



Commentary

Race, COVID-19 and deaths of despair

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It is well documented that ethnic and racial disparities in income, housing, access to education, healthcare, and exposure to violence and trauma lead to poorer health among Black, Latinx and other racial minority groups. Even for racial/ethnic minorities with higher socioeconomic status (SES), chronic high stress takes a disproportionate toll on health.¹

The higher burden of Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2) infection and COVID-19 mortality among ethnic and racial minorities does not appear to be explained by biological factors, but instead by longstanding discriminatory societal and historical factors whereby the simple fact of belonging to a specific race/ethnicity limits access to education and wealth and precipitates exposure to the criminal justice system and poor health outcomes.²

As the COVID-19 pandemic ebbs and flows across the world, many countries are witnessing differential health outcomes according to race/ethnicity. COVID-19 morbidity and mortality is influenced by specific pre-existing health conditions, such as diabetes, hypertension, heart disease, food insecurity and lack of health insurance, all of which are highly prevalent among ethnic and racial minority groups, such as Black, Latinx and Native American populations in the United States (US).

For instance, Price-Haywood et al.³ conducted a retrospective cohort study within an integrated-delivery health system in Louisiana and concluded that Black patients were overrepresented among all COVID-19 hospital fatalities. Similarly, a recent systematic review suggested that Black, Asian, and minority ethnic (BAME) individuals had a higher risk of SARS-CoV-2 infection and also experienced worse clinical outcomes than White individuals.⁴ In this light, Martin et al.'s⁵ single-center observational cohort study is a welcome

addition to the burgeoning literature regarding the experience of COVID-19 among BAME individuals within the United Kingdom (UK).

Consistent with reports from the US, Martin et al.⁵ found that the odds of SARS-CoV-2 positivity was significantly higher among BAME individuals compared to White individuals. In their analysis that adjusted for household size, age and comorbidities, the odds of SARS-CoV-2 positivity among South Asian, Black and other individuals was roughly 2.5 times that of White individuals. Furthermore, their exploration into associations between disease severity and household size with SARS-CoV-2 positivity provides novel insights into viral load dynamics as well as the effect of increased household size on the odds of SARS-CoV-2 infection.

However, it was their secondary finding that we find to be especially relevant to public health professionals and policymakers as the pandemic rages throughout the world. Their findings suggest that shelter-in-place 'lockdowns' may decrease viral transmission more quickly among White than among BAME individuals. For many low-income Black, Latinx, indigenous and other ethnic/racial minorities, working from home is not an option. As government officials and scientists grapple with appropriate strategies to handle the prospect of a "second wave" of COVID-19,^{6,7} specific strategies need to be tailored to the needs of each county, municipality, state and country. Although some public health officials are taking concrete steps to address COVID-19 disparities among impacted ethnic groups,⁸ data on the effectiveness of lockdowns on BAME communities is lacking. We thus hope that Martin et al.'s⁵ conclusion regarding pandemic control measures spurs further research into the differential effects of public health mandates on individuals from BAME groups during emerging infectious disease outbreaks, as well as interventions that mitigate any unintended consequences.

We commend Martin et al.⁵ in their efforts to disentangle the complex relationship between race/ethnicity and COVID-19 outcomes. We hope that future research in this area can expand upon our understanding of how race/ethnicity, SES and household size affects SARS-CoV-2 infection risk to provide more direct insights into the effectiveness of lockdowns on BAME communities, as well as other populations that are at increased risk of adverse COVID-19 outcomes, such as the elderly or those with pre-existing medical conditions.

Worldwide, hundreds of millions of people have lost their jobs during the pandemic. Globally, more than 13 million cases and over 570,000 deaths have been recorded so far, with a heavy burden among racial/ethnic minorities. It is inevitable to wonder: are we capable of taming the

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E-mail address: patarena@g.ucla.edu (P.J. Arena).<https://doi.org/10.1016/j.eclinm.2020.100485>2589-5370/© 2020 The Author(s). Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license. (<http://creativecommons.org/licenses/by-nc-nd/4.0/>)

beast? And at what costs? We contend that an appropriate response to the COVID-19 pandemic should be to address the root causes of health inequality, including racism and socioeconomic disparities. Without timely structural interventions, countries with wide disparities like the US and the UK might be forced to grapple not only with this public health crisis, but additional increases in ‘deaths of despair’^{9,10} from other causes, including suicide, overdose and food insecurity.

Authors' contributions

PJA drafted the original comment and coordinated subsequent edits and revisions. MM, AWR and SAS participated in drafting the comment and its finalization. All authors have read and approved the final comment.

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Declaration of Competing Interests

MM, AWR and SAS declare no competing interest for this study. PJA is a part-time contractor for Pfizer Inc., New York, NY, US.

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