Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Editorial

Follow the Money: Childhood Health Care Disparities Magnified by COVID-19

There are two primary choices in life: to accept conditions as they exist, or accept the responsibility for changing them.

Denis Waitley

Although health care disparity has received increased attention in recent years, unequal health care is certainly not new. What is new, however, is the concept that health care disparity is socially and morally wrong. Long before the advent of insurance plans and government-funded health care, altruistic physicians cared for people of limited means, typically providing a much different level of service to the poor than to the paying clients who supported their practice. These physicians were considered noble for caring for the unfortunate, not pariahs for treating people differently because they could not afford to pay.

The love of money may or may not be the root of all evil, but money ultimately underpins much of the existing health care disparity. As long as health care is considered a commodity instead of a basic right, it will be susceptible to market forces and to efforts to maximize profit. Our entrepreneurial health care system all but ensures that patients with more resources will receive different care than other individuals. The recent COVID-19 pandemic has strained many of our health care systems to the breaking point, and it also illuminates many of the ways that our health care system promotes unequal health care.

Four decades of urban health care

Striking health care inequities already existed in most large urban health care facilities when the authors began practicing medicine close to four decades ago. Children with Medicaid or lacking health care coverage went to "teaching" clinics that were often crowded, poorly staffed, and largely resident run. There was little continuity of care. The attending physicians served as teaching preceptors but took little responsibility for the patient care provided. In the spirit of the *noblesse oblige* of prior generations, many of the neurology attendings espoused egalitarian virtues but were mostly interested in caring for the wealthy, especially the famous ones. This was deemed a "carriage trade" practice.

With the advent of the new millennium, New York and other states initiated universal Medicaid health maintenance organizations. This approach made health care reimbursement for children more equitable across the income, race, and ethnic spectrums. For the next decade or so, the delivery of health care was more equal than we had previously experienced.[1] However, the system's new-found equity began to erode as institutions devised approaches to maximize profitability.

In New York, the major Manhattan and Long Island hospital corporations established clinics throughout the outer boroughs (Brooklyn, Queens, The Bronx, and Staten Island; all with poorer patients and payer mixes) and advertised heavily in print, digital, and television media. The Manhattan hospital physicians began seeing patients in the boroughs where the poorer hospitals existed, focusing on conditions that typically require surgery and garner the best compensation. They largely ignored patients with chronic labor-intensive and poorly reimbursed disorders such as autism and developmental disabilities, promoting disparity of care by skimming valuable resources that could have supported community facilities. None of these activities is illegal, of course, but the unfortunate result is that poor people with marginally reimbursable conditions languish in underfunded facilities while the rich hospitals thrive. Although much has changed in the last 40 years, the power of money as the driving force of inequity remains a constant.

Similar scenarios have played out in smaller cities and towns. Austin, Texas, for example, with a population of about one million people, now has one free-standing children's hospital that gamely cares for all children regardless of their diagnosis, immigration status, or wealth. Another "children's hospital" is embedded within a for-profit adult hospital with a more robust payor mixture. Still another freestanding children's hospital is being planned by a large hospital that is based in a distant city, cynically justified as a desire to make great care available to all children in the state (but conveniently starting with the ones who live in the most lucrative health care market in the state). Just as in New York, the competing hospitals will shamelessly siphon away vital funds needed by the local institutions to continue providing equal care for all children.

Lessons from COVID-19

COVID-19 ravaged New York City in early 2020 and, shortly afterward, the rest of the country. Pediatric wards were closed, and access to general care was limited for the entire population. When it came to the care of individuals with COVID-19, the richer hospitals had more supplies and more beds. Protective equipment was donated to the large medical centers by wealthy individuals while little was donated to the outer borough hospitals. The New York Times opined about the haves and have-nots among New York City hospitals, noting that the outer borough hospitals had fewer supplies, overcrowded conditions, and inadequate infrastructure requiring duct tape to keep walls upright during the pandemic.[2] COVID-19 stressed the system, ultimately aggravating

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the structural inequities. A shortage of supplies and personnel during a crisis situation is likely to affect a stressed institution more severely than a wealthy one, thereby aggravating existing inequities. Patient care decisions should not hinge on a patient's resources, ethnicity, or position.[3,4]

Black and Latinx communities and other historically marginalized groups have higher infection and death rates,[5] but we cannot lay these statistics *solely* at the feet of the health care system. As a consequence of structural racism in many aspects of our society, historically marginalized groups are more likely to be low-income, more likely to live in overcrowded quarters, and less able to avoid catching the virus by working from home. Requiring masks and symptom screening at a construction site, for instance, is unlikely to be effective when workers must commute to work together cramped into a single car and then return to homes that are crowded with extended family or friends who have also been exposed. Here we are discussing economic disparities; racial and ethnic disparities certainly add to the problem but are beyond the scope of this article.

Efforts to avoid spread of the virus also have a disproportionate effect on poor communities. Losing a job is worse when one has no reserve funds, and unskilled workers seldom have an option to work from home or take time away from work, even to go get a COVID-19 test or to get vaccinated. Converting to remote school classes and implementing telemedicine visits are likely to work better in families whose children have individual computers and robust internet access as well as an available adult to monitor the situation.[6,7]

Failed political leadership

The response of our government leaders to the COVID-19 pandemic has been deeply disappointing. On the positive side, an aggressive government effort supporting the development of COVID-19 vaccines has been dramatically successful. Developing the vaccines, completing large-scale clinical trials, and achieving emergency approval in less than a year are wonderful accomplishments. However, the same politicians who claim credit for the rapid vaccine development promoted a narrative that downplayed the pandemic's seriousness, undermining the recommendations for facial masks and social distancing that could have dampened the rapid spread of the infection and prevented many individual infections and deaths. Equally at fault, members of the opposing party pandered for votes by publicly questioning the safety of the new vaccines, evidently loathe to give their political opponents any credit for facilitating the vaccine development. A few weeks later, these same self-serving politicians were naturally among the first people to be vaccinated. One wonders how much of the current vaccine hesitancy tracks to these irresponsible remarks and how many lives these comments will ultimately cost, especially among the people who are already victimized by substandard health care who look to their leaders for guidance.

Vaccine distribution disparities

Developing effective vaccines in record time is a remarkable achievement, but being able to quickly manufacture and distribute these vaccines on a mass scale represents a completely different challenge. Vaccine distribution constitutes another opportunity for health care disparity, especially when magnified by inadequate vaccine supplies.

A lower vaccination rate among marginalized citizens cannot be fully explained by the purposeful exclusion of these individuals, although some of them were likely pushed aside by lower-risk well-connected people who found their way to the head of the vaccine queue are disappointing. Vaccination rates increase when the injections are readily available within communities, but some poor communities have few suitable venues for vaccination drives. In other instances, the people leading the vaccination effort schedule the vaccine clinics in their own familiar facilities, which are often not located in less-affluent areas. Vaccine clinic appointments are often offered online, usually to the detriment of individuals without a computer or internet access or the digital literacy to navigate an often complex registration processes. Few vaccine clinics are prepared to efficiently handle inquiries in languages other than English. When there are ample doses of vaccine, delays caused by computer access or language would not prevent vaccination, but in a shortage situation in which all available appointments are claimed within minutes, meaningful barriers are created.

The reluctance of people in some communities to participate no doubt contributes to their lower vaccination rate. Lack of understanding of the severity of the infection, potential ways to limit the number of infections, and the potential benefits of vaccines likely play a role, yet there have been few public health education efforts directed specifically to marginalized communities. Generations of poor treatment promote distrust in the health care system, and fearmongering politicians promoting doubt about the vaccines add to the toll.

And the future?

Little has changed, and the recent pandemic has only aggravated the inequity in health care. In an urban environment, health care disparities are still fueled by predatory competition between the affluent hospitals and the less-affluent institutions. The pandemic stressed all institutions, but it disproportionately affected those with fewer resources. A structural inequity is in part related to economic inefficiencies in health care superimposed on structural isolation and poverty in historically marginalized communities. A lack of personal resources and generations of poor education and distrust compound the problems in health care.

It is a small comfort that health care disparities are now fueled by predatory business practices possibly more than overt prejudice. There must be a realigning of payments based on diagnosis that does not encourage increased care for those with highly reimbursed diagnoses. Children with many chronic diseases do not get the same quality of care as those with cancer because of differences in reimbursement. This needs to stop, because payment inequities translate to care inequities. Outreach into poor and black and Latinx communities needs to be part of any plan to ameliorate systemic problems in the health care system. COVID-19 aggravated and stressed an already damaged system that encourages unfairness. Equity need not be politicized in a democracy, but if we fund health care disproportionately, then we can expect nothing better than inequality of care.

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