VIEWPOINT

COVID-19 and African Americans

Clyde W. Yancy, MD, MSc
Department of Internal Medicine, Division of Cardiology, Northwestern University, Feinberg School of Medicine, Chicago, Illinois.

Related article

Much has been published in leading medical journals about the phenomenon of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection. The resulting condition, coronavirus disease 2019 (COVID-19), has had a societal effect comparable only to the Spanish flu epidemic of 1918. As the flow of clinical science has better informed the contemporary narratives, more is being learned about which individuals and groups experience the most dire complications. Researchers have emphasized older age, male sex, hypertension, diabetes, obesity, concomitant cardiovascular diseases (including coronary artery disease and heart failure), and myocardial injury as important risk factors associated with worse outcomes; specifically, case-fatality rates vary over 100%.[1-3] These data sourced from China and Europe have not been replicated in the US, but the US experience may nevertheless represent similarly distressing outcomes in these highest-risk phenotypes.

The concerns about these observations are appropriate and the published data are indeed actionable; those who fit the highest-risk phenotypes can be advised to assiduously adhere to safe practices including hand hygiene, use of masks in public spaces, and social distancing/physical isolation.[4] These measures not only are flattening the curve but are no doubt saving lives. However, a new concern has arisen: evidence of potentially egregious health care disparities is now apparent. Persons who are African American or black are contracting SARS-CoV-2 at higher rates and are more likely to die.[5]

The US has needed a trigger to fully address health care disparities; COVID-19 may be that bellwether event.

Why is this uniquely important to me? I am an academic cardiologist; I study health care disparities; and I am a black man.

What is currently known about these differences in disease risk and fatality rates? In Chicago, more than 50% of COVID-19 cases and nearly 70% of COVID-19 deaths involve black individuals, although blacks make up only 30% of the population. Moreover, these deaths are concentrated mostly in just 5 neighborhoods on the city's South Side.[6] In Louisiana, 70.5% of deaths have occurred among black persons, who represent 32.2% of the state's population.[7] In Michigan, 33% of COVID-19 cases and 40% of deaths have occurred among black individuals, who represent 14% of the population.[5] If New York City has become the epicenter, this disproportionate burden is validated again in underrepresented minorities, especially blacks and now Hispanics, who have accounted for 28% and 34% of deaths, respectively (population representation: 22% and 29%, respectively).[8]

The Johns Hopkins University and American Community Survey indicate that to date, of 131 predominantly black counties in the US, the infection rate is 137.5/100 000 and the death rate is 6.3/100 000.[5] This infection rate is more than 3-fold higher than that in predominantly white counties. Moreover, this death rate for predominantly black counties is 6-fold higher than in predominantly white counties. Even though these data are preliminary and further study is warranted, the pattern is irrefutable: underrepresented minorities are developing COVID-19 infection more frequently and dying disproportionately. Do these observations qualify as evident health care disparities?

Yes. The definition of a health care disparity is not simply a difference in health outcomes by race or ethnicity, but a disproportionate difference attributable to variables other than access to care.[9] Given the known risk factors for COVID-19 complications, the confluence of hypertension, diabetes, obesity, and the higher prevalence of cardiovascular disease among black persons may be driving these early signals. Data fully adjusted for comorbidities have not been reported but it is likely that some, if not most, of these differences in disease rates and outcomes will be explained by concomitant comorbidities.

But concerns go beyond these comorbidities. Where and how black individuals live matters. If race per se enters this discussion, it is because in so many communities, race determines home. Once adverse outcomes attributable to known risks for COVID-19 complications are disaggregated from total morbidity and mortality burden due to COVID-19, the pernicious influence of adverse social determinants of health is likely to become apparent.[10] The communities where many black people reside are in poor areas characterized by high housing density, high crime rates, and poor access to healthy foods. Low socioeconomic status alone is a risk factor for total mortality independent of any other risk factors. These social determinants of health must be considered in a complex equation, including known cardiovascular risk factors, which puts underrepresented minorities who live in at-risk communities at greater risk for disease, not just for cardiovascular diseases but now for COVID-19 mortality.

The most effective strategy known to reduce COVID-19 infection is social distancing, but herein lies a vexing challenge. Being able to maintain social distancing while working from home, telecommuting, and accepting a furlough from work but indulging in the plethora of virtual social events are issues of *privilege*. In certain communities these privileges are simply not accessible. Thus, consider the aggregate of a higher burden of at-risk comorbidities, the pernicious effects of adverse social determinants of health, and the

Corresponding Author: Clyde W. Yancy, MD, MSc, Division of Cardiology, Northwestern University, FSM, 676 N St Clair, Chicago, IL 60611 (cyancy@nm.org).

absence of privilege that does not allow a reprieve from work without dire consequences for a person's sustenance, does not allow safe practices, and does not even allow for 6-foot distancing. The consequent infection and death rates due to COVID-19 complications are no longer surprising; they should have been expected. These observations are rooted in the recalcitrant reality of the deeply entrenched history of health care disparities and may settle as the most painful example yet of the regressive tax of poor health. COVID-19 has become the herald event that now fully exposes the deep and chronic social wounds in US communities.

What makes this particularly egregious is that unlike the known risk factors for which physicians and others can stridently offer clear advice regarding prevention, these concerns—the burden of ill health, limited access to healthy food, housing density, the need to work or else, the inability to practice social distancing—cannot be well-articulated as clear, pithy, and easily actionable items.

What is the action plan? It is less an action plan and more of a commitment. 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 reckoning. The scourge of COVID-19 will end, but health care disparities will persist. Does the US chronicle these poor outcomes due to COVID-19 complications with the higher burden of cardiovascular disease, poorer outcomes for breast cancer, higher amputation rates for peripheral vascular disease, lower kidney transplant rates, and worse rates for maternal mortality, then safely park everything in the health care disparity domain and go back to "normal"? Or will the nation finally hear this familiar refrain, think differently, and as has been done in response to other major diseases, declare that a civil society will no longer accept disproportionate suffering?

Public health is complicated and social reengineering is complex, but change of this magnitude does not happen without a new resolve. The US has needed a trigger to fully address health care disparities; COVID-19 may be that bellwether event. Certainly, within the broad and powerful economic and legislative engines of the US, there is room to definitively address a scourge even worse than COVID-19: health care disparities. It only takes will. It is time to end the refrain.

ARTICLE INFORMATION

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