



Review Article

Covid-19 and Racial Inequity: A Silent Conversation

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Abstract

COVID-19 and its devastating effects on the American population continue to dominate news outlets with stories of crowded hospitals, overworked nurses and dwindling supplies. Little attention, however, has been paid to the disparate infection rates of minorities. While only a handful of geographic locations reported data by race/ethnicity, it appears that African Americans and, to a lesser extent, Latinos bear a disproportionate burden of COVID-19-related outcomes. The most common explanations for disproportionate burden involve

- The higher prevalence of underlying comorbidities among racial and ethnic minorities and
- The concentration of these groups in crowded urban housing and public-facing occupations that prevent physical distancing.

Furthermore, the lack of wide-spread racial and ethnic data is troubling given the long history of racial disparate outcomes during a pandemic. While the African American population is disproportionately uninsured, low income and lower education, society has ignored the current COVID-19 implications for racial inequality, both during the pandemic and the subsequent recovery. This article addresses this crucial topic and its effects on the mental and behavioral health of the African American population. It urges public health officials to acknowledge the low-income, disadvantaged, populations who stand to suffer more devastating physical and mental health consequences from Covid-19 if not immediately acknowledged and addressed.

Introduction

The notion that COVID-19 does not discriminate by racial-ethnic group has been an emerging headline and talking point early in

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disease progress. Despite research suggesting the pandemics do not impact all racial/ethnic groups equally, the disparate infection rates of minorities with Covid-19 appear is being ignored. Despite a letter from Democratic lawmakers to the Centers for Disease Control and Prevention to collect race data no formal response has been obtained [1]. The current lack of wide-ranging collection of racial-ethnic data is troubling because of the long history of racial disparities in outcomes during pandemics. For example, African Americans had lower morbidity and mortality from the 1918 influenza pandemic than whites [2]. They also experienced a greater number of hospitalizations and deaths from the 2009 H1N1 spread [3]. Significant racial and ethnic differences in the prevalence of infectious disease in the US population have been well documented [4-7]. Racial/ethnic differences in the morbidity and mortality from disease are attributed to a range of social determinants of health that are not easily addressed. Given the existing impediments to care for African Americans and Latinos due to social determinants of health, the COVID-19 pandemic will place those with behavioral health problems at even higher vulnerability. These groups have lower access to needed treatment, often terminate treatment prematurely, and experience less culturally responsive care [8].

The COVID-19 pandemic has illuminated the racial and ethnic disparities in access to health care including behavior health care. While their rates of behavioral health disorders may not significantly differ from the general population, African American and Latinos have substantially lower access to mental health and substance-use treatment services [9]. The limited access combined with the disparate impact of the pandemic on these vulnerable populations could have lasting impacts on the mental and emotional well-being of minority populations (Holmen, et al. 2020). Increases in the incidence of chronic mental illness, higher rates of suicide and increased prevalence of abuse and neglect are only a handful of the potential ramifications from mental health neglect. Yet, a critical first step in addressing the mental health devastation of pandemics is to determine which groups are most affected with data collection processes that extend beyond simple counts [10]. This step appears to be absent in regards to race-ethnicity during the COVID-19 pandemic despite a long a sorted history of racial-ethnic disparities in mental health outcomes in the US. In fact, recent narrowing of the racial disparities in mortality have not been observed among those attributable to infectious disease [11]. While the coronavirus is infecting and killing Americans of all races, there is little public data on whether the virus is having a disproportionate impact on some racial/ethnic groups and how these vulnerable groups are coping with the devastation. Few states release data about the racial makeup of those who have been tested, tested positive for the coronavirus, been hospitalized, become critically ill, have recovered, or have died from COVID-19 [12].

A handful of states including North Carolina, Virginia and Illinois and counties (Mecklenburg County, NC and Milwaukee County, WI) have started to publish race-ethnicity data related to COVID-19 confirmed cases and deaths. In North Carolina, Blacks make up 36 percent of Covid-19 cases and 25 percent of deaths, but only 22

percent of the population (NC Department of Health and Human Services). In Illinois, the first state to start publishing racial statistics, African Americans make up 14.6 percent of the state population, but 31 percent of the confirmed COVID-19 cases [13]. Comparatively, whites account for 76.9 percent of the population but only 29 percent of confirmed cases. Similarly, Latinos in Illinois comprise 17.4 percent state populous and nine percent of confirmed cases [13]. Lack of access to testing, fear of being profiled while wearing face masks, and other issues are increasing toxic stress and straining mental health of African Americans and Hispanics.

The lack of attention given to these startling disparities suggests, at minimum, that African Americans have few advocates at the highest levels of public health and could indicate another example of conscious ignorance [14]. Scholar contend that failure to focus on racial disparities in mental health outcomes undermines black health fueling the development or progression of chronic depression, anxiety and other forms of mental/emotional distress [15]. Research shows a historic trend of institutionalized white socioeconomic resources, discrimination, and racialized framing that severely limited and restricted access of many minority groups to adequate mental health care and subsequently worsened mental health outcomes [16]. The testing, diagnosis and acknowledgement of continuing racial disparities of Covid-19 represent a paradigm of U.S. society's dismissal of racial realities. First, we must acknowledge the historic causes of mental health challenges: the legacy of racism, ableism, economic stressors, and systemic failures that contribute to mental health struggles. Adding COVID-19 has greatly amplified this distress.

The mental and emotional distress will be confounded by those clinical characteristics leading to higher mortality across racial-ethnic groups [10]. Furthermore, the currently available data highlights only those infected or dying from the virus. There is increasing but limited available information on who exactly is being tested. Recent headlines suggest it may only the sickest or wealthiest who receive tests and the COVID-19 test program reflects a longstanding racial wealth gap [17]. After several notable sports figure tested positive for COVID-19, some began question whether testing patterns fall along racial and socioeconomic lines [18]. If so, this would further contribute to persistent health disadvantages experienced by African Americans from a biased system that contributes to disparities [19,20]. Research shows significant racial disparities in health outcomes, particularly chronic diseases including diabetes, cardiovascular disease, asthma, and diabetes exist among racial-ethnic minorities and are the same diseases that contribute to worse outcomes in early research emerging from China and anecdotal reports in the US [21,22]. Furthermore, inequities in neighborhood environments, socioeconomic circumstances and access to medical care contribute to the gap in health outcomes [19]. The low healthcare utilization, reduced access to health care services and smaller proportion of insured among racial and ethnic minorities can likely explain the lower rates of testing and higher proportion of deaths among those diagnosed with Covid-19 [23].

The U.S. government is one of the few developed nations that does not routinely report health statistics by class [24]. For example, time series are readily available on the black-white life expectancy gap, there is a dearth of corresponding data on trends in class disparities, whether measured by income, occupation, or educational

attainment [25]. Much of the history of thinking about inequality in the United States, including health inequality, has usually been framed in terms of race or class, but seldom both [26]. Given that the intersectionality of social circumstance and health outcomes cannot be separated, independent examination of these factors ignores their fundamental interdependence [27]. The low-income, disadvantaged, black population will likely suffer more devastating consequences from Covid-19 a likelihood that could go unacknowledged until the situation is too dire.

It is faulty to presume that public health and policy officials are overtly neglecting the potential devastation of Covid-19 on racial minorities. It could, more likely, be the results of longstanding structural racism the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups [28]. At the most fundamental level, structural racism may affect racial and ethnic mental health inequities through birth outcomes, increased exposure to air pollutants, decreased longevity, increased risk of chronic depressed, and increased rates of homicide and other crimes [29]. Or it may be simply the results of rapid progression of the disease in the US and the lack of early coordination between federal and state entities. Many suggest the US response has been slow and fraught with mixed messaging about the extent, severity and potential impact of the condition and need for social distancing [30]. The lack of federal and state coordination resulted in significant non-compliance even after states started to implement social distancing guidelines [31-35]. When these combinations of errors occur on a wide scale, racial-ethnic minorities and other marginalized populations are the most likely to be impacted both short and long term [36-38]. Consequently, the US should utilize lessons learned from the study of racial-ethnic disparities over many decades in America and urgently collect race-ethnicity data to limit the likely impact on racial-ethnic minorities nationwide.

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