

A PIECE OF MY MIND

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Viewpoint

Failing Another National Stress Test on Health Disparities

The African American daughter of one of us called from New York City in early March, worried about her Hispanic partner's health. Did his high fevers, worsening shortness of breath, and painful cough indicate coronavirus disease 2019 (COVID-19) infection? Given his history of asthma and hypertension, was he at high risk? What should they do? Urged to seek medical attention, he resisted. The nearby affordable and accessible urgent care clinics were staffed by physicians who, based on his previous experiences, "just didn't get it," and he anticipated that his concerns would be dismissed. When he relented and requested a coronavirus test, he was asked about international travel, but not about their small apartment or his use of public transportation. He was told "no test," once again confirming his impressions of an uncaring system. He decided to stay at home and tough it out.

But he got worse. The fevers were unrelenting, and it was hard to breathe. He was finally cajoled to try a different clinic. There, the African American receptionist conveyed their concerns and the staff agreed to provide a COVID-19 test. The patient was handed a flyer with home care instructions, but no one asked about financial consequences of staying home and no follow-up plans were provided.

And then good news—the clinic called and reported that the test was negative. Yet, a week later, the high fevers continued. They reached out to the clinic again and were reassured that "there [was] nothing to be done for coronavirus." When they asked why the nurse was labeling him a "COVID patient" when his test was negative for coronavirus, the response was an unapologetic "Oops, you got the wrong result." Now a month later, he is still recovering from COVID-19 and from another painful health care encounter.

Why are we—a black senior educator, a white medical foundation president, and a Hispanic public health leader—coming together to share this story? This case is a personal illustration of how the long-standing systemic inequalities in the US health care system result in the tragically unequal effect of COVID-19. Many of the contributing factors—from higher rates of underlying disease risk factors, to long-standing lack of access to health care, to lack of cultural competency, to adverse social determinants of health—predict a higher incidence and worse outcomes for minorities. We are deeply disappointed, but not surprised.

As of April 7, disturbing national trends are suggested, despite incomplete data capture. In New York, Hispanic and black people accounted for 34% and 28%, respectively, of deaths from COVID-19, even though they represent only 29% and 22% of the population; while white people accounted for 27% of deaths, even though they represent 32% of the population. In Chicago, black people comprise 32% of the

population but thus far have accounted for 52% of nearly 5000 reported cases and approximately 70% of COVID-19 deaths. The infection rate among black people is twice their percentage of the population across Illinois. Across the state of Michigan, black individuals account for 33% of positive COVID-19 tests and 41% of deaths yet represent only 14% of the population. In Louisiana, black people comprise 32% of the population but account for 70% of the COVID-19 deaths. Black individuals comprise 35% of the residents of Charlotte, North Carolina, but more than 40% of COVID-19 cases. In Milwaukee, 26% of the residents are black but account for almost half of the COVID-19 infections and 81% of deaths. North Carolina and South Carolina report a ratio of black to white residents who have tested positive that exceeds predictions from the general population. Data are more limited for Hispanics, but similar troubling statistics are emerging.

We propose that the overarching cause of these tragic statistics is decades of the effects of adverse social determinants of health. Even biological risk factors for COVID-19 like diabetes, obesity, asthma, and hypertension can reflect environmental and sociological precipitating and contributing factors, as much as racial differences in biology. A noninclusive list of confounders from the ecosystem of social determinants of health relevant to COVID-19 include struggling in poverty with limited job and social mobility; working front-line jobs with lack of adequate personal protective equipment (eg, public transportation, pharmacy, grocery, and warehouse distribution workers); living in crowded apartments where social distancing is impossible; shopping in food deserts or swamps without access to healthful foods; being underinsured and using self-rationing of health care as a strategy; relying on public transportation on crowded buses and subways; and having a public kindergarten through 12th-grade education that too often leads to functional health illiteracy.

Other contributors may have reinforcing effects, including health beliefs and behavioral choices that manifest differently across cultures. Workforce diversity within health care makes a difference, especially in decision-making by minority patients. The persistent racial, ethnic, and cultural incongruity between physicians and patients, especially for African American men, reached a nadir last year after 35 years of decline. Subconscious racial bias in health care exists, as documented by differences in cardiovascular procedures and solid organ transplants. Patient choice and responsibility could be factors as well. Late self-referral because of distrust, health beliefs, and even disease fatalism may be present in some minority communities. Dangerous behavioral choices, such as attending events with large crowds or partying on spring-break

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beaches, increase the risk to the individual and to others. People must make good choices, but they must have good choices to make. An adequate pandemic response requires understanding of the cultural differences that drive these choices.

The data, while still limited, are compelling and make a strong case for including health disparities and the effect of the social determinants of health on COVID-19 in pandemic response planning. Only with such data can pandemic response planners and policy makers design interventions targeted to and accepted by different subgroups of our population. An emerging infection like coronavirus falls under “all threats and hazards” preparedness in the National Response Framework (NRF), which is a guide to how the US responds to all types of disasters and emergencies. Based on principles of scalability, flexibility, and adaptability identified within the National Incident Management System, sections of the NRF address vulnerable populations like older adults and those with chronic diseases and selected racial and ethnic populations like American Indians and people on tribal lands.

But this key document does not address the vulnerability of other minority populations and thus does not provide a data-driven context for designing and implementing programs for those who likely require more outcome monitoring and differential assistance in national health crises. Identifying these populations in advance or in this case as the pandemic evolves can raise sentinel observations on the local levels, increase the timeliness and community acceptance of interventions, and encourage science-based refutation of incorrect claims of biological differences. The current pandemic brings to the surface the need for consideration of the specific risks for African Americans and Hispanics under an “all threats and hazards” approach, based on data and social determinants of health. Moreover, we are further concerned that the COVID-19 pandemic may identify other demographic groups for consideration like poor whites in rural areas and the Deep South. The best stress test, in this case data, is often the one that identifies risk as it is occurring and prompts a preemptive response at the federal, state, and local level.

We favor 2 immediate interventions for the COVID-19 pandemic. First, mandate that the collection and reporting of COVID-19 cases and outcomes be stratified by race/ethnicity, sex, socioeconomic status, and community health status in all states. This will allow targeting of resources and development of culturally relevant interventions that are accepted by the highest-risk groups. To do so, more testing must be done, and the results used to design responses. For instance, as of April 9, only 14 states (≈ 10% of the US population) have publicly shared COVID outcomes by race/ethnicity with the Centers for Disease Control and Prevention (CDC).

Second, begin multilingual targeted public service announcements (PSAs) for minority communities that emphasize the unequal risk and the importance of empowered solutions like social distancing and how to access testing and health care services. A powerful example of a PSA is the video by actor Idris Elba,¹ who told of his COVID-19 infection and urged all people “to take this seriously.” Messages of early self-referral, reassurances of compassionate and culturally sensitive care that is not dependent on insurance and wealth, and a pithy reminder to “Be Kool, Stay Home” could be delivered by well-recognized and influential people, including the minority bedrock faith community.

COVID-19 is not the “great equalizer” but the great tester of differences. To some, the disproportionate effects of COVID-19 may represent a Hurricane Katrina redux.

The next stress test of the health system could have a different outcome if we learn from the tragic racial and ethnic disparities of the current pandemic and make changes in the US clinical care delivery and public health policy. Ensuring access to culturally competent health care and creating policies and programs that address the social determinants of health are key to moving toward health equity. Public health policies must be tailored to the needs of all communities and reflect that health equity can only be achieved if interventions are made with an understanding of the differing and unequal life realities of minority populations. Addressing the contribution of historical and social racism must be pillars for the future and in place before the next pandemic occurs.

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Additional Contributions: We thank the patient described with COVID-19 for granting permission to publish his story.

Additional Information: Dr Carmona served as the 17th Surgeon General of the US.

1. @idriselba. This morning I tested positive for Covid 19. I feel ok, I have no symptoms so far but

have been isolated since I found out about my possible exposure to the virus. Stay home people and be pragmatic. I will keep you updated on how I'm doing. No panic. March 16, 2020. Accessed April 13, 2020. <https://twitter.com/idriselba/status/1239617034901524481?lang=en>