



## Cases in An Equity Approach to Pandemic Preparedness and Response PPR\_14 July 2020

# COVID-19: Racism and other systems of inequity in the United States

*As COVID-19 cases surged in Alabama, on June 16, 2020, the City Council of Montgomery voted on passage of a mandatory mask ordinance. Doctors and residents testified.*

*Dr. Bill Saliski described hospital units full of critically ill COVID-19 patients, 90% of whom were Black Americans. City resident Willam Boyd spoke in favor of the ordinance, saying he had lost six family members to COVID-19.*

*“The question on the table,” Boyd said, “Is whether Black lives matter.”*

*The City Council killed the ordinance with a 4-4 tie after it failed to garner a majority. The vote was mostly along racial lines (Harper, 2020).*

In Alabama, as across America, the pandemic is moving along the fault lines of inequity, with higher rates of disease and death among Black Americans, indigenous peoples, and among other communities of color. COVID-19 is laying bare and amplifying long-standing social and economic inequities tied to racism, wealth inequality and poor access to health care.

Recent data show that the age-adjusted COVID-19 mortality rate for Blacks is 3.8 times as high as for whites; for Indigenous people it is 3.2 times as high; for Pacific Islanders it is 2.6 times as high; for Latinos it is 2.5 times as high; and for Asians it is 1.5 times as high (APM Research Lab Staff, 2020).

City-by-city and state-by-state the picture is stark. In Washington, DC, the Black community represents 44% of the population but close to 75% of deaths from COVID-19. In Arizona, the Latinx community represents 11% of the population but 32% of COVID-19 deaths. As of April 30, the Navajo Nation, with a population of 300,000, had the third-highest per capita rate of COVID-19 in the country, after New Jersey and New York (Mineo, 2020).

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## Disproportionate impact on people and communities of color

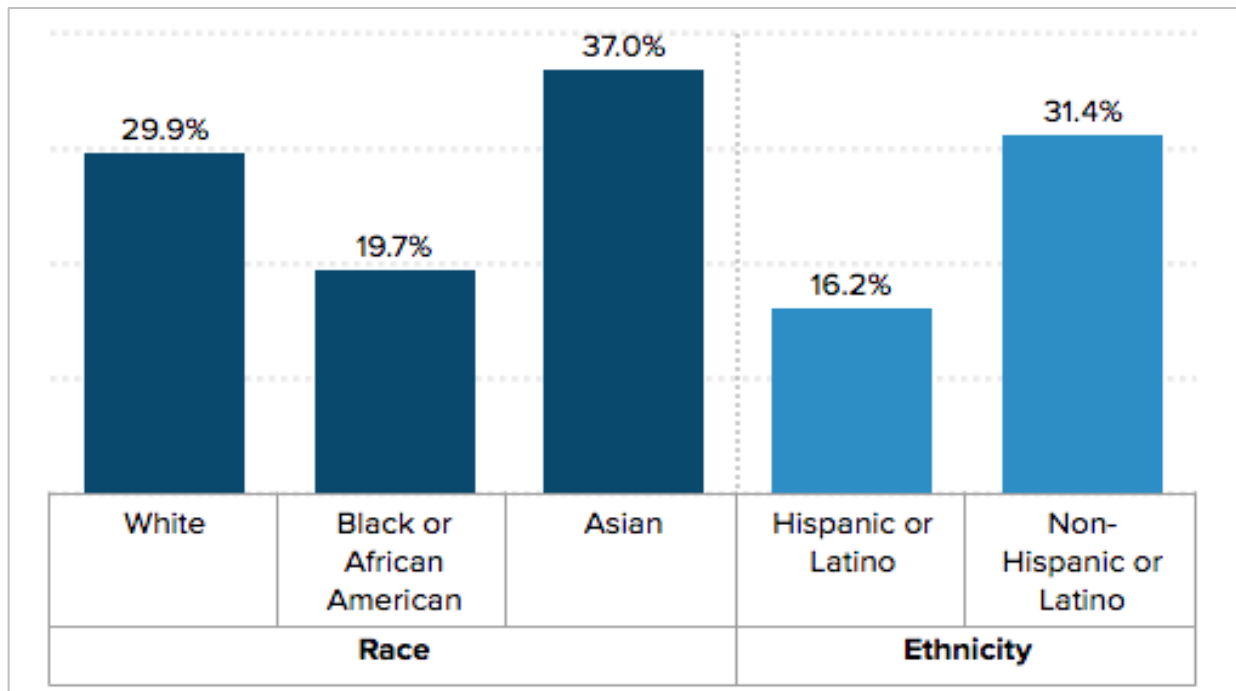
Black, indigenous, and other people of color in the United States are disproportionately impacted by COVID-19 because they are more likely to get infected--because they are more exposed and less protected. Once infected they are more likely to die--because they are more burdened by chronic diseases and have less access to health care.

Black people are more likely to get infected with SARS-CoV-2 because they are more exposed and less protected. Black people are more exposed because they are over-represented in low-paid frontline jobs (including as home health aides, transit drivers, postal workers, sanitation workers, hospital orderlies and custodians, grocery workers, meat packers, warehouse workers, others). In these roles, they do not have the luxury to work from home nor the savings nor paid sick leave to be off the job to preserve their health. The over-representation of Black workers in low-paid frontline jobs results from racial residential segregation which results in racial educational segregation which results in racial occupational segregation (Jones, 2020).

### People of color are over-represented in high risk jobs and settings:

- *Black Americans make up 12% of all employed workers but account for 30% of licensed practical and licensed vocational nurses. (U.S. Bureau of Labor Statistics, 2019)*
- *Hispanic workers account for 17% of total employment but 53% of agricultural workers. (U.S. Bureau of Labor Statistics, 2019)*
- *Less than 30% of workers can work from home, and the ability to do so differs enormously by race and ethnicity (Gould and Shierholz, 2020).*

Share of workers who can telework, by race and ethnicity, 2017-2018



Source: U.S. Bureau of Labor Statistics as cited by Gould and Shierholz, 2020

Black people are also more exposed because they are more reliant on public transportation; live in more crowded home settings and more densely populated communities; and are overrepresented in jails and prisons and among the unhoused (Jones, 2020). For example, although Black Americans and Latinx made up approximately 32% of the U.S. population, they comprised 56% of all incarcerated People in 2015 (NAACP, 2020).

Compounding the injury of being made more exposed is the insult of being less protected. Many low-paid workers are not provided adequate personal protective equipment to prevent them from acquiring the virus on the job, even though their work is now being deemed “essential.” In jails, prisons, and homeless shelters, the public health mitigation strategies of social distancing and frequent handwashing are virtually impossible.

Once infected, Black people are more likely to die from COVID-19 because they are more burdened by chronic diseases and have less access to health care. Black people are more burdened by chronic disease because Black communities are more likely to be disinvested and actively neglected communities of concentrated poverty with poor access to healthy foods including fresh fruits and vegetables; poor access to green space and healthy environments for active living; increased likelihood of proximity to polluting industries which poison the air, soil, or water; and crowded and unhealthy living spaces. These conditions greatly constrain residents from making healthy behavioral choices, resulting in higher prevalence of obesity, high blood pressure, diabetes, asthma, heart disease, and kidney disease (among many other environmentally-conditioned health outcomes), all of which make COVID-19 more severe and potentially deadly (Jones, 2020).

In Florida’s Pinellas County, as the number of daily new COVID-19 cases reached record highs, two zip codes are responsible for the highest numbers of cases. Both are located in south St. Petersburg and have majority low-income African American populations. The median income is just \$35,000. Zip code 33712 is located in a ‘food desert,’ with no major grocery store. It is home to a large public housing development with high rates of poverty and to an elementary school that several years ago was ranked worst in the state (Morrow, 2020).

Black people also have less access to timely, responsive, and physically proximate health care in the United States. Even during the COVID-19 pandemic, testing sites were first located in affluent communities (with lower proportions of Black residents) and persons seeking a test were required to have an order from a primary care physician (which Black residents are more likely to lack). In rural areas, recent hospital closures have exacerbated the lack of ready access to health care.

## **Impact of wealth inequity**

Even more significant than income, however, is wealth: the total assets, financial and material, available to an individual or household. The typical white family has 10 times the wealth of the typical Black family and seven times the wealth of the typical Latinx family (Solomon and Hamilton, 2020). Black Americans constitute 13% of the nation’s population, but possess only 2.6% of its wealth (Darity and Mullen, 2020).

Women are particularly disadvantaged. One study of wealth found that median wealth for single Black women is \$200 and for single Hispanic women is \$100, compared with \$15,640 for single white women and \$28,900 for single white men (Frye, 2020).

This wealth gap represents a stark divide in people's ability to respond to life's events, especially emergencies such as job loss or health crisis—both of which are hitting communities of color particularly hard during the pandemic.

As William Darity Jr. and A. Kirsten Mullen write in their new book, *From Here to Equality: Reparations for Black Americans in the Twenty-First Century*, the wealth gap is an opportunity gap. In this pandemic, it translates into the opportunity to live.

## Racism is a public health crisis

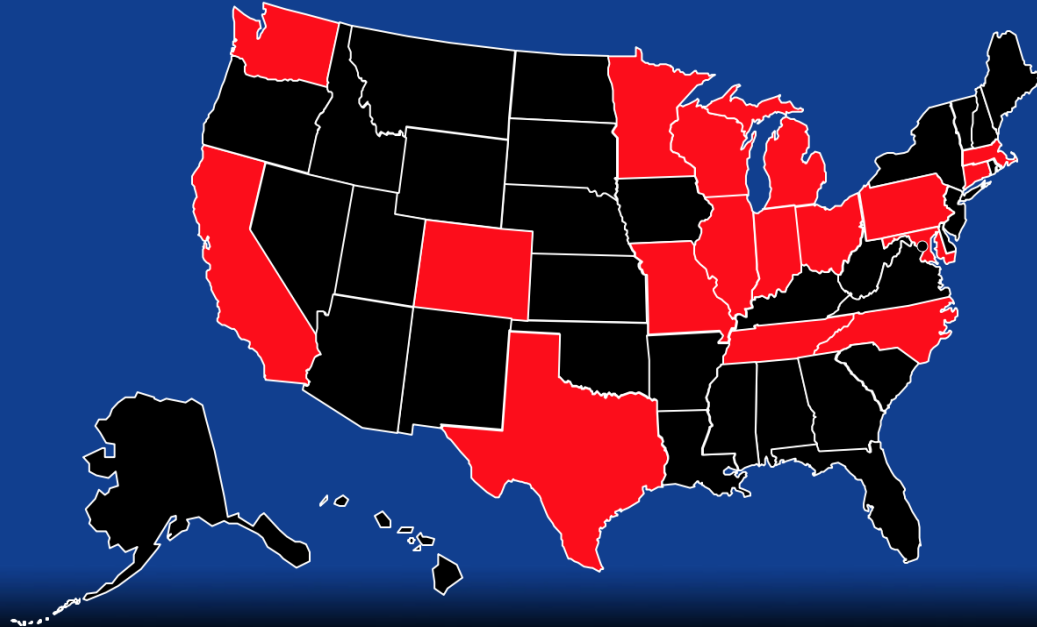
Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities and saps the strength of the whole society through the waste of human resources (Jones, 2003).

In order to understand the impacts of racism on the health and well-being of the nation, as well as how we can intervene, it is useful to describe three levels of racism:

- **Institutionalized (structural) racism** is the system (the constellation of structures, policies, practices, norms, and values) which results in differential access to the goods, services, and opportunities of society, by "race".
- **Personally-mediated racism** includes differential assumptions about the abilities, motives, and intents of others, by "race", and differential actions based on those assumptions.
- **Internalized racism** is acceptance by members of stigmatized "races" of negative messages about our own abilities and intrinsic worth (as well as the reciprocal sense of entitlement internalized by members of the dominant "race") (Jones, 2000).

Racism is increasingly recognized as a public health crisis in the United States. The American Public Health Association (APHA) is tracking the states with cities and counties that have named racism as a public health crisis or emergency and a social determinant of health. As of July 11, this includes 66 cities and counties in 17 states, and the State of Wisconsin at large (American Public Health Association, 2020).

## States with jurisdictions declaring “Racism is a public health crisis”



**California 6, Colorado 1, Connecticut 6, Illinois 1, Indiana 3, Maryland 2, Massachusetts 8, Michigan 9, Minnesota 1, Missouri 1, North Carolina 2, Ohio 15, Pennsylvania 2, Tennessee 1, Texas 1, Washington 2, Wisconsin 6**

American Public Health Association. <https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations>

Racism is built into the very structure of our society. As Ed Yong wrote in *The Atlantic*, “after the Civil War, white leaders deliberately kept health care away from black communities. For decades, former slave states wielded political influence to exclude black workers from the social safety net, or to ensure that the new wave of southern hospitals would avoid black communities, reject black doctors, and segregate black patients” (Yong, 2020).

Similar practices have been carried forward up until today, whether through the lack of affordable health services in black communities, a lack of access to health insurance, or the compromised quality of health care delivered due to the implicit bias of providers (Hall et al., 2015).

Furthermore, personally mediated racism and structural violence, including police brutality, fuel chronic stress that weakens immune function and health. Police killings of unarmed Black Americans have been found to cause long-lasting mental health trauma in affected communities (Bor et al., 2018). And the stress of every day discrimination is linked to higher levels of inflammation and high blood pressure, which in turn raise risks of COVID-19.

The resurgence of the Black Lives Matter movement during the height of the pandemic further underscores the destructive forces of racism and structural violence on the Black community.

The U.S. is facing a critical reckoning of racially-motivated police killing of Black Americans and other people of color. The brutal video recording of the torture and murder of Mr. George Floyd under the knee of Minneapolis police officer Derek Chauvin (Hill et al., 2020) has highlighted the impact of racism on the lack of freedom and agency of Black Americans. Sparking protests in all 50 of the United States--as well as abroad--protesters are demanding justice for Mr. Floyd and others killed by state-sponsored violence. This fight has re-ignited calls for reparations to Black Americans. Many in the Black Lives Matter movement have linked violence at the hands of police with the structural impoverishment of the Black community, which has resulted in increased infection rates and deaths from the COVID-19 pandemic. Social forces drive epidemics and these are in plain sight in the current U.S. environment.

In recent decades, dramatically increased spending on policing, criminalization and mass incarceration has been matched by declining investments in public health, education, safe housing, healthy food, environmental protection, and other social programs at all levels of government (Center for Popular Democracy, 2017).

Meanwhile, a racist pandemic narrative from national and local leaders has deepened divisions and increased pandemic harm. Rather than consistent and coherent information and analysis, the Trump administration has consistently used racially-charged language to describe the virus as a "Chinese virus," and COVID-19 as "Kung-flu," inflaming anti-Asian sentiment in the U.S. and triggering a dramatic rise in anti-Asian violence (A3PCON, 2020).

This racist narrative, articulated almost daily by the U.S. President, is part of a continuum that intentionally and repeatedly dehumanizes people of color, whether characterizing Mexican immigrants as "rapists" or Black Lives Matters protesters as thugs. It includes praising white supremacists as "good people" and "my supporters," (in reference to a tweet of a fist-pumping white man in a golf cart repeating the words "white power") even as they perpetuate and incite violence.

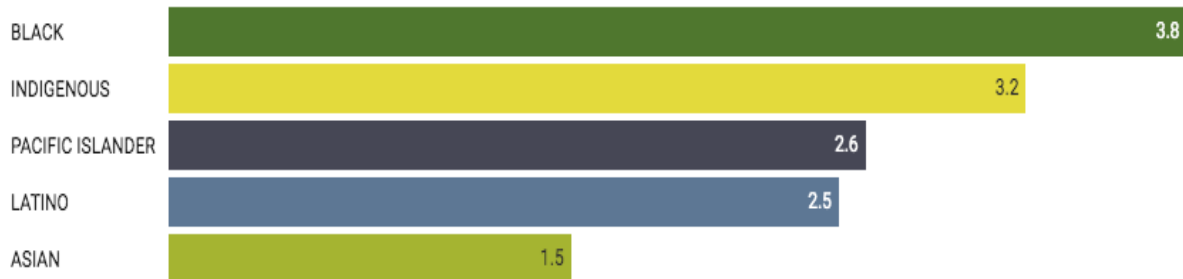
Paired with these overt verbal assaults is another, more insidious narrative. As the pandemic's disproportionate impact on communities of color became increasingly clear, rather than funding access to care and public health initiatives in the most affected communities, top government officials, including Secretary of Health Alex Azar, have responded with "victim blaming," implying that individual behaviors of Black Americans, rather than racism and deep social and economic inequity, are the cause of the disparity (Beckett, 2020). And just two weeks after the first data documenting the disproportionate impact of COVID-19 on Black Americans (Johnson and Buford, 2020), the President was tweeting "Liberate Minnesota!," "Liberate Michigan!," and "Liberate Virginia!" and calling for rapid re-opening of the country (Collins and Zadrozny, 2020).

The disregard of the rising toll of COVID-19 on people and communities of color is in essence a death sentence for tens of thousands of vulnerable people. In the U.S., that means Black people, Indigenous people, and other people of color.

Meanwhile, communities of color, including majority African American cities such as Atlanta, Georgia, and Newark, New Jersey, are implementing comprehensive public health approaches to tackle the pandemic, often with minimal support from the federal government.

## Adjusted for age, other racial groups are this many times more likely to have died of COVID-19 than White Americans

Reflects mortality rates calculated through July 7.



Indirect age-adjustment has been used.

Source: [APM Research Lab](#) • [Get the data](#) • Created with [Datawrapper](#)

The definition of racism above can actually be generalized to be a definition of any system of structured inequity. For example, what is sexism? That is a system of structuring opportunity and assigning value based on gender, that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources (Jones, 2014). There are many axes of inequity operating in U.S. society today, intersecting in communities and in individuals. These include:

- Race
- Gender
- Ethnicity, Indigenous status, and colonial history
- Labor roles and class markers
- Nationality, language, and immigration status
- Sexual orientation and gender identity
- Disability status
- Geography
- Religion
- Incarceration history

*These are risk markers.*

Recognizing that all of these axes of inequity underlie systems of structured inequity operating in the United States, some ask “Why focus on ‘race’ and racism?” It is because racism is foundational in the history of the United States, and yet many people in this country are in staunch denial of its continued existence and its profoundly negative impacts on the health and well-being of the nation. Many activists assert that all of us should become actively anti-racist, even as we also engage in struggles around these other systems of structured inequity. To the extent that we are successful in dismantling the mechanisms of systemic racism, the other struggles will benefit as well.

## Public health is an equalizer

Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health disparities will be eliminated when health equity is achieved (Jones CP. Medical Care 2014). The achievement of health equity is an ongoing process, not a one-time victorious outcome.

As has been evinced by responses to other epidemics and pandemics throughout history, a comprehensive public health response focused on the most affected communities is the only way to end the pandemic. Five key elements anchor this response: testing, contact tracing, isolation and quarantine, treatment and social supports, all delivered with dignified care and compassion. Contact Tracers or dedicated Care Resource Coordinators (CRCs) link people affected by COVID-19 to the resources and services they need to successfully self-isolate, whether that be food, medication delivery, hygiene supplies, or shelter. Reliance on social distancing alone to reduce transmission is a regressive and racist response, which benefits only those people privileged enough (by virtue of their home situations, ability to work from home, and access to private transportation) to implement it.

To prevent further disparities in who dies from COVID-19 in the United States, resources must be directed toward the most impacted communities. This includes the federal allocation of funds to address acute food shortages, income losses, and access to everything from cleaning supplies to home PPE; and the hiring of contact tracers, care resource coordinators and other essential health workers directly from affected communities. This will ensure representation of communities of color more prominently in the health care system, and work to build trust in contact tracing systems that will lead to better health outcomes. Short-term aid should be part of the long-term case for reparations and economic justice.

As of June 13, 2020, the US Centers for Disease Control and Prevention had only 607 CDC staff working in state, tribal, local, and territorial health agencies (CDC, 2020b). The dearth of workers is a result of layoffs due to neoliberal policies that de-emphasize the role of the public provision of services and basic economic rights in favor of a privatized system (Mukherjee, 2018). These policies gained political momentum in the Regan era and continued apace, even causing the Great Recession of 2007-2009. In the last two decades alone, the U.S. has lost 50,000 public health jobs (Barna, 2019). Rather than reinvesting, the current administration has further reduced health spending in a variety of crucial areas (Morris, 2020)

Meanwhile, the U.S. urgently needs an estimated 100,000 contact tracers and massive expenditures to provide a social safety net to support the vulnerable if we are to stop the exponential spread of COVID-19. Without a strong federal response, the responsibility falls on states--which have varying degrees of political will for equity, varying beliefs in science, and varying flexibility in their state budgets. Thus, spikes have been recorded throughout June as services and businesses re-open, marked by lapses in social distancing and in the enforcement of mask requirements.

Fully-funded and operational public health systems can quickly identify individual cases or localized outbreaks as was demonstrated over the past several months in Wuhan, New Zealand, Vietnam, and South Korea. If and when we have a vaccine or effective treatment for COVID-19, a public health response will still be necessary to assure people get vaccinated and that vaccinations reach the most vulnerable.



## Health equity and advocacy

The pandemic in the U.S. has not yet peaked--we are very much still in the midst of the first wave. Although the work may appear daunting as the toll of COVID-19 continues to mount, it is not too late to mobilize, take on the virus, and win. Yet it will require leadership and not only a recognition, but at long last funding that can mitigate risk and repair the harm suffered by Black and Native Americans and other people of color.

What is needed today, above all else, are timely and decisive investments in clinical care and public-health systems, big enough to meet the challenge and focused on the hardest hit communities. In the rebuilding process, we must examine and change the policies and systems that perpetuate inequity so that the short-term devastation of COVID-19 leads to positive change for longer-term investments in an equitable public health system here in the U.S.

On May 12, the House included \$75 billion in the much more robust trillion-dollar Heroes Act, the second package of COVID-19 related stimulus funding. These additional funds are allocated specifically as grants for states to increase their integrated public health response to COVID-19-- funds to increase testing capacity, hire, equip and train a robust network of contact tracers, and ensure fully-resourced care coordination for supported quarantine and isolation (HEROES Act, H.R. 6800, 2020).

Since then, the ball has been in the court of the Senate to take action. As the days and weeks have passed, with hope that this funding will be included in the Senate version of the Act, the disparate impacts of the pandemic on low-income essential workers and communities of color have become increasingly clear. As we've seen with previous moments of large-scale policy change in the U.S., policy makers acting alone have not instituted significant change. Real change has resulted when it is demanded by citizen movements.

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