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VIEWPOINT

Ameliorating COVID-19's Disproportionate Impact on Black and Hispanic Communities: Proposed Policy Initiatives for the United States

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The COVID-19 epidemic has shone a bright light on structural racism in US society and on the inadequacies of a health care system that has significantly disadvantaged racial and ethnic minorities while giving preference to white Americans.[1] Research and disease surveillance have documented the disproportionate impact of the virus on the Black and Hispanic communities. Confirmed COVID-19 cases and deaths are disproportionately higher in communities in which these groups predominate. According to data from the US Center for Disease Control and Prevention (CDC), people of color are three times more likely to become infected with the coronavirus. The COVID Racial Data Tracker, an initiative that compiles data from state and local authorities, also indicates that Black people with the virus die at nearly 2.5 times the rate of white people, and Hispanic, American Indian, and Alaskan Native die at about 1.3 times the rate.[2] These trends are significant both in and of themselves and also because the United States is a party to the International Convention on the Elimination of All Forms of Discrimination which in Article 2 condemns racial discrimination and requires states to eliminate racial discrimination in all of its forms, including in the right to public health and medical care.[3]

These patterns reflect structural racism, which refers to the mutually reinforcing and inequitable systems of disadvantage that in turn reinforce discriminatory beliefs, values, and distribution of resources.[4] Past and often continuing discriminatory policies towards racial and ethnic minorities in the United States have skewed the social determinants of health in neighborhoods that consist mainly of minorities in ways that have significantly disadvantaged them. Racial and ethnic communities living in segregated neighborhoods often lack accessible and good quality health care. They also suffer from considerably higher rates of poverty, poor quality and often crowded housing conditions, greater exposure to toxic pollutants in their air and water, and lack of available healthy food. In addition, they have fewer quality educational opportunities and less well paid employment. These social determinants in turn create conditions which leave people of color more susceptible to chronic diseases including asthma, diabetes, high blood pressure, heart disease, and obesity that make these populations more vulnerable to COVID-19.[5]

Eliminating the impact of decades of structural racism in US society and its health system, and transforming inequitable social determinants of health is nearly impossible in the short term but there are initiatives that could begin to ameliorate their effects during the pandemic. To begin with, it is important to have continued monitoring of the pandemic's impact on these communities. For example, there is little data available by zip code that would show how race and ethnicity interacts with places where structural racism is most embedded and affects disease rates.

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Racial and ethnic minorities have often had difficulty receiving testing and treatment for COVID-19. In large cities testing sites tend to be located in predominantly white areas. For example, when the radio network NPR investigated the location of public testing sites in Texas it found that in four out of six of the state's largest cities testing sites are disproportionately located in white neighborhoods despite the evidence that Black and Latino communities were harder hit. Testing disparities have also been reported in New York City and Chicago, and media reports suggest that the patterns identified in Texas are happening in other parts of the country. There are other barriers to COVID-19 testing for at-risk people, including cost, particularly in states which have not expanded Medicaid. Lack of transportation to testing sites is yet another issue.[6] There is a need to reverse these trends in order to protect the most vulnerable populations by concentrating COVID-19 testing in areas in which ethnic and racial minorities live and, if needed, setting up testing sites in churches and other community centers. Additionally, the testing and follow-up treatment should be made available without cost, especially since so many in racial and ethnic communities lack insurance.

The failure to invest in adequate contact tracing has also disproportionately disadvantaged racial and ethnic minorities. It has meant that members of these communities who have been exposed in work or living situations have not been informed and as a result, they do not know to take measures to protect their communities and families. Moreover, where there has been contact tracing there has not been sufficient diversity among those conducting the efforts. So another helpful measure would be to institute adequate contact tracing in these communities and to train community-based partners who are more likely to win the trust of those who have been exposed to COVID-19.

Racial and ethnic minorities are overrepresented in jobs deemed essential to the functioning of the economy, and which cannot be performed from their homes. These jobs, such as agricultural workers, processors in meat packing plants, and home health workers, often require them to work closely with others, and to be unable to maintain social distancing. Furthermore, they are often low paying jobs, without paid sick leave, resulting in sick people having little choice but to work.[7] Black and Hispanic workers are often employed in jobs without occupational protections or benefits to ensure they receive minimum wages and access to sick leave. This is partly because these workers are not covered by the Fair Labor Standards Act of 1938 which exempted protections from domestic, agricultural, and service workers.[8] Neither do these groups always have access to protective gear, something which should be mandatory for all in such situations. It has also been suggested that all workers considered essential should receive a guaranteed basic minimum income and paid sick leave at least until the end of the pandemic and that low-wage workers, who are predominantly racial and ethnic minorities, should receive savings accounts to help equalize their pay to that of white workers who have benefitted from employment law protections.[9] I concur with these proposals.

It is important to have data to show that vaccines are safe and effective in the groups most effected by the pandemic. This requires their representation as participants in clinical trials, equal at least to their proportion of the population or even better represented commensurate with how much they are being effected by the disease. However, efforts so far to recruit minority populations into clinical trials for COVID-19 vaccines have been inadequate. Dr. Francis Collins, director of the National Institute of Health, described Moderna, one of the vaccine developers supported by the US government, as deserving a C for their efforts to recruit minorities.[10] While minority populations account for some 32% of the US population, they have constituted far less of the population recruited into vaccine trials by US based vaccine sponsors. There are several reasons. Minority recruitment entails considerable extra effort and often increased costs. Also, a result of past neglect and abusive practices by medical practitioners many people of color are suspicious of medical research and the health care system. But vaccine sponsors could try to assuage these concerns by enlisting more Black

doctors as coordinators of the trials and minority church and community leaders to help recruit their members into clinical trials. They could also locate the trials at respected minority institutions. Two such institutions, Morehouse School of Medicine and Meharry Medical College, have been identified as clinical trial sites but other Black colleges and universities and schools with significant Hispanic representation need to be involved as well.[11]

Moreover, it will be important to prioritize members of these communities to receive a vaccine once vaccines are available, and to provide the vaccine free. The draft guidelines of the panel sponsored by the National Academies of Science, Engineering, and Medicine propose a four phased approach reflecting the likely availability of vaccines. In the first phase all frontline health workers involved in direct patient care as well as others who risk exposure to bodily fluids and aerosols would be given the vaccine. In the second phase when more doses are available, individuals with co-morbidities and underlying conditions with increased risk are given priority. Within each phase vaccine access would also be prioritized for geographic areas identified as vulnerable through CDC's Social Vulnerability Index.[12] If these proposals are followed, many members of racial and ethnic communities will likely be among those offered the possibility of immunization in early stages of the vaccine rollout, but for the reasons mentioned in the preceding paragraph many of them may be reluctant to take it. Therefore efforts to win trust should start immediately, before any vaccine is available, using members of their communities to conduct educational initiatives that show the benefits and relative safety of the vaccines.

Compensating for centuries of discrimination and the effects of structural inequalities that favor whites at the expense of people of color in the United States will require a long-term effort. However, a commitment to racial equality and to human rights demands that meaningful measures be undertaken immediately. This viewpoint has sought to identify some of the initiatives that could begin to ameliorate the disproportionate impact of COVID-19 on Black and Hispanic communities.

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