

# **At the Heart of the Matter: Unmasking and Addressing COVID-19's Toll on Diverse Populations**

**Running Title:** *Haynes et al.; Unmasking COVID-19 Health Disparities*

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## Introduction

The COVID-19 pandemic has unmasked longstanding racial and ethnic health-related disparities. As noted by Ta-Nehisi Coates in reference to racial/ethnic inequities, the “*sociology, the history, the economics, the graphs, the charts, the regressions all land with great violence upon the body*”<sup>1</sup> and COVID-19’s impact on the body, especially on bodies of color is too often fatal.

## Epidemiology

Emerging racial/ethnic data from local health departments and the CDC indicate alarming fatality statistics for COVID-19 by race/ethnicity. Data indicate that co-morbidities such as hypertension, diabetes, cardiovascular disease, obesity, chronic lung disease, and kidney disease are risk factors for poor COVID-19 outcomes.<sup>2</sup> African-Americans (Blacks) have the highest prevalence of hypertension and kidney disease, with an earlier age of onset.<sup>2</sup> Native Americans have an extremely high prevalence of diabetes, and Hispanic/LatinX individuals suffer from similar comorbidities at comparable rates.<sup>2</sup> Thus, it is no surprise that people of color have been disproportionately impacted by the present pandemic.

On a national level, CDC data representative of 10% of the US population reveals that Blacks account for 33% of COVID-19 hospitalizations, despite consisting of 18% of the sample population. In Louisiana, Blacks make up 32% of the population, yet account for 70% of COVID-19 related fatalities.<sup>2</sup> In NYC, Hispanic/LatinX persons account for 28% of the population, but 34% of COVID-19 related deaths.<sup>2</sup> In New Mexico, Native Americans account for 11% of the population, but 37% of COVID-19 positive cases.<sup>3</sup>

The outsized impact of COVID-19 on communities of color extend beyond the U.S. In the United Kingdom (UK), data show that while UK Blacks comprise approximately 3% of the UK population, they represent 12% of COVID-19 ICU patients.<sup>2</sup> By contrast, Blacks only

accounted for 3% of non-COVID-19 viral pneumonia ICU admissions.<sup>2</sup> Blacks were also disproportionately represented among those with COVID-19 who required ventilators; ventilation was associated with a 67% mortality rate.<sup>2</sup>

### **Social Determinants**

The health disparities exposed by the current public health crisis did not materialize in a vacuum, but are largely driven by socio-economic and environmental factors. The effects of COVID-19 on vulnerable populations highlight large disparities in resource allocation which perpetuate poverty and segregation. Data show that the most impoverished communities, which are largely communities of color, have been hardest hit by COVID-19.<sup>2</sup> Moreover, social distancing is difficult in impoverished communities due to overcrowding, residence in multi-generational households, and the inability to work from home. For example, 16% of Hispanic/LatinX and 20% of Black workers can telework compared to 30% of White and 37% of Asian workers.<sup>2</sup>

Given that unemployment rates for Blacks are typically twice that of Whites, the full impact of the economic fallout from COVID-19 will be especially hard-felt in Black and other communities of color. After the 2008 recession, while white household wealth stabilized, the median Black household wealth continued to fall. If the 2008 recession is an indication of the future, the wealth gap will continue to widen given the steeply rising unemployment rates due to COVID-19. Additionally, the insurance coverage gap will undoubtedly increase. A significant percentage of communities of color are uninsured.<sup>4</sup> With increasing unemployment rates, public insurance options such as Medicaid will be vital.

### **Clinical Presentation**

The emerging differences in COVID-19 complications by race/ethnicity are disturbing and as previously noted might be in part driven by a higher prevalence of co-morbidities at an earlier

age among U.S minorities. Furthermore, against a historical backdrop of healthcare system mistrust, marginalized groups may present to hospitals later, during the late pulmonary phase and the hyper-inflammatory phase.

There remains a lack of published data regarding racial/ethnic variance in COVID-19 presentation. However, San Francisco county data from 4/15/20 showed that young Hispanic/LatinX persons are disproportionately affected by COVID-19 such that 42% of cases are among persons <40 years old of which 24% are of Hispanic/LatinX heritage. These reports are contrary to published data annotating that the most severe disease presents in individuals older than 60 years of age.

Additionally, as the social distancing messaging permeates media airwaves, the number of medical encounters and hospitalizations for non-COVID-19 related illnesses has sharply decreased. For example, emerging research indicates, a 38% reduction in the activation of the cardiac catheterization laboratory for acute myocardial infarction at some centers.<sup>5</sup> The decrease is likely due to people delaying medical attention for cardiac symptoms out of concern for becoming infected with COVID-19. Although systematic data are currently unavailable, other vulnerable groups, including those of lower socioeconomic status, low health literacy, undocumented immigrants and non-English speakers are also likely at differential increased risk due to delayed presentations.

Additionally, the mental health impact of COVID-19 on society, especially on COVID-19 survivors and their families cannot be overstated. For survivors and their families, the tincture of time will reveal long-term clinical effects typically patterned by race/ethnicity, including disproportionate levels of psychosocial stress and anxiety.

## Potential Solutions

In order to mitigate the spread of COVID-19, attenuate further stigmatization of communities of color, and decrease the effects of the economic downturn, several actions must be taken **(Figure)**. Healthcare entities must collect and present COVID-19 data according to socio-demographic characteristics. COVID-19 testing must be easily available in all communities and contact tracing must be relentless. Housing availability should be expanded. Facilities such as hotels and dorms should be used to quarantine symptomatic individuals to avoid spread to family members and neighbors. Suspension of foreclosures and evictions should occur. Incentives to provide free or discounted food delivery to low-income neighborhoods and the elderly are necessary. Food banks will benefit from additional funding to reduce food insecurity. Due to the increased reliance on telemedicine and distance learning, policymakers should support broad access to computers and free internet for vulnerable communities. Employers should provide paid sick and quarantine leave to help reduce the risk of unwitting spread. Ultimately, lessons learned from the COVID-19 pandemic must be taken as an opportunity to address long-standing social and racial/ethnic disparities. Our vulnerable interconnectedness highlighted by the COVID-19 pandemic should ignite meaningful solution-focused collaborations among community leaders, scholars and policymakers to orchestrate sustainable change aimed at addressing pervasive healthcare disparities.

## Conflict of Interest Disclosures

All authors have no conflicts of interest

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## Figure Legend

**Figure.** Novel Coronavirus Health Disparities and Solutions



Circulation

# Coronavirus (COVID-19) Health Disparities and Solutions

