COVID-19: Limelight on Existing and Pervasive Health Disparities in Connecticut
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By Kaydian Reid, DrPH, MA • Dr. Reid is an Assistant Professor and Program Director for the Master of Public Health Program.

COVID-19 has been called "the great equalizer" by numerous media outlets--an equal opportunity disease, which puts everyone at risk regardless of race, ethnicity, and income. However, infectious diseases often burden ethnic and racial minority populations disproportionately. Throughout the United States, individuals are beginning to receive news that someone they know, such as an immediate family member or work colleague has been diagnosed with COVID-19 or succumbed to the disease. For people of color, this unwelcome news frequently impacts them and shines a light on existing and pervasive health disparities within their communities.

In Connecticut, there was initially little data collection on COVID-19 cases by race and ethnicity. For example, of the 3,141 laboratory-confirmed cases reported in Connecticut on April 1, 2020, over 50 percent did not indicate race/ethnicity (Laurencin & McClinton, 2020). During that same period, mortality rate by race and ethnicity were inadequate due to this lack of data collection. However, findings from the limited data collected and reports from other states have revealed that COVID-19 cases and associated deaths disproportionately impact people of color (e.g., Connecticut as of April 16, 2020, New York City, Detroit, Chicago, and New Orleans). Yet, health disparities are largely preventable by addressing underlying social factors that impact health in general.

So why should we care in Connecticut?

Population density in Black neighborhoods. When a disease like COVID-19 infects individuals in a densely populated area, the disease spreads quickly from person to person, as observed in New York City. This is evident where large proportion of Connecticut's Blacks reside in the three hotspot counties, where the most populated cities are located. Recent data from the Connecticut Department of Health shows that laboratory-confirmed cases and COVID-19-related deaths are greater in counties and urban areas where majority of the state's Black population live. For example, New Haven and Hartford counties' COVID-19 cases and death rates are among the highest. Unlike the other two counties, Fairfield County does not have the same distribution of Blacks yet has seen a surge in hospitalization at Bridgeport Hospital, situated in a densely populated Black community.

Doubling up in housing. In addition, it is plausible to say that Black families in dense populations are more likely to live with multigenerational or extended families. Although these extended families have many positive aspects when it comes to caregiving and social support, in an infectious disease situation there is a certain liability. Residing in a multifamily or extended family home or apartment building makes social distancing from a family member who is potentially

infected/having Covid-19 symptoms more difficult compared with home owners with homes where these individuals can isolate in a basement or bedroom.

Comorbidities. Studies have documented that comorbidities are associated with elevated risk of COVID-19-related death. People with preexisting comorbidities such as diabetes and hypertension, which disproportionately affect Connecticut Blacks, are at a higher risk of succumbing to COVID-19. Type II diabetes is among Connecticut's 10 leading causes of death ranking seventh (CDC, 2018). A recent report on health disparities in Connecticut reveal that Black Connecticut residents are more than twice as likely than White residents to have diabetes.

Reducing risk. The aforementioned risk factors implicated in health disparities derive from systemic racist and discriminatory policies both in health care and society as a whole, rather than solely from individual behaviors. Densely populated Black communities, multigenerational or extended families, and co-morbidities contribute to increased risk of COVID-19-related deaths. The novel emergence of infectious disease—COVID-19—shines a light on health disparities and racial inequalities, and brings awareness of its magnitude. This is not unique but has been discussed repeatedly with regard to type 2 diabetes, hypertension, asthma, and cardiovascular diseases that disproportionately impacts Black and Hispanic residents in CT. Now we must make substantial effort to reverse and resolve racial and ethnic disparities that lead to poor health outcomes.

But what can we do now in the current crisis. We need more completely disaggregated data by race and ethnicity for COVID-19 cases and deaths. Second, we need timely diagnostic and antibody tests in adversely impacted communities to have a sense of who is infected and who is immune. Third, the protocol around getting tested (i.e., doctor notification required) should be revised. Accommodations should be included for persons who do not have access to primary care physicians. Furthermore, accessibility to testing sites needs to be facilitated since potential cases of COVID-19 need their own transportation to get to the testing sites. Lastly, once contact tracing is implemented, especially in communities of color, cultural brokers are needed to bridge the cultural gap in the healthcare settings that also foster the manifestation of health disparities.

In the long run. To reach health equity, we need to address the historic and systemic racist and discriminatory policies that adversely impact Black communities. Now is the time, let's act and lessen the spread among the most vulnerable communities.