

Racial Health Disparities, COVID-19, and a Way Forward for US Health Systems

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The coronavirus disease 2019 (COVID-19) pandemic highlights long-standing inequities in health along racial/ethnic lines in the United States. Black, Hispanic, and Indigenous people have been disproportionately affected during the pandemic. For example, the age-adjusted mortality rate among Black people with COVID-19 is 3.4 times as high as that of White people.¹

Structural racism shapes social forces, institutions, and ideologies that generate and reinforce racial inequities across different aspects of life. In this perspective, we discuss how, in the COVID-19 context, structural racism shapes access to and quality of care, as well as socioeconomic and health status. We offer guidance to health systems and healthcare providers on addressing health inequities.

HEALTHCARE QUALITY AND ACCESS

Disparities in access to and quality of care contribute to racial health disparities. At the onset of the COVID-19 pandemic in the United States, guidelines for COVID-19 testing were restrictive, only investigating those who had symptoms and had recently traveled to Wuhan, China, or had contact with someone who may have had the virus.² News reports show disparities in access to testing, with testing sites favoring wealthier, Whiter communities, a feature of racial residential segregation.³ Residential segregation has also contributed to a concentration of closures among urban public hospitals, affecting access to care.⁴ In New York City (NYC) and Boston, early hotspots of the pandemic, Black and Hispanic patients and underinsured/uninsured patients were significantly less likely to access care from academic medical centers (AMCs) compared with White, privately insured patients.⁵ AMCs boast greater resources, and inequalities produced by this segregated system of care are often exacerbated by governmental allocation of resources. For instance, NYC's public hospitals care for the city's low-income residents (who are disproportionately insured by Medicaid), yet received far less federal aid from the Provider Relief Fund COVID-19 High Impact Payments, which favored larger, private hospitals in Manhattan. These public hospitals, however, face

looming Medicaid cuts.⁶ Similarly, the federal government delayed the release of funds to health centers located on Native American reservations, adversely affecting the Indian Health Service's preparedness to face the pandemic.⁷ In tandem with the effects of residential segregation, these data highlight the tiered nature of the US healthcare system, a structure that significantly impacts the quality of care patients receive along racial and socioeconomic lines. Furthermore, studies have documented racial disparities in the provision of advanced therapies: in the case of predicting algorithms that identify patients with complex illnesses, reliance on cost (thus, previous utilization data) rather than actual illness means that only 17.5% of Black patients receive additional help.⁸

SOCIOECONOMIC STATUS, OCCUPATIONAL AND RESIDENTIAL RISK

Healthcare alone does not explain the observed disparities. The disproportionately high risk of contracting the SARS-CoV-2 virus among Black, Hispanic and Indigenous people can be explained by factors that render physical distancing a luxury. First, in terms of occupational hazards, only 1 in 5 Black and 1 in 6 Hispanic workers can work remotely compared with 1 in 3 White workers. Additionally, Black and Hispanic workers are more likely to have jobs classified as critical in industries such as food retail, hospitality, and public transit. In NYC, Metropolitan Transportation Authority (MTA) employees reported using their own masks and home disinfectant at work, only to be reprimanded. By April 8, 2020, at least 41 MTA workers had died of COVID-19, and more than 6,000 were ill or self-quarantining, resulting in a transit crisis with increasingly long wait times and crowded subway platforms.⁹ Jason Hargrove, a Black bus driver in Detroit, shared a video underscoring the dangers of his work in which he says, "We're out here as public workers, doing our job...but for you to get on the bus and stand on the bus, and cough several times without covering up your mouth . . . in the middle of a pandemic...some folks don't care." He died of COVID-19 complications 11 days after sharing his video.¹⁰ Such conditions likely also increased riders' risk of contracting COVID-19. And while in aggregate, essential workers in healthcare receive more personal protective equipment (PPE) than those in other occupations, within NYC hospitals, the rationing of PPE was such that low-wage, nonmedical workers (79% of whom are Black or Hispanic) were given less PPE or none at all compared with nurses and physicians.¹¹

Beyond occupational hazards, Black and Hispanic people are more likely to live in multigenerational homes, an identified

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Received: June 29, 2020; Revised: September 29, 2020;

Accepted: October 10, 2020

© 2020 Society of Hospital Medicine DOI 10.12788/jhm.3545

risk factor of COVID-19 infection.¹² Furthermore, Black and Hispanic people are overrepresented among homeless people as well as among those incarcerated. These social conditions, all products of structural racism, substantially and adversely affect the health status of Black, Hispanic, and Indigenous people, especially as it relates to comorbidities associated with higher COVID-19 mortality.

DISPARITIES IN HEALTH STATUS

Black people are disproportionately represented among COVID-19 patients requiring hospitalization, consistent with more severe disease or delayed presentation. For instance, among a cohort of 3,626 patients in a health system in Louisiana, 76.9% of COVID-19 patients hospitalized and 70.6% of those who died were Black, even though Black people comprise only 31% of this health system's patient population.¹³ Conditions associated with COVID-19 mortality include heart failure, obesity, and chronic obstructive pulmonary disease. Black, Hispanic, and Indigenous people have higher rates of these chronic illnesses,¹⁴ increasing COVID-19 mortality risk. The increased prevalence of these illnesses is attributable to the aforementioned social conditions and environmental factors and to the additional stress associated with repeated exposure to discrimination.¹⁵

RECOMMENDATIONS

Although the disparities highlighted during the pandemic are staggering, this moment can serve as a portal to reimagine a more equitable healthcare system. Health systems and providers should (1) remain vigilant in addressing bias and its effects on patient care; (2) implement strategies to mitigate structural bias and use data to rapidly mitigate disparities in quality of care and transitions in care; and (3) address inequities, diversity, and inclusion across the entire healthcare workforce.

Addressing Provider Bias

At the patient care level, healthcare providers have a role in ensuring patients have positive experiences with the healthcare system; this is an opportunity to address medical distrust. Providers should recognize the burden of psychosocial stress and place-based risk that contributes to patients' presentations and clinical courses. In patient encounters, this awareness should translate to action, acknowledging patients' experiences and individuality and upholding their dignity. Under conditions of burnout, physicians' biases are more likely to manifest in patient encounters,¹⁶ and although stress and burnout among providers are likely at an all-time high during the COVID-19 pandemic, patients of color must not suffer disproportionately.

Addressing Structural Bias in Care Provision

Health systems should establish checklist-based protocols in order to mitigate the impact of bias on patient care, such as on referrals for advanced therapies. Algorithms used to automate certain aspects of care should not be biased against Black, Hispanic, and Indigenous patients, as has been the case with algorithms that lead to Black patients receiving low-

er levels of care compared with White patients with similar clinical presentations.⁸ Health systems should therefore systematically collect racial and sociodemographic data and implement rapid-cycle evaluation of processes and outcomes to root out biases. In tracking their own performance in providing equitable care, health systems should create feedback systems that inform individual providers of their practices for improvement, and individual departments should hold frequent "morbidity and mortality" style reviews of practices and outcomes to continuously improve. Additionally, collaborations with and financial support of community-based organizations to ensure safe transitions of care and to contribute to addressing patients' unmet social needs should become the norm. This is particularly relevant for COVID-19 survivors who may face long-term chronic physical and mental sequelae such as post-intensive care syndrome and require multidisciplinary care.¹⁷

Workforce Equity, Diversity, and Inclusion

Health systems should also examine and address the ways in which they contribute to racial health inequities beyond healthcare provision. Among healthcare organizations, hospitals employ the majority of low-wage healthcare workers, most of them Black or Hispanic women. Nearly half of Black and Hispanic female healthcare workers earn less than \$15 hourly (cited as a living wage, which could help prevent a significant number of premature deaths),¹⁸ and a quarter are uninsured or on Medicaid. Raising the hourly minimum wage to at least \$15 would reduce poverty among female healthcare workers by 27.1%.¹⁹ Mortality decreases as income increases, and the lowest-income healthcare workers have a nearly six-fold higher risk of death relative to their highest-earning counterparts, a gradient steeper compared with other fields.²⁰ Health systems should guarantee occupational safety and adequate wages and benefits and provide employees with career-advancing opportunities that would facilitate upward mobility.

In addition to the aforementioned structural inequities embedded within the healthcare infrastructure, low-wage Black healthcare workers report experiencing interpersonal discrimination at work, such as being assigned more tasks compared with their White peers and having others higher up the hierarchy, such as supervisors, nurses, and physicians, assume they are incompetent. Workplace discrimination spans across the organizational hierarchy. Black nurses and physicians report both interpersonal and organizational discrimination from patients and other healthcare workers and in terms of barriers to opportunities through hiring and credentialing processes.²¹ Black physicians are at greater risk of burnout and attrition, which is partly attributable to experiencing discrimination.^{22,23}

To address these experiences, health systems should invest in creating a work climate that is inclusive and explicitly stands against racism and other forms of discrimination. The rise of the Black Lives Matter movement has contributed to improving people's attitudes toward Black people over the

past years,²⁴ whereas implicit bias trainings, commonly employed to improve diversity and inclusion, may unwittingly further entrench the denial of the impact of racism (by attributing it to implicit rather than explicit attitudes)²⁵ or heighten intergroup racial anxiety and reduce individuals' intentions to engage in intergroup contact.²⁶ Moreover, evidence shows interracial contact in medical school yields more positive explicit and implicit attitudes toward Black people among non-Black medical trainees, whereas bias trainings do not,²⁷ and a positive racial climate in medical school yields a greater interest in serving underserved and minority populations among non-Black medical trainees.²⁸ In other words, fostering a culture and structure that champions racial justice and diversifying the healthcare workforce would synergistically improve non-Black healthcare workers' attitudes toward Black people while also improving the working conditions of Black healthcare workers and the experiences of Black patients. Health-

care is the fastest growing industry in the United States, and such initiatives would likely have a tremendous impact on moving the needle toward health equity.

CONCLUSION

The COVID-19 disparities were predictable. This pandemic may not end any time soon and certainly will not be the last we experience. Therefore, healthcare workers and health systems should recognize the societal barriers patients and workers face and implement strategies to eliminate biased practices in the provision of healthcare as well as through the compensation structure and workplace protection of healthcare workers, especially when the healthcare system experiences undue stress.

Disclosures: The authors have nothing to disclose.

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