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This Time Must Be Different: Disparities During the COVID-19 Pandemic

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Abstract

African Americans and Latinos are overrepresented among cases of and deaths from COVID-19 nationally and in many of the U.S. regions hardest hit by the pandemic. The editorialist discusses lessons that we should have learned from prior experiences and strategies to reduce observed disparities.

After reports of racial and ethnic disparities in the U.S. pandemic, a large, nationally representative survey provided empirical evidence regarding the sources of these disparities (1). The authors found that increased likelihood of exposure to the virus, increased susceptibility to severe consequences of the infection, and lack of health care access were all important contributors, and they concluded with pointed, domain-specific recommendations to mitigate these disparities. The clarity of this path forward would be alluring and reassuring were the historical nature of these observations not so alarming. These data are not based on the coronavirus disease 2019 (COVID-19) pandemic; rather, they describe the nation's experience of the 2009 H1N1 influenza pandemic.

Unfortunately, things have not changed for the better. African Americans and Latinos are overrepresented among cases of and deaths from COVID-19, both nationally and in many of the areas hardest hit by the pandemic (2, 3). In New York City, African American and Latino residents have the highest age-adjusted rates of hospitalized and nonhospitalized COVID-19, and age-adjusted death rates for African Americans are more than twice those for white and Asian residents (4). Throughout the United States, data by race and ethnicity are incomplete and highly dependent on what information is collected at the local level—a glaring omission in data collection that was highlighted for remediation during the 2009 H1N1 pandemic (1).

The likely causes of the disparities are also distressingly similar. Minority communities are more likely to be exposed to the virus because they are overrepresented in the low-wage, essential workforce at the front lines, including low-wage health care workers who often move between clinics, hospitals, and nursing homes to make a living, thereby magnifying their risk (5). Poor communities may face challenges implementing social distancing because of housing density and overcrowding, and minority populations are overrepresented in congregate settings, such as homeless shelters and prisons, that increase exposure risk. Minority communities may be more susceptible to severe forms of COVID-19 because of existing disparities in underlying conditions known to be associated with COVID-19 mortality, including hypertension, cardiovascular disease, kidney disease, and diabetes. Although largely preventable or amenable to medical management, these chronic conditions are more common, less likely to be controlled, and more likely to occur at younger ages in these communities. Health care access is also a probable contributor to COVID-19 mortality given the limited availability of both testing and treatments. Much of the testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has occurred in the context of a health care evaluation, resulting in barriers for those without insurance. Although data are not yet available, concerns about the equitable distribution of ventilators and treatments have also been raised.

We simply cannot afford to bear witness to yet another manifestation of health inequities. This time must be different because we are living in a global pandemic of massive proportion and uncertain duration, the management of which will require ongoing, effective, and equitable attention to the areas of greatest need if we are to avoid even more devastating consequences. This time must be different because the increasing diversity of the U.S. population and our essential workers reminds us of our interdependence and means that focusing on minority communities is essential both to relieve suffering in these communities and to effectively manage this crisis. This time must be different because the economic underpinning of these disparities has worsened over the past decade and threatens to deteriorate further in the face of the anticipated global depression, likely exacerbating the COVID-19 disparities we are already witnessing.

It is time to learn from the lessons of past epidemics and their disproportionate effect on minority communities. We need robust data to guide these efforts, but better information must be coupled with urgent and effective action to decrease exposure, susceptibility, and limitations in health care to achieve the desired results. For our public health efforts at mitigation and containment to be most effective, resources must be invested in the communities hardest hit by COVID-19 to redress past underinvestment and the ongoing impact of the economic crisis. Our clinical and public health sectors that have been relentlessly focused on addressing the acute issues of COVID-19 over the past months must refocus to also address prevention and treatment of the underlying cardiovascular and metabolic conditions that are the major contributors to morbidity and mortality in these communities.

As we plan for a SARS-CoV-2 vaccine, we must heed the lessons from past vaccination campaigns. During the 1970s, the gap in measles vaccination rates between minority and white children was as high as 18 percentage points. Consequently, the U.S. measles epidemic of 1989 to 1991 that resulted in more than 55 000 cases included 4- to 7-fold higher rates among minority children than white children. Today, gaps in measles vaccination rates by race and ethnicity are nonexistent thanks in part to a dual strategy of boosting universal childhood vaccination and implementing targeted measures in minority communities. These targeted approaches have included increased funding to urban health departments; development of local action plans; linkage of vaccination to other programs like the Special Supplemental Nutrition Program for Women, Infants, and Children; increased reimbursement for Medicaid providers; reduced vaccine prices for Medicaid programs; adjustment of hours in public health clinics to meet the local needs of populations; ongoing monitoring and surveillance through annual surveys; and broad engagement with community organizations with specific targeted messages to minority communities (6). Unfortunately, influenza vaccinations and most other adult vaccinations have not seen similar success. Although influenza vaccination rates improved in the 2018 to 2019 season compared with prior years, the rate overall was only 45.3% (far short of the 70% goal of Healthy People 2020), and rates were substantially lower among African American, Latino, and American Indian/Alaska Native adults (7). Achieving the desired population benefit of a SARS-CoV-2 vaccine will require an implementation strategy that addresses the current gaps in overall rates of adult vaccination, as well as specific issues in minority communities. Establishing and nurturing trust and partnerships within affected communities will be critical because diminished trust in health care borne from a legacy of unethical experimentation, including the Tuskegee study, has been identified as an important contributor to vaccine hesitancy among African Americans (8, 9).

To borrow the words of Dr. Martin Luther King Jr., "We are now faced with the fact that tomorrow is today. We are confronted with the fierce urgency of now. In this unfolding conundrum of life and history, there *is* such a thing as being too late. This is no time for apathy or complacency. This is a time for vigorous and positive action" (10). Can we eschew our collective amnesia, acknowledge the persistence and pervasive nature of our health and health care disparities, and draw on our experience to overcome? Or will the failure of our collective will define us as a generation that refused to care and refused to act?

Biography

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Footnotes

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