

*Viewpoint*

## **Eliminating Health Disparities Is Essential to Achieving Racial Justice—Alzheimer’s Disease, COVID-19, and Related Comorbidities Disproportionately Impact Minority Communities in the Fight for Health Equity**

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At no time in recent history have the importance and necessity of fighting for health equity and access and against racial health disparities been more apparent than in the past several months.

The onslaught of the COVID-19 pandemic has brought a disproportionate impact on racial minorities [1], most notably in nursing homes and other long-term care communities [2]. It is the latest example of how inequality reaches into the U.S. healthcare sector, where Black, Indigenous, and People of Color (BIPOC) populations experience health disparities as a result of a lifetime of social and economic discrimination.

The impact of health disparities on the Black American community in particular is profound. Black Americans are dying from COVID-19 at alarming rates [3]—when compared to White communities, Black Americans have been dying at about 2.4 times the rate of White Americans [4]. Black Americans also are more likely to experience a stroke, obesity, heart disease, diabetes, and hypertension. Specifically, Black Americans are 44 percent more likely to die from a stroke, 23 percent more likely to be obese, 25 percent more likely to die from heart disease, and 72 percent more likely to be diabetic [5]. The presence of these conditions was not only a common factor in COVID-19 hospitalizations, but brings increased risk for COVID-19 [6,7].

These are all negative health outcomes on their own, but, importantly, they also put Black Americans at greater risk for Alzheimer’s disease and related dementias (ADRD). When it comes to ADRD prevalence, Black Americans are two to three times more likely than non-Hispanic whites to develop Alzheimer’s disease [8]. Despite this higher prevalence, Black Americans are less likely to receive a timely diagnosis or participate in Alzheimer’s research [9].

Addressing these health disparities at their root is critical to alleviating the disparate impact of ADRD and improving health outcomes for minority communities across the United States.

### Open Access

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Over the past several weeks, amidst the threat of COVID-19, the US has witnessed a renewed and courageous movement for racial and social justice that is working toward true equality. The confluence of events our nation is now experiencing has provided organizations such as UsAgainstAlzheimer's (UsA2) the opportunity to address the diseases and conditions at the core of our work while we also meaningfully contribute a patient- and science-driven perspective to the goal of "health equity."

Health equity and health disparities continue to command attention within medical circles against the backdrop of the ongoing conversations on race and equality in the United States. Black Americans in particular continue to experience health outcomes that are markedly poorer than White Americans in every age group and across disease states.

UsA2 is contributing to this conversation where we have relevant expertise, and calling attention to the injustices that we see in ADRD every day. Our work to stop Alzheimer's has shined a light on the exclusion of Blacks, Latinos, and other communities of color in medical research essential to improving healthcare for families and communities.

For example, while there are 38,000 residential zip codes in the US, 70 percent of Black and Hispanic Americans live in just 6000 of them [10]. Combining this statistic with the fact that social determinants of health within zip codes are in fact the greatest predictor of a lack of health equity, UsAgainstAlzheimer's partnered with the National Minority Quality Forum to create the National Alzheimer's Disease Index.

The index analyzes a range of ADRD health statistics (e.g., prevalence, Medicare costs) by different demographic indicators (e.g., race and ethnicity, gender, etc.) across specific geographies among Medicare Fee-for-Service (FFS) beneficiaries. This will be a valuable toll for informing our nation's public health response to dementia in underserved communities by helping the field target interventions and tailor messaging.

Moreover, we have found that our healthcare system often fails communities of color and poor people, limiting equal access to the promising treatments and other interventions essential to stopping Alzheimer's and related risk factors. As research continues into treatments, it is important that clinical trials include communities of color to ensure that therapies work for everyone.

While the health disparities noted above are experienced over the course of a lifetime, and troubling enough on their own, we should note something frequently obscured in the discussion of health and race. The fact is, we know that there is a general five- to 10-year discrepancy in overall total life expectancy between Black Americans and White Americans that begins *at birth* [11].

Take, for example, the latest data from the CDC that notes the leading cause of death for Black American males under the age of 44 isn't heart disease or hypertension—it's homicide [12]. For Black American females, the leading cause is categorized as "unintentional injuries" [13]. In both

cases, the CDC data paints a bleak picture of a population whose young people are taken, in the prime of their lives, by avoidable circumstances more than anything else.

While the CDC numbers in and of themselves don't have much to do with ADRD, the sad reality they communicate is that large numbers of the Black American population aren't even aging to the point where they might get Alzheimer's—but if they do, they are then two to three times more likely to develop it than their White peers because of structural and systemic barriers to equitable health outcomes.

Said differently, Black Americans can't even have the "privilege" of being impacted by long-term health disparities if they can't make it to their fifth decade of existence. But homicide is not an Alzheimer's prevention strategy.

There are potential solutions to address the inequities in the American health care system. Ways to help enact accelerated system change through disparities reduction may include: increasing clinical trial participation from communities of color through culturally tailored outreach; advancing race-based research to develop a cure that works for all individuals; clearly spotlighting the disparate impacts of Alzheimer's on BIPOC communities and making the effects easy to visualize using new technology and tools (like the aforementioned National Alzheimer's Disease Index); and partnering with community groups, healthcare providers like Federally Qualified Health Centers, and other trusted local voices to share the impact of early interventions on improving brain health across the lifespan, and the effects of comorbidities on Alzheimer's disease for disproportionately impacted individuals.

In addition, there is a fundamental knowledge gap that must be addressed. This includes educating communities on general healthcare, ADRD prevention and risk-reduction strategies, nutrition, and comorbidities and related health factors, just to name a few. More money, resources, and attention must be paid so that impacted communities can receive information from their local providers and community-based organizations, trusted voices, churches, and other well-established institutions and individuals within these communities.

This is what is meant by the term "precision engagement"—it is fundamentally about getting the right information to the right people at the right time, using the right messenger, and in a way that is accessible and actionable to them.

The only way that a history of deeply ingrained racial and social disparities will begin to be righted is by identifying the communities that have been most impacted, and quickly and effectively delivering them the information they have already gone far too long without.

Now is the time to embrace the learning from Juneteenth—celebrated in new light last month in the US—and emancipate Black Americans and other people of color from health inequities that have shackled them not just in the context of ADRD, but across all disease states and health

disparities. It is time that our most vulnerable, systemically disadvantaged populations are given culturally tailored information that will empower them and allow them to lead longer, healthier, more equal lives.

As advocates for health equity, this is what we fight for, and what we must demand.

#### **AUTHOR CONTRIBUTIONS**

Stephanie Monroe, JD, is executive director of AfricanAmericansAgainstAlzheimer's and a former U.S. Department of Education Assistant Secretary for Civil Rights. David Satcher, MD, PhD, served as the 16th U.S. Surgeon General, Assistant Secretary for Health at the U.S. Department of Health and Human Services, and Director of the Centers for Disease Control and Prevention. A member of the UsAgainstAlzheimer's Board of Directors, Dr. Satcher is the Founding Director and Senior Advisor at the Satcher Health Leadership Institute at Morehouse School of Medicine.

Both of authors contributed to writing the paper.

#### **CONFLICTS OF INTEREST**

Author David Satcher declares that he has no conflicts of interest. Author Stephanie Monroe serves on the Steering Committee on Inclusive Research, for Genentech, 2018 to present; the Global Alzheimer's Advocacy Steering Committee for Biogen, 2018 to present; and is a consultant to the Alzheimer's Clinical Trial Consortium, 2018 to present.

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