Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

COVID-19 compels closer scrutiny of disparities in dermatology

To the Editor: The coronavirus disease 2019 (COVID-19) pandemic has had profound impact. As of August 22, 2020, the United States (US) has reported 5,686,305 cases and 176,583 deaths.[1] Beyond the substantial health and economic consequences, COVID-19 has exposed the profound health disparities that have long plagued the US, illuminating the disproportionate suffering of minorities and other marginalized populations. Blacks comprise a disparate number of COVID-19 hospitalizations and deaths. In New Orleans, 76.9% of COVID-19 hospitalizations and 70.6% of deaths were among Blacks, although they only comprised 31% of that health system's population.[2]

The reasons for increased COVID-19 severity among minorities are multifactorial, including a higher prevalence of comorbidities (ie, diabetes, hypertension, obesity) and longer waits to access health care. Moreover, Blacks are more likely than Whites to hold occupations (ie, restaurants, retail, hospitality) and reside in housing (multigenerational homes, public housing) that facilitate community transmission, rendering strategies to prevent COVID-19 spread (social distancing, teleworking) less feasible.[2] The pandemic has not only provoked national discourse on inequities in health care but also calls for more rigorous examination of this topic in dermatology.

The Department of Health and Human Services' Healthy People 2020 defines a health disparity as

> *…a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; . . . or other characteristics historically linked to discrimination or exclusion.*[3]

Expectedly, the limited studies probing disparities in dermatologic outcomes reveal existing inequities. For example, minority patients diagnosed with melanoma are 2- to 4-times more likely than Whites to receive an advanced-stage diagnosis.[4] Privately and publicly insured outpatient dermatology visits are less common for Blacks and Latinx compared with Whites after adjustments for patient demographics and primary diagnosis.[4] However, the individual, contextual, and structural determinants of these disparities and the pathways through which they operate are unknown.

With US demographics shifting toward a minority-majority by 2045 and recognizing the profound impact of cutaneous disorders on health and quality of life, there is an urgent need to drive health disparity inquiry to the forefront of the research agenda. Based on the conceptual framework of Kilbourne et al,[5] a basic strategic roadmap should include detecting disparities, understanding their determinants, and implementing evidence-based policies to eliminate inequities. At a minimum, a requisite series of actions must occur. Dermatologists must begin the difficult task of evidence generation by supporting investigators who study disparities. Dermatology leadership, nationally and institutionally, should intensify longitudinal pipeline efforts to diversify the dermatology workforce, because under-represented minorities are more likely to practice in underserved communities. There must be a contemporaneous and explicit effort to mentor and develop under-represented minorities to assume academic and nonacademic leadership positions, because this will broaden and balance research and policy directives.

COVID-19 has highlighted the pervasiveness of disparities in medicine that we, as dermatologists can no longer ignore. The disproportionate suffering by any population from any condition, including skin diseases, is simply unacceptable.

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