Invited Commentary | Health Policy

Breaking Links in the Chain of Racial Disparities for COVID-19

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The burden of COVID-19 in the United States has fallen disproportionately on Black and Hispanic/Latino individuals. According to the Centers for Disease Control and Prevention, the rate of COVID-19 infections is approximately 10% higher among Black individuals and 30% higher among Hispanic/Latino individuals compared with White non-Hispanic individuals. The higher incidences may be substantially underestimated because these same communities often lacked access to COVID-19 testing, leaving many cases uncounted. The differences in hospitalization are even more substantial, with Black and Hispanic/Latino individuals being approximately 3-fold more likely to be hospitalized with COVID-19 than White non-Hispanic individuals. Finally, mortality risk is 1.9-fold higher for Black individuals and 2.3-fold higher for Hispanic/Latino individuals compared with White non-Hispanic individuals.

It has been said that statistics are people with the tears washed away. Every death in these figures represents a loss for a family and community. It is time for a reckoning, a full elucidation, of why COVID-19 mortality disparities occurred. The study by Asch and colleagues provides important insights into one facet of the problem: disparities in mortality for hospitalized patients. Their study assessed differences in a combined adverse outcome (inpatient mortality or discharge to hospice within 30 days of admission). The study population included a large sample of 44,217 Medicare beneficiaries; 76% were White patients and 24% were Black patients admitted with COVID-19 to 1188 US hospitals during the first 9 months of the pandemic. After adjusting for Black patients being younger and more likely to be female (factors that were associated with lower risk of death or discharge to hospice), Black patients had higher odds of inpatient death or discharge to hospice (odds ratio, 1.23; 95% CI, 1.16-1.32; P < .001). The higher rate of comorbidities among Black patients explained approximately one-quarter of their higher mortality. The timing of admission was also associated with Black patients' higher mortality: Black patients were more likely to be admitted during the early months of the pandemic, when little was known about optimal care and inpatient mortality rates were approximately 2-folder higher compared with later in the year. But the factor that contributed the most to the association of Black race with higher mortality was that Black patients were more likely to be admitted to hospitals with higher mortality rates for all patients, regardless of race. After adjusting for sociodemographic and clinical factors, if the patterns of admission had been similar for Black and White patients, there would have been no significant excess mortality for Black patients (fully adjusted odds ratio, 1.02; 95% CI, 0.94-1.10; P = .71).

The study has significant strengths, including the large, national sample of patients, the detailed information on comorbidities, and the use of discharge to hospice as part of a combined outcome with inpatient death. Only one previous study of disparities in COVID-19 hospital mortality included a large number of hospitals. That study by Yehia et al found no differences in mortality, but all hospitals were part of a large system that had implemented standardized protocols for the care of patients with COVID-19, and the final models adjusted for site of care. The inclusion of discharge to hospice as an outcome in the study by Asch and colleagues is important because White patients were substantially more likely than Black patients to be discharged to hospice. Not including discharge to hospice would have resulted in an overestimate of the excess mortality among Black patients.

These strengths give us confidence in the findings of Asch and colleagues and support the study's main conclusion that site of care is associated with the higher mortality rate in Black patients. This is consistent with several previous studies of disparities, including analyses of processes of care.
and outcomes. In contrast, there was no evidence of differential outcomes within individual hospitals that could raise concerns of differential treatment: after adjusting for sociodemographic characteristics, comorbidities, and site of care, Black and White patients had similar outcomes. This should not be interpreted as evidence that there was no differential treatment of Black and White patients within individual hospitals, since the study was not designed to examine this. However, it does suggest that although disparities are usually due to a combination of who you are (individual characteristics) and where you go for care (structural factors), for outcomes after COVID-19 hospitalization, the latter plays the larger role and must be addressed if we are to eliminate disparities.

Why are Black patients cared for disproportionately in hospitals with higher mortality rates than White patients? Or conversely, why do hospitals that care disproportionately for Black patients have worse outcomes for COVID-19? There is a long legacy of structural racism in the US health care system going back to Jim Crow laws. Prior to the passage of Medicare, many hospitals would not admit Black patients or admitted them to separate facilities. Medicare used the Title VI ban on segregated organizations receiving federal funding to mandate that hospitals in the US racially integrate. When I was an attending physician at Grady Memorial Hospital in Atlanta, Georgia, my older patients would still refer to “The Grads,” a reminder of the days when the hospital had separate buildings for White and Black patients. And like the famous Supreme Court ruling said about educational facilities in Brown v Board of Education, separate was inherently unequal. Unfortunately, although the passage of Medicare integrated hospitals, there were no major policies or funding initiatives to ensure that the inferior conditions in hospitals that disproportionately cared for Black patients were rectified.

Many hospitals in predominantly Black communities continue to face financial challenges and limited resources, and structural racism contributes to this. Black communities were subjected to redlining and predatory lending, leading to a chronic inability to build property values, equity, and net worth. Hospitals serve their surrounding communities, and when those communities struggle financially, hospitals do as well. Unequal schools and limited job opportunities are associated with lower income. Communities with lower incomes have more people working in jobs that do not offer health insurance, and a higher proportion of the insured population is covered by Medicaid. This means that hospitals in these communities must operate with lower revenues because of charity care and an adverse payer mix, meaning that they have few resources for staffing, training, and quality improvement activities.

Structural racism pervades our society in other ways that appear to have contributed to the COVID-19 mortality differences reported by Asch and colleagues. Black patients were more likely to be admitted during the early months of the pandemic when mortality rates were higher. There are likely many factors associated with the higher early incidence of COVID-19 infection among Black communities, such as higher proportion of people working in essential services, lack of paid sick time, lack of clear public health messaging targeting Black communities, distrust of public health messages and the health care system, poor access to testing, and financial and nonfinancial barriers to care.

This complicated story of the factors contributing to disparities in COVID-19 mortality is typical. There is rarely, if ever, a single cause for disparities in health care or health outcomes. Rather, differences are due to a combination of factors, including lack of health insurance, financial and nonfinancial barriers to care, low health literacy, differential treatment by clinicians, distrust, where people receive care, and many more. Moreover, the set of factors associated with disparities varies for each treatment, procedure, or outcome examined. To achieve large gains rather than marginal improvements, we must understand the full set of root causes for disparities in COVID-19 incidence and mortality and use a broad combination of policies and programs to mitigate them and move our country toward equity. But we must dig deep. We must trace these roots to their origin, for there we find the legacy of structural racism, the most difficult and lasting cause that we must finally address if we are to succeed.
REFERENCES


