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THE CURRENT: Why are Black Americans more likely to die from COVID-19?

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PITA: You're listening to The Current, part of the Brookings Podcast Network. I'm your host, Adrianna Pita.

Part of the psychological weight of life during a pandemic is the daily and weekly rollcall of rising death tolls and infection rates. Much as the crisis has exposed systemic weaknesses in the U.S. healthcare system, and worker and unemployment protections, it's also highlighting deep racial inequities, as seen in the disproportionate number of Black Americans among the sick and the dying.

With us to discuss the racial gap in COVID-19 deaths – and most importantly, what to do about it – is Rashawn Ray, a David M Rubenstein fellow in Governance Studies here at Brookings. Rashawn, thanks for talking to us today.

RAY: Thanks for having me on the show; I really appreciate it.

PITA: I think many people familiar with the more everyday existing racial gaps in health care access, health outcomes, but in the cities and states that are tracking this information, the difference in the ratio of Black people as a percentage of their local populations compared to their representation in the infection and death rates is really staggering. So that everyone knows what we're talking about, are on the same page, maybe you could start us off with some of these numbers.

RAY: Yes, the racial gap we're seeing in COIVD-19 diagnoses as well as deaths, as you noted, is extremely staggering. If you look at the states I analyzed in my recent articles on FixGov, is if you look at Michigan, Wisconsin, Illinois, and Louisiana, we actually see that Blacks are 74% more likely to be diagnosed with COVID-19. In St. Louis, for example, nearly all of the deaths from COVID-19 have occurred among Black Americans. In Louisiana, as well as in the city of Chicago, as well as Milwaukee county, about 70% of the people who die from COVID-19 are Black Americans. So, we're seeing huge racial gaps that don't necessarily seem to be about pre-existing health conditions or other sort of behavioral outcomes that people might try to attribute to deaths in this regard.

PITA: Yes, you've written about the multitude of factors contributing to these disparities. It can be everything from the types of jobs Black Americans hold to where they live, as well as other issues deep-rooted in systemic racism. Why don't you tell us about these factors?

RAY: Yes, that's exactly right. What the research shows – and it's overwhelmingly in the academic literature, public health literature show this – is that structural conditions undergird pre-existing health conditions. Not only that, structural conditions also impact health care access, and then

racism, and structural racism in particular, impact people's ability to get high-quality social interactions from health care providers once they get to hospitals and urgent care clinics.

So breaking it down, what that means is, if you look at an average, predominantly Black community, compared to an average, predominantly white community, or predominantly affluent community, what we see are Black neighborhoods are less likely to have green spaces, less likely to have healthy food options, less likely to have recreational spaces, less likely to have high-quality health care access. They pretty much don't have hospitals; they don't have urgent care clinics. They also don't have pharmacies, or high-level pharmacies, so that when they actually get a prescription, that the pharmacy will actually have the medicine they need on the spot.

Black neighborhoods also oftentimes are located in more urban areas, more dense areas, like New York City, but then also even in rural communities they often don't have this level of health care access. If we look at rural America – the deep South hasn't even been hit hard yet, outside of New Orleans and Louisiana – most counties in the deep South and rural America do not have one hospital bed. Now, part of that has to do with the lack of population in those areas, but it also has to do with the fact that in some of these states and some of these counties, they actually chose to deny some of the Affordable Care Act funding that would provide more universal health care coverage. So, we have to look at this in its totality.

You also mentioned work. Black Americans are overrepresented when it comes to these "new essential workers." People who work in grocery stores, people who work in transit – bus drivers, train drivers – people who work in restaurants, people who work in cleaning services, also people who work in cleaning services in health care facilities, health care aides, and the like. So, it seems this overrepresentation there, combined with the structural dynamics of people's communities, leads to Black people being more exposed, and then more likely to contract and die from COVID-19.

PITA: So many of these issues are these large-scale, really deep-seated problems that have existed for decades. And when it's time to think about how to fix things caused by these systemic problems, these aren't things that have quick fixes, right? Structural change doesn't get implemented overnight. But in the middle of a pandemic, we need to find at least some faster solutions, while also laying the groundwork for longer-term reform. I'm going to ask you to break that down into two parts. What are some of the more immediate responses that are options for cities and states to be looking at?

RAY: In one of the articles I recently wrote about how do we reduce the racial gap in COVID-19 deaths, what I laid out were essentially long-term solutions. On the short-term side, there are a few things that can be done. The first thing that needs to happen is we need better demographic data. We're starting to see this in some places – that's how we got to this point. People were extremely shocked because they could see that COVID-19 was an equal-opportunity disease. Well, just because it's an equal-opportunity disease does not mean that our health care system and our broader society is an equal-opportunity society; instead it's deeply embedded with structural inequality, as you mentioned.

So, the first thing deals with testing, and not just collecting data on race, but collecting data on age, race, place, and other factors. One thing that we know is that race is intrinsically tied to place. We can learn a lot about people from the zip code that they live in. We've seen that in a place like Maryland, which has a more affluent Black population compared to the rest of the country, we're still seeing these particular neighborhoods being hit extremely hard as it relates to COVID-19. So, testing is key.

The second thing is, we need triage places, testing and triage places, in predominantly Black neighborhoods. This deals with a couple of things: the first thing it deals with is health care access. The second thing it deals with is the fact that studies show – and I've done some of this research on medical mistrust – that when Black Americans go to seek health care, they are more likely to be spoken to rather than spoken with. A lot of affluent Americans, and oftentimes white Americans, are accustomed to their health care providers talking with them, having a conversation. That is not the reality for Black Americans. So not only is mistrust a problem, but then it means Black people might be less likely to seek health care. Part of putting testing and triage places in Black neighborhoods also means that, what's going to happen is, you can put these places in, say Black churches. Part of what that does is it deals with medical mistrust, it helps to create these health equity zones, or as President Obama would say, these promise zones, to actually deal with a host of things. Black churches are already giving out hundreds of sack lunches. They are giving out laptops to kids. We can also do testing and triage, and we'll see numbers pick up.

COVID-19 and outbreaks and pandemics like this aren't just about the numerators. It's not just about how many people are contracting the disease. It's also about how many are being tested. Who might be immune, who might have antibodies built up? So, these are some of the short-term things.

Workers also need hazard pay and paid leave. What's happening is, you might have a grocery store worker – this happened right outside of DC in Prince George's County – a 27-year-old grocery store worker was going to work. Couldn't afford to take off, because they don't have any sick leave or any paid leave. Contracted the virus, brought it back to her family. She ended up passing away because she sought a test, was denied a test, and was essentially sent home to die. So, these are the manifestations of what happen for Black Americans that don't happen for others, and these solutions can do a lot to solving the racial gaps in COVID-19.

PITA: Absolutely. Are there any cities or counties that are starting to take some steps to address these issues? Maybe they're stepping up their tracking, or starting to put some of these policies into place?

Yes, there are some places that are doing a good job. There are three states that have done a really good job. They're spread out and they have different political ideologies, which I think is really important. On the West Coast, there's California, which has done a really, really good job statewide and locally, with Gavin Newsom and the mayors of San Francisco and Los Angeles. In the middle of the country, you have Ohio. That governor has done a great job and locked it down. Part of thinking about California and Ohio, they're very important from a demographic standpoint because they do not show the same racial gap that other places do. Cleveland has a lot of the same structural inequities that other cities do, like Milwaukee and St. Louis. What that means from a research standpoint is that's a place we need to go. We need to know why are we not seeing the racial gap there, and how can we replicate it in other places. Finally, Governor Hogan in Maryland has done a really good job. He set up a large testing site in Prince George's county, the most affluent predominantly Black neighborhood in the United States, at FedEx Field, where the Washington Redskins play, and I think that's a reason why we're seeing lot of testing, a lot of spikes in cases, in the state of Maryland and Prince George's county has a lot to do with that. So, in the short-term it looks bad, but in the long-term it's a good thing. So, we're seeing this layering up of resources and thinking consciously about using neighborhood resources to deal with this pandemic.

PITA: And when we're looking at longer-term solutions and the role of the federal government versus local governments, what are some of the options there?

RAY: The federal government has continued to step in a really, really big way. Part of this is important because, up to this point, policies that have been enacted federally as well as state and locally in a lot of ways have been taking a colorblind approach. I argue that that's the wrong approach to take. When you live in a society that is not colorblind, you can't have colorblind policies. Instead what we need are health equity policies. Policies that empower people and empower places that are continually disenfranchised. So, from a federal government standpoint, not only do we need to think about these "new essential workers," seeing just how important they are to our lives, as it relates to hazard pay, paid leave, and sick leave.

But then we also need to be thinking about universal health care. Part of thinking about universal health care is they need to really expand the Affordable Care Act. When I was a Robert Wood Johnson Foundation health policy scholar at UC Berkeley, the Affordable Care Act was just being rolled out. And a lot of the provisions put in the Affordable Care Act, the original drafting of that legislation, really helped to reduce a lot of health care expenditures and improve health care access and quality. This is important for people, because the U.S. spends 25% more on health care than any other country in the world per capita. And that's important because the U.S. also has some of the most extreme forms of health care inequality. So while we might be able to simply go to the doctor, get our prescription on the spot, go home and start being well, these low-wage workers who are putting their lives on the line so we can stay at home and make brownies with our kids don't have that same access. So, I think longer-term, universal health care needs to be put in place.

We also need a living wage, which means the minimum wage needs to be raised. In Tennessee, the minimum wage is $7.25. That's less than $1200/month before taxes. The average rent in the city of Nashville is $1400-1500. People cannot afford to live on that. So, we need a living wage. I do think part of that is a guaranteed income for people as they put their lives on the line to help us, that we are also doing something in return to make sure that they can put food on the table.

PITA: This is all fantastic stuff, Rashawn, thanks so much for telling us about this. What are you going to be keeping your eye out for next?

RAY: The big thing I'm going to be keeping my eye out for is whether or not we start to see a change in focus from a colorblind approach to a health equity approach. If we look at Governor Cuomo, it seems like that he read my article or some other people's work that's really pinpointed these structural factors, because one of the things he said recently is that they're going to start ramping up testing and triage places in predominantly Black and Latino neighborhoods. And that's exactly what needs to happen, because in a city like New York, where they have reduced public transit, what that means is the trains still run, the buses still run, they just run less frequently. Well, now you're stripping away the main mode of transportation for essential workers: people who work in hospitals, people that are working in grocery stores, sanitation workers. They're being further exposed because there's no way they can practice social distancing based on the number of people who are on those trains.

So, I'm looking for more health equity approaches. I'm also looking to see if we're going to see a ramp-up of testing and triage in predominantly Black communities so people can get the testing they

need, and so they can get the medication and care they need so we can reduce the number of people who are dying from COVID-19.

PITA: We'll hope for that. Thanks again for your time today. We'll have links to your pieces in the show notes and we'll look forward to what else you have to say next.

RAY: Thank you for having me, I really appreciate it.