Structural Racism in the U.S. under the Covid-19 Pandemic

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The term "health disparity" was first used in the United States in the 1990s. It was used to denote the worst health affairs existing among socially disadvantaged people and members of specific racial and ethnic communities and underprivileged. Today, the definition of health disparity has broadened. It refers to differences in health and healthcare among different population groups. Disparities can occur across many aspects such as race, ethnicity, socioeconomic status, gender, age, location, sexual orientation, etc. Disparities in the healthcare system cause some communities to receive less or lower-quality healthcare than others and consequently experiencing worse outcomes. Ultimately, these disparities result in increased morbidity and mortality.

Of all the aspects of health disparities in the USA, racial and ethnic health disparities are more pronounced, persistent, and pervasive. Many of these differences are deeply rooted in healthcare and social setups that have been running for decades. It, collectively, refers to "structural racism." This term describes how societies imply systems of housing, education, employment, earnings, benefits, healthcare, and criminal justice that cultivate racial discrimination.

In the United States, the coronavirus disease (COVID-19) pandemic has disproportionately affected racial/ethnic minorities and underserved groups, especially African American, Latinx, and Native American communities. The striking disparities result from important medical, social, economic, environmental, and political aspects that predate the pandemic. Many potential factors are contributing to COVID-19 inequality in the United States. Of these factors, biomedical and social determinants are the major ones.

Facts and Figures

As of June 2020, the Centers for Disease Control and Prevention (CDC) had reported that 21.8% of cases of COVID-19 in the United States were African Americans, and 33.8% were Latinx[1]. These striking stats contrast with the fact that these groups are only 13% and 18% of the US population, respectively. It is stated there could be many more cases going unreported. In another report depicting the percentage distribution of hospitalized patients, it was found that 33% of the hospitalized patients were African Americans, despite representing only 18% of a catchment area population[2]. This disproportion has been consistent throughout the USA.

The mortality rate for COVID-19 among African Americans is two times more than that in Whites. In most states reporting COVID-19 cases, African Americans covered a higher proportion of deaths than their percentage in those states' populations[3]. The numbers may fluctuate, but the evidence of racial discrimination is evident.

New York City was the city hit the hardest by this pandemic in the United States. Age-adjusted data for COVID-19 deaths in this city showed that deaths were 220 and 236 per 10000 for African Americans Latinx patients, respectively. This data was double in comparison to 110 deaths per 100000 for Whites.

Looking at other examples, 13% of cases and 18% of deaths in Arizona were among Native Americans, even though they only make up 5.3% of the state's population[45].

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[1] *Cases in the U.S.* Centers for Disease Control and Prevention; June 5, 2020. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (Accessed June 24, 2021) [Google Scholar]

[2] Garg S, Kim L, Whitaker M, et al. Hospitalization rates and characteristics of patients hospitalized with laboratory-confirmed coronavirus disease 2019—COVID-NET, 14 States, March 1–30, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:458–64.

[3] Egbert A. COVID-19 deaths analyzed by race. APM Research Lab. Available at: https://www.apmresearchlab.org/covid/deaths-by-race. Published 11 May 2020. Accessed 25 June 2021.

[4] AZDHS | COVID-19 Dashboards. Arizona department of health services. Available at: https://www.azdhs.gov/preparedness/epidemiology-disease-control/infectious-diseaseepidemiology/covid-19/dashboards/index.php. Published 2020. Accessed 24 June 2021.

[5] US Census Bureau QuickFacts: Arizona. Census Bureau QuickFacts. Available at: https://www.census.gov/quickfacts/fact/table/AZ/PST045218. Published 2018. Accessed 28 April 2020.

Socioeconomic Determinants

A wider societal lens is needed to understand disparities in pre-existing medical problems, healthcare availability, and other factors that may contribute to the disproportionate impact of COVID-19 on minority groups. Social determinants of health are the conditions in the places where people live, learn, work or do a job, and rejoice.

Before this pandemic and associated economic shrinkage, poverty rates were 24% for Native Americans, 22% for African Americans, and 19% for Hispanics, compared to 9% for Whites[6]. Keeping in view all the income brackets, the wealth of white households is ten times higher than that of Black households[7]. As a result, these minority populations have less economic capacity to make healthful decisions amid financial problems associated with this pandemic.

Moreover, minority groups represent a disproportionately higher percentage of workers in essential industries that keep on running during the pandemic. In addition, only 20% of African American workers have the privilege of working from home. This figure is lower than compared with Whites, 30% of whom work from home[8]. A report from the New York City comptroller office indicated that 75% of frontline workers in the city were people of color.

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[6] . Poverty Rate by Race/Ethnicity. The Henry J. Kaiser Family Foundation. Available at: https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity. Published 2018. Accessed 25 June 2021.

[7] Kochhar R, Cilluffo A. How US wealth inequality has changed since great recession. Pew Research Center. Available at: https://www.pewresearch.org/fact-tank/2017/11/01/how-wealth-inequality-has-changed-in-the-u-s-since-the-great-recession-by-raceethnicity-and-income/. Published 2017. Accessed 24 June 2021.

[8] Bureau of Labor Statistics. The employment situation March 2020. Washington, DC: Bureau of Labor Statistics; 2020.

34% of African Americans use public transportation to travel to their woke places, compared to 14% of Whites[9]. More than 40% of transit workers are African Americans.

A separate statement is that only 55% of essential workers in the food industry have access to paid sick leaves[10]. As most of the essential workers are minorities, they are at higher risk of occupational hazards.

These working conditions undoubtedly contribute to the disproportionate effects of COVID-19 on minority groups.

Living conditions in many minority communities further increase the risk of catching SARS-CoV-2 infection and its transmission. Communities with higher racial and ethnic minority populations have higher housing density, more housing insecurity, and a lack of clean drinking water[11]. There are more multigenerational households that make social distancing harder to adopt[12]. Likewise, lower access to healthy foods makes improvement in chronic conditions more difficult[13]. Moreover, high air pollution in minority groups may play a role in COVID-19 severity[14].

During a pandemic, disbursement of credible, accurate, and helpful health information from healthcare professionals and institutions to the public is

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[9] Anderson M. Who relies on public transit in the US Pew Research Center. Available at: https://www.pewresearch.org/fact-tank/2016/04/07/who-relies-onpublic-transit-in-the-u-s/. Published 2016. Accessed 23 June 2021.

[10] . Schneider D, Harknett K. Essential and vulnerable: service-sector workers and paid sick leave. Berkeley, CA: Shift Project; 2020. Available at: https://shift. berkeley.edu/files/2020/04/Essential_and_Vulnerable_Service_Sector_Workers_ and_Paid_Sick_Leave.pdf. Accessed 23 June 2021.

[11] *COVID-19 in racial and ethnic minority groups.* Centers for Disease Control and Prevention; June 4, 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html [Google Scholar] [Ref list]

[12] . Taylor J. Racism, inequality, and health care for African Americans. The Century Foundation. Available at: https://tcf.org/content/report/racism-inequalityhealth-care-african-americans. Published 2019. Accessed 25 June 2021.

[13] Dutko P, Ver Ploeg M, Farrigan T. Characteristics and influential factors of food deserts, ERR-140. Washington, DC: US Department of Agriculture, Economic Research Service, August 2012

[14] Tessum C, Apte J, Goodkind A, et al. Inequity in consumption of goods and services adds to racial-ethnic disparities in air pollution exposure. Proc Nat Acad Sci USA 2019; 116:6001–6

important. Unfortunately, minority groups suffer from communication gaps due to health literacy issues, socioeconomic disadvantage, and limited English language proficiency[15]. Justifiable mistrust of health instructions in some minority groups further exacerbates the situation[16].

The ultimate result is a relative lack of credible COVID-19 information reaching minorities, increasing disease contraction and transmission risk.

Conclusion

The above statements summarize that both the disproportionate biomedical risk factors and social determinants contribute to COVID-19 health disparities affecting the racial and ethnic minorities. The cause of these factors can be traced back, in part, to structural racism[17].

Minority groups have been fighting for equal rights under the law in the United States for decades. Though there have been some achievements, many still suffer under the systematic racism that exists in the United States. That racism is very clear in the medical systems. Past trauma of medical experimentation and neglect have left many to not seek care until it is their last resort. It has caused a lot of instances of people not getting their Covid-19 vaccination; even with results showing it to be safe and effective at preventing Covid-19.

More recently on the federal policy level we have still not seen an expansion of healthcare options under the Trump or Biden administrations. Over 30 million people are without health insurance, and many more lost it during the pandemic. While most essential workers were minorities, many lacked healthcare and it was

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[15] . Blumenshine P, Reingold A, Egerter S, Mockenhaupt R, Braveman P, Marks J. Pandemic influenza planning in the United States from a health disparities perspective. Emerg Infect Dis 2008; 14:709–15.

[16] . Bergstresser SM. Health communication, public mistrust, and the politics of “rationality.” Am J Bioeth 2015; 15:57–9.

[17] Structural racism and health inequities in the USA: evidence and interventions.
Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT
Lancet. 2017 Apr 8; 389(10077):1453-1463.

not expanded by government action. Guaranteed healthcare plans like Medicare for All still have not had a vote or a hearing in Congress; a bill that now President Biden said that he would veto if it were sent to his desk.

There is also no action on enacting the healthcare policy that the Biden Administration promoted during its presidential campaign; that being the public option. Even after over 600,000 people have died from Covid-19 there is still little appetite in the U.S. Federal Government to expand healthcare, especially to minority groups who need it the most.

Thus, we must recognize what lies at the heart of most health disparities. Policies and practices in healthcare, education, housing, employment, and criminal justice promote racial discrimination. Without rectifying these policies, health disparities will never cease to exist. Deconstruction of the legacy of structural racism is the only way forward towards achieving the goal of health equity.

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