Soon after severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was recognized in the United States in early 2020, troubling patterns emerged, revealing that US Black and Hispanic residents were experiencing several-fold greater incidence of infection and increased rates of hospitalization. These data have been widely publicized to great consternation both in and outside the public health and medical arenas. Coronavirus disease 2019 (COVID-19) is another unwelcome addition to the long list of health conditions that disproportionately affect Black and Brown lives in the United States. Because of its rapid spread and severe complications, COVID-19 has quickly crystallized the need to identify root causes of these disparities and to set an agenda for decisive action.

In this issue, Yehia et al.1 offer compelling findings that help elucidate key factors associated with COVID-19 disparities. Their retrospective study of 11,210 patients, cared for at 92 hospitals in 12 states, investigated the association of race with mortality among patients hospitalized for COVID-19 while accounting for other factors, including age, sex, comorbidities, and social factors. This study featured a reasonably complete ascertainment of patients’ race, and it was strengthened by including patients receiving care in hospitals located in diverse geographic regions. Yehia et al.1 also ascertained patients’ comorbidity using validated measures, and they attempted to account for patients’ social contexts through the Neighborhood Deprivation Index, a measure that incorporates 8 indicators of an individual’s residential social and environmental contexts, including indicators of their neighborhoods’ educational, financial, housing, and employment resources.2 Similar to other studies, the authors found that Black patients accounted for a greater proportion of patients admitted to hospitals with COVID-19 compared with White patients. Black patients with COVID-19 were younger, were more likely to be women, had more comorbidities, and resided in more socially disadvantaged neighborhoods compared with White patients. However, despite this, they found no differences in in-hospital death rates due to COVID-19 between Black and White patients.

Insight into the nature of COVID-19 and other race-based health disparities can be gleaned from this study’s descriptive findings. First, Black patients’ greater comorbidity at presentation despite their younger age reflects, at least in part, the substantially greater burden of poor health that Black US residents experience throughout their lives compared with White US residents. This is evidenced not only through Black patients’ well-documented greater prevalence of communicable and noncommunicable conditions but also through their higher infant mortality rates and shorter average life spans compared with White patients.3 Second, Black patients in the study lived in more socially disadvantaged neighborhoods (comprised of households reporting less income, poorer housing conditions, and fewer educational and employment opportunities compared with other neighborhoods) than White patients. These neighborhood-level factors reflect broader social and environmental conditions that are the result of long-standing systemically racist social policies and practices that have permeated US life since the founding of the nation, leading to generations of wealth inequality, poorer safety, housing segregation, and poorer life opportunities for Black US residents compared with White US residents. In addition to their association with poor health, these policies and practices have resulted in Black US residents experiencing unemployment or employment through lower wage jobs, persistently lower access to health-promoting environments (such as healthy grocery stores or venues for safe exercise), poorer health literacy, and poorer access to health care services than White US residents.4 The composite effect of these factors is being vividly illustrated through this pandemic, which has preyed on Black and Hispanic individuals living...
in densely populated conditions and those who have essential and often lower-paying jobs in the
service, hospitality, or food supply industries, often with limited health insurance benefits, placing
them at greater risk of infection and poor outcomes. What could explain this study’s finding that there are no differences by race in COVID-19 mortality? As with any observational study, it is important to consider that findings might be subject to residual confounding introduced through the study’s inability to account for factors that were not observable through hospital records. For instance, factors possibly related to both race and mortality, including the severity (rather than presence) of comorbid conditions, whether individuals were taking medications for these conditions, or whether they were able to obtain routine care for these underlying conditions, could not be accounted for in this study. Nonetheless, an important alternative explanation has implications regarding mechanisms through which COVID-19 and other health disparities could be eliminated. Specifically, this study was conducted among individuals who were able to obtain health care, and most had health insurance. Although Black patients presented more frequently than White patients to hospitals (and admission was related to social and contextual factors as well as increased prevalence of comorbid health conditions), their outcomes were similar to those of White individuals once they reached the health care system, suggesting that the equitable delivery of medical care within hospitals provided an outcome-equalizing benefit. If this inference is valid, it provides an argument against potentially misguided calls for new studies to identify and target as-yet unrecognized race-based biological differences as explanations for COVID-19 disparities. Rather, it strongly supports an argument for eliminating disparities through policies designed to improve the social and environmental conditions leading to poor health and to ensure that Black US residents and others have equitable access to health care. This argument is increasingly relevant as reports emerge that millions of individuals at risk of COVID-19 have recently lost their health insurance because of pandemic-related unemployment, with the risk of potentially worsening COVID-19 and other health disparities through a lack of access to health care.

The social and environmental contexts that serve as both powerful antecedents and as a rich substrate for COVID-19 disparities underlie nearly all race-based health inequities. These inequities can only be mitigated by dismantling housing, education, employment, and health care policies that currently contribute to poor health for Black US residents and others. New policies are needed to promote health equity for all US citizens. As this study suggests, providing universal access to health care is a logical first step. However, access to health care alone will not prevent substantial comorbidity among Black individuals and others, which results in their disproportionate need for health care. In the case of COVID-19, workplace protections and programs providing education and preventive interventions are needed. To address the root causes of these disparities, policies that incentivize the creation of equitable employment opportunities, address long-standing resource and wealth inequality, and promote healthy living environments are also required.

Recent events suggest change is possible. In just a few months during early and mid-2020, we have witnessed unprecedentedly swift and sweeping actions on the part of US federal, state, and local policy makers to slow the spread of infection and support the US economy. We have also witnessed policies upending precedent to accelerate the speed at which COVID-19 treatments, testing technologies, and vaccine development are being pursued. Similar sweeping efforts to address COVID-19 race disparities are urgently needed, and they are necessary to build the foundation for an effective strategy to counter the pandemic at large. SARS-CoV-2 does not distinguish among its human hosts by race, and the rippling effects of this infectious pandemic cannot be isolated to specific subgroups. In 1963, Martin Luther King, Jr, noted, “Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.” These words still ring true. If the SARS-CoV-2 infectious risk remains high among Black US residents and others, our entire populace will remain at risk. If we fail to develop policies that will meaningfully address COVID-19 and other racial and ethnic health disparities now, we will fail to create health and health equity for everyone now and in the future.
REFERENCES


