBHC)[40] so they can reopen and safely operate at their pre-COVID levels.
3. Grants should be made available for the development of alternative creative, flexible, culturally sensitive, and affordable healthcare delivery options, such as mobile healthcare clinics (MHC), which can bridge healthcare disparities in "health deserts."[41,42]

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ENDORSEMENTS

ACBS Association for Contextual Behavioral Science

American Psychological Association

PCNA Preventive Cardiovascular Nurses Association

Society for Health Psychology

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