Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the novel coronavirus causing the disease COVID-19, has rapidly transformed our lives. Fears of community spread of the virus have led policy makers to close schools and nonessential businesses and implement orders to shelter in place. While these efforts have slowed the spread of the virus, some parts of the country, including New York City and New Orleans, have nevertheless witnessed overwhelming increases in COVID-19 cases and related deaths.

The burden of COVID-19 morbidity and mortality has disproportionately fallen on minority populations. Early in the pandemic, lower rates of COVID-19 testing were reported among minority communities. Now, emerging data illustrate that black and Hispanic Americans are dying at far higher rates from the novel coronavirus than any other groups in the nation. These disparities are just the most recent manifestation of centuries’ worth of racial and ethnic gaps in health outcomes.

Structural and Clinical Determinants of COVID-19 Disparities

As clinicians and policy makers in recent years have shifted their attention to rising mortality from drug overdose and suicide—the “deaths of despair”—among working-class, non-Hispanic white men and women, the long-standing health crisis among minority populations has continued to evolve. The prevalence of cardiometabolic disease and related risk factors in black and Hispanic communities has continued to rise, compounding decades-old disparities in health outcomes from these clinical conditions, many of which raise the risk of severe disease and death from COVID-19. However, focusing on individual clinical factors may mislead clinicians and policy makers from identifying the true root causes of racial and ethnic disparities observed in COVID-19 mortality. Instead, we must look to history—namely, the underlying structural causes—that have produced these health inequities in the first place.

The 1964 passage of Title VI of the Civil Rights Acts made discrimination by race in programs that receive federal financial assistance, including health systems, illegal. This federal law had important implications for health and well-being but in many respects was too late, as the imprint of historical discrimination on health had already been cast. For example, redlining had forced black Americans who escaped the terror of the South to live in poor, segregated neighborhoods in the North. Wages were low, as black workers took on manufacturing, janitorial, and other service industry jobs.

These disparities have persisted into the present day. Black Americans remain more likely to work in low-wage jobs and to live in segregated, crowded neighborhoods with high rates of poverty, increased pollution, and limited transportation. Minority communities also have lower levels of employment, home ownership, and wealth. Black Americans also experience higher rates of incarceration and homelessness.

Similarly, within the health care system, whereas only 5% of physicians are Black and 5.8% are Hispanic, substantially higher proportions of environmental service staff, home health aides, and medical assistants are from these racial and ethnic groups. Thus, as states and local municipalities shut down services and nonessential businesses as social distancing measures, many within communities of color are left with the perverse choice of staying home to avoid contracting COVID-19.
COVID-19 or continuing to work to maintain their livelihoods—all within the confines of disadvantaged neighborhoods and jobs that may elevate the risk of contracting severe disease.

As COVID-19 spread across the nation, so too did stories about who was more likely to receive COVID-19 testing and how discrimination may influence acute medical care. Whereas a recent statement by the Department of Health and Human Services Office for Civil Rights emphasized that states cannot discriminate on the basis of disability, race, and age when deciding who receives life-saving therapy, the fear of potential rationing of critical care resources has heightened in communities of color for whom long-standing discrimination and mistrust of the health care system have persisted. Undocumented immigrants have lower rates of health insurance coverage and an added fear of deportation. Furthermore, Spanish-speaking patients with limited English proficiency and poorer health literacy may have reduced access to timely and high-quality public health information and medical care during this pandemic. In this context, black and Hispanic Americans are dying at much higher rates of COVID-19 than their white counterparts.

Policy-Based Approaches to Address COVID-19 Disparities

Health system leaders and policy makers should take the lead in addressing these alarming disparities. In the short run, policy makers and leaders of health systems and health plans should heed calls by national medical organizations to expediently release racial and ethnic demographic data on COVID-19 infection and mortality. These data are necessary to accurately measure disparities and inform additional testing, medical resources, and ultimately preventative vaccination. Second, expanding access to Medicaid nationwide would support individuals who lose employer-sponsored insurance due to COVID-19–related job losses. Reducing administrative barriers to accessing key social services, such as the Supplemental Nutritional Assistance Program or the Temporary Assistance for Needy Families, will also be important. Third, policy makers must invest in community-based care and the social safety net. We support the recent funding of $1.3 billion to nearly 1400 community health centers provided through the federal Coronavirus Aid, Relief and Economic Security Act to provide additional support for managing COVID-19. More must also be done to strengthen public health departments and social service organizations with deeper relationships in minority communities. These short-term approaches will need to be bolstered by policies that support social and economic flourishing in minority communities, such as interventions to improve access to high-quality education and address ongoing discrimination in labor markets, housing, and the justice system.

This month marks the 105th anniversary of the establishment of Negro Health Week, an effort founded by Booker T. Washington and created to raise awareness about the health disparities that continue to affect racial minority communities today. Just 3 years after that inaugural event, the 1918 influenza pandemic was rampant across the US. We do not yet know the full course of the current COVID-19 pandemic, but if we can boldly address health equity in this crisis today, we have the opportunity to greatly shape how history looks back at this moment—and perhaps permanently reduce health disparities moving forward.

ARTICLE INFORMATION

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Corresponding Author: Utibe R. Essien, MD, MPH, Division of General Internal Medicine, 3609 Forbes Ave, Suite 2, Pittsburgh, PA 15213 (uessien@pitt.edu).

Author Affiliations: Division of General Internal Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania (Essien); Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania (Essien); Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia (Venkataramani); Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia (Venkataramani).
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REFERENCES


