Social Injustice and Pediatric Health: Pediatric COVID-19 Guidelines are Exacerbating Health Disparities

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Abstract

Fewer cases of COVID-19 and hospitalizations have been reported in children. This has impacted the prioritization of pediatrics in understanding the infection, transmission, and treatment of SARS-CoV-2 in children. Unfortunately, COVID-19 rates are higher among racial and ethnic minoritized children. Simultaneously unfolding during this pandemic is a national outcry to address systemic injustice, including institutional racism in healthcare which are driving these disparities. Aligned with social justice, this paper reflects on how Pediatric COVID-19 guidelines may be exacerbating existing health disparities among racial and ethnic minoritized youth, as well as urges for and provides possible ways to culturally tailor current guidance.

Keywords

COVID-19, Pediatrics, Health Disparities, Social Injustice, Institutional Bias

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ABSTRACT

Fewer cases of COVID-19 and hospitalizations have been reported in children. This has impacted the prioritization of pediatrics in understanding the infection, transmission, and treatment of SARS-CoV-2 in children. Unfortunately, COVID-19 rates are higher among racial and ethnic minoritized children. Simultaneously unfolding during this pandemic is a national outcry to address systemic injustice, including institutional racism in healthcare which are driving these disparities. Aligned with social justice, this paper reflects on how Pediatric COVID-19 guidelines may be exacerbating existing health disparities among racial and ethnic minoritized youth, as well as urges for and provides possible ways to culturally tailor current guidance.

Keywords: COVID-19, Pediatrics, Health Disparities, Social Injustice, Institutional Bias

COMMENTARY

The pediatric community has been limited in the discussion of COVID-19 because of the low hospitalization rates and symptom severity in this population. However, recent research has highlighted that children with mild to moderate COVID-19 infections have high amounts of SARS-CoV-2 viral RNA (Heald-Sargent, Muller, Zheng, et al., 2020). Since children with high viral loads are more likely to transmit the virus, they may be a crucial vehicle in the spread of SARS-CoV-2 (Heald-Sargent, Muller, Zheng, et al., 2020). Moreover, there have been an increase in the documented cases of multisystem inflammatory syndrome in children (MIS-C) associated with SARS-CoV-2 (Fox, 2020). Preliminary data on COVID-19, has revealed social injustices are driving disparities. In particular, the slight majority (57%) of pediatric cases are male and (based on 14 states) Latinx and Black children had higher cumulative hospitalizations than White children (CDC, 2020; Korioth, 2020). Similar to adults, common comorbidities in pediatric COVID-19 patients include those with significant racial and ethnic disparities, including obesity, chronic lung disease (including asthma), cardiovascular diseases, and prematurity (Korioth, 2020). This aligns with data from England, which suggest disproportionate numbers of children diagnosed with MIS-

C are racial minorities – with 46% of cases being children of Black, African, or Caribbean descent (Fox, 2020). National racial and ethnic aggregate data on pediatric COVID-19 cases is currently unavailable, which is problematic. With the number of documented pediatric cases increasing, hopefully this data will be released soon.

Especially in the context of our national call for social justice, even more problematic is that pediatric COVID-19 recommendations appear culturally irresponsive and may exacerbate existing health and healthcare disparities. This is a call for action to engage in proactive mitigation efforts -- to be more culturally responsive and aligned with social justice in our decision making around and provision of pediatric care during the COVID-19 pandemic. The American Academy of Pediatrics (AAP) supports conducting "well visits for newborns and for infants and younger children who require immunizations" (AAP, 2020). They also support "attending a well-visit and receiving necessary immunizations and screenings" that are "balanced with … community spread of COVID-19 and the volume of sick patients they are currently seeing in clinical settings." Given that communities of color are more heavily impacted, how should this risk be balanced? With no specific guidance, minoritized parents and guardians may be scared and confused. They may choose to prioritize acute health and safety, given low levels of healthcare related trust and disproportionate SARS-CoV-2 infections (Joszt, 2019; Thebault, Tran, & Williams, 2020). As a result, immunizations will be delayed and developmental screenings for infants and toddlers who are in need of early childhood intervention may be missed -- a service minoritized children are already underserved with (Morgan, Farkas, Hillemeier, & Maczuga, 2012; Santoli, Lindley, DeSilva, et al., 2020).

Also proposed is that pediatricians "reschedule well-visits for those in middle childhood and adolescence to a later date" (AAP, 2020). However, adolescence is a unique developmental period integral to the detection and prevention of mental and behavioral health concerns; behaviors with significant health disparities (e.g., high risk sexual behavior and drug use). Similar to infants and toddlers, decreasing opportunities to screen and intervene will worsen existing disparities. Furthermore, this is also when the HPV vaccination is administered. Young men of color have both low rates of vaccination initiation and completion – which will worsen with delayed well-visits (Jenco, 2019).

Race and ethnicity are associated with poor quality care, even when controlling for other demographic variables such as socioeconomic status (Nelson, 2003). While we must not conflate race and socioeconomic status; we must also recognize that the minoritized lived experience with health and healthcare disparities is more likely to be compounded by multidimensional poverty and impoverishment (van Dorn, Cooney, & Sabin, 2020). It is suggested to limit "well-visits to early morning while reserving the remainder of the day for sick visits" (AAP, 2020). While separating acute sick visits from well-visits is important at curbing the spread of the disease, more effective flexibility is needed. Minoritized populations disproportionately comprise essential workers, including grocery workers, public transport employees, and custodial staff (van Dorn, Cooney, & Sabin, 2020). Their schedules may change weekly or even daily. In addition, the use of dedicated drive thru COVID-19 testing and vaccinations sites are recommended (AAP, 2020). This guideline stems from the desire to social distance and limit close contact. Unfortunately, accessing this service is a privilege that many minoritized individuals may not have. Racial minoritized individuals are more likely to experience multidimensional poverty. As a result, they may not have consistent access to private transportation and may rely more heavily on public

transportation or walking. This will limit testing availability, early detection, and vaccinations.

To limit non-essential, in-person health visits, it has been recommended that pediatricians "increase their capacity to deliver telehealth." Despite high rates of smartphone ownership among racial and ethnic minoritized groups, barriers to accessing traditional telehealth persist (O'Dowd, 2018; Perrin & Turner, 2019). Cellular data coverage, while able to support low band-width activities (e.g., using social media) without disruption; the bandwidth is often insufficient to support seamless, non-disrupted, high quality imaged video conferencing (i.e., those supported by Doxy or Zoom; O'Dowd, 2018). To support such platforms, patients need high quality, costly broadband internet (e.g., high speed, greater bandwidth) to engage in effective telehealth visits, which may be difficult for those from low socio-economic backgrounds (O'Dowd, 2018). Related, while patients may be open to using their cellular data, even with diminished access, barriers in data limits and data overage costs pose an additional barrier, as video conferencing on smartphones utilizes significant data. To add, until recently, publicly funded health care for telehealth was limited (Weigel, Ramaswamy, & Sobel, 2020). This may cause patients, especially those from low resource backgrounds, to avoid telehealth visits due to fears of inadequate healthcare coverage.

Finally, healthcare facilities in underserved areas are often inadequate. Will resources be allocated to upgrade these facilities to meet social distancing requirements? Providers are exploring systematic, evidence-based approaches to rationing healthcare resources and treatment planning for children with and without COVID-19 infection (Laventhal, 2020). Nevertheless, due to provider-level factors that are operative in pediatric care, the minoritized receive lower quality care that is far from equitable (Nelson, 2003). Providers may lack a well-defined understanding of minoritized patients' clinical presentations and struggle with treatment considerations (Nelson, 2003). This leads to inaccurate diagnoses and treatment decisions that are poorly matched to patient needs (Nelson, 2003). As objective as providers attempt to be -- unconscious bias, prejudice and stereotyping -- will continue to negatively impact quality of care and resource allocation for minoritized patients during this pandemic.

The mental and physical repercussions caused by, as well as social injustices highlighted by the COVID-19 pandemic is overwhelming, and the fallout is likely to be long-lasting. While addressing structural inequities and social injustices can seem almost impossible and the motivation to change waning as the pandemic progresses, we cannot continue to discount the lives of the minoritized and forget that minoritized children and adolescents are among the most vulnerable. This call to action is not meant to be disheartening but an impetus for change. Below is some guidance on ways we can culturally tailor existing recommendations to begin addressing the worsening health disparities caused by COVID-19:

1. Monitor national racial and ethnic data in pediatric COVID-19 to maintain accountability.
2. Provide clear recommendations for communities with high prevalence rates of COVID-19 with regard to well-child visits for infants, children *and* adolescents. Providers should reach out to families within their communities to discuss the benefits and risks of avoiding well-visits to promote informed decision making.
3. Offer varying schedules (e.g., alternating days in which well-visits are done in the morning vs. afternoon) to provide greater opportunities for youth to attend well-visits and if needed, sick visits.
4. Set aside a certain number of in-clinic and walk-in testing (based on community and family socioeconomic need) to families who do not have access to private transportation.

5. Be flexible in the delivery and definition of telehealth. This may include synchronous communication such as use of video or telephone, or asynchronous communication such as secure text messaging, email or patient portal.
6. Clearly and widely disseminate new telehealth coverage policies that have emerged in response to COVID-19 to all patients. This will assuage concerns of hefty medical bills.
7. Recognize the importance of education and training around cultural humility to reduce provider bias, prejudice and stereotyping. This should include a discussion of being mindful of the lingering ramifications on pediatric health disparities.

This guidance is not perfect nor an inclusive list of solutions. I have hope that as a collective of pediatric providers, we can come together to foster a comprehensive and equitable list of solutions.

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