

## VIEWPOINT

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Multimedia

## Racial and Ethnic Health Disparities Related to COVID-19

**One of the most disturbing aspects** of the coronavirus disease 2019 (COVID-19) pandemic in the US is the disproportionate harm that it has caused to historically marginalized groups. Black, Hispanic, and Asian people have substantially higher rates of infection, hospitalization, and death compared with White people.<sup>1,2</sup> According to an analysis by the Kaiser Family Foundation and the Epic Health Research Network, based on data from the Epic health record system for 7 million Black patients, 5.1 million Hispanic patients, 1.4 million Asian patients, and 34.1 million White patients, as of July 20, 2020, the hospitalization rates and death rates per 10 000, respectively, were 24.6 and 5.6 for Black patients, 30.4 and 5.6 for Hispanic patients, 15.9 and 4.3 for Asian patients, and 7.4 and 2.3 for White patients.<sup>2</sup> American Indian persons living in the US also have been disproportionately affected by COVID-19.<sup>1</sup>

### Accounting for Differences in COVID-19 Outcomes

In the US, racial and ethnic minority status is inextricably associated with lower socioeconomic status. Black, Hispanic, and American Indian persons in the US are more likely to live in crowded conditions, in multigenerational households, and have jobs that cannot be performed remotely, such as transit workers, grocery store clerks, nursing aides, construction workers, and

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household workers. These groups are more likely to travel on public transportation due to lack of having their own vehicle. Even for persons who can shelter at home, many persons with low incomes live with an essential worker and have a higher likelihood of exposure to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection.<sup>3</sup>

Once infected with SARS-CoV-2, persons who have been marginalized are at greater risk for hospitalization because they often have a higher number of chronic medical comorbidities. The prevalence of hypertension, diabetes, and obesity are higher among low-income, minority populations; all 3 of which have been associated with worse outcomes among patients with SARS-CoV-2 infection. In addition, racial and ethnic minority populations have poorer access to health care, which likely results in persons initiating care later in the course of their illness with COVID-19. Through July 21, 2020, 1.6 million

Hispanic persons in the US lost access to their health care coverage since the start of the COVID-19 pandemic.<sup>4</sup> Immigrants, whether undocumented or legally in the US, are likely to avoid the health care system altogether due to concerns about deportation or that use of publicly supported services would be used as a reason for denying future immigration.

In a study that compared mortality rates due to SARS-CoV-2 infection by race among 11 210 hospitalized adults, Yehia et al<sup>5</sup> found that after adjustment for age, sex, insurance status, comorbidities, neighborhood deprivation, and site of care, there was no significant difference in mortality between Black patients and White patients. Their findings highlight several salient points. First, because only hospitalized patients were included in the analysis, the findings suggest that if access to hospital care was equitably available to all, there may be decreased or no racial and ethnic differences in mortality due to COVID-19. Second, the study reinforced the idea that race is a social construct rather than a homogeneous genetic or ancestral category. After adjustment for differences in life experiences, the differences in mortality were not statistically significant. However, unlike in statistical analysis, the differences in life experiences that accrue across racial lines cannot be adjusted away. Racial or ethnic minority patients in the US often lack health insurance, have greater comorbidities, predominantly live in low-income and often violent neighborhoods, and are dependent on care from less well-funded safety net institutions.

Patients with limited English proficiency, and especially limited health literacy, also are more likely to have worse health outcomes. This concern was recently highlighted in a study by Alsan et al<sup>6</sup> that found Black men (n = 830) were less likely than White men (n = 3759) to have health-related knowledge about the symptoms and the mechanisms to spread COVID-19. This suggests that public health information may not be disseminated in ways that are equally understandable to different groups.

Disparities in socioeconomic conditions across racial lines have been exacerbated during the COVID-19 pandemic. More than 40 million individuals in the US filed for unemployment benefits, but Black and Hispanic individuals in particular, have experienced disproportionate job loss.<sup>7</sup> In April 2020, at the height of the first wave of the COVID-19 pandemic, national unemployment rates for Black persons (16.7%) and Hispanic persons (18.9%) were 17.6% and 33.1% higher, respectively, compared with White persons (14.2%).<sup>8</sup> As of April 10, 2020, an estimated 6 in 10 working-aged Hispanic adults lived with someone who either lost

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employment, work hours on the job, or income.<sup>9</sup> Food insecurity also has been an issue for many families. These challenges can have detrimental effects on downstream health outcomes.

### Addressing Health Care Disparities

A multipronged strategy is needed to eliminate the persistent racial and economic disparities in health that were exacerbated by COVID-19.

1. **Expand access to health care:** The US would benefit from increased investment in community health centers and safety net hospitals that disproportionately serve individuals who are from minority, low-income, and undocumented immigrant groups in the US. An expansion of Medicaid eligibility for those who have recently lost employer-based insurance would prevent further decreases in access to health care. In addition, hospitals should be prohibited from pursuing debt collection measures against patients who have received COVID-related health services.
2. **Establish equitable care models:** To encourage patients to seek needed care, whether for COVID-19 or other issues, health systems should facilitate establishment of multidisciplinary teams that build culturally appropriate communication and outreach practices. This information and these activities must be multilingual and universally accessible. The use of approved encrypted free platforms to communicate with patients beyond traditional phone calls and office visits can help break down access barriers. Systems should establish robust equity and quality measurements for delivering COVID-19 self-care information and prioritize groups that have persistently been excluded from receiving health information. The use of trusted

community voices (such as clergy and sports and entertainment stars) should be promoted to encourage vaccination against COVID-19 to ensure that minority communities are not disproportionately unvaccinated.

3. **Address social determinants of health:** Although there is limited evidence that it is effective, health care systems should consider screening patients for social needs (eg, housing, food, legal assistance) and connecting patients to existing community resources to address these needs. The 3-month waiting time for adults without children to receive Supplemental Nutrition Assistance Program benefits should be waived through the end of the COVID-19 pandemic. Extending unemployment benefits would enable many people to have sufficient economic resources to be self-sustaining.

### Conclusions

Disparities in disease outcomes by racial, ethnic, and socioeconomic status in the US are not new. COVID-19 has served to emphasize the deadliness of these disparities and has made social conditions far worse for many Black, Hispanic, and American Indian persons living in the US. But these inequities are not immutable. Future versions of federal COVID-19 legislation should address these gaps in access to care and public health education.

However, true change will require more than an expansion of services. The COVID-19 pandemic provides an opportunity for clinicians, health systems, scientists, and policy makers to address social disparities, and thereby improve the health and well-being of all persons in the US for both known and future illnesses. Societal efforts to improve conditions for minority communities should build on the intrinsic strengths of each unique community.

#### ARTICLE INFORMATION

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