Medical Mistrust in the COVID Era:

Challenges & Opportunities

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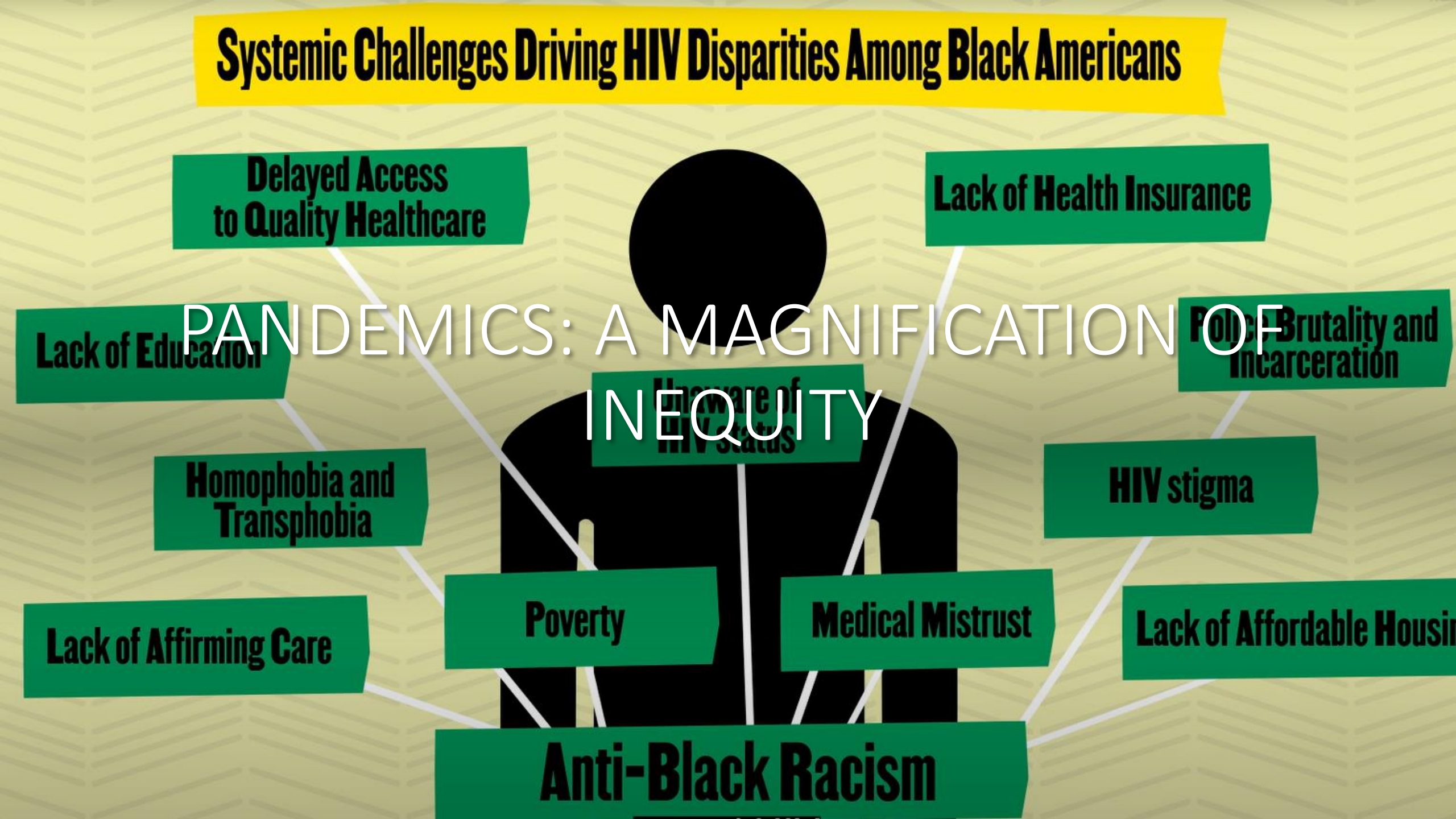
OBJECTIVES

By the end of this plenary, participants will be able to:

- Identify ways the continuing legacy of anti-Black racism exacerbates medical mistrust
- Detail opportunities to erode medical mistrust for better uptake of HIV/AIDS and COVID-19 prevention and intervention strategies in Black communities

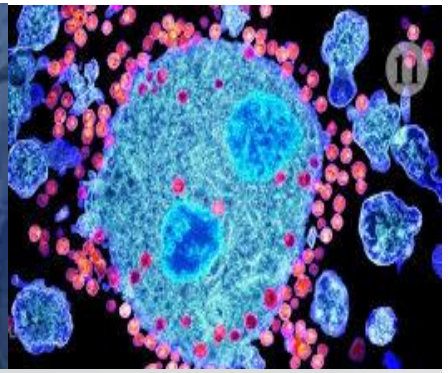

#UNIQUELYANDUNAPOLOGETICALLYBLACK

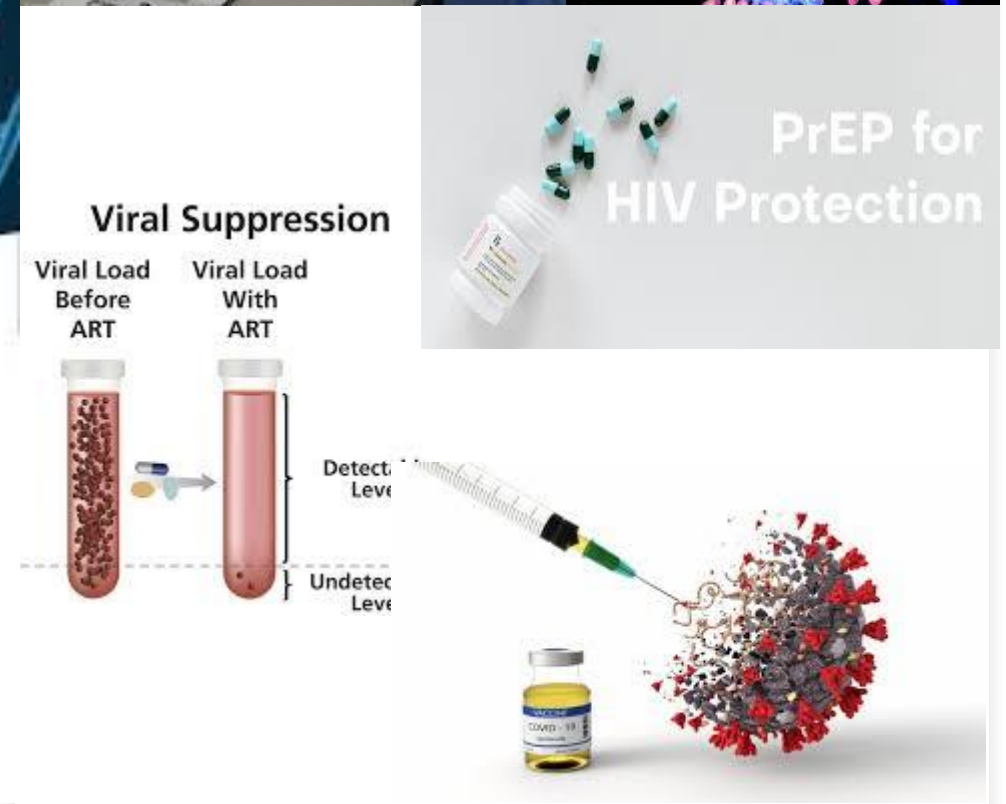
INEQUITY & MEDICAL MISTRUST



PANDEMICS: A MAGNIFICATION OF INEQUITY

BIOMEDICAL & SCIENTIFIC REVOLUTIONS: HIV & COVID



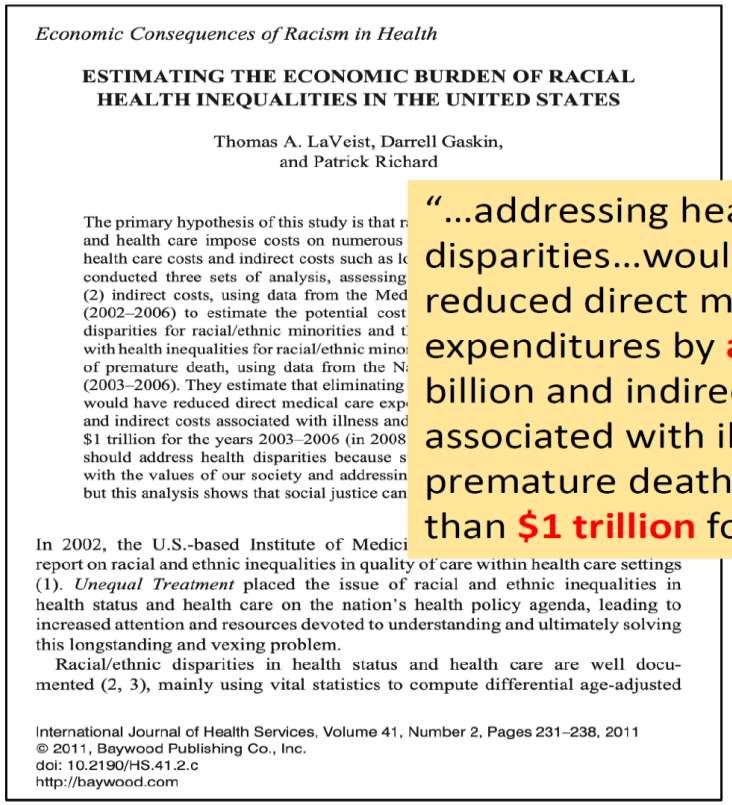


Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Health Inequity, Lives Lost, & Skyrocketing Costs



Economic Consequences of Racism in Health

ESTIMATING THE ECONOMIC BURDEN OF RACIAL HEALTH INEQUALITIES IN THE UNITED STATES

Thomas A. LaVeist, Darrell Gaskin, and Patrick Richard

The primary hypothesis of this study is that r
and health care impose costs on numerous
health care costs and indirect costs such as l
conducted three sets of analysis, assessing
(2) indirect costs, using data from the Med
(2002–2006) to estimate the potential cost
disparities for racial/ethnic minorities and t
with health inequalities for racial/ethnic mino
of premature death, using data from the N
(2003–2006). They estimate that eliminating
would have reduced direct medical care exp
and indirect costs associated with illness and
$1 trillion for the years 2003–2006 (in 2008
should address health disparities because s
with the values of our society and addressin
but this analysis shows that social justice can

In 2002, the U.S.-based Institute of Medici
report on racial and ethnic inequalities in quality of care within health care settings (1). *Unequal Treatment* placed the issue of racial and ethnic inequalities in health status and health care on the nation's health policy agenda, leading to increased attention and resources devoted to understanding and ultimately solving this longstanding and vexing problem.

Racial/ethnic disparities in health status and health care are well documented (2, 3), mainly using vital statistics to compute differential age-adjusted

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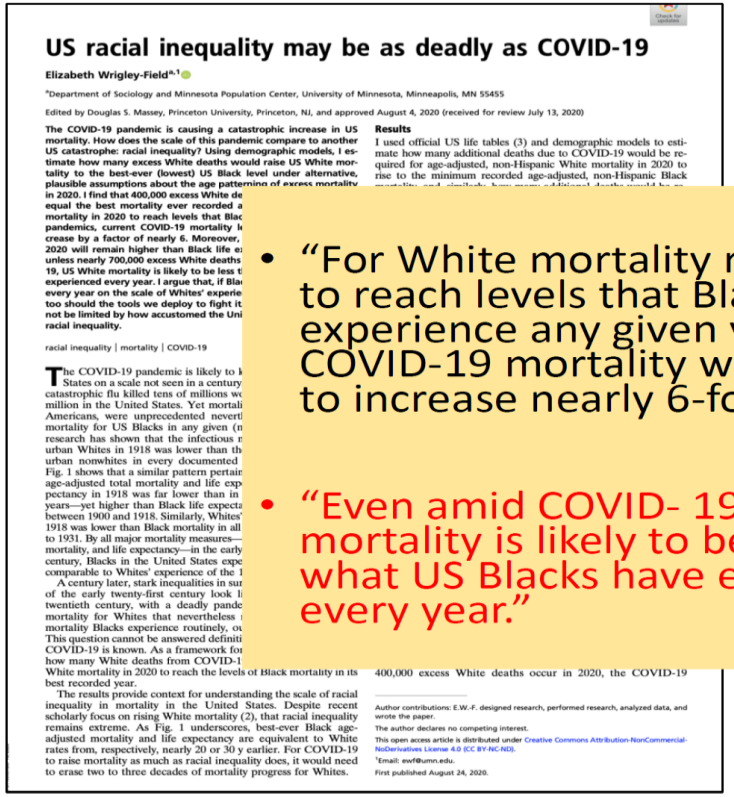
http://baywood.com

"...addressing health disparities...would have reduced direct medical care expenditures by **about $230** billion and indirect costs associated with illness and premature death by more than **$1 trillion** for the years"



US racial inequality may be as deadly as COVID-19

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Edited by Douglas S. Massey, Princeton University, Princeton, NJ, and approved August 4, 2020 (received for review July 13, 2020)

The COVID-19 pandemic is causing a catastrophic increase in US mortality. How does the scale of this pandemic compare to another US catastrophe: racial inequality? Using demographic models, I estimate how many excess White deaths would raise US White mortality to the best-ever (lowest) US Black level under alternative, plausible assumptions about the age patterning of excess mortality in 2020. I find that 400,000 excess White de equal the best mortality ever recorded a mortality in 2020 to reach levels that Blac pandemics, current COVID-19 mortality l crease by a factor of nearly 6. Moreover, 2020 will remain higher than Black life e unless nearly 700,000 excess White deaths 19, US White mortality is likely to be less t experienced every year. I argue that, if Bla every year on the scale of Whites' experie too should the tools we deploy to fight it not be limited by how accustomed the Uni racial inequality.

racial inequality | mortality | COVID-19

The COVID-19 pandemic is likely to
States on a scale not seen in a century
catastrophic flu killed tens of millions w
million in the United States. Yet mortali
Americans, were unprecedented neverth
mortality for US Blacks in any given (n
research has shown that the infectious
urban Whites in 1918 was lower than th
urban nonwhites in every documented
Fig. 1 shows that a similar pattern pertain
age-adjusted total mortality and life exp
pectancy in 1918 was far lower than in
years—yet higher than Black life expecta
between 1900 and 1918. Similarly, Whites'
1918 was lower than Black mortality in all
to 1931. By all major mortality measures—
mortality, and life expectancy—in the early
century, Blacks in the United States expe
comparable to Whites' experience of the
A century later, stark inequalities in su
of the early twenty-first century look li
twentieth century, with a deadly pande
mortality for Whites that nevertheless
mortality Blacks experience routinely, ou
This question cannot be answered definiti
COVID-19 is known. As a framework for
how many White deaths from COVID-1
White mortality in 2020 to reach the levels of Black mortality in its best recorded year.

The results provide context for understanding the scale of racial inequality in mortality in the United States. Despite recent scholarly focus on rising White mortality (2), that racial inequality remains extreme. As Fig. 1 underscores, best-ever Black age-adjusted mortality and life expectancy are equivalent to White rates from, respectively, nearly 20 or 30 y earlier. For COVID-19 to raise mortality as much as racial inequality does, it would need to erase two to three decades of mortality progress for Whites.

Results

I used official US life tables (3) and demographic models to estimate how many additional deaths due to COVID-19 would be required for age-adjusted, non-Hispanic White mortality in 2020 to rise to the minimum recorded age-adjusted, non-Hispanic Black

400,000 excess White deaths occur in 2020, the COVID-19

Author contributions: E.W.-F. designed research, performed research, analyzed data, and wrote the paper.

The author declares no competing interest.

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- "For White mortality rates in 2020 to reach levels that Blacks experience any given year, White COVID-19 mortality would need to increase nearly 6-fold."
- "Even amid COVID- 19, US White mortality is likely to be less than what US Blacks have experienced every year."

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MAKING AIDS HISTORY

ERODING MEDICAL MISTRUST WITH SYSTEMS CHANGE

WE THE PEOPLE: ENDING HIV & COVID THROUGH ENDING SYSTEMIC OPPRESSION

- **DISMANTLE** anti-Black practices, systems, and institutions that endanger the health and well-being of Black people and undermine an effective and equitable response to HIV in Black America.

- **INVEST** in Black communities through resources and services that address the fullness, richness, potential, and expertise of Black people and mitigate social and structural factors that worsen health outcomes in Black communities.

- **ENSURE** universal access to and robust utilization of health care that is high-quality, comprehensive, and affordable, as well as culturally, and gender-affirming. This enables Black people to live healthy lives in our fullest dignity.

- **BUILD** the capacity and motivation of Black communities to be the change agents for ending HIV.

COMMUNITY EMPOWERMENT & MOBILIZATION

- **Decolonize** science and educate communities on the science of new biomedical tools
- **Hire** staff from community to lead programs and efforts
- **Recruit and educate** Black public health equity activists
- **Engage** stakeholders with different perspectives when designing HIV and COVID-19 interventions
- **Empower and equip** communities to transform realities, decreasing the perception that other individuals and entities have control over Black health and well-being
- **Partner** meaningfully with civil society
- **Share** publicly your organization level efforts to respond to and dismantle anti-Black (and other) racism

CULTURAL COMPETENCE & HUMILITY

- Government suspicions/fears are understandable and expected.
- Medical mistrust should not be dismissed.
- Mistrust might also be tied to other parts of a patient's identity.
    - E.g., Black MSM experiencing stigma from a provider
- Mistrust and other cultural attitudes are ever-evolving, given the changing political and social climate.
- Making assumptions about mistrust may lead to greater mistrust.
- Cultural competence does not have an endpoint; the learning does not end.

OUR PEOPLE. OUR PROBLEM. OUR SOLUTION.

"Trusted gatekeepers" in the community should deliver and *lead* messaging and programming in their own communities

" [T]hese issues could better be addressed if a social movement of Black healthcare and research activists could be better supported to both better engage community concerns that might improve healthcare engagement and to directly challenge the institutions, laws, and policies that actually do continue to perpetuate…medical apartheid."

-Kenyon Farrow, Treatment Action Group (TAG), 2016

Q & A