OPINION

As coronavirus infections peak, profit-driven hospital systems must be held accountable

Vulnerable populations are on the losing end of too many decisions in health care.

By Alecia McGregor, Shalanda Baker, Camara Jones and Michelle Morse Updated April 30, 2020, 4:13 p.m.

If you are Black or brown in this country, you are more likely to contract and die from COVID-19. According to a recent Washington Post analysis, counties that are majority-Black have three times the rate of infections and almost six times the rate of deaths as their white-majority counterparts.

As alarming as those statistics are, they are, sadly, not surprising. Even in a crisis, the same profit-driven decision-making and disregard of vulnerable populations responsible for the inequities and injustices that plague American health care in normal times are at work. That means that people of color and other vulnerable populations are at a disadvantage that can be fatal.

This is the product of a national trend in which decision-makers pay insufficient regard to communities that are home to these groups.

The announcement that Carney Hospital in Dorchester would become the country's first dedicated COVID-19 hospital was largely hailed as a welcome expansion of hospital capacity in response to the outbreak. This hospital normally serves as a safety net for low-income residents in Dorchester.

In Seattle, King County lawmakers made the decision to locate the Seattle area's first COVID-19 dedicated facility in an Econo Lodge motel in the working-class community of Kent. The site was purchased by the county as a quarantine site, without consulting with the community.

California Governor Gavin Newsom made the decision to disembark passengers of the Grand Princess cruise ship, on which two passengers had died from COVID-19, in Oakland instead of San Francisco Bay, which raised alarm in the community. Oakland Mayor Libby Schaaf insisted that authorities do everything possible to limit virus exposure to Oakland residents.

Although it is unclear whether these decisions put the surrounding communities at greater risk of infection, they follow a broader pattern emerging in COVID-19 hot spots.

As New York, Boston, and other jurisdictions decide where to erect makeshift hospitals, stakeholders must remain vigilant regarding this pattern of burdening low-income communities and communities of color. This oversight is especially needed in the case of for-profit entities.

For example, Carney Hospital, a historically Catholic hospital that cares for a disproportionately poor and elderly population, is owned by the Texas-based for-profit hospital system Steward Health Care. Among the Steward hospitals, Carney has struggled financially for a number of years. In 2018, the hospital lost $23 million.

It is the only hospital in its racially and ethnically diverse neighborhood, and approximately three-quarters of its reimbursements come from Medicare and Medicaid.

Dedicating Carney to critically ill COVID-19 patients appeared to us to be a move to free up Steward's other Massachusetts hospitals to schedule better-reimbursed procedures, though the hospital's management says this is not the case. Although the Emergency Department remains open, the move also, critically, temporarily removes other types of inpatient care from the local community. Viewed more cynically, it may be a strategic way, in the middle of a crisis, to turn Steward's money-losing location into a potential source of additional revenue.

In the United States, private hospital systems like Steward, which operate as big businesses, will be responsible for distributing care during this crisis. But we should be on alert. The market should not be left to its own devices to provide comprehensive testing and treatment, and equitable care must be guaranteed for all who need it. This may require that the government goes beyond merely sending a $175 billion in bailout money to hospitals, and that local authorities temporarily take control of the private hospital system, as Ireland recently did.

Achieving health equity requires three things: valuing all individuals and communities equally, recognizing and rectifying historical injustices, and providing resources

according to need. A health equity approach to the distribution of hospital resources during this COVID-19 pandemic therefore requires that:

1) Communities of color and poor communities not be used as sacrifice zones.

2) Poorer health status and lower insurance coverage are properly understood as resulting from societal disinvestment rather than individual neglect.

3) Pre-existing conditions are not used as a basis for allocating scarce ventilator resources, since that would systematically disadvantage people of color and poor people.

As the United States enters a time when hospitals are experiencing a surge of COVID-19 cases, and having seen Italy ration hospital beds by age and pre-existing conditions, we watch in fear knowing that our health care system is built to ration care by wealth, status, and race. Black, Latinx, and indigenous people are the most likely to be uninsured and underinsured in the United States. In China, mortality for patients living in economically deprived areas was four times higher than in other areas.

Over the last several decades, urban hospitals have been more likely to close in majority-Black neighborhoods than in other locales. People of color and low-wealth individuals are also disproportionately affected by the underlying conditions that have been identified as risk factors for critical complications of COVID-19. Thus, the accessibility of ICU beds in this time is paramount, and this critical care must be distributed equitably.

We call on lawmakers to ensure that people of color and vulnerable populations are not exposed to disproportionate risk in our fight to expand health system capacity. Moreover, we request that lawmakers remain vigilant to ensure that market-based rubrics, such as ability to pay for care or reimbursement rate, do not dictate who lives or dies.

This op-ed was updated on May 1 to correct the description of the services that remain open at Carney Hospital.

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