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COMMENTARY

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Elderly African Americans: The vulnerable of the vulnerable in the COVID-19 era

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The COVID-19 pandemic has highlighted underlying racial disparities for racial/ethnic minorities, especially African Americans (AAs).[1,2] Data from the Centers for Disease Control and Prevention show that 37.3% of elderly patients (aged 65 years and older) who have been hospitalized for COVID-19 in the United States are AAs.[3] This is over 400% of the demographic fraction occupied by AAs among the elderly US population, as AAs comprise just 9% of this population. Recent data show that elderly AAs had a 3.8-fold higher rate of hospitalization due to COVID-19 compared to elderly non-Hispanic White patients; moreover, elderly AAs have a disproportionately high mortality rate due to COVID-19.[4,5]

Many hypotheses exist regarding why elderly AAs and other racial/ethnic minorities remain vulnerable during the COVID-19 pandemic. One suggestion is an interplay of various social, economic, and discriminatory factors embedded within the health system.[6,7] More recently, evidence suggests that structural racism and pathways through which racism generates and reinforces inequities among racial and ethnic groups are significantly associated with worse physical and mental health outcomes.[1,8] Elderly minorities bear a double burden, being predisposed to poor health outcomes due to old age and race/ethnicity.[9] The aim of this perspective is to illustrate actions needed to address the increased vulnerability of elderly AAs during the COVID-19 pandemic and beyond.

1 | ADDRESS SOCIAL DETERMINANTS OF HEALTH

Historical data on pandemics (including the medieval Black Death, which decreased the European population by 30%-50%) highlight the significant role that socioeconomic status, a key social determinant of health (SDOH), plays on negative health outcomes.[10] The COVID-19 pandemic is no exception. SDOHs are conditions in environments where people are born, live, and work that impact health. Minorities living in inner cities or urban areas often face challenges implementing social distancing due to crowded or multigenerational housing environments.[7] Additionally, AAs are often overrepresented in low-paying essential-service industries, thereby increasing the risk of exposure due to the need to continue working and maintain a source of income. Data from 2016 show that the proportion of elderly AAs in the US labor force is steadily increasing, and unfortunately more low-income, elderly AAs are at risk of exposure to COVID-19.[11]

As SDOH accounts for 70%-80% of health outcomes,[12] it is important to incorporate SDOH into the care of vulnerable patients, such as elderly AAs, by using a multifaceted approach to screen for unmet social needs and leverage existing resources to fulfill these needs.[13] First, physicians should have social service catalogs readily available to provide to patients who screen positive for unmet social needs. Second, health systems should build

a network of community-based partners to allow direct referral to services when unmet social needs are identified. Third, health-care professionals should gather evidence to identify effective interventions designed to improve health for individuals with unmet social needs, and support policy change that addresses upstream SDOHs. Finally, a multidisciplinary approach incorporating sustained efforts and deployment of resources to address existing basic and social needs in the inner-city environment can help alleviate the health disparities that are pervasive among marginalized communities.[6]

2 | BUILD TRUST

Mistrust of the health-care system among AAs is deeply rooted in history, with centuries of exploitation in research, including the Tuskegee Syphilis Experiment.[1,14] Mistrust among elderly AAs is further substantiated as they are less likely than non-Hispanic White patients to receive evidence-based treatments and more likely to be undertreated for various diseases and receive less time during health-care encounters.[15]

As trust in the physician positively correlates with medication adherence, compliance with the physician's advice, and perceived effectiveness of care,[16] it is imperative that physicians are educated about the historical mistreatment and exploitation that has transpired among AAs and that they incorporate strategies to build trust. Effective communication between elderly AAs and health-care providers, driven by greater empathy and emphasis on personal preferences, is critical to improving trust and health outcomes.[15] It is equally important to practice cultural humility and be cognizant of individual cultural and religious beliefs. This can be further augmented by embracing race-concordant community leaders and partners to disseminate messaging around COVID-19. Nevertheless, community engagement and expanded access to AA communities should transcend a time of national crisis to build lasting trust.[1]

3 | INCREASE AWARENESS OF NEED FOR VACCINATION

In addition to disseminating knowledge about COVID-19, including its etiology, transmission, and prevention, providers should begin to share information on the importance of being vaccinated once a vaccine becomes available. While there is no vaccine available currently, now is the time to prime elderly AAs, a population at higher risk for infection and complications, to make them more amenable to discussion about the need for potential vaccination. Evidence suggests that racial differences exist in perceptions of vaccination efficacy and vaccination rates.[17] Physicians should begin to address concerns around vaccines among elderly racial/ethnic minorities, including AA elderly. First, clinicians should allocate time during in-person or telehealth visits to discuss the vaccine-development process. Second, clinicians, researchers, and community partners should work together to develop culturally appropriate messaging. Third, clinicians should use personal-level experience around COVID-19 and be proactive in thwarting misinformation regarding vaccination.[17]

4 | COLLECT MORE DATA BY RACE AND AGE

Although the available data suggest that COVID-19 is disproportionately impacting elderly AAs, many states do not report age-stratified racial distribution of COVID-19 cases and deaths. Furthermore, reporting COVID-19 data by race/ethnicity is not a requirement, leaving some states without race/ethnicity information. There is a need for more reporting of data on the age-stratified racial distribution of cases and deaths that incorporates the community, state, and national levels, thereby offsetting the possible concerns of small sample size, missing information, and resulting issues with analysis for a broader assessment; this will be critical to elucidating the reasons for underlying disparities and to developing focused interventions for vulnerable groups, including elderly AAs.[18]

5 | CONCLUSIONS

In conclusion, elderly AAs are one of the most vulnerable groups in terms of morbidity and mortality. In light of the COVID-19 pandemic, the vulnerability of elderly AAs and other ethnic minorities calls for concerted efforts to address disparities in these groups to mitigate the overall aftermath of the pandemic. Understanding the impact of structural racism, addressing SDOHs, building trust, increasing awareness around vaccination, and collecting more data by race and age are some of the needed strategies that might help identify, understand, and ultimately reduce the health disparities that the COVID-19 pandemic has uncovered. What is needed is not mere equality—everyone receiving the same thing—but health equity, which "requires concerted effort to achieve more rapid improvements among those who were worse off to start, within an overall strategy to improve everyone's health."[19]

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CONFLICTS OF INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

AUTHOR CONTRIBUTIONS

All authors were involved in the original concept and contributed to the writing and editing of the manuscript.

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