Centering Equity and Community in the Recovery of the COVID-19 Pandemic

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The COVID-19 pandemic has exposed socioeconomic, geographic, and medical vulnerabilities in our country. In North Carolina, inequalities resulting from centuries of structural racism exacerbate disparate impacts of infection and death. We propose three opportunities that leaders in our state can embrace to move toward equity as we weather, and emerge from, this pandemic.

An Intersection of COVID-19 Disparities and Racial Inequities in North Carolina

The COVID-19 pandemic has exposed existing deep-seated social, economic, geographic, and medical vulnerabilities across our country and here in North Carolina. Against the backdrop of stark and distressing racial and ethnic disparities in the pandemic, public murders of Black men and women at the hands of law enforcement have reignited the Black Lives Matter movement and call on institutions across the globe to prioritize racial equity. This prioritization reflects the interlocking complexities of practices, policies, and beliefs that reinforce structural racism and perpetuate early, preventable deaths of people of color.

In North Carolina, existing racial and ethnic inequalities have exacerbated the disparate impact of COVID-19 infection and death in our state. Race and ethnicity reporting has been shockingly incomplete given the ethical and scientific standards we collectively endorse. Data as of October 23 indicate that indicate that Black individuals in North Carolina represent 29% of COVID-19 deaths, but only 22% of the population, while Latinx or Hispanic individuals represent 28% of cases but only 10% of the population [1]. Moreover, these medical statistics fail to convey the breadth and depth of Black and Latinx families' suffering and resilience beyond COVID-19 cases, including the impact on economic viability, social networks, support services, and community resources to help with recovery. There is a clarion call for leaders within and outside of health care and public health to seize overdue opportunities to address inequities and social injustice that brought us to this point. In the absence of dedicated and intentional leadership, these stark COVID-19 disparities will not only continue but further exacerbate underlying racial and ethnic inequities moving forward.

How Disparities Got Us Here and How the Pandemic Is Perpetuating Them

While distressing, racial disparities in COVID-19 morbidity and mortality are not surprising. For decades, communities of color have continued to bear a disproportionate burden of the conditions that are risk factors for poor outcomes in this pandemic, including chronic conditions like high blood pressure and diabetes [2]. The disproportionate risk of morbidity and mortality among racial and ethnic minorities is a result of centuries of structural inequalities that increase the risk of chronic conditions by limiting opportunities to lead healthy lives. These structural factors are the product of broader systemic social and economic inequalities that yield uneven opportunities in—and access to—quality of health care, support services, housing, education, and employment.

In North Carolina, we have witnessed how intersecting vulnerabilities across communities lead to a disparate risk of infection and inadequate access to testing and care. Individuals in minority, rural, and poor communities are disproportionately represented as essential workers, who are at significant risk for COVID-19 exposure. Despite their heightened risk, they have kept the state and the country moving forward. Agricultural, construction, and meat processing industries in our state rely heavily on people who are immigrants for their labor pool. Immigrant workers have limited labor protections and access to health care, often working and living in conditions where public health prevention guidelines, including social distancing, are impossible to comply with under present conditions. Individuals at high risk for COVID-19 infection are also more likely to live in medically under-resourced communities and are less likely to have adequate health insurance [3].

Poor and racial and ethnic minority communities experi-

ence disproportionate police surveillance and consequently are overrepresented in the criminal justice system. Disease transmission—especially for a highly contagious coronavirus—is amplified for people who are incarcerated because the current built environment within US correctional settings makes it impossible to comply with public health prevention guidelines [4]. The risk of infection spread is consequently high for individuals who interact with the criminal justice system, either through incarceration or through employment, and then reenter communities [5]. Furthermore, the fragmented and seemingly conflicting information about the pandemic has fed existing distrust of the medical establishment among historically marginalized communities, potentially limiting the acceptability of new technologies and strategies to mitigate viral exposure.

While communities of color disproportionately experience infection, morbidity, and mortality rates, so too will the enduring effects of the pandemic be felt most acutely by these communities. We expect significant impacts on total well-being, including physical, psychosocial, behavioral, and socioeconomic effects, already known to have disparate impacts by race due to structural racism [7]. Besides affecting the lungs, cardiovascular conditions associated with COVID-19 include inflammation, heart damage, myocarditis, and pericarditis. This damage may be related to long-term symptoms such as shortness of breath, chest pain, and heart palpitations [6]. Living in a highly politicized pandemic requires inordinate coping skills, social supports, and mental health care to stabilize in the midst of uncontrollable, societal-level trauma. These needs are amplified in vulnerable and marginalized communities of color experiencing dwindling health care infrastructure and often unequal access to resources. The ripple effects of a severe economic downturn are often felt by those who are already exploited in our society—workers without sufficient legal protections, pay, or benefits to live healthy lives. The global pandemic has intensified existing economic disparities through job loss, unpaid leave, lost wages, and housing insecurity. This pandemic has revealed that health is not just about health care; it is about housing, transportation, food access, and educational opportunity. It is about the duality of essential workers being dubbed essential, yet policies failing to protect them, and about requiring a systemic change to reduce their risk. It is about the ability to be employed without experiencing heightened risk to the health of one's family.

Action-oriented and Equity-driven Opportunities for Leaders in North Carolina

We assert three opportunities that leaders in North Carolina can embrace now to move toward equity beyond the COVID-19 crisis.

Practicing Intentional Leadership that Centers Both Racial and Health Equity

Our state needs health care leadership that values and integrates an equity lens in its initatives and approaches to change as we emerge from this pandemic. Every leader's journey will look different, but a hallmark of this equity-centered journey is a realization that there is no final arrival or destination. Lifetime commitments to self-examination of privilege and power, self-education on antiracist approaches, and responsibility for and accountability to system change are essential components to leadership that advances equity.

Medicine and public health have entered a new era of expecting antiracism to be a strategic priority at every organizational level. This expectation means not just hiring people of color as if callously checking a checkbox, but reforming organizational and team cultures, policies, structures, and processes. Intentional leadership will upend the system as we know it, and it will create a climate that centers equity, diversity, and inclusion competencies to the same degree as other leadership competencies. Resources will be diverted to treat the current racist disparities as the crisis that they are. The expected outcome requires new tools, training, and transformation of organizations to meet this goal.

Centering racial and health equity as a strategic priority means that leaders take a systems-level view of the generative nature of health inequalities and how they can be mitigated now and ended in the future. It requires leaders to leverage policies and practices that embrace antiracism both within and beyond the walls of an organization. The reach of antiracist practices and policies must extend outward to create and nurture new partnerships within communities that can act on and dismantle long-standing inequities. Scholars of engaged research and community leaders have a wealth of wisdom regarding true partnership and effective collaborations. We must be open to new ways of reaching in and reaching out in order to transform where our work intersects and ultimately impacts whether someone lives or dies.

Prioritizing Collection and Use of Robust Data in the Recovery of Health Care Systems and Public Health

The risk to racial and ethnic minority populations has been multifaceted for individuals, health systems, and communities. Yet, we still have incomplete data on coronavirus infection and hospitalizations by race and ethnicity [8]. Inadequate data make it difficult to understand the full scope of this problem and incredibly challenging to envision the full spectrum of possible solutions. Without a clear and thorough understanding of the current reality, researchers and health systems leaders are unable to understand whether interventions to prevent the pandemic's spread are mitigating inequities or perhaps reinforcing them. Complete and accurate data on who is experiencing and dying from COVID-19 will inform ways to support the critical work of providers and hospitals.

The financial and human toll on already-strained medical practices and health care systems caring for historically

marginalized populations will be staggering. Small rural practices, health care systems, and federally qualified community health centers caring for poor, minority, and rural communities will need continued financial support during and after the pandemic. Timely data will illustrate both the short-term impact of the crisis and the long-term implications for patients who have recovered from an infection or those who have deferred care entirely. All of these changing patient care needs pose significant demands on under-resourced care providers.

The need for robust data in our effort to center equity in the recovery of public health and the health system highlights how those data can inform critical policy decisions. This includes policy decisions about internet access and broadband infrastructure, as we have a heightened awareness about bridging the digital divide after seeing how critical telehealth has been in ensuring access to care in a time of physical distancing [9]. It also includes decisions about Medicaid expansion and the transformation of our health insurance enterprise—both of which are exceptionally important considerations in states, like North Carolina, where the majority of racial and ethnic minorities are disproportionately affected by the pandemic and loss of employment, and thus, loss of employer insurance.

Finding Ways to Reinvest in Communities for Recovery and Resilience

The national- and state-level responses to the pandemic have revealed the fault lines between our public health emergency response system and our health care systems. The appropriate and necessary emergency response of stay-at-home orders meant that patients with chronic conditions had to forgo care, potentially exacerbating chronic diseases like hypertension and diabetes. As the economic downturn continues for already-underserved communities, the pandemic has amplified health-related socioeconomic risks like domestic violence, family caregiving, unemployment, food, and housing insecurity, where many of these health-related socioeconomic risks could have possibly been met in health care systems. Actions taken to keep people safe from COVID-19 exposure have simultaneously put vulnerable patients at increased risk for poor physical health and mental health outcomes [10].

As we continue to rebuild beyond the pandemic, we need to recognize and foster community resilience. Resilience is the sustained ability of a community to withstand and recover from adversity and trauma, such as a natural hazard or health crisis. Community resilience is about creating an infrastructure so that recovery restores a sense of self-sufficiency that matches or exceeds the level of health and social functioning pre-incident.

The work of building community resilience happens at the intersection of emergency preparedness and management, traditional public health, and community development. This process is a collaborative endeavor that brings together community partners, public health agencies, first responders, and other stakeholders to prepare for, respond to, and recover from adversity. Importantly, community resilience requires knowledge from past crisis response to strengthen the community's ability to withstand the next incident and offers opportunities to align everyday clinical and public health practice for chronic disease prevention with health emergency preparedness to support health equity [11]. Embracing a community resilience paradigm is critical, not just for health disasters such as the current pandemic, but also for persistent kinds of vulnerabilities such as the increasing rate and severity of adverse weather conditions due to climate change.

A community resilience framework requires us to think about the levers of community resilience and how they can be pulled and pushed to improve social and economic well-being. For example, one of the eight levers of community resilience is access [12]. Many states and communities have realized the power and expertise of non-medical community leaders in providing accessible care. Community health workers, peer supports, and contact tracers are being called on to create a local bridge between public health and health care settings. Formally recognizing this expertise and creating pathways for these cohorts to become valued, permanent members of the public health and health care workforce is one way to build community resilience through access. Community resilience offers ways to integrate emergency preparedness with ongoing chronic disease reduction efforts to advance health equity, especially in the face of persistent and emergent health crises that disproportionately affect communities of color.

Conclusion

These opportunities center equity in the planning and implementation of interventions for recovery during and after the pandemic. To foster a more equitable recovery as North Carolina emerges from this crisis, we need to practice intentional leadership; prioritize robust data collection and use; and build community resilience that endures beyond the pandemic. Our country is only as healthy as those at the margins, and to ensure equity in the face of future health crises, we need to center those margins in the priorities of our health care leadership. NCMJ

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