How COVID-19 is exposing healthcare inequities

April 17 2020, by Caroline Newman

From left to right, Dr. Taison Bell, Dr. Ebony Hilton-Buchholz, Dr. Bryant Cameron Webb and Dr. Leigh-Ann Webb. Credit: UVA Health

As the COVID-19 pandemic sweeps across the United States, data is beginning to emerge showing the disproportionate impact of the virus in

minority communities, particularly African American communities.

Last week, the Centers for Disease Control released a study of a representative group of hospitalized patients showing that the percentage of black patients hospitalized for COVID-19 was much higher than the percentage of African Americans in the population as a whole, "suggesting that black populations might be disproportionately affected by COVID-19."

For example, in Michigan, a hard-hit state, African Americans make up 14% of the state's population, but accounted for 41% of its COVID-19 deaths as of April 6. In Louisiana, Gov. John Bel Edwards has said that African Americans account for slightly more than 70% of the state's COVID-19 deaths, a statistic he called "disturbing."

Four University of Virginia doctors—Dr. Taison Bell, Dr. Ebony Hilton-Buchholz, Dr. Bryant Cameron Webb and Dr. Leigh-Ann Webb—are among a group of physicians who initially raised the alarm about these trends, pushing state and federal officials to release demographic data about the spread of COVID-19.

Bell, who met Cameron and Leigh-Ann Webb when they were all undergraduates at UVA, is an assistant professor of medicine specializing in infectious disease and critical care and is the medical director of the medical intensive care unit. Hilton-Buchholz is a critical care doctor and anesthesiologist; Cameron Webb is an assistant professor of medicine and public health science and a congressional candidate for Virginia's 5th District; and Leigh-Ann Webb is an assistant professor of emergency medicine. (Cameron and Leigh-Ann Webb are married)

All four doctors are African American and are deeply concerned, personally and professionally, about how this virus will affect their communities. They began sharing their concerns on Twitter earlier this

month, and, in addition to working with colleagues at UVA, have now spoken to national media outlets and national health care and policy officials, including the Congressional Black Caucus, to push for more transparent data and urgent efforts to help minority and low-income communities likely to be affected by the virus.

Cameron Webb is also a faculty leader at the UVA Equity Center, launched in 2019 to build stronger relationships between UVA and the Charlottesville community and tangibly redress racial and socioeconomic inequality. Faculty and community leaders involved in the center are working together to identify community concerns, highlight potential gaps or inequities and make recommendations to University leaders.

We spoke with all four doctors to learn more.

Q. What trends have you noticed as this pandemic has hit the U.S.?

Bell: As an African American health care provider, there are already health disparities that are distressing to us at baseline—higher rates of diabetes, heart disease and other chronic conditions that make African Americans more vulnerable to acute illnesses like COVID-19. We were seeing all of these fancy dashboards and graphs showing hotspots, or curves, but I worried that a lot of people in African American communities were getting very, very sick, but not getting tested at the rate we would expect. There was a gap between what we were projecting overall and what this virus could do in underserved communities.

When we started looking for that data, it was very scarce. That's when we started putting out calls for more data, more transparency about the race and ethnicity of COVID patients. We need to know how much suffering is disproportionately happening in minority and underserved

communities.

Hilton-Buchholz: I think this pandemic will reveal the systemic racism that is in every sector of society, and how that factors into health outcomes.

For instance, you can't talk about those with comorbidities being vulnerable without talking about the disproportionate impact of industry, air and water pollution on minority and low-income communities, or how food deserts affect obesity and diabetes rates. Many essential workers—often working low-paid jobs that are now critical to keep this country running—tend to be black and brown people of lower socioeconomic status. Our prisons, which are very vulnerable to this pandemic, are overwhelmingly crowded with black and brown people.

Although these systems, and our health care system, can and do discriminate, the virus does not. I think this will be one time where we really see the cracks that have always existed, cracks where the virus can now spread and fester.

Cameron Webb: We and many others in the medical community were concerned about the national paucity of data in the beginning. We did not know much about who was being tested and who was being impacted. We took note of the lack of useful geographic and demographic information.

And, from the beginning, it was evident that the dynamics of this particular pandemic would disproportionately affect people with less access and fewer resources to protect themselves. We knew that lower-income and minority communities—particularly low-income minority communities—would be very vulnerable, and the first wave of national data has confirmed that.

Q. How can race and ethnicity data about the impact of COVID-19 help the country fight the pandemic?

Leigh-Ann Webb: If we don't have access to transparent and comprehensive data, we can't meaningfully inform health policy and resource utilization to benefit the communities that are the most vulnerable. If we have actionable data, we can identify vulnerable communities and do boots-on-the-ground work in those areas, getting information and resources where they are most needed and tracking cases as they appear. From a public health standpoint, this is critical to use as an adjunct to other strategies we are using to fight for patients' lives during the pandemic.

Bell: Think of it like a wildfire. Even if it is not your house on fire, you should care about it being on fire because it could spread to your neighborhood or your house, too. If there is one section of our country where COVID-19 is exploding, we all need to be invested in finding and treating those vulnerable groups. If we aren't, it will ultimately make the whole country sicker. The virus does not respect the boundaries of ethnicity or geography that we normally place around ourselves.

Cameron Webb: We need more widely available testing, if we are going to get ahead of this. We need to know where the hotspots are so that we can do more testing and contact tracing in the communities that are hardest-hit.

We also need to recognize that essential workers, many of them from minority or low-income groups, need testing and adequate protection—not just at work, but on their way to and from work. And, we need to focus on resources for those with chronic disease, who are very vulnerable to this virus and who, in many cases, cannot visit their primary care doctors during this time of physical distancing. We will be

dealing with this virus for a while, and we need to look at ways to protect people with chronic illnesses while making sure they have access to care they need. Data will be critical to all of this, because it can help us see where the problems are.

Q. What else can be done to address these concerns?

Hilton-Buchholz: If we know that African American communities are experiencing this virus at a higher rate, then we know which neighborhoods and communities we should be focusing on, and we should meet folks there. Many African Americans rightfully distrust the medical community, so providers need to make an effort go there and help right some of those wrongs. People are dying, we must do everything we can to meet them where they are.

We also need people to keep talking about this. When I posted on Twitter, I started getting responses, starting hearing from companies that are helping to collect this data, talking to the Congressional Black Caucus and to the media. That is the way information moves today, and we need to keep speaking up.

Bell: Now this issue is being mentioned even at the president's press briefings, and different states and locales are starting to release race and ethnicity data. Progress requires pressure, and we need to keep amplifying the message to our leaders, to push for accountability and transparency.

Leigh-Ann Webb: In Charlottesville, we have the benefit of looking at other communities that have reached their peak volumes before us, and learn lessons from those communities and providers. UVA Health has been very proactive—preparing for PPE shortages, being on the forefront of in-house testing, participating in drug trials, including one that Dr. Bell is leading. Thankfully, we had a bit of a head start and lots

of smart people who have worked tirelessly to make sure we are as prepared as we can be to face COVID-19.

Nationally, I would like to see a comprehensive release of data by the CDC, as well as continued private-public partnerships with biotech companies, innovators and academic institutions. An interactive national model built with comprehensive data (including demographic variables) could assist health care providers with critical information so that we can respond in a real-time, data-driven way in communities all over the country.

Cameron Webb: As a University working toward being a better neighbor, we owe it to our communities to fight the racial disparities that our own health system helped to create. The Equity Center is intended to serve as a bridge between the University and the community, and we are fortunate to already have good relationships with community leaders. We want to advocate for some of the social determinants that can put people at risk during COVID—income threats, housing adequacy or inadequacy, food access and other issues. We have been engaging in these conversations for a while now, and will continue working closely with community leaders to make recommendations to the University and advocate for those recommendations.

I would also like to add that, while we have not yet seen as robust a number of coronavirus cases as some other areas, the threat is still significant. Often, moments of crisis are the medium where bias really grows best. In the middle of a crisis, when you lack time think as critically and are pulled in a million directions, you take cognitive shortcuts. That is where bias can play much more of a role. We are fortunate to have time before we get to that crisis point here in Charlottesville and Albemarle County, in terms of COVID-19 cases. We have to start building an equitable infrastructure now to fight this pandemic and the inequalities it exacerbates.

Provided by University of Virginia