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GUEST EDITORIAL

COVID-19 and African Americans: ethical considerations on the inappropriate burden on emergency rooms caring for chronic conditions

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The disproportionate morbidity and mortality of chronic conditions in African Americans is well-documented. Recent research shows that 54% of African American adults have hypertension; 16.4% of African American adults have diabetes; and 38.4% of African Americans are considered obese [1]. In navigating the healthcare system, most African Americans disproportionately to rely on emergency rooms for the management of, or complications from chronic conditions [2]. Studies show that patients with one to four chronic conditions are more likely to visit the ED [3].

The shrinking availability of adequate continuity in primary care, particularly in African American community settings (mostly a result of the economic ravages of COIVD-19), is fueling the inappropriate use of the hospital emergency room for chronic disease management.

Health inequities during the COVID-19 pandemic have had an unprecedented negative impact on hospital emergency departments. The first study to quantify the contribution of emergency department care to overall healthcare in the United States found that almost half of all medical care is delivered in hospital emergency rooms [4]. However, the magnitude of the COVID-19 pandemic's impact on US hospital Emergency Departments has largely gone mostly unnoticed. The culprit? The historically dismal systemic management of chronic diseases in community primary care settings.

While chronic conditions are prevalent throughout the general US population, the brunt of that burden is carried by African Americans. As evidenced in medical ethicist, Harriett Washington's seminal book, *Medical Apartheid,* the history of the injustices and inequities experienced by African Americans is clearly documented at every level of the US healthcare system.

In spite of the current national acknowledgement of how hard COIVD-19 hit the African American community, there has been no systemically appropriate preventive interventions implemented to ensure adequate availability and access to primary care for the management of the chronic conditions that put them at higher risk for infection or death from this virus.

According to a 2012 National Health Interview Survey, approximately 80% of adults who visited the ED over a 12-month period did so because of a lack of access to primary healthcare providers. When healthcare is not available in community settings, emergency rooms become the only place to get this care. At the core of this concern is the continuity of care for African Americans, who have proved to more vulnerable to being infected with the virus, due to, among other things the disproportionate incidence of chronic conditions. This is presented in current data from the *Centers for Disease Control* [5].

These trajectory from the demands during COVID-19 for primary care and clinics in community settings, lead to the care for associated complications being sought in emergency rooms (already stretched-thin during the pandemic) which in turn negatively impacts the allocations of hospital resources other departments' needs, especially the increased human and financial costs associated with caring for hospitalized COIVD-19 patients. This is a contributing factor into the over $4-billion dollars in excess costs that such inappropriate care costs in the United States each year, as reflected in the data for the costs associated with African Americans, who in the last six months of life is $7,100 more expensive to the Medicare system [6]. With lower reimbursement rates for primary care, doctors are being forced to accept fewer Medicare and Medicaid patients.

With more and more community health centers facing closings, layoffs, or reduced hours, leaving patients with

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chronic conditions the only option of seeking care at emergency rooms; we are not only creating conditions for fanning the flames of spreading virus, but also compounding the struggle for hospitals to provide care for hospitalized patients. Under normal circumstances, almost half of all US medical care is delivered in hospital emergency rooms.

In the current COVID-19 pandemic, a serious ethical concern is revealed. As reported by the Milbank Memorial Fund in 2019, the countries in the Organization for Economic Co-operation and Development (OECD) spend an average of 14% of their healthcare spending on primary care, the United States spends a dismal 5%-7%.

With the most expensive healthcare system in the developed world, and the only country whose healthcare system is tied to the free market, America must develop the *political will* to devote the appropriate human and financial resources to address this unsustainable trajectory. The solution is simple. We must focus on the core principals of Bioethics; **justice, *benevolence, non-malfeasance, and autonomy***.

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