


TMI BRIEFS

STRUCTURAL RACISM IS A PUBLIC HEALTH CRISIS

ADDRESSING RACIAL DISPARITIES IN
COVID-19



This TMI Brief is one of several reports the Thurgood Marshall Institute is publishing on racial disparities and COVID-19. While the COVID-19 pandemic has revealed the pre-existing fractures and inequalities in our society, it has also revealed the inherent interdependency of our lives. We can see now more than ever that the health and safety of our society is inextricably connected to the health and well-being of us all. By facing the structural racial inequities revealed in this pandemic, we can develop and implement creative solutions that will make us a better, healthier, and more just society now and in the future.



Recent reports have revealed stark [racial disparities](#) in the prevalence and death rates of COVID-19.¹ For example, Black people comprise only 26% of the population in Milwaukee, WI, but are 73% of the people who have died from COVID-19 and 32% of the population in Chicago, but 67% of the COVID-19 deaths. This same pattern of racial disparity can be seen in states that have released COVID-19 data by race: Louisiana, Illinois, and Michigan.² It is important to understand that these differences in vulnerability to the pandemic reflect larger structural inequalities in the economy, housing, criminal justice, and health care delivery systems rather than biological differences or cultural difference in the value of health.³

Structural racism is a public health crisis. It is the underlying condition fueling disparities in COVID-19 outcomes. Our ability to respond adequately to this public health crisis requires an understanding that “many health-related factors previously attributed to culture or ethnicity also represent the downstream consequences of decisions about larger structural contexts, including health care and food delivery systems, zoning laws, local politics, urban and rural infrastructures, structural racisms”⁴

”

“Racial differences are linked to opportunity at the neighborhood level. African Americans are not doing poorly because of their genes, they’re doing poorly because of the policies we’ve created that constrain their access to resources.”⁵

-David Williams, Scholar of Racial Health Disparities

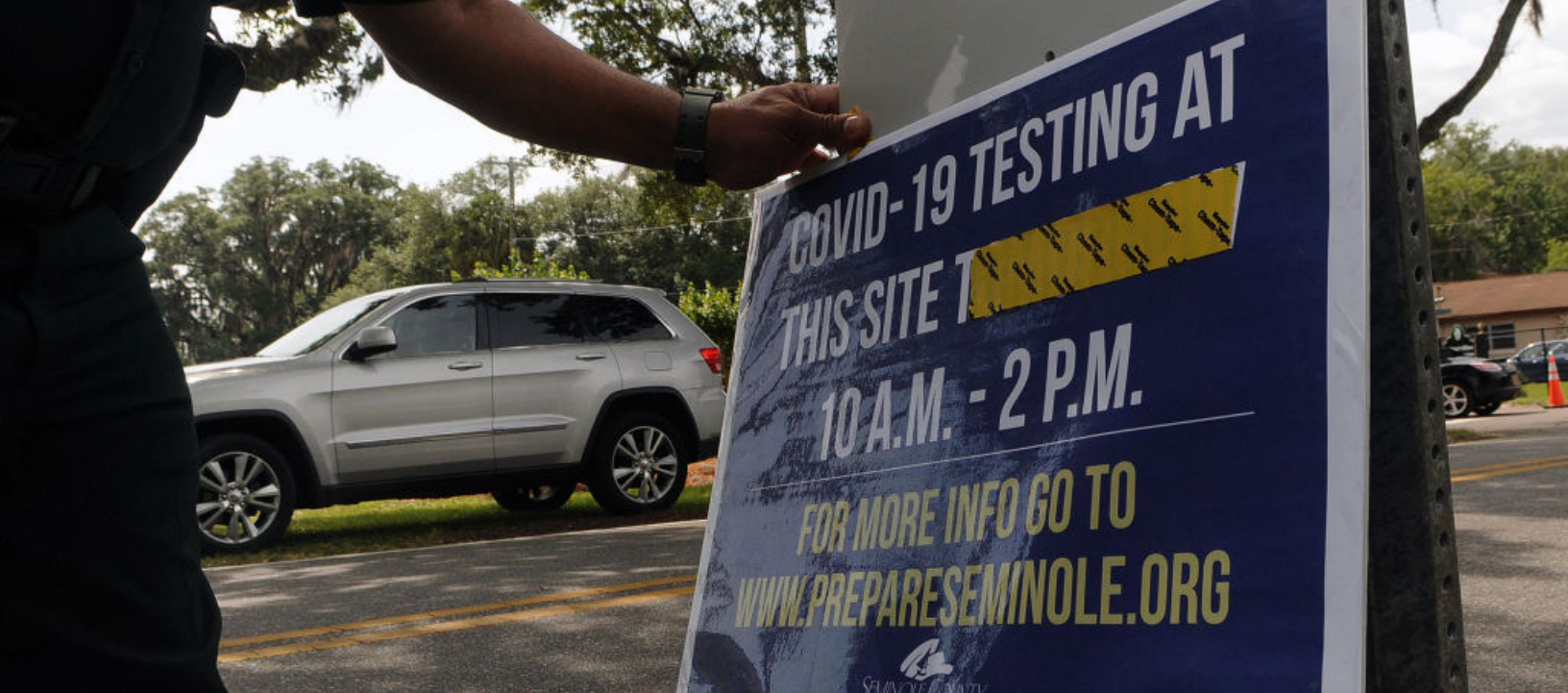
Not all Black people are equally at risk; residential racial segregation generates and magnifies the vulnerability of particular groups of Black people to COVID-19. Local government officials have also observed that vulnerability to COVID-19 varies across neighborhoods. As Baltimore Council President Brandon Scott said, "[w]e know that in black neighborhoods in Baltimore and brown neighborhoods in Baltimore and poor neighborhoods in Baltimore and certain zip codes, your health determines [sic] - are significantly different than those in others."⁶

In order to effectively combat this pandemic and save millions of lives, **we must target resources to those places and individuals most likely to be negatively impacted.** The necessary level of targeting will require collecting and publicly releasing data on COVID-19 testing, hospitalizations, and death by race and ethnicity. This level of tracking would allow for a rapid, data-driven response that can save lives.⁷

Dr. Poonam Alaigh, Research Professor at the University of Pittsburgh and former Commissioner of Health and Senior Services of New Jersey, urged a data-driven, racial equity response to this pandemic. "I do think you drive your interventions based on data that has been collected . . . The infections rates are probably higher in certain races and ethnicities. So it's critical to be able to [collect data by racial demographics]."⁸

This level of targeted tracking and intervention to promote racial equity has already been [implemented in Illinois](#) and needs to be expanded through the nation.⁹ The Illinois Department of Public Health (IDPH) was one of the first in the nation to start tracking COVID-19 data by race and ethnicity. This enabled IDPH Director, Dr. Ngozi Ezike, to observe that Black people are five times more likely to die from the disease than white people, and to implement a racial equity response to their public health intervention.¹⁰





While numerous reports¹¹ have identified the particular vulnerability of Black people to serious complications from COVID-19 because of “underlying health conditions,” what remains unsaid is the fact that those underlying health conditions are products of racial segregation and economic inequality. A National Survey of Black Americans conducted over a period of 13 years revealed that, the more segregated the neighborhood they lived in, the less likely they were to survive the study period, controlling for age, health status, and other predictors of mortality.¹² This study revealed that 90.8% of Black survey respondents who live in racially isolated (predominately white communities) survived the 13 years of the study as compared to 82.9% of Black people in racially integrated communities and 69.3% of Black people in segregated neighborhoods.¹³

This pattern of racial segregation that negatively impacts the health of Black people holds true for rural communities as well. Premature death rates are much higher in rural counties with a majority of Black and Native American residents as compared to predominately white rural counties.¹⁴

Conditions comorbid with COVID-19, such as asthma and hypertension, have been empirically linked to patterns of residential segregation. As of 2018, the rate of childhood asthma was more than double for non-Hispanic Black people as compared to non-Hispanic whites.¹⁵ While a fraction of the difference in the prevalence of childhood asthma can be explained by differences in birth weight, a 2010 study of health records in New Jersey showed that this remaining difference between Black and white rates of childhood asthma can be entirely accounted for by whether the child lived in a predominately Black zip code.¹⁶ In addition, a study of Type II diabetes among residents of Durham, North Carolina suggests that the built environment influences the odds of diabetes, and that Black residents may have less variation in quality of built environments due to patterns of racial segregation.¹⁷

AS OF 2018, THE RATE OF CHILDHOOD
ASTHMA WAS MORE THAN

2X

THE RATE IN BLACK COMMUNITIES THAN IN
WHITE COMMUNITIES

89%

OF THE
MAJORITY BLACK
COMMUNITIES
IN LOS ANGELES
ARE IN TRAUMA
DESERTS.

73%

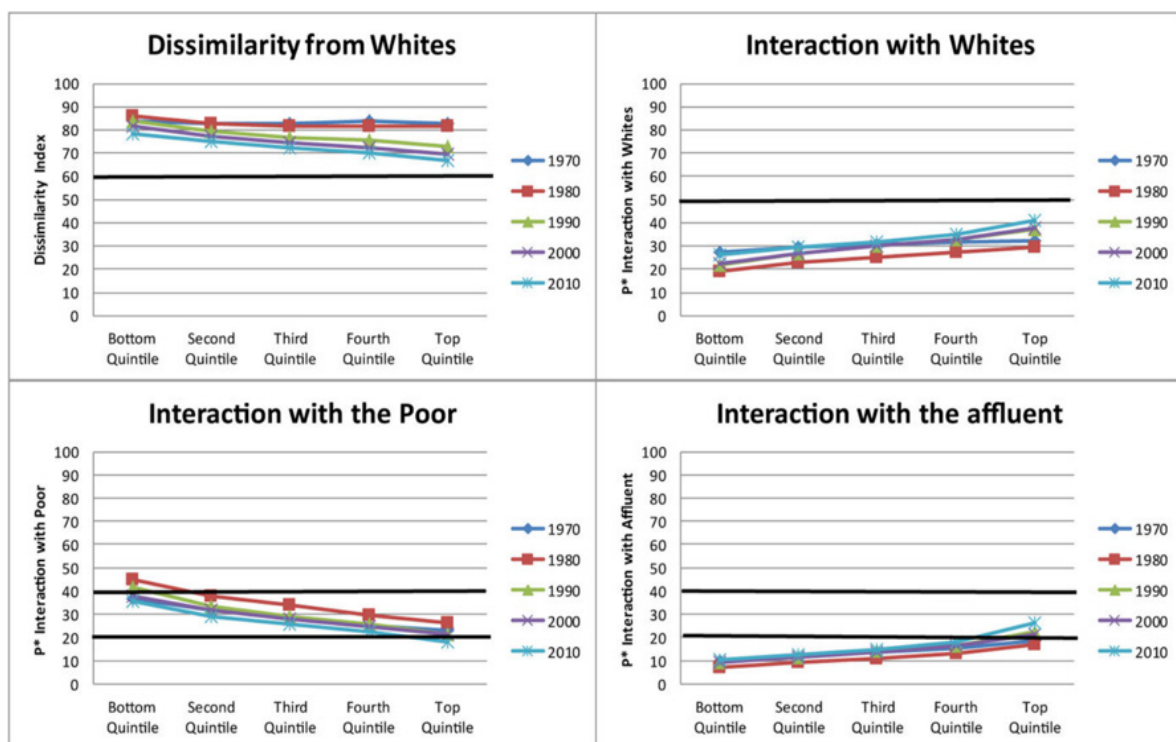
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Residential segregation not only increases Black people's risks of chronic illnesses, it also limits their access to health professionals and hospitals. According to a recent study, 89% of the majority Black communities in Los Angeles and 73% of the majority Black communities in Chicago are in "trauma deserts."¹⁸ Trauma deserts are communities in which residents would need to travel more than eight kilometers (approximately five miles) to reach the closest trauma center. While Black and Latinx populations experience segregation in the three largest cities (New York, Los Angeles, and Chicago), once adjusted for neighborhood poverty only, Black neighborhoods remained as a significant predictor of access to trauma centers. Non-poor Black neighborhoods are more likely than non-poor white neighborhoods to be in trauma deserts. Non-poor Latinx neighborhoods were equally as likely or slightly less likely than non-poor White neighborhoods to be in trauma deserts.¹⁹ This study suggests that the only racial/ethnic group that showed a consistent pattern of limited access to trauma centers were those living in majority Black census tracts.

Black people remain the most segregated population in the country.²⁰ The combination of racial segregation and [economic inequality](#)²¹ creates bubbles of magnified risks that make some, but not all, Black Americans extremely vulnerable to high rates of mortality from COVID-19. This combination of race and place that undergirds health disparities highlights the need for targeted interventions to protect and serve those communities made vulnerable to this pandemic.

Figure 1 (below) documents the spatial disadvantage experienced by Black people in the nation's most segregated metropolitan areas. In these areas, Black people live in highly segregated neighborhoods that are racially isolated with high to moderate concentrations of poverty.²³ This pattern has been fairly stable over time and decreases only slightly as income increases. According to 2010 Census data, 32% of urban Black people live in hypersegregated communities with an additional 21% living in highly segregated communities.²⁴

FIGURE 1. INDICATORS OF SEGREGATION AND INTERACTION FOR BLACKS IN HYPERSEGREGATED COMMUNITIES²²



These highly segregated neighborhoods also face high levels of [policing and incarceration](#).²⁵ The risk presented by COVID-19 to incarcerated persons, disproportionately comprised of Black people, is life threatening because they are at serious disadvantage with respect to the ability to protect themselves, practice social distancing, and gain access to healthcare and testing.²⁶

Below, we discuss some of the major structural inequalities that increase the risks posed by COVID-19 for residents of Black communities with high levels of segregation. We also share some potential responses to consider in trying to stem the tide for what is looking like a grossly unequal and deadly share of the fallout from this virus being borne by Black people.

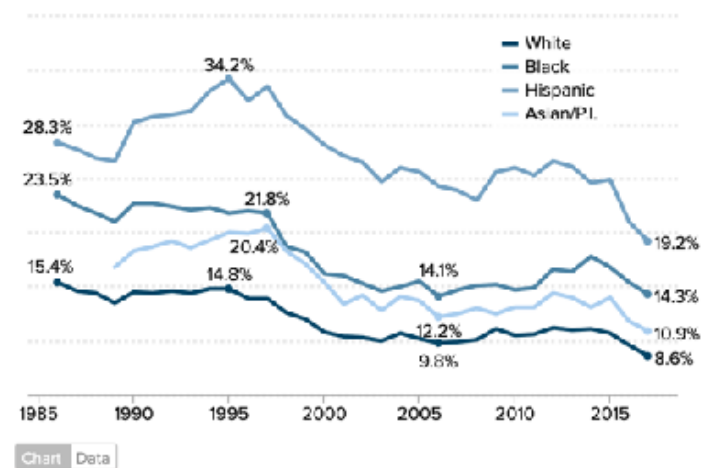
1. Black and Latinx people's high rates of employment in low-wage work puts them at an increased risk of exposure to COVID-19.

As we see in the Figure 2 (right), Latinx workers make up 19.2% of the poverty-level wage earners and Black workers make up 14.3% as compared to white workers that comprise 8.6% of the lowest wage earners.²⁷ This pattern of low-wage work of Black and Latinx employees is especially true for individuals employed in the food services, delivery services, and home healthcare industries. While the current public sentiment acknowledges the importance of these positions in keeping us all safe and keeping our society running during this crisis, many low-wage workers are denied the protections necessary to ensure their own health and safety, including health insurance, paid sick leave, and personal protective equipment (PPE). The Economic Policy Institute's analysis of [flexible work schedules](#) in 2018 revealed that only 19.7% of all Black workers were able to telework as compared to 29.9% of white workers.²⁸ This pattern has only been exacerbated by COVID-19. Using aggregated cellphone data, a [New York Times report](#) showed that, in nearly every state, wealthier people were able to stay home more and earlier than low-income people in response to the stay home orders issued during the pandemic.²⁹

FIGURE 2. WORKERS OF COLOR ARE FAR MORE LIKELY TO BE PAID POVERTY-LEVEL WAGES THAN WHITE WORKERS

Workers of color are far more likely to be paid poverty-level wages than white workers

Share of workers earning poverty-level wages, by race/ethnicity, 1986–2017



Notes: A "poverty-level wage" is a wage that would leave a full-time, year-round worker below the federal poverty guideline for their family size if they are the sole earner in the family. Poverty wage thresholds are specific to each family size, and family sizes are calculated using the total number of people in each family or subfamily within the CPS data. The "Asian or Pacific Islander" race category is only available beginning in 1989.

Source: EPI analysis of Current Population Survey Outgoing Rotation Group microdata

Potential responses to address this disparity include:

Expand provisions for paid sick leave and health insurance to low-wage essential workers, as well as providing them with hazard pay. [Worker strikes](#) at Instacart, Amazon, and Whole Foods highlight the dangerous health conditions of employees who are providing essential services for our nation during this crisis.³⁰

Protect the health of low-wage essential workers by providing the necessary PPE, as well as increased sanitization/disinfection measures on public transportation.

Re-open enrollment in public health care offered through the Affordable Care Act. At a time when so many individuals are losing their jobs, those who did receive health insurance through work are now losing that as well. Re-opening Affordable Care Act enrollment would allow those in need of health insurance to acquire it.

2. The high rates of economic insecurity and housing insecurity experienced by Black and Latinx people make them less able to practice the safety measures recommended by the Centers for Disease Control and Prevention (CDC) to prevent the spread of COVID-19.

Lack of health insurance is likely to be a significant barrier for many Black people in getting tested and treated for the disease. The high costs of housing have led many low-income and working-class households to live with overcrowding. Black, Latinx, and Asian people are significantly more likely than white people to live in [multigenerational households](#).³¹ In addition, Black and Latinx households are much more likely to experience overcrowding as compared to white families.³² [Overcrowding](#) is linked to increases in the risk of infectious diseases³³ and makes it impossible to practice the kind of [social distancing](#) and isolation recommended by the CDC.³⁴

Potential responses to address this disparity include:

Provide funding for hotels to make rooms available to individuals in crowded households in need of quarantine. While this is already being done for some [healthcare workers and patients](#), it needs to be expanded to include low-wage essential workers and individuals living in overcrowded households.³⁵ Moreover, it needs to be focused on communities that are at high-risk due to patterns of racial segregation.³⁶ These temporary shelters are an important mechanism to stop the spread of COVID-19 from at-risk and infected people to their families.

Provide free testing (including costs of doctor referrals) for all individuals regardless of insurance or doctor's referral.³⁷ As of 2018, 11% of Black people in the U.S. were uninsured as compared to 8% of white people.³⁸ The [CARES Act](#) makes COVID-19 testing free, but most testing guidelines have required a doctor's referral, which often comes at a cost and can be difficult to obtain, especially for a person without a primary care physician. Because Black people are more likely to be low-income and without health insurance, they will disproportionately lack the means to get a testing referral and/or the ability to afford the cost of a referral. This will likely present a significant barrier to testing.



3. The hypersegregation of Black people places them at increased risks for comorbidity with COVID-19.

In an analysis of CDC national data on COVID-19 hospitalizations from February 12–March 28, 71% of individuals hospitalized and 78% of those in Intensive Care Units had one or more underlying health conditions, the most common were diabetes, chronic lung disease, and cardiovascular disease.³⁹ Black people have the highest rate of [diabetes](#)⁴⁰ (16.4%) and [asthma](#)⁴¹ (9.1%) relative to any racial/ethnic group in the U.S. Although the Black community's rate of [heart disease](#) (9.5%) is not higher than that of whites (11.5%), Black people are more likely to die from heart disease.⁴² Scholars have documented the relationship of many of these chronic illnesses to residence in segregated neighborhoods.⁴³ Thus, hypersegregation increases the likelihood that Black people without comorbidities will be in close contact with those who do, increasing the risk of death in those communities.

16.4%
OF BLACK PEOPLE
HAVE DIABETES

Potential responses to address this disparity include:

Provide free testing sites in hypersegregated neighborhoods.

Given the fact that these segregated communities are at higher risks for exposure to and death from COVID-19, the most effective response is to target free, easily accessible testing locations to these neighborhoods. In Illinois, state and city health care institutions are partnering with community health centers in low-income and underserved neighborhoods in the south and west sides of Chicago, as well as the Metro East area, to provide increased numbers of, and accessibility to, testing to these residents.⁴⁴

9.1%
OF BLACK PEOPLE HAVE
ASTHMA

Partner with community-based organizations that are trusted institutions in racially segregated communities to create and disseminate targeted public health messaging about the spread of the virus, available testing locations, and vaccinations when available. Given the longstanding discriminatory history of the U.S. healthcare system,⁴⁵ there is a high degree of mistrust of government health officials within the Black community. To ensure that the public health messages and resources reach this population, it is essential for trusted community organizations and [digital hoods](#) to be partners in public education and communications.⁴⁶ “Digital hoods” are a nexus of existing social networks, entertainment, and neighborhood communities that exists online. Studies show that these may be a useful point of intervention for promoting healthy sexual behaviors among urban, minority youth.⁴⁷ An example of this digital hood as a public health intervention is [“Diddy’s Black America Coronavirus Town Hall”](#) where hip hop mogul Sean “Puffy” Combs hosted a two hour live video stream that brought government officials, public health scholars, civil rights activists, and popular hip hop artists together for a candid discussion on the dangers of COVID-19 for the Black community.⁴⁸

4. Black and Latinx people are more likely to live under medical apartheid.

Given the increased hospital closures in the past decade, Black people in low-income urban neighborhoods typically have limited access to local hospitals and healthcare providers. Urban hospital closures are more likely to happen in racially segregated neighborhoods. [Healthcare deserts](#) are most common in Black neighborhoods.⁴⁹ A national study combining Census data with data from the American Medical Association reported that 25.6% of Black people and 24.3% of Latinx people lived in zip codes with few or no primary care physicians, compared to 9.6% of Asian and 13.2% of whites.⁵⁰ This pattern of healthcare deserts applies to Black rural communities. For example, in [Alabama](#) the recent closure of a hospital in a community where 72% of the people are Black means that residents now have to drive for 50 minutes to get to the closest hospital.⁵¹

Potential responses to address this disparity include:

Create a racial equity regional health approach for COVID-19 hotspots and at-risk communities.⁵²

A regional planning approach has been shown to be effective in addressing the needs of individuals with chronic illnesses, substance abuse, and epidemic hot spots. Dr. Alaigh recommends that the response include: targeted public education about managing underlying risk factors and social distancing, mass testing in at-risk communities to determine the degree of community spread, wellness kits (thermometer; PPE; pulse oximeter; educational information) delivered to every household in the target area, access to 24/7 telemedicine, nutritional support for households (safe delivery of adequately nutritious meals), and a public regional health dashboard with live data about wait times, bed/ventilator capacity, and location of available health facilities.

The zip codes in existing and future hotspot communities with the highest density of cases and/or underlying conditions, least availability of life-saving health care resources, and shortest days before duplication could be targeted for this focused community level intervention. Dr. Alaigh suggests a triage model that treats everyone in those neighborhoods as “high risk populations” similar to health care workers who have high exposure to the virus. She states: “It’s important to target the minority communities, especially in urban areas where you know there are structural inequalities . . . a population that truly needs [an] all hands on deck effort to help protect them, and that includes mass testing because that’s the population that’s most at-risk.”

Prioritize hospitals and healthcare providers serving low-income, Black and Latinx residents in the distribution of the \$100 billion of funding from the CARES Act.⁵³

5. Given the disproportionately high rates of policing and incarceration of residents of low-income Black neighborhoods, high numbers of Black people are in jails, prisons, and detention centers and at increased risk of death from COVID-19.

The U.S. has the highest rate of incarceration in the world,⁵⁴ with an overrepresentation of Black and Latinx individuals among those incarcerated.⁵⁵ As seen in the Prison Policy Initiative’s graph below (Figure 3), the rate of incarceration for Black people is almost six times that of white people⁵⁶. The overcrowding in prisons and jails, as well as [youth](#) and immigrant detention centers, creates a serious health hazard for incarcerated individuals, the individuals who work in these institutions, and the public at large.⁵⁷ For the [incarcerated population](#), it is impossible to adhere to the CDC recommendations around social distancing.⁵⁸ Moreover, many incarcerated individuals have [underlying conditions](#) that make them extremely vulnerable to COVID-19⁵⁹.

A large share of those people being held in U.S. jails have never been convicted of a crime or are being held for technical parole violations. Under the current conditions, these individuals’ lives are being put at risk because they did not have enough money to afford bail or missed an appointment with their parole officer. A coalition of civil rights organizations called on decision makers nationwide, and specifically in the Southern states, to take speedy measures to address the impending public health and human rights crisis in prisons, jails, and juvenile facilities.⁶⁰ Southern states incarcerate a larger proportion of their population than the rest of the country and a disproportionate number of the persons incarcerated are Black.⁶¹

FIGURE 3. UNITED STATES INCARCERATION RATES BY RACE AND ETHNICITY, 2010



The coalition of civil rights organizations encourages the following responses to address racial disparity in COVID-19 resulting from the mass incarceration of Black people:

Create procedures for the quick and early release of categories of incarcerated people, including: people who have completed most of their sentences; elderly prisoners and those with comorbidities; pregnant women and women with babies in prison nurseries; people held on probation or technical parole violations; people experiencing pretrial incarceration only because they cannot afford bail; and youth in the juvenile justice system that have not been found to pose significant and imminent danger to the community.⁶² This categorical release of people incarcerated could also include people participating in work-release programs. Many jurisdictions have already begun such measures, but they need to be expanded nationwide.⁶³

Create procedures to ensure the health and safety of individuals who remain incarcerated, including: free soap and hand sanitizer; PPE for people who live and work in prisons and jails; regular disinfection of the facilities; broad testing for COVID-19; medical and humane quarantine for prisoners who test positive for COVID-19; daily temperature screenings for employees and incarcerated persons; and safe and sanitary working conditions for prisoners working in culinary, porter, and support services for jails and prisons.

Provide access to appropriate medical care in medically appropriate settings. Incarcerated people who test positive for COVID-19 should be transferred to local health care facilities to receive the necessary level of care. They should not be held in solitary confinement or forced to remain in prison facilities that do not have the needed equipment to treat acute conditions.

Release data to the public about the COVID-19 pandemic in all correctional facilities, including any racial disparities. This includes the publication of real time data broken down by race, as well as COVID-19 policies adopted by the facility.

We have highlighted some of the key ways in which structural racism causes a heightened threat from COVID-19 to the lives and well-being of many Black and Latinx people. An effective public health intervention requires a racial equity lens and the targeting of resources to racially segregated communities at greatest risk.



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