ISSN 2472-3878

PUBLIC HEALTH
Open Journal

Openventio PUBLISHERS

Mini Review

Improving Health Equity for Black Communities in the Face of Coronavirus Disease-2019

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Article information
Received: June 2nd, 2020; **Revised:** June 22nd, 2020; **Accepted:** June 23rd, 2020; **Published:** June 23rd, 2020

Cite this article
Jones-Burton C, Olugemo K, Greener JR. Improving health equity for Black communities in the face of coronavirus disease-2019. *Public Health Open J*. 2020; 5(2): 38-41. doi: 10.17140/PHOJ-5-146

ABSTRACT

The impact of coronavirus disease-2019 (COVID-19) in the U.S. to date is staggering and Blacks across the country are being infected and dying at rates far in excess of Whites. Although health disparities have been part of America's reality for decades, the pandemic has exposed the failure of the healthcare system to adequately serve minority patients. There are immediate solutions that can help to balance the inequity now and position us well for the future. Five suggested solutions are described which focus on greater inclusion of Blacks in activities such as clinical trials, encouraging community-based resources and providing comprehensive racial data on COVID-19 cases. We are not all in the fight against COVID-19 together. Solutions must be adopted to help to address the current disparities now as well as beyond the immediate crisis.

Keywords
Health disparities; COVID-19; Minorities; Health equity; Black communities.

INTRODUCTION

By all measures, the impact of coronavirus disease-2019 (COVID-19) in the U. S. to date is staggering and no racial group has been impacted as severely as the Black community. Blacks across the country are being infected and dying at rates far in excess of Whites and implicated are historical structural issues, current biases and shortfalls in the healthcare system. Immediate solutions, grounded in the community, are required to ensure more equitable outcomes in the face of this pandemic.

The Hispanic/Latino population, along with other underrepresented racial and ethnic groups, are also facing grave challenges in the face of COVID-19.[1] Data documenting the impact of the virus on Hispanic/Latino communities is not yet as developed as that available for the Black population. However, many of the structural issues, biases and healthcare limitations described below also apply to this population and appropriate solutions will need to be developed.

DISCUSSION

Data released by the Centers for Disease Control and Prevention (CDC) details the number of COVID-19 cases reported by state and demographic characteristics.[2] Among those cases for which race is specified, 30% mortality is shown for Blacks, although they represent 13% of the U. S. population. Most troubling is the extreme imbalance on a state and city basis between Blacks and Whites who have been infected and succumbed to COVID-19. For example, in Illinois, 42% of people who have died from the disease are Black, a group that makes up just 14% of the state's population.[3] In Chicago specifically, over 70% of the deaths occurred among Black residents although they represent only about a third of the population.[4]

Historical imbalances in wealth and opportunity have created structural conditions that underlie both the racial imbalances in coronavirus deaths and a healthcare system that promulgates the disproportional risk experienced by Black patients.[5] Structural conditions are numerous; a partial accounting includes segregated

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neighborhoods that have insufficient services and funding, poor access to healthy foods, disproportionate placement of toxic dump sites, overrepresentation in low wage jobs, and life stressors from institutional bias.[6] Low socioeconomic status alone is a risk factor for total mortality.[7] Focusing on healthcare specifically, Blacks are less likely to be insured, more likely to have underlying health conditions, and face bias that prevents them from getting guideline-appropriate treatment. Co-morbidities such as hypertension, diabetes, obesity, renal disease and cardiovascular disease, along with underlying elevated levels of lipoprotein(a) [Lp(a)],[8] are all risk factors for poor COVID-19 outcomes, and Blacks suffer from a high prevalence of these conditions.[9] In addition, data indicates that a high proportion of COVID-19 patients die from complications related to heart failure and renal disease in particular.[9,10]

Conditions for Blacks exacerbate the links to increased exposure and worse outcomes in the face of COVID-19. Many essential workers are Black, and they must continue reporting to work even though it means ongoing contact with the public. Black workers may have to take public transportation to and from work and come home to multigenerational dwellings, making social distancing in general, and from older and more vulnerable family members, impossible. Black communities, especially those in states without Medicaid expansion, have less access to testing and medical care.

Health disparities have been part of America's reality for decades; however, the pandemic has exposed the failure of the healthcare system to adequately serve minority patients. As such, COVID-19 is not an equal-opportunity disease. The fact that a higher number of individuals in the Black community are contracting and dying of the virus exposes the country's "*deeply rooted social, racial and economic health disparities*"[11] Changing this reality is a moral imperative. As Dr. Clyde Yancy, a researcher and physician at Northwestern University, states: "*a 6-fold increase in the rate of death for African Americans due to a now-ubiquitous virus should be deemed unconscionable. This is a moment of ethical non-reckoning*".[4]

Solutions must be able to address these issues in the short term as well as longer-term. In keeping with society's crisis mentality, once an acute situation resolves, root causes are forgotten along with the need to permanently address them. How can this be prevented from continuing to occur? Many of the underlying factors that have persisted would require policy or system changes that could take years. Included are such factors as cost of care, which may hinder patients from seeing a physician or having the ability to access the most appropriate and effective medication; the lower-value care Blacks receive compared to Whites; lack of providers or clinics in the communities with high Black populations; and a shortage of Black physicians, who have been found to engender greater trust and use of the health system among Black patients.[12-15]

However, there are immediate steps that can help to balance the inequity now.

Apply the Lens of Distributive Justice and an Inclusive Well-Rounded Perspective to Considerations of Scare Resource Allocation

An issue of current concern is the scarcity of medical resources in many cities, and guidelines are being created to help physicians ethically make rationing decisions. An article by Dr. Ezekiel Emanuel and colleagues provided recommendations consistent with save-the-most lives principle; that is, save the life of the healthier patient that will be more likely to successfully recover.[16] The authors, while attempting to operationalize ethical values for the fair allocation of scarce resources, were remiss in considering the challenges faced by Black patients, thereby promulgating existing inequities.

The first recommendation prioritizes patients with a reasonable life expectancy. This is tied to structural conditions as well as current socio-economic status which disadvantages minority patients. Assigning value to quantity versus quality of life is not in the remit of medical practice. Public sentiment differs from the authors' perspective; a PEW research study shows that U. S. adults are split on whether a scarce ventilator goes to a person most in need or the one most likely to successfully recover.[17]

The second recommendation assigns COVID-19 interventions first to front-line healthcare workers designated as physicians and nurses. However, essential staff from critical infrastructure positions who face the same exposure risk, such as transportation, food and sanitation workers, are disproportionately minorities. A third recommendation prioritizes providing scarce resources to people who participate in clinical research of COVID-19 vaccines and therapeutics as a tie breaker for people with similar prognoses. Minorities are often not given equal opportunities to clinical trials, and trust in research has been eroded through historical unethical practices. A prime example is the paucity of Black patients, typically less than five percent, in clinical trials of new cancer drugs for conditions that disproportionately affect them.[18]

Applying these criteria evenly to everybody does not recognize that factors impacting health status are not evenly distributed. The adage – *where the pain is, the power ought to be* – speaks to the perspective of distributive justice.[6] This asserts that it can be ethically justified to give more resources to the least well off if this is what is required for all individuals to reach the same level of health. Focusing on the most vulnerable and underserved creates a path toward health equity that will help everyone overcome this pandemic.

Having Comprehensive Racial Data on COVID-19 Cases

The CDC data referenced earlier contains a partial accounting of race and ethnicity associated with coronavirus cases; this information is only reported for about 25% of cases. However, having comprehensive national data on race, ethnicity, gender, age, and location is critical to developing preparedness plans for this wave and the next waves of COVID-19. This data will be instrumen-

tal in directing appropriate resources to where they are critically needed, ensuring that response to cases is fair and equitable. In addition, this data can also provide insight into the areas with no apparent disparities, and this can be used as a guide toward promoting equity.

A tool in this effort could be the Surgo Foundation, a British nonprofit that uses data science to address global development and health care issues.[19] Scientists at the foundation have developed a new metric called the COVID-19 Community Vulnerability Index that is designed to capture where the impact of the virus will be most severe. It looks at 34 socioeconomic and epidemiological factors such as residents' poverty and income, age, race, and ethnicity, as well as their disabilities and underlying health issues and transportation, housing, and healthcare system capacity in their county. The index builds upon the Center for Disease Control's social vulnerability index, which quantifies a community's ability to cope with disasters in general.

Areas in the U. S. found to be most vulnerable to COVID-19 are counties in the South, in states such as Mississippi, Louisiana, Arkansas, Oklahoma and Alabama. Being able to plan and allocate resources up front will go a long way to drive more equitable health support in the many large Black communities in these states.

Make Centers for Testing and Care Available in Black Neighborhoods

In order to address the spread of COVID-19, people need to be tested and treated in a timely way. In Black communities, this is not occurring based on the location of healthcare facilities and the clogged pipeline. Initial indications are that doctors are less likely to refer African-Americans for testing when they visit a clinic with symptoms of COVID-19, and delaying care with this aggressive virus can lead to poorer outcomes.[20] Pop-up centers that offer access to free testing and treatment are critical to help speed care for Black individuals. This can help to mitigate the long waits at emergency rooms in public hospitals that result in patients risking exposure on public transportation and returning home without getting the care they need or the means to purchase medication. The fact that many city residents do not have cars is overlooked with drive-through testing sites. Instead of placing sites wherever they can be set up quickly, officials must target the communities in need.

Make Education and Outreach Available on a Community Basis

In the U. S., and particularly in the Black community, there was a lack of early communication about the threat of COVID-19 as well as transmission of confusing messages. The fact that information was not forthcoming allowed unfounded rumors to propagate, such as Black people were immune to the disease. And, some government representatives and spokespeople put the blame on Black Americans for contracting and dying of the virus, based on genetics, underlying conditions, the foods they eat, lifestyle, etc.[21] As a result, some areas lagged in terms of taking required action to slow the spread.

In many Black communities, trust in government is low and incomplete; confusing and inaccurate information only serves to enhance this sentiment. State and local governments will have to step up to address Blacks at the community level, using trusted individuals and institutions, such as churches and faith-based leaders, community non-profits, trusted community sources, local health leaders, and advocacy groups to reach out to vulnerable people. How education and outreach is transmitted through focused and culturally nuanced messages and targeted channels is critical. Public health information is required, including which comorbidities have been associated with greater risk, dispelling myths on exposure, transmission and convalescence, when patients should present to urgent care, and key issues to discuss with health care professionals (HCPs).

Provide Appropriate Protection

The country's response remains hampered by medical supply shortages which need to be shared with all essential workers, not just emergency and medical personnel. This includes janitors, home health aides, delivery people, grocery, farm works and sanitation workers, and transportation workers. In many cities, Black municipal employees have not been provided adequate protection, exacerbating the spread of disease to their families as well as the segments of the public they come into contact with.

CONCLUSION

In the fight against COVID-19, it may feel good to say we are all in this together, but in reality, we are not. The Black community is experiencing a disproportional burden of the pandemic. This will continue unless short-term solutions are adopted and are able to facilitate the longer-term solutions that will extend far beyond the immediate crisis.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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