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COVID-19 Information

Unmasking Treatment Disparities: Insights on the 300% Black Tax of COVID-19

These are unsettling times. COVID-19 has devastated the world, killing more than 2.4M people and nearly 500,000 in the US.[i] Even into the New Year, there is still much mystery as to this virus as well as how to treat it and best immunize our families. Not to diminish the lives and loved ones of other races who were also unfortunately lost—three Caucasians dying for every African American in this country—COVID is still infamously three times more likely to kill blacks than whites.[ii] This burdensome 300% tax has been placed upon the black community. To make matters worse, the offered explanations are opaque, neither adding up or sufficiently mitigating COVID's consistent and heartless impact.

Think about it… what kind of blank-check precedent are we setting for future health disparities to justify significantly higher COVID deaths with rigid socioeconomics and preexisting conditions? Blacks cannot become complacent in

COVID. Faith without works is dead. We must be critical but not paranoid and ask what we can do to reduce the burdens of COVID upon ourselves and others?

One offered explanation is that blacks are dying more often because we have higher instances of preexisting medical conditions that make COVID more difficult to manage.[iii] This explanation does not hold water, however, because even though blacks have higher occurrences of health issues like diabetes and hypertension, that usually occurs 10-50% more often than whites; not 300% or three times more likely such that blacks should be dying that much more frequently.[iv]

Yet another estimation given is that blacks tend to more often work manual-labor jobs that cannot be performed remotely thus they are more vulnerable to infection. But blacks are only 24% more likely to work in-person positions according to the Bureau of Labor Statistics, again far from 300%. [v]

Another hypothesis circulated is that blacks tend to live in more densely populated areas, which facilitates greater transmission of the virus. Though the death tolls somewhat trend with population density they do not consistently do so. For example, cities like Detroit, Houston, Las Vegas and McAllen, Texas are in the top 20 deadliest counties, but their population densities are significantly less than San Jose, San Francisco, Seattle and Washington DC—cities not located in the top twenty deadliest counties.[vi] Moreover, blacks are only contracting the disease 31% more often than whites, not three hundred percent.[vii]

Most of us who are familiar with unethical, racially motivated medical experimentations of the past like the Tuskegee Study and the Legacy of Henrietta Lacks are apt to default to racially divisive conspiracy theories for explanations of COVID's disparate impact. While we know America has never been perfectly equal, multiplying ones racial enemies is counterproductive. It is unrealistic to believe that modern hospitals throughout the country employ large numbers of notoriously, racially motivated staff. Today's hospitals are relatively diverse—including 35% racial minorities who are nurses, support staff and administrators, if not physicians.[viii] Overt or noticeable race-based distinctions are not likely being made in any contemporary hospital with respect to hundreds of COVID patients.

More realistically, medical treatment is inherently regional because emergency wards are position proximate to accident scenes and residences where the need for care is often first realized. Because American cities (and neighborhoods) are still largely racially segregated, hospital clientele follows. Plainly, where neighborhoods are blacker, COVID is often deadlier.

Shockingly, it is not the melanin, seven of the ten "blackest" cities in the US are in the top 20 deadliest COVID counties.[ix]

Cities with the Highest Black Populations								
#	City	Total Population	White Population	% of the US White Population	Black Population	% of the US Black Population	Ratio Black to White per Population	Ranking on Top 25 Deadliest County List
1	New York, NY	8,336,817	3,559,821	1.42%	2,025,847	4.61%	324%	1
2	Chicago, IL	2,693,976	1,346,988	0.54%	797,417	1.81%	337%	3
3	Philadelphia, PA	1,584,064	709,661	0.28%	690,652	1.57%	554%	10
4	Houston, TX	2,320,268	1,322,553	0.53%	524,381	1.19%	226%	7
5	Detroit, MI	670,031	98,495	0.04%	524,634	1.19%	3033%	6
6	Memphis, TN	651,073	190,113	0.08%	417,338	0.95%	1250%	N/A
7	Baltimore, MD	593,490	181,014	0.07%	370,338	0.84%	1165%	N/A
8	Los Angeles, CA	3,979,579	2,073,361	0.83%	354,183	0.81%	97%	2
9	Washington, DC	705,749	291,474	0.12%	326,762	0.74%	638%	N/A
10	Dallas, TX	1,343,573	842,420	0.34%	326,488	0.74%	221%	14

"Blackness," as shown in the Top 10 List above, is defined by the volume of African Americans living in a city. The New York counties have (by far) the highest number of deaths from COVID with over 28,000. Chicago, Philadelphia and Detroit counties also have had higher numbers of deaths. Blacks are more likely to live in the most heavily affected areas. For example, taking into consideration the entire population of blacks and whites in the country, blacks are over 300% more likely to live in New York, Chicago and Philadelphia than are whites. They are further over 3000% more likely to live in the city of Detroit, having the highest concentration of blacks of any major city in the Union. Therefore, the standard of COVID care offered in hospitals in these cities—however successful or unsuccessful—is three (or more) times likely to impact blacks.

Ironically, blacks are more likely to seek out hospital care for COVID than whites, suggesting an overreliance on hospital treatment.[x] The CDC reports that the hospitalization rate for blacks is 287% to 440% times that of whites, depending upon age. In this regard, blacks may have chosen the worst time in history to become more avid in obtaining medical treatment than whites as blacks hasten to the hospital three to four times faster for COVID care and it is yielding worser outcomes for the black community.[xi]

Knowing this, African Americans must study *how our local hospitals are treating COVID-19 patients* as compared to hospitals in cities like Washington DC, San Jose, San Francisco and Seattle. For example, many hospitals moved away from intubated mechanical ventilation use with COVID patients after the spring.[xii] Perhaps the vents need to be used even less often. Some hospitals may not appreciate that blood oxygen readings can be thrown off by an infection, like COVID, due to an increased white blood cell released into the blood stream.[xiii]

It is not time to get discouraged, rather now is the time for Black America to unmask COVID-19 treatment disparities between the aforementioned cities' hospitals.

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[i] Johns Hopkins University, Coronavirus Resource Center, https://coronavirus.jhu.edu/ (Assessed 01-05-2021).

[ii] Centers for Disease Control and Prevention, COVID-19 Racial and Ethnic Health Disparities – Disparities in COVID-19 Deaths & What We Can Do to Move Towards Health Equity, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html (Dec. 10, 2020)(Assessed 01-04-2021)(Figure 1 for Crude and age-adjusted percents of COVID-19 deaths)(*see also*: "A study of selected states and cities with data on COVID-19 deaths by race and ethnicity showed that 34% of deaths were among non-Hispanic Black people, though this group accounts for only 12% of the total U.S. population").

[iii] Centers for Disease Control and Prevention, COVID-19 Racial and Ethnic Health Disparities – Risk of Severe Illness or Death from COVID-19, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html (Dec. 10, 2020)(Assessed 01-04-2021).

[iv] *See e.g.*, Centers for Disease Control and Prevention, National Diabetes Statistics Report, https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf, p3 (Assessed 12-7-2020)(showing a 50% increase in diabetes for blacks); CDC, High Blood Pressure, https://www.cdc.gov/bloodpressure/facts.htm#:~:text=Rates%20of%20High%20Blood%20Pressure%20Control%20Vary%20by%20Sex%20and%20Race&text=A%20greater%20percent%20of%20men,pressure%20than%20women%20(43%25).&text=High%20blood%20pressure%20is%20more,or%20Hispanic%20adults%20(36%25), (Assessed 12-7-2020)(showing a 17% increase in hypertension for blacks).

[v] Labor force characteristics by race and ethnicity, 2018, https://www.bls.gov/opub/reports/race-and-ethnicity/2018/home.htm (October 2019) (Assessed 01-04-2021)(reporting that 37% of whites work in production, transportation, material moving, natural resources, construction, maintenance and service while 46% of blacks work in those industries).

[vi] Governing.com, Population Density for U.S. Cities Statistics, https://www.governing.com/archive/population-density-land-area-cities-map.html (Nov. 29, 2017)(Assessed 01-04-2021)(reporting the following 1,000 persons per square mile for cities, Detroit: 4.849, Houston: 3.842, Las Vegas: 4.660 and McAllen, Texas: 2.942 versus San Jose: 5.808, San Francisco: 18.581, Seattle: 8.391 and Washington DC: 11.158).

[vii] Centers for Disease Control and Prevention, COVID-19 Racial and Ethnic Health Disparities – Disparities in COVID-19 Illness & What We Can Do to Move Towards Health Equity, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html (Dec. 10, 2020)(Assessed 01-04-2021)(citing black cases at 988,530 or 2.25% of the black population and white cases at 4,316,063 or 1.72% of the white population).

[viii] *See* US Dept of Health and Human Services, Sex, Race and Ethnic Diversity of U.S. Health Occupations (2011-2015), https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/diversity-us-health-occupations.pdf, Table 2 (August 2017)(Assessed 01-05-2021).

[ix] US Census Bureau, Quick Facts, https://www.census.gov/quickfacts/fact/table/US/PST045219 (Assessed 01-02-2021); and Johns Hopkins University, Coronavirus Resource Center – U.S. Map, https://coronavirus.jhu.edu/us-map (Dec. 28, 2020).

[x] Centers for Disease Control and Prevention, COVID-19 Racial and Ethnic Health Disparities – Disparities in COVID-19-Associated Hospitalizations & What We Can Do to Move Towards Health Equity, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html (Dec. 10, 2020)(Assessed 01-04-2021)(CDC data on the rate of intubated mechanical ventilation, underlying medical condition or symptoms by race was not accessible on this site at the time of review).

[xi] *Id*.

[xii] *See e.g.*, The COVID Tracking Project, Michigan, New York and Illinois: Hospitalization, https://covidtracking.com/data/state/michigan/hospitalization (Michigan hospitals now using advanced ventilation one third as often as in March)(Assessed 01-05-2021).

[xiii] Schramm et al., Effect of local limb temperature on pulse oximetry and the plethysmographic pulse wave, https://pubmed.ncbi.nlm.nih.gov/9127780/, 14 Int. J Clin Monit. Comput. 17-22 (Dec. 11, 1996), p21 ("[T]he obtained SpO2 in septic patients could be expected to be too low due to a low peripheral resistance.")(also reporting a slight decrease in blood oxygen with increase in temperature).