Letter to the Editor: In Response

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To the editor:

We wish to thank Muñoz-Price et al. [1] for their response to our article. We validate the conclusion of their study: poverty, not race, accounts for increased risk of severe COVID-19 disease. Socioeconomic status (SES) plays a crucial role in the severity of disease among minority populations. The pandemic has importantly magnified the health and healthcare disparities in the USA, exposing the underlying systems of inequity that produce them. Detroit and Milwaukee are cities that can be generalized to a national and global level.

In Detroit, over one-third of its 700,000 residents live under the poverty line [2]. This is a poverty rate which is nearly three times the national average [3]. Approximately 88% of persons experiencing homelessness in Detroit are African American [4]. As described by Muñoz-Price et al., regardless of SES, African Americans were more likely to test positive for the virus than persons of another race [1]. In the USA, racial minorities are more likely to have lower wage jobs, and more likely to work in "essential services" or in frontline occupations including healthcare support systems, public transportation, grocery stores, and food handling [5]. Issues with job stability may affect health insurance, and they may forgo testing and treatment of disease due to fears about costs, and inability to take time away from work [6]. In addition, there may be a general mistrust of the healthcare system due to historical and continuous racially motivated discriminatory practices and institutional biases [7]. They could lack access to a car and need to use public transportation, increasing the risk of acquiring COVID-19 [5].

We must acknowledge that these differences in health are a result of the unequal distribution of resources and power, which excluded people of color long ago. This institutionalized racism produces the very vulnerability that renders populations such as African Americans susceptible to the poor health outcomes of the COVID-19 pandemic. We must concede that numerous events in history rooted in systemic institutionalized racism and persisting today have led to the disproportionate chronic health problems among minority communities, especially among African Americans. As history has taught us, the most vulnerable populations will inevitably be more heavily affected by disease. The healthcare community has been quietly calling out for help for populations made vulnerable for years, but now is the time to shout for a call to action. If we, the medical community, do not demand and provoke change around structural and institutional racism, socioeconomic disparities, and their relationship with healthcare and disease, how can we stop the loss of these valuable lives that matter?

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