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EDITORIAL

Reversing the Tide of Racial and Ethnic Disparities in Excess Deaths During the COVID-19 Pandemic

The COVID-19 pandemic has resulted in disproportionately higher hospitalization and mortality rates in Non-Hispanic (NH) Black, Latino, and American Indian/Alaska Native (AI/AN) persons than NH White persons (1). The United States reached a grim milestone on 15 September 2021: 1 in 500 residents had died of COVID-19 (2).

In their study, Shiels and colleagues (3) sought to capture racial and ethnic disparities in the excess death toll between March and December 2020. Using surveillance data from provisional death certificates from the Centers for Disease Control and Prevention and the U.S. Census Bureau, they examined deaths directly or indirectly caused by COVID-19.

Prior studies have shown excess deaths in the United States due to the COVID-19 pandemic. Woolf and colleagues (4) examined COVID-19 deaths from March through July 2020 and observed a 20% increase over expected deaths, with COVID-19 documented as the cause in 67% of deaths. An updated analysis capturing excess deaths for the remainder of 2020 (5) found a 22.9% increase over expected deaths, with COVID-19 accounting for 72.4% of excess deaths.

Shiels and colleagues' analysis (3) documented 477 200 excess deaths during March to December 2020. The researchers analyzed racial and ethnic disparities in excess deaths attributed to COVID-19 and non–COVID-19 causes, including Alzheimer disease, heart disease, cerebrovascular disease, diabetes, cancer, and other causes yet to be classified. They estimated excess deaths as observed deaths minus expected deaths from March through December 2020 by cause of death, race/ethnicity, sex, age group, and month. The age-standardized COVID-19 and non–COVID-19 death rates among NH Black, AI/AN, and Latino adults were at least 2 times higher than among NH White and NH Asian adults. A striking finding was that non–COVID-19 death rates were 9 times higher among Black males than White males.

It is clear that the pandemic widened existing racial and ethnic disparities in all-cause mortality between 2019 and 2020 (3). These data are even more troubling when we consider that such disparities have persisted for decades. Although cardiovascular disease mortality decreased between 1968 and 2015 in the general U.S. population, it decreased more slowly among Black than White persons and remained 21% higher among Black persons in 2015 (6). Although the life expectancy gap between Black and White persons decreased from 8 years in 1950 to 4 years by 2015, it took 40 years (1990) for Black persons to achieve the life expectancy that White persons had in 1950 (7). The current analysis reveals that the pandemic has rapidly reversed the gains that were made at a slow and painful pace, at a time when experts have called for accelerated efforts to close racial gaps in health in the United States.

It is challenging to unpack the specific mechanisms that underpin racial and ethnic disparities in excess deaths; however, several factors may explain these findings. Although the whole nation has been affected by the pandemic in some way, people of color were employed in essential sectors that exposed them to a higher risk for contracting and dying of COVID-19. Also, NH Black, Latino, and AI/AN adults have a higher underlying burden of hypertension and obesity (so-called preexisting conditions) that can be attributed not to a biological predisposition to these conditions but rather to existing health and economic policies that increase their exposure to negative social determinants of health that were magnified by the pandemic (8). Stress associated with police violence and other racially motivated violence also increased during the past several years, contributing to higher levels of depression and complications due to poor control of chronic conditions. Finally, people of color in the United States have faced economic inequality for generations, manifested in higher levels of unemployment and overrepresentation in essential and low-paying jobs than White persons. To make a bad situation worse, these groups were unduly affected by the economic fallout from the pandemic, thus increasing their risk for poor mental health and death from drug overdoses and suicides.

Early in the pandemic, the Coronavirus Aid, Relief, and Economic Security (CARES) Act helped many people of color, especially those with low income, to stabilize their financial circumstances. However, as months passed, delays in benefits and uncertainty around the effects of the pandemic on jobs disproportionately threatened the health and well-being of these groups. The American Rescue Plan also addressed health equity in several ways, including closing gaps in access to medical care, investing in community health, and addressing social contributors to health. However, many of the legislation's provisions are time-limited and do not address critical issues for the health of communities of color, including colorblind economic policies and negative effects of climate change.

The study by Shiels and colleagues (3) highlighted the importance of identifying subpopulations that are being harmed by the ongoing pandemic. However, the data do not reveal the extent of trauma that communities of color experience due to these excess deaths. The mental trauma of losing family members and friends is incalculable in the context of racial tension and enduring social injustices that have outlived the civil rights movement (9). Unless health and social policies are instituted to curb these excess deaths, people of color may experience protracted "community bereavement" (9). The study also did not include an examination of racial and ethnic disparities in *morbidity* from COVID-19; however, given higher rates of infections in Black, Latino, and AI/AN persons, COVID-19 survivors in these groups may be at greater risk for postacute COVID-19 syndrome and its associated disabilities.

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These findings have several implications for future research, practice, and policy. Researchers and public health leaders should conduct longitudinal studies and monitor all-cause and cause-specific mortality data by race/ethnicity at the national, regional, and local levels. These efforts may provide insights into the effect of the pandemic on health disparities and actions needed to mitigate the incidence of and morbidity from long-term sequelae of COVID-19 and other chronic conditions in communities of color.

Along with Shiels and colleagues (3), we are sounding the alarm. Until our nation commits to addressing upstream factors, such as structural racism, that are woven into the fabric of society, we will continue to see widening gaps in health between NH White persons and other racial/ethnic groups. Because conditions that lead to health disparities have spillover effects on the entire society, such as through the spread of infectious diseases, crime, and violence, we will also see widening gaps in health status between our nation and other high-income countries that prioritize the health of their citizens through strong social and economic policies.

We need policies such as the new federal infrastructure bill (10), which increases access to lead-free drinking water and affordable and reliable broadband, expands home- and community-based services, and extends many Affordable Care Act expansions from the American Rescue Plan. However, we also need policies that will comprehensively address structural inequities for those who have experienced the most harm from the pandemic. Only then will we meet this moment, turn the tide of excess deaths in people of color in the United States, and begin to close the gap between where we are today and our vision of health equity, where everyone has a fair and just opportunity to be as healthy as possible.

Yvonne Commodore-Mensah, PhD, MHS, RN
Johns Hopkins School of Nursing and Johns Hopkins Bloomberg School of Public Health
Baltimore, Maryland

Lisa A. Cooper, MD, MPH
Johns Hopkins School of Medicine, Johns Hopkins Bloomberg School of Public Health, and Johns Hopkins School of Nursing
Baltimore, Maryland

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Corresponding Author: Lisa A. Cooper, MD, MPH, Johns Hopkins Center for Health Equity, 2024 East Monument Street, Suite 2-500, Baltimore, MD 21287; e-mail, lisa.cooper@jhmi.edu.

Current author addresses are available at Annals.org.

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Current Author Addresses: Dr. Commodore-Mensah: Johns Hopkins School of Nursing, 525 North Wolfe Street, Room S407, Baltimore, MD 21205.
Dr. Cooper: Johns Hopkins School of Medicine, 2024 East Monument Street, Suite 2-500, Baltimore, MD 21287.