COVID-19 and Health Disparities: the Reality of "the Great Equalizer"

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From government officials to mainstream media and even celebrities, coronavirus disease 2019 (COVID-19) has been touted as "the great equalizer." It is a disease that transcends wealth, fame, prestige, or age. We are all at risk. The statement highlights our vulnerability as part of a society that lacks any immunity to the novel virus. However, it also inaccurately assumes that we will all be equally affected by it. History has shown that this will not be the case.

Pandemics have the unique ability to amplify existing health inequalities, disproportionately affecting socially disadvantaged groups, including racial and ethnic minorities and low-income populations. During the 2009 H1N1 influenza pandemic, minority groups had higher rates of serious infection requiring hospitalizations compared with non-minority groups.[1] Similarly, during the 1918 "Spanish" influenza pandemic, racial minorities had both higher all-cause mortality and influenza mortality rates compared with Caucasians.[2]

Early data from COVID-19 hot spots around the country are beginning to tell a similar story. In New York, now the epicenter of the outbreak, predominantly black and Hispanic neighborhoods are seeing higher numbers of cases and fatalities. Hispanic and black patients currently make up 34% and 28% of all fatalities in New York City despite only comprising 29% and 22% of the population, respectively. Concurrently, deaths among whites are at 27% of all cases despite constituting 32% of the population.[3] Similar findings are being reported in other parts of the country as well. Data from Michigan shows both higher percentages of cases (33% vs 24%) and deaths (40% vs 30%) in blacks compared with whites even though blacks only account for 14% of the population.[4]

The consistency of outcomes from pandemics spanning decades reveals deep underlying truths about health disparities. Racial and ethnic minorities are at both a higher risk of contracting COVID-19 and suffering worse outcomes.

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Chief strategies for minimizing the spread of a pandemic include early detection, isolation of confirmed cases, and social distancing. Across the country, states have implemented shelter-in-place orders, requesting citizens to remain at home and limiting non-essential services. Additionally, infected individuals are instructed to quarantine at home if well enough to do so. While these steps are necessary to "flatten the curve" and reduce transmission of COVID-19 and the strain on healthcare facilities, the recommendations inadvertently preferentially harm the socially disadvantaged.

Longstanding inequalities have placed a greater proportion of racial and ethnic minority populations near or below the federal poverty line. Low-income groups are more likely to work in the service industry doing jobs that reduce their ability to work from home and historically lack sick leave.[5] They are also more commonly single-income families, and a greater dependence on their income may leave them continuing jobs that place them at a higher risk of contracting COVID-19.[5] Conversely, government regulation that stops all non-essential services leads to higher unemployment rates among this population, evidenced by the recent dramatic rise in first time unemployment claims. Unemployment comes with a loss of employer-based health insurance leaving a population with already lower rates of insurance even more vulnerable.[5, 6]

Low-income populations are more likely to live in crowded conditions and rely on public transportation, both of which limit their ability to successfully social distance.[6] Minority groups also more commonly speak another language, impeding their ability to obtain information and also delaying care and reducing the quality of care they receive.[5, 6]

Once infected, racial and ethnic minorities are at a greater risk of increased disease severity. It is well known that comorbidities are associated with more severe influenza illness.[6] Initial studies from China have shown a similar pattern with COVID-19. Hypertension, diabetes, coronary artery disease, chronic obstructive lung disease, and chronic kidney disease have all been associated with increased mortality.[7] Previous epidemiological studies have consistently shown many of these conditions to be more prevalent in racial/ethnic minorities, likely contributing to the worse health outcomes seen from COVID-19.[2]

The current pandemic is highlighting the health disparities that already exist within our communities. Steps must be taken to better understand and mitigate this complex crisis. First, the issue needs to be better identified. Until recently, there has

been minimal comprehensive demographic data reported from the Centers for Disease Control and Prevention (CDC) or other governing bodies around the racial/ethnic characteristics of patients infected with COVID-19. Many people, including those in the medical field as well as politicians, are now calling for more transparency around this topic.

Once this data becomes more widely available, it will need to be strategically leveraged in order to improve the care of these patients. Specifically, it should shape our allocation of resources to ensure that there is sufficient screening and treatment of COVID-19 in resource limited settings that have higher proportions of racial and ethnic minorities.

Finally, as a vaccine becomes available, vaccination strategies could worsen disparities.[6] Historically, racial and ethnic groups have had suboptimal influenza vaccination rates, particularly among young adults.[2, 6] A vaccine response to COVID-19 might include large-scale vaccination clinics or delivery through primary care offices. Both would require patients to seek vaccination and thus may accentuate the problem and widen differences in vaccination rates.[2] Grassroots vaccine campaigns that meet people in their communities through mobile health centers or clinics at nontraditional sites like shelters will need to be utilized. It will be important to engage local and trusted partners with both the development and implementation of these programs.

Health disparities have long plagued our country and greatly impacted racial and ethnic minorities. COVID-19 is already showing signs of accentuating these disparities. While COVID-19 places everyone in this country at risk, it is not "the great equalizer." It will continue to preferentially affect the socially disadvantaged. It is our responsibility as the medical community to work to identify and alter these outcomes for our patients.

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