The Ethnogeriatric Implications of the COVID-19 Pandemic

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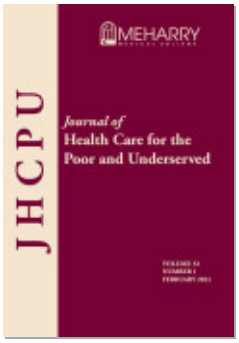

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The Ethnogeriatric Implications of the COVID-19 Pandemic

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Abstract: Disproportionate impact of COVID-19 is another in a long line of racial, ethnic, and socioeconomic disparities throughout the many realms of health care. The reasons for the disparities are manifold, with social determinants of health contributing heavily. Older adults have been identified as being at high risk of significant complications from COVID-19, and age coupled with other factors seems to put older adults belonging to underserved minorities at greatly heightened risk of those complications. The COVID-19 pandemic has magnified yet again racial and ethnic differences in health care that still must be addressed. This will require a multi-pronged approach to move beyond identifying racial, ethnic, and socioeconomic disparities in health care to full-force design and implementation of interventions that address this important issue. The next generation of clinicians, researchers, leaders, and policymakers can help advance the cause of eliminating fundamentally unjust health disparities, and our nation's older adults should not be left behind.

Key words: COVID-19, ethnogeriatrics, disparities.

> *So when all this is over—and, as we've said, it will end—we will get over coronavirus, but there will still be health disparities which we really do need to address in the African American community.*[1]
>
> *—Dr. Anthony Fauci*

One day during the height of the COVID-19 pandemic here in the U.S., I woke to find a text message from a friend. The message read, "Hey! [Insert grocery store] now currently has open delivery slots. Order now if you need something!" I quickly pulled out my phone and tried to place my order. Luckily, I was still within the window for delivery. I then thought, from my seat of what most would consider economic privilege, of the words above from Dr. Anthony Fauci, and how my family would've responded to COVID-19 had the pandemic occurred when I was younger. I grew up in Arkansas, surrounded by a "village" of older adults. My mother was a single parent

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of two daughters. We lived, for a time, with my grandmother in a two-bedroom, one (and one-half) bathroom house that my great-grandparents had built. My mother lived in that house with my grandparents and her seven siblings during her own childhood. When I was growing up, my grandmother did private duty housekeeping and cleaning for the local rural electric company office. Her age would have put her at higher risk of COVID-19 complications. Another family member who lived with us had a chronic medical condition that would've put her at risk as well. We likely would not have had the option for [insert grocery store] delivery, and depending on the grocery store, we might not have been able to afford to shop there. My mother was a bank teller. In some places, she would have been considered an essential employee, and she would have gone to work. Had she not been able to go, we would certainly have felt the financial strain. Social distancing and self-quarantine in my grandmother's house would have been nearly impossible for us. I dare say that many of my childhood friends would have a similar story to tell. This was certainly the story for many in my "village." While the rural nature of our community may have protected us, no one can say for sure.

Data have shown that COVID-19 has affected older adults at increased rates, as it has members of underserved groups disproportionately. During the first month of surveillance in the U.S., the Centers for Disease Control and Prevention reported that most COVID-19-associated hospitalizations were for people 65 years of age and older, and there was an overrepresentation of Blacks among patients hospitalized for COVID-19.[2,3] Several cities including New York have also reported increased incidence and mortality among underserved minority groups, including persons who identify as Hispanic/Latino or Black/African American.[4] Seemingly countless other disparities have been documented from birth to the end of life, and disparities as they relate to COVID-19 morbidity and mortality are no different, except maybe they are even more glaring. The reasons for these disparities are often described as multifactorial and demonstrably are related to social determinants of health including race, ethnicity, socioeconomic status, education, neighborhood, physical environment, employment, and access to health care.[5] Higher rates of pre-existing conditions such as diabetes, hypertension, and other chronic medical conditions among these groups than among the U.S. population as a whole are increasingly serious dangers facing underserved communities in the present day.

Older adult members of underserved groups—like elderly people in general—are certainly more likely than younger people to be affected by the pandemic. In light of this, we must acknowledge that disparities disfavoring elderly people in general may certainly be potentiated when race, ethnicity, culture, and socioeconomic status are taken into account. Given concerns about potential differences in resource allocation based on age, timely discussions about advance care planning and end-of-life care have become even more important. Here again, however, we must note that racial, ethnic, and cultural differences have been found in advance directive completion and hospice utilization.[6,7] Organizations have drafted position statements that address these issues in hopes that they can be disseminated more broadly.[8] While these efforts are helping to shed additional light on issues that have significant ethical and clinical implications

for older adults of diverse racial and ethnic backgrounds, there is still more work to be done.

The COVID-19 pandemic has magnified racial, ethnic, and socioeconomic disparities yet again. This time, and now, given disparities that are multifactorial in nature, we must respond with multifaceted solutions. These solutions must address social determinants of health, the manifestations of implicit and explicit bias in health care, recruitment and retention of underserved groups in research, and the development and nurturing of members of underserved groups as clinicians, scientists, and policymakers. The time to move beyond identification of racial, ethnic, and socioeconomic disparities to the development of "broad spectrum" interventions has come . . . again. Our nation's older adults should be considered in the process.

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