Observations from the COVID-19 Pandemic

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AS OF THE AFTERNOON of April 20, the Johns Hopkins University of Medicine's COVID-19 Dashboard revealed the worldwide total of confirmed cases of coronavirus disease 2019 (COVID-19) as 2,447,920. The United States had the distinction of having the highest recorded total of any country in the world at 766,644. The worldwide total of recorded deaths due to COVID-19 was 168,500 of which 35,012 had occurred in the United States. New York City (all boroughs) accounted for 14,551 deaths, which, if considered a country, would rank 5th in the world.¹ Within the United States, limited emerging data reveal that Hispanic and African Americans residing in the urban cores of many large U.S. cities appear to account for an alarmingly disparate proportion of both cases and deaths relative to their respective populations in these heavily populated urban centers. In Chicago, in early April, African Americans accounted for 68% of the city's 118 deaths and 52% of the roughly 5,000 reported cases, despite accounting for only 30% of the city's population based on data from the Chicago Department of Public Health. Included in this report were similar data from nearby Milwaukee, Wisconsin, where African Americans accounted for 73% of the deaths due to COVID-19 while accounting for only 38% of the city's population.²

Remarkably, many if not most of the states are yet to report racial data in regard to COVID-19 infection and fatalities. However, numerous reports from providers on the front line in cities such as Atlanta, New Orleans, and New York report similar observations.

The Brookings Institution has published a number of reports based on observations during the COVID-19 pandemic. In the institution's article "Who lives in the places where coronavirus is hitting the hardest?" published April 10, it was noted that people living in the urban cores of large metropolitan areas comprise more than half the residents who live in counties with the highest COVID-19 prevalence. The report also noted that fully two-thirds of those living in lower-prevalence counties reside outside of urban cores and their close-in suburbs.³

Across the country, a strong relationship between the size of the African American population of a county and its COVID-19 prevalence has been noted. In such counties, COVID-19 prevalence rates well in excess of 175/100,000 population have been observed. In counties where in one early report African American residents comprised 90% of the population, the COVID-19 death prevalence was 13.4/100,000 residents in contrast to 6.7/100,000 in the nation as a whole.³

Clearly, these are crude emerging data but consistent with albeit anecdotal discussions with providers on the front line of this pandemic who have understandably asked to remain anonymous in consideration of patient and institutional privacy.

In one large inner-city "safety net" hospital, a colleague recounted the overwhelming majority of his patients who succumbed to COVID-19 were indeed black. These patients all had poorly controlled comorbid conditions, including chronic obstructive pulmonary disease, diabetes, asthma, cardiovascular disease, and renal disease. A colleague at the suburban flagship hospital of a large regional health-care system noted almost exclusively Hispanic laborers with often underdiagnosed and undertreated comorbidities as discussed above. These patients were involved in various service occupations supporting affluent communities in the area and had neither a medical home nor health insurance.

In rural areas in the South, similar disparities and high mortality rates have been noted in smaller black communities. In one such community in the Southeastern United States where many residents live below the federal poverty level, more than 30 African Americans succumbed in an early wave of the pandemic. Most of these victims could be linked to attendance at 2 local funerals in the preceding 2 weeks.

While it is clearly too early in the pandemic to make absolute conclusions based on these limited data, the observations seem to point clearly to previously well-described social determinants of health among high risk, excessively morbid, and minority populations. These include limited access to care, poverty, minority status, substandard and often overcrowded housing, low health literacy, and lack of the so-called medical home. These facts are not new, though they appear to have as yet escaped any systematic models to change the observed patterns of morbidity and mortality. These issues persist in a country of considerable aggregate wealth and health-care resources when compared to the rest of the world. If the COVID-19 pandemic and its associated suffering and death does not motivate substantive change, what does that say about our society, given our aggregate wealth in this age of expanding knowledge and discovery?

A national plan of universal health care easily accessed by all citizens at a cost scaled to an accurate assessment of resource-based ability to pay would seem logical, given all the health inequities blatantly revealed by this calamity.

Instead of coming together, as we have done in the past after major disasters, health-care reform is currently under attack as opposed to being refined to be both effective and inclusive.

Additionally, effective models of community-based health education and screening are sorely needed to foster enhanced health literacy in high-risk communities of individuals and families with limited resources. Models that partner with validated community partners (places of worship, educational institutions, and fraternal organizations) that have established trust within at-risk populations deserve further attention and deployment as part of a concerted multilateral approach to improve health literacy and engagement to reduce well-documented health disparities.

Author Disclosure Statement

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References

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