

Disparate Impact of the COVID-19 Pandemic and Health Equity Data Gaps

Denys T. Lau, PhD, and Paulina Sosa, MPH

ABOUT THE AUTHORS

Denys T. Lau is an AJPH Associate Editor and is an associate faculty member with the Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD. Paulina Sosa is a doctoral candidate with the Bloomberg School of Public Health.

 See also COVID-19 and Health Equity Data Gaps, pp. 1404–1453.

The COVID-19 pandemic has had disproportionate effect on marginalized populations, especially among racial and ethnic minorities and older adults with complex needs, putting them at significantly high risk for COVID-19–related severe illness, hospitalization, and mortality.^{1,2} These disparate impacts have shone a spotlight on the structural racism and pervasive socioeconomic inequities that persistently disadvantage certain communities, particularly by race, ethnicity, and age.

COVID-19 SHARED EXPERIENCES

Information about marginalized communities and their shared COVID-19 experiences has been documented throughout the pandemic. For example, Black communities, even before COVID-19, were more likely to have high rates of underlying health conditions, lower levels of health insurance, and more individuals working in front-line jobs, therefore putting individuals in these communities at elevated risk for infection, poorer health outcomes, and death during the pandemic. Compared with White individuals, COVID-19 mortality rates were 3.8

times higher among Black individuals.³ With such a high death toll, many Black children disproportionately lost their primary—and often sole—caregiver to COVID-19. Compared with White children, Black children were 2.4 times more likely to have experienced death of a parent or grandparent because of COVID-19.⁴

Latinx/Hispanic people accounted for 24.7% of COVID-19 infection cases, second only to White people (53.6%).⁵ In addition, Latinx/Hispanic communities had the greatest number of COVID-19–related deaths among all racial and ethnic minority groups. Social distancing policies were especially challenging for Latinx/Hispanic communities because individuals were more likely to reside in households with higher numbers of people, travel via mass transit, and be part of the essential workforce that must work outside of their home in food, hospitality, agriculture, and other service-based industries.⁶ Much of these circumstances were concentrated among Latinx/Hispanic immigrants.

Several US states, including California, Hawaii, Oregon, and Utah, with large numbers of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) residents have reported significantly

higher rates of COVID-19–positive cases among NHPIs than other racial and ethnic groups, including Black and American Indian residents.⁷ Furthermore, throughout the pandemic, AANHPI communities across the United States experienced a rise in hate crimes and xenophobia. The Federal Bureau of Investigation documented a 77% increase in hate crimes against Asian American people from 2019 to 2020.⁸

For American Indian and Alaska Native (AI/AN) persons, COVID-19 incidence rates in 23 states with adequate race/ethnicity data were 3.5 times higher than for their White counterparts in the first seven months of the pandemic.⁹ Recent data showed that one in 475 AI/AN individuals had died from COVID-19, compared with one in 825 for White individuals and one in 645 for Black individuals.¹⁰ Compared with White children, AI/AN children were 4.5 times more likely to lose a parent or grandparent caregiver to COVID-19–related death.⁴ The loss of many elders in AI/AN tribes has been particularly profound given their wisdom and status as cultural tradition and unwritten language keepers.

Older adults, especially those of racial and ethnic minority descent, were severely impacted by COVID-19, with more than 95% of COVID-19–related deaths occurring in people aged 50 years and older, despite that fact that most infections occurred in people younger than 50 years.¹¹ Social distancing policies aimed to prevent COVID-19 infection were particularly challenging for many older adults who needed functional, health, and social support from family, friends, community services like adult day services centers (ADSCs), or residential care settings like nursing homes. Many older adults need community-based daily support and social services to remain

aging in place, but almost three quarters of ADSCs across the country had to limit hours or close temporarily during the first year of the pandemic.¹²

HEALTH EQUITY DATA GAPS

Despite the availability of descriptive statistics noted previously, understanding the disparate impact of COVID-19 and advancing health equity require consistent, high-quality, and timely health data from communities disproportionately affected by the pandemic. In this issue, *AJPH* has several invited articles that discuss our current understanding of COVID-19's inequitable effect on selected marginalized populations, describe existing data gaps that persistently hinder our ability to effectively monitor and reduce health disparities in these populations, and propose recommendations to close the data gaps to support decision-making and advance health equity science:

- Black children and adolescents: Mays et al. (p. 1407) discuss the lack of data collection and accuracy needed to monitor and predict COVID-19 in Black children and adolescents. Besides race/ethnicity data, they argue that data are also needed on the social context and social vulnerabilities of racial/ethnic minorities that decrease their opportunity for optimal health. Finally, they discuss the need for continuous data on the long-term, multigenerational impact of COVID-19 on educational attainment, mental health, and social well-being of Black children.
- Latinx/Hispanic language and data gaps: Lemos et al. (p. 1412) discuss the importance and power of narrative, language, and data needs in

Latinx/Hispanic communities. They first provide an overview of the health data gaps in our understanding of COVID-19's impact on Latinx/Hispanic communities. They then describe the recently formed Health Access for Communities in Emergency Response Campaign and their ongoing efforts to improve Latinx/Hispanic community health data quality in terms of adequacy, accuracy, and consistency. Such efforts would provide more and better information about Latinx/Hispanic communities to be able to advocate for sustainable political actions to meet their health and social needs. Finally, the article discusses the importance of community engagement in data collection, as well as some best practices and lessons learned from their efforts in addressing data gaps.

- AANHPI hate incidents: Shimkhada and Ponce (p. 1446) first provide an inventory of salient national and local data sources on anti-AANHPI hate incidents, building the mosaic of evidence on the effect of COVID-19 on AANHPI persons. They then present findings from the California Health Interview Survey on the experience with hate within different AANHPI subgroups and the impact of hate incidents on their mental health, delays in care, and perceived neighborhood safety in California. Finally, the article discusses where gaps remain and where investments in data collection may help move health equity science and public health actions forward.
- Meaningful and usable data on AI/AN persons: Mays et al. (p. 1416) discuss the importance of including indigenous principles in obtaining health

equity data for AI/AN persons while advancing indigenous innovation and governance that stem from sovereignty and self-determination. They argue that public health data need to be respectful and meaningful to AI/AN sovereign tribes, as well as sharable, usable, and congruent with federal, state, and local authorities for the purpose of ensuring well-being in these populations. In addition, they advocated that AI/AN persons and other indigenous people need to be active partners in the data and intervention planning to protect against unanticipated exploitation and harm.

- Older adults in ADSCs: Sadarangani et al. (p. 1421) describe the disproportionate effect of COVID-19 on older adults who rely on essential daily services from ADSCs. They highlight the experiences and vulnerabilities of diverse older adults with complex health and social needs when their access to community-based services was abruptly cut off during the pandemic. In addition, they discuss potential underdocumentation of unmet needs in older adults attributable to the lack of systematic data collection on social determinants of health and health outcomes in community service settings, undermining efforts to achieve health equity.

This collection of articles is intended to further the discourse on how to address health equity data to better understand, track, and improve the experiences of racial and ethnic minorities and older adults who have been disproportionately affected by the COVID-19 pandemic. As articulated in President Biden's Executive Order 13985, "a first step to promoting equity in Government action is to gather

the data necessary to inform that effort” (<https://bit.ly/3b1aKg9>). High-quality health data that are collected in a culturally competent way and disseminated in a timely and useful manner are fundamental to informing public health actions toward achieving health equity. Accurate, reliable, adequate, and meaningful data are essential for identifying where health disparities lie, informing efforts to reduce disparities, monitoring progress toward achieving health equity, and establishing accountability for achieving progress. More importantly, public health data collection, analysis, and reporting that incorporate authentic community engagement with marginalized populations would help prevent misuse of such data and avoid unintended stigmatization and mistreatment (<https://bit.ly/3vbUEXM>). Without such data and process, health inequities would persist.

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CORRESPONDENCE

Correspondence should be sent to Denys T. Lau, PhD, Department of Health Policy and Management, 624 N Broadway, Baltimore, MD 21205 (e-mail: dlau1@jhu.edu). Reprints can be ordered at <https://ajph.org> by clicking the “Reprints” link.

PUBLICATION INFORMATION

Full Citation: Lau DT, Sosa P. Disparate impact of the COVID-19 pandemic and health equity data gaps. *Am J Public Health*. 2022;112(10):1404–1406.

Acceptance Date: July 13, 2021.

DOI: <https://doi.org/10.2105/AJPH.2022.307052>

CONTRIBUTORS

D. T. Lau drafted, revised, and finalized the editorial. P. Sosa provided edits to the editorial.

CONFLICTS OF INTEREST

There are no potential or actual conflicts of interest from funding or affiliation-related activities to disclose.

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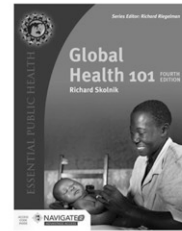
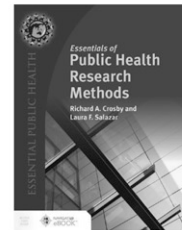
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