

# COVID-19: Shedding light on racial and health inequities in the USA

The sudden and rapid advancement of the novel coronavirus (COVID-19) pandemic has led to an unanticipated and unprecedented global crisis. Since its emergence in the USA, there is increasing discussion surrounding the impact of the virus among vulnerable populations. Older adults, young children, persons with chronic medical or mental health conditions, persons with disabilities, pregnant women, immunocompromised persons and those who are institutionalised or homeless are considered most vulnerable to death and lost quality of life (World Health Organization, W. H. 2020). Furthermore, populations vulnerable to complications from COVID-19 also include persons who are socially at-risk such as those who may experience any kind of abuse, housing instability, substance use disorder, food insecurity and have limited access to health care. High numbers of racial and ethnic minority groups often experience vulnerability because of structural racism, segregation, discrimination and marginalisation. Health inequities occurring among vulnerable populations, socially at-risk groups and racial/ethnic minority groups are nothing new. In fact, it is well documented in the literature that social determinants of health are associated with health outcomes (Smedley et al., 2003; Havranek et al., 2015). Nurses in and out of the frontlines should have heightened awareness of the social determinants of health and inequities that influence poorer health outcomes for patients infected with COVID-19.

Despite being the world's wealthiest nation, racial and ethnic minorities—people with global numbers in the majority but who lack societal power, privilege and influence—(e.g., Black, Native American and non-White Hispanic people), and those living in urban areas, or below the poverty level in the USA are constantly challenged to access quality health care—free of coercion, stigma and discrimination. Public health emergencies can further isolate members of these groups through diminished access to resources needed to prepare or respond to a disease outbreak such as COVID-19. Among racial and ethnic minority groups in the USA, Black people bear a disproportionate burden of cardiovascular disease risk factors with higher mortality rates than any other racial group (Havranek et al., 2015). There is a saying, “when America catches a cold, Black people get the flu” (Unknown, n.d.). This quote was a response to the 2008 global financial collapse, stating the adverse outcomes affected Black communities harder; in the case of COVID-19, this is no different. Persons who identify as Black are contracting COVID-19 at higher rates and are more likely to die from it than any other race (Centers for Disease Control and Prevention, 2020; Yancy, 2020).

The full impact of COVID-19 on Black communities is not thoroughly characterised, but the pandemic itself sheds light on pre-existing health inequities that are pervasive across the spectrum of disease in the USA. Early analyses show there are increased deaths and overrepresentation of Black people hospitalised with COVID-19. Across densely populated cities in the USA, Black people make up more than 50% of COVID-19 cases and up to 70% of COVID-19 deaths involve Black individuals (Yancy, 2020). Higher prevalence of diabetes, cardiovascular disease and asthma among Black people might partially explain these inequities. Diabetes and atherosclerosis share the common inflammatory processes observed among patients with diffuse pulmonary alveolar damage that commonly occurs among COVID-19 cases (Bloomgarden, 2020). The incidence of diabetes among COVID-19 cases with severe disease is threefold greater than mild disease cases (Yan et al., 2020; Zhou et al., 2020). For Black people with underlying cardiovascular conditions, the virus can have catastrophic effects. Similar to previous coronaviruses such as severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS), COVID-19 has been known to destabilise plaques increasing the risk for heart attack and stroke (Li et al., 2020; Xiong, Redwood, Prendergast, & Chen, 2020). Previous studies reflect a higher prevalence of cardiovascular disease among Black persons despite higher socio-economic status (Kanchi et al., 2018). This is a significant concern as Black people with chronic cardiovascular conditions already carry higher risks for experiencing cardiovascular events.

In addition to underlying chronic conditions, nurses must also consider the social factors that are powerful indicators for poor outcomes among Black people infected with COVID-19 (Dennison Himmelfarb & Baptiste, 2020). Social and living conditions contribute to higher risks for exposure, transmission, infection and death from COVID-19 among Black people. U.S. Census data suggest that Black people are more likely to live in more densely populated areas, making it harder to practise social distancing (Center for Disease Control and Prevention [CDC], 2020; Williams & Collins, 2001). The Pew Research Center has reported that Black, Hispanic and other ethnic minority groups are more likely to live in multi-generational homes than White families (CDC, 2020; Pew Research Center, 2011). Therefore, those living in multi-generational households may find it challenging to protect older adults in the household from exposure to COVID-19. Moreover, due to historic disinvestment in Black communities, Black people often live in low-income areas with limited access to groceries stores and pharmacies, making it difficult to

stockpile food and vital medications (Massey, 2020). Data from New York City, the epicentre of COVID-19 in the USA, show that Black people are more likely to be frontline workers, further increasing risk for exposure (Dorn, Cooney, & Sabin, 2020). They are also less likely to have paid sick leave and three times less likely to have health insurance coverage compared to people who are White (CDC, 2020; Stringer, 2020). Beyond everyday stressors, there is overwhelming evidence that Black people and other persons of colour encounter bias and discrimination in healthcare settings in the USA, where they receive inferior care (Moore, Mompe, & Moy, 2018). These systemic inequities contribute to toxic stress that can further exacerbate underlying conditions and increase susceptibility to more severe complications from COVID-19 infection (CDC, 2020). Although these inequities have been persistent for decades, they are exacerbated by the COVID-19 crisis and will most likely persist thereafter.

In his commentary published in the *Journal of the American Medical Association*, Dr. Clyde Yancy (2020) wrote about the sixfold increase in death rates among Black people in America—calling this a moment of “ethical reckoning.” Yancy (2020) calls on the health professional field to contribute to the social reengineering needed to fully address health disparities—transforming values, laws and policies. This call to action is long overdue as we have known for years that laws and social policies ensure Black people are systemically placed in poorer social and living conditions. Furthermore, Black people have historically had poorer health outcomes for cancer, low kidney transplant rates, cardiac and respiratory diseases, and alarming maternal mortality rates (Yancy, 2020). Coronavirus and the prevalence of chronic health issues in communities of colour provide an invitation for examining larger American culture. Conditions in these communities are generated by social policies and socially normed forms of discrimination. Williams and Cooper, in an editorial in the same issue of the *Journal of the American Medical Association* (2020), likened health inequities to an epidemic; they called for the USA, to develop a new form of “herd immunity” where a sufficiently high proportion of individuals in all social groups are protected from and “immune” to negative social determinants, leading to resistance to the spread of poor health in the population.

Social determinants of health play a significant role in how people access and receive care, and thus require close attention to structural factors that contribute to poor health outcomes among ethnic minority people. The emergence of the COVID-19 pandemic exacerbates these issues 10-fold. History shows that serious illness and death are higher among people of colour and other vulnerable groups during public health emergencies. It is unclear at this time how COVID-19 will further impact health inequities among socially at-risk and racial and ethnic minority groups. However, Black populations in the USA are not immune to the projected long-term effects of this global crisis. The pandemic has increased social and health needs and will likely precipitate an increase in health inequities. As information is rapidly evolving, nurses must consider social determinants of health that affect outcomes for racial and ethnic minority individual patients and communities as a whole. There are also concerns that this public health crisis, similar to the HIV epidemic, will

exacerbate discrimination, racism and stigma. To tackle these concerns, Williams and Cooper (2020) suggest three strategies: raising awareness of racial and ethnic health inequities, bringing clarity to the contributors to these inequities and increasing empathy for the plight of people of colour, in order to build support for political change. Thus, addressing underlying social and healthcare inequities will require transformation of societal values and widespread change in health and social policies.

A responsive shift is required in nursing education and practice, in order to meet the articulation of provision 9.3 and 9.4 of the US Nursing Code of Ethics (Davis, 2015). Yet, the Nursing Code of Ethics indicates nurses should not stop there, but leverage their collective voice in political advocacy to advance equity and anti-racist practices in national policy, hospital hiring and retention efforts, and ethical conduct of research. Nurses are called to exhibit and embody human dignity for Black people. Institutional and structural reengineering will be demonstrated in actions, methods and ideologies that can be measured as equitable access to care and comparable disease rates; interpersonal reengineering will be demonstrated when the contextualised truths found in the social determinants of health are broadly known and understood—with and without the racialised results of a global pandemic. But most importantly, reengineering will be demonstrated when we can no longer highlight disproportionate outcomes in health based on race.

#### CONFLICT OF INTEREST

The authors report no conflict of interest.

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