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NOTE

The impact of COVID-19 on older minority adults in the United States: challenges and potential solutions

Key words: *COVID-19 pandemic, elderly, minority populations, older persons, United States.*

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Coronavirus disease (COVID-19) was the third leading cause of death in the United States, accounting for one in eight deaths, between March 2020 and October 2021.[1] Older age, defined by the United Nations as above 60 years old, was associated with severe COVID-19 illness and increased mortality.[1,2] Independently, ethnic, and racial minorities, were disproportionately impacted by the pandemic. Compared to White non-Hispanics, African Americans and Hispanic/LatinX individuals were more likely to contract the virus, be hospitalised, and die from COVID-19.[2,3] Given this scenario, we conducted a non-systematic PubMed literature search and reflected on the challenges and potential solutions to help meet the post-pandemic needs of these populations.

ENCOUNTERED CHALLENGES

Older adults are more likely to have pre-existing chronic comorbidities, particularly, among minority populations. They were already at higher risk for a compromised immune system, due to adverse socioeconomic circumstances, leading to greater mortality and morbidity as a result of a weakened cell-mediated immunity.[4]

Furthermore, fuelled by ageist media narratives, older minority populations had disparate healthcare experiences, as scarce medical resources were triaged and allocated away from them.[5]

With the burdens of weathering xenophobia and stereotyping, minority groups faced additional barriers to accessing the healthcare system (Fig. 1). Racism debilitated the already weakened trust in the system and facilitated COVID-related adverse health outcomes within these groups.[5]

From the economic perspective, minorities are overrepresented in populations working at the frontlines or providing essential services. Poor job and housing conditions enabled increased exposure to COVID-19. Unstable pay and poor medical insurance contributed to limited access to treatment, leading to worse outcomes.[5,6]

Lockdown measures and social distancing during the pandemic exacerbated the lack of social support for older-age minorities. Mental and physical health suffered as elders were disconnected from family, friends, and faith group members.[6] Lack of language-appropriate and culturally appropriate messaging contributed to widening the knowledge gap between older minority adults and other groups.[7]

PROPOSED SOLUTIONS

Healthcare/medical solutions

Providing minority groups with better access to care can happen at many levels. Primary healthcare and outreach centres should be mobilised to target older minorities by increasing medical information about any impending problem (e.g. COVID-19), facilitating access to care with professionals speaking the same language and helping with medical literacy, hiring an ethnically diverse workforce that minority elders feel they can identify with, and helping with insurance and socioeconomic issues. In 2021, Massachusetts created a Title III-D Preventive Health Services Plan for older adults that uses evidence-based programs to ameliorate health outcomes. It partnered with the AAA network to reduce medical costs for older adults, promote preventive health services, and reduce future need for emergency health services.[7] Similarly, the SHINE (Serving the Health Insurance Needs of Everyone) Program, provided older persons with insurance knowledge through free health insurance information and counselling. For low-income older adults, SHINE matched them with programs

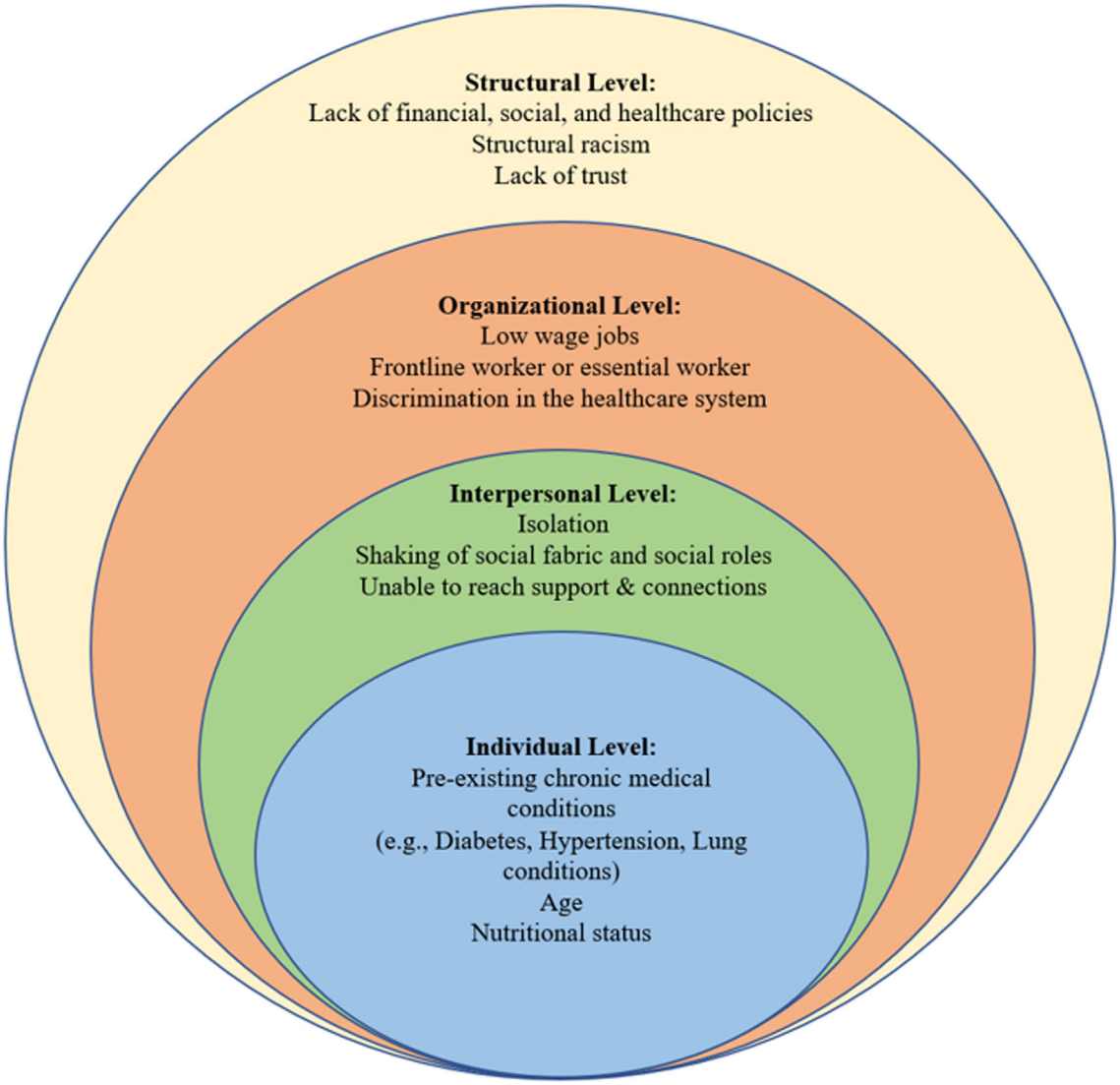

Figure 1 Social-ecological model explaining main barriers faced by older minority populations as a result of the pandemic.

that helped pay their health costs.[3] While SHIP (State Health Insurance Assistance Programs) is available at the federal level, these Massachusetts policies could act as role models at the federal level to serve the US older age population.

Data acquisition

Data are needed to quantify the needs of older minorities. Despite the immense volume of information already obtained, specific studies should involve this subpopulation to provide reliable information that can be disseminated urgently to policymakers and the healthcare system.

Financial solutions

Economic support can alleviate multiple concerns faced by this at-risk population in the post-pandemic era.[6] Safety nets in the form of housing vouchers, food assistance, and stimulus checks are imperative to decrease economic instability. Other policies should consider the type of employment minority groups have, aiming for increased job security and ensuring paid sick leave and pension plans.

Community solutions

Social support betters the health and well-being of older adults, particularly after the restrictive social measurements that took place during the pandemic.

If friends, faith groups, and family member support are a given, investing in the training of community health workers (CHWs), at the healthcare system level, can show promise in improving health behaviour while maintaining psychosocial support and presence with daily check-ins. It is key to create a national recruitment program for CHWs that includes culturally sensitive training and multilanguage competencies to target the needs of minority older adults.

Policy solutions

COVID-19 post-pandemic should be used as an opportunity to seek clear-cut policies ensuring the continuation of efforts, the provision of funding, and the support of the legal system. Continuing measures such as telemedicine, interstate licensure waivers, coverage of testing and treatment, and special enrolment periods for insurance should be considered, particularly among those older minority populations with new infections or persistent health sequelae. These strategies can guarantee that in future crises this population is not left behind. Lastly, the feasibility of implementing these solutions will rely on trust and partnerships between communities, leaders, and policy makers to tailor these proposed solutions to each context.

ACKNOWLEDGMENTS

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DISCLOSURE

The authors declare they have no conflicts of interest in the research.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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