

# Spotlight on How COVID-19 Has Brought Racial Inequities to the Forefront in Older Adults: An Expert Discussion



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Part I of II

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By Adwoa Nantwi, MPH, AFAR Clarence Pearson Fellow in Public Health and Aging

*Part I of a two-part of Expert Discussions arranged by AFAR  
to lend insights on health disparities and COVID-19.*

The COVID-19 pandemic has shed an intense light on many of the health disparities within the aging population given that older adults above the age of 65 have accounted for [79% of all COVID-19-related deaths](#) within the United States. Disparities in race and ethnicity have been directly associated with poor health outcomes as a result of multiple systems that have been built upon institutional racism and discrimination. These institutions foster environments that contribute to a plethora of vulnerabilities experienced by racial/ethnic minorities, such as minimal access to adequate health care, increased stress and disproportionate disease burden. Public health emergencies such as COVID-19 have highlighted the role that racial inequities in resource accessibility have in understanding the distribution of disease rate and burden.

To examine the impact that COVID-19 has had on older Black adults in the US and identify ways in which aging research can become more involved in addressing racial inequities, AFAR collected enlightening perspectives from esteemed practitioners and sociobehavioral scientists.

The experts address:

- **How have comorbidities contributed to the rates of COVID-19 cases, hospitalizations, and deaths observed in Black older adults?**  
“Black elders are more likely to be in situations where they’re exposed, more likely to have chronic conditions that come from a lifetime of inequities that leads to high rates of diabetes and asthma, and less access to the resources to fend off the worst consequences.”  
– Steven Wallace
- **How do biases among health professionals impact diagnosis and treatment in older, Black adults?**  
“By definition, we’re not aware of our unconscious biases, so we have a high level of unconscious biases that may or may not come out. We may be able to overcome that in making recommendations, but it may come out in our interactions with patients and their families.”  
– Keith Norris
- **Why is medical mistrust a barrier that impacts the recruiting of older Black adults for vaccine trials and testing?**  
“The impact of the Tuskegee study and other histories of medical exploitation of Black people includes misgivings and deep mistrust of doctors and the medical establishment. This makes it extremely difficult to convince older black adults—some of whom were similar in age to those in the Tuskegee study—to be accrued to clinical trials or anything on an experimental basis.”  
– Karyn Faber

## Featured Experts



**Karyn E. Faber, EdD, MPH [KF]**

Director of Undergraduate Experiential Learning and Clinical Assistant Professor of Social and Behavioral Sciences, New York University School of Global Public Health



**Stephanie Lederman, EdM [SL]**

Executive Director, American Federation for Aging Research



**Keith C. Norris, PhD, MD [KN]**

Professor of Medicine, UCLA Division of General Internal Medicine and Health Services Research; Editor-in-Chief Emeritus of the international journal, *Ethnicity & Disease*; Executive Committee Member of the NKF Kidney Early Evaluation Program (KEEP)



**Monique Pappadis, MEd, PhD [MP]**

Assistant Professor, Division of Rehabilitation Sciences, University of Texas Medical Branch; Communications Officer, ACRM Brain Injury Interdisciplinary Special Interest Group (BI-ISIG)



**Steven P. Wallace, PhD [SW]**

Associate Center Director, UCLA Center for Health Policy Research  
Professor, Community Health Sciences, UCLA Fielding School of Public Health  
Director, Coordinating Center for NIH/NIA Resource Centers on Minority Aging Research (RCMAR)

## In the context of racial disparities, how do you define health equity?

**[KN]:** Health equity would be a state where people from every background have similar access and opportunities to receive societal benefits that are important to health, from education to housing to access to care. Within the healthcare space, [everyone] is treated equitably or fairly. At no time is there a difference of health outcomes based on structured discrimination or structured inequities based on society as a whole or as a healthcare system.

**[SW]:** Health equity involves eliminating differences between populations and between racial and ethnic groups that are avoidable. Health equity also has a moral component to it, where it's not just avoidable differences, but it's unjust differences. These differences are based on historical inequities, power, and access to resources, where in a more just society, those differences shouldn't be there. The example I give is that just because there's a higher rate of injury among people who do extreme sports than people who don't, that's not an inequity. There's a difference, but it's a chosen difference. It's avoidable by the people who are being injured if they take the right precautions or don't do the sport, but that's not an inequity. The inequity is part of the power differential.

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## Many diseases such as cardiovascular disease, diabetes, and asthma have a higher prevalence in Black individuals and are COVID-19 co-morbidities. How has this contributed to the rates of COVID-19 cases, hospitalizations, and deaths observed in Black older adults?

**[MP]:** Such diseases already place Black individuals at an increased risk for multimorbidity, hospitalization and death. Coupled with COVID-19, the symptoms of these diseases are exacerbated. If individuals have poor control of these pre-existing diseases along with reduced capacity or desire to follow appropriate practices to health self-management, they might be less likely to follow public health guidelines to reduce their risks of contracting COVID-19 placing their health at greater risk for adverse outcomes.

**[KN]:** Among the reasons there are higher comorbidities of these conditions is because of the structured inequities in society that position people to be more susceptible to develop these diseases, both the disease incidence and progression of the disease. If you're in communities and housing situations that are suboptimal, you're likely to have asthma. For many diseases, if you're in an oppressed, discriminated community, you have all these additional stresses, which lead to what's called weathering. People are ageing more quickly, developing more physiologic dysregulation, and having higher levels of inflammatory markers. Once you become COVID-positive and have comorbidities, possibly delayed access to care, this leads to increased hospitalizations. The data suggests that once you're hospitalized, and once you control for comorbidities, mortality is equal across all racial and ethnic groups. Now in addition to comorbidities, age is another risk factor for susceptibility to COVID, so for older Black/Hispanic patients, that confluence of conditions—be related to this underlying weathering that doesn't get captured anywhere on an admission form to the hospital—can contribute to poor outcomes, such as the likelihood of getting COVID.

**[SW]:** All the epidemiological information suggests that if you have diabetes, asthma, or other chronic conditions, then you're more likely to have adverse consequences for getting COVID-19. If you look at the

infection rates, they are relatively similar across age, so it's the impact of those infections that is the most challenging. The infection rates aren't the same across races. Some of the racial differences are due to participation in the essential workforce. African-Americans and Latinos are more likely to live in intergenerational households than whites and more older adults in those households were more likely to be exposed to COVID-19 because family members were more likely to be out working in the community versus working from home. If you're an accountant or a university professor, you can work from home, but if you're a grocery store worker or a delivery person, that's not an option for you. That becomes a higher risk for older adults because of the hybrids of co-residents. Then older adults are more likely to have diabetes, asthma, or hypertension, so that if they do get exposed and they do get COVID-19, it increases the risk for hospitalization and death. Black elders are more likely to be in situations where they're exposed, more likely to have chronic conditions that come from a lifetime of inequities that leads to high rates of diabetes and asthma, and less access to the resources to fend off the worst consequences.

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## What role does access to healthcare play for COVID-19 outcomes in Black older adults?

**[KN]:** There is health, which is one's overall wellbeing and there's healthcare, which is the access to and delivery of care. A lot can vary on one's background. At a particular age, particularly if you've been in the United States and working, you have access to Medicare. If they are low income and not eligible for Medicare, then you can be eligible for Medicaid. If you're older and low income, you can be eligible for Medicaid even if you do have Medicare. The challenge with Medicaid, and to some extent Medicare, is the restructuring into Medicare or Medicaid Advantage companies, which are these healthcare entities where there are care providers that tend to be disproportionately lower in communities of color. What insurance gives you is theoretical access to care. For a lot of people, they may be limited to a number of providers and, if those providers are not in their area, then their functional access to care may still be constrained. There are communities who, due to historical and ongoing contemporary mistreatment, have a high level of mistrust, so they may opt to delay seeking care in a traditional, western, allopathic medical setting, which can further adversely impact their care due to delayed diagnosis. There's more parity in access to care and it still may not lead to the degree of equity we would have hoped for because there are still other barriers that exist.

**[KF]:** Access to healthcare is a major determinant of health outcomes for Black older adults, and this is especially true with the COVID-19 pandemic. The intersectional identities of being black, aged, and poor/low income place them in grave danger of poor outcomes if COVID-19 is contracted. Considering that, on average, Blacks experience lower quality and access to healthcare along with poor outcomes, elderly blacks' hospitalizations and deaths due to COVID-19 are not surprising. The reality is that they are disproportionately impacted by the virus; are hospitalized at higher rates, and are also dying at higher rates compared to other groups.

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## How do biases among health professionals impact diagnosis and treatment in older, Black adults?

**[KN]:** There's a lot of literature that supports provider bias as a contributor to disparities in care. If you look at the [Harvard Implicit Association test](#), there's data that shows: the average American has a racial bias that is considered to be on the border of moderate to large, which is not unexpected in this country. Physicians score large and have high implicit bias. The first major report on this was the Heckler Report in 1984, then there was the Unequal Treatment by the Institute of Medicine in 2003 and several other papers along the line that show disparate treatment with racial/ethnic and gender/sex biases among providers. While physicians strongly believe that they are not biased because they're dedicated to do their best for all patients, that's an external belief and position that many may take. By definition, we're not aware of our unconscious biases, so we have a high level of unconscious biases that may or may not come out. We may be able to overcome that in making recommendations, but it may come out in our interactions with patients and their families. There can be microaggressions that can lead to fragmentation of the relationship. As physicians, we do a lot of anti-bias training, but we don't know what happens afterward. I think there are more and better quality. I sense that there's more and more physicians who see this as a good thing. My *a priori* supposition would be there's a higher percentage that doesn't believe racism exists at all.

**[SW]:** There's plenty of literature on the implicit bias that physicians bring in diagnosis to different groups of people. For example, if you see an older Black person with diabetes, you may ask fewer questions or assume *a priori* that they're less likely to be adherent to medication or less likely to try more physical activity and a diet before moving toward medication on an assumption that they wouldn't do it or benefit from it. They might also assume that those individuals live in a community where it's unsafe to engage in outdoor physical activity rather than actually asking the questions around like, "Tell me about your neighborhood, do you have sidewalks? Do you have parks?" They may or may not, but you don't know until you actually talk to the individual. There's also been research where they've done interesting studies where they would show physicians a video of diagnostic interviews with patients that have the same underlying conditions, just varying by race and gender. Black patients are often recommended different non-evidence-based differences in treatment or follow up from physicians who think they're applying the same medical standards to everybody. Physicians can say, "I treat everybody the same," but when you look at certain scenarios and assess what their treatment plan would be, you find that there really are differences based on unconscious biases.

**[KF]:** There is a lot of research detailing the effects of health provider biases on the treatment of ethnic minority patients or adults, especially Black adults. Most studies determined that provider bias is highly correlated with interactions between patient and provider, treatment adherence and decisions, and patient outcomes. What's important here is implicit bias – unconscious beliefs, attitudes, or views that influence their judgements about ethnic minorities – which may lead to unintentional but harmful decisions about treatment or the way they practice medicine. These biases, for example, may influence whether a patient is referred to a clinical trial, such that an older Black adult is not told about a clinical study; or pain medications are not prescribed to Black patients compared to whites. Diagnosis and treatment is negatively impacted.

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**The APHA has suggested key principles to advancing racial equity, some of which include: raising awareness surrounding health inequity, addressing and clarifying the roots of health inequity, and developing empathetic health care approaches and practices to support people of color. How do you address these principles within your research?**

**[KN]:** I'll start with the last. With empathetic approaches, when I lecture on bias and disparities, my focus is to try to minimize disparities and attenuate potential healthcare biases by focusing on being compassionate, empathetic, and caring. If you care about everybody, then that should minimize the level of bias you have and the way you treat people. By humanizing groups that are traditionally oppressed, then that inherently reduces the bias and the discrimination that comes with it. The other one is increasing awareness, which I think is very important. We've previously put into medical school curricula lectures on the social determinants of health, race, racism in health, health disparities, but for many medical schools, the curricula is being redone so that it's not just a separate lecture, but it's actually weaved into everything.

To understand the mechanisms, you need to talk about the mechanisms for each condition when it arises, some of which will be similar and unique. I think those are all important things to do, but I would add one more: having awareness and talking about the underlying problem. With the underlying problems, a part of it is within the direct influence of a healthcare provider, who has biases and different beliefs than what we may bring. The root causes come down to the inequitable distribution of the social determinants of health and the inequitable distribution of resources and adverse consequences of how society is structured. If you understand the need for this work, then you must ask yourself - are you actively looking at institutional and more societal policies, helping to revamp the institutional policies, being thoughtful for who you are voting for, and holding them accountable to move to change societal laws, policies, and practices?

**[KF]:** In my research, I prefer to incorporate community-based participatory research models, or at the very least, participatory action research models. These frameworks encourage the inclusion, as research partners, of the people who will be impacted by the health initiatives and programs that I plan and evaluate. My goal is to create sustainable programs that are eventually "owned" and sustained by community residents, leaders, and stakeholders.

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## Why is medical mistrust a barrier that impacts the recruiting of older Black adults for vaccine trials and testing?

**[SW]:** There's a concept of historical trauma, which involves knowing what's gone on in history. It's particularly discussed among American Indians in regard to genocide and dis-appropriation of territory, while in the Black community, the medical experimentation, lack of concern over safety of health services, and greater likelihood to be in low quality nursing homes. People assume that if you're Black, the medical care system is not going to treat you as well as if you're white. It's logical, given what we see around us and the way the criminal justice system and the educational system treats Black people. So why would we expect the healthcare system to treat them any differently than the other institutions? This is why I think trusted community leaders are so important in getting older Black adults, in particular, to accept the COVID-19 vaccine. Many older, Black adults have lived their lives for 60-80 years and know all the bad things that can happen to and around them. To overcome that level of institutional mistrust and skepticism about medical authorities, it takes an extra effort.

**[KF]:** The long-standing mistrust of the medical establishment is well-documented, and goes farther than the well-known Tuskegee study that started in the 1930s. The impact of the Tuskegee study and other histories of medical exploitation of Black people includes misgivings and deep mistrust of doctors and the medical establishment. This makes it extremely difficult to convince older black adults – some of whom were similar in age to those in the Tuskegee study – to be accrued to clinical trials or anything on an experimental basis. This breach of trust caused by the medical establishment is a difficult one to overcome. But what should happen is 1) continued acknowledgement by the medical establishment of the medical abuse and atrocities that have happened for centuries, even before the well-known Tuskegee study, and 2) the medical establishment must provide honest, accurate, and up-to-date information to the Black community—including older adults—about the vaccine and how it was developed.

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## Once a COVID-19 vaccine is approved, how can we best provide public health messaging and educational tools to improve vaccine adherence among older Black adults?

**[MP]:** Due to media coverage, older Black adults are becoming more aware that the Black community has been impacted negatively by COVID-19. They will have reservations about getting a vaccine for fear of not having enough evidence to prove its effectiveness. Public health messages and educational tools should be developed in partnership with members of the Black community (if they are your target population). Messages should be easy to understand and well balanced with positive (i.e., the direct positive impact of the individual being vaccinated along with how one person vaccinated can positively impact a community) and honest, negative consequences (i.e., any potential adverse events associated with the vaccine).

**[SW]:** I think it is probably the biggest challenge. I think the most important messaging is to get people in the communities where you're trying to get uptake, who are trusted by people in those communities to be on TV or Facebook getting the vaccine. It could be your pastor, an entertainer, or even the mayor. It should be whoever it is in that the community, where people say, "Oh, she or he is doing it, so it must be okay." or "If he or she is telling me this is important, then it must be believable." You need to figure out who the most trusted individual is in the local community because, it's one thing to have an image of



somebody on TV, but if it's somebody who you've had interaction with before or know from experience is trustworthy, then I think that has a much higher likelihood of uptake. Also, the best vaccine would be a single dose, highly effective, and, to administer, you go to where the people are. You don't make people go to the hospital, but rather you go out into the community and give it, whether it's in schools, churches, barber shops, or the grocery store, you have to make it easy for people.

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## What are effective and ineffective strategies for improving COVID-19 vaccine education among older Black adults?

[MP]: In older Black adults, I believe that:

Effective strategies include:	Negative strategies include:
<ul style="list-style-type: none"><li>• Messages from older Black individuals who are from the community that is being severely impacted by COVID-19.</li><li>• Personal stories from those who were hesitant but then decided to get vaccinated and why they chose to do so.</li><li>• Messages that communicate the importance of a vaccine to the individual, their loved ones, and the community.</li><li>• Communicating whether the vaccine is affordable and accessible to all.</li><li>• Educational workshops or community groups with medical professionals as well as individuals within the community to get questions answered.</li><li>• Using community organizers to share the message and work as a collective.</li></ul>	<ul style="list-style-type: none"><li>• Only targeting vaccine education to the Black community (in other words, the Black community is tired of feeling like they are guinea pigs to the science community).</li><li>• Including too much statistical data to make an argument of its importance.</li><li>• Including individuals who are not relatable in images or other educational communications</li><li>• Not using simple and targeted message approaches.</li></ul>

## What are immediate research priorities to explore and address racial inequities and what recommendations do you have for ensuring this research is translated into practice?

**[KN]:** What we have is a lot of descriptive work on disparities because that's easier to do. A lot of our work is done by clinical guidelines and algorithms, so we need to evaluate those, cause some of those will have race or gender in there. There could be good reasons why they're in there, but we need to go back and see: (1) Why it was there and what was the foundation for putting it there?; (2) We do epidemiological studies, but how does that translate and how reliable are those numbers at an individual level? Our whole practice is saying what happens to the whole and applying that generality to the individual, which may have no relevance at all to that individual; (3) Does having that character, via racial/ethnic background or sex as a distinguishing characteristic in a clinical guideline, help or hurt a group that is at greater risk? If it's hurting, then we have to ask, "why is it there?" A lot of times, they get put in there because we see disparities by race/ethnicity and sex and we include them because they're important and we need to control for them. There may be other things that need to go into a formula with them, many of which we can measure and many that we can't measure (e.g. discrimination), which may not go into the development of those formulas. We put it there and say the issue or the problem is that "this person is at an increased risk because of their race." We end up saying, "What's wrong with that person or these people?" rather than saying "Because of their race, society has placed them in this situation" and instead of asking "What's wrong with that person or these people?," we should be asking "What did we do to this person or these people?" If you ask that question differently, that brings with it a different sense of empathy and compassion immediately because now there's a sense that some harm has been done to this person or these people that makes you feel more empathetic vs. fulfilling an existing narrative of inferiority, so it's a lot easier to not be empathetic or compassionate.

## Additional Resources

[African-American older adults and race-related stress: how aging and health-care providers can help](#)

[Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. J Gen Intern Med. 2013;28\(11\):1504-1510. doi:10.1007/s11606-013-2441-1](#)

[Confronting Ageism, Racism, and Abuse in Later Life During COVID-19](#)

[Green AR, Carney DR, Pallin DJ, et al. Implicit bias among Physicians and its prediction of thrombolysis decisions for Black and White patients. J Gen Intern Med 2007; 22:1231-1238. doi: 10.1007/s11606-007-0258-5.](#)

[Institute of Medicine. 2003. \*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care\*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/12875>.](#)

[Report of the Secretary's Task Force on Black & Minority Health \(The Heckler Report\)](#)

[Sabin JA, Nosek BA, Greenwald AG, et al. Physicians' implicit and explicit attitudes about race by MD race, ethnicity, and gender. J Health Care Poor Underserved 2009; 20\(3\): 896-913. doi: 10.1353/hpu.0.0185](#)

### AFAR COVID-19 WEBINARS AND ARTICLES

Like you, the staff and board of the American Federation for Aging Research have been deeply concerned by the rapid impact of the COVID-19 pandemic, particularly on the health of older adults.

The evolving response to COVID-19 calls on insights and talents that AFAR has supported and advanced for 4 decades:

- building and applying the foundation of knowledge on the biological processes of aging,
- understanding how the biology of aging impacts the biology of disease,
- improving care by supporting physician-scientists,
- encouraging cross-disciplinary collaboration, and
- sharing insights from trusted experts.

Now more than ever, the coronavirus shows us, we must remain dedicated to solid science, accurate information, and proactive solutions.

Through webinars and articles, AFAR is working to share the insights of AFAR experts on the relationships between the biology of aging and COVID-19 and the promise of geroprotectors.

Visit [www.afar.org/covid-19](http://www.afar.org/covid-19) to watch and read.