

African Americans are contracting and dying from COVID-19 at higher rates. **We know why.**

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Executive Summary

African Americans are disproportionately contracting and dying from COVID-19.

- Data from states such as Michigan, Illinois, New York, Alabama and Louisiana show that the percentage of African Americans who have been diagnosed with and died from COVID-19 is considerably higher than their representation as a percentage of the population.
- If current trends hold, 162 African Americans will die from COVID-19 in North Carolina—70 more than would be expected to die based solely on the state’s demographic makeup.

Historical discriminatory policies and practices, as well as the nation’s failure to value its “essential workers,” have put African Americans at greater risk.

- African Americans are more likely than white Americans to work jobs—even multiple jobs—that do not offer health insurance. Many of these workers fall into the “coverage gap,” meaning they earn too much to qualify for Medicaid and too little to qualify for financial assistance under the Affordable Care Act.
- African Americans are overrepresented in occupations now deemed essential to the wellbeing of the nation, such as food service, food production, home health care and nursing home care. These jobs put the people who work them at higher risk for contracting the coronavirus.
- Neighborhoods and counties with high populations of people of color have fewer health care providers and grocery stores, as well as lower air and water quality due to the legacy of environmental discrimination. As a result, African Americans have a higher rate of conditions that make COVID-19 more deadly, such as diabetes, chronic lung disease and hypertension.

State lawmakers should immediately approve Medicaid expansion, which would reduce African American deaths from COVID-19 and long-term measures to improve the health of African American individuals and communities.

- Approving Medicaid expansion is the most impactful step North Carolina lawmakers can take to both protect African Americans from the lethal effects of COVID-19 and improve the health and resiliency of African American communities, making them better able to combat this and future outbreaks.
- Expanding Medicaid would provide a much-needed financial boost to rural hospitals, which currently face high costs for uncompensated care, and improve the health outcomes of rural communities.

In what seems like a decade ago, the Chinese government reported a cluster of mysterious cases of pneumonia in Wuhan, Hubei Province on December 31, 2019. This would eventually be identified as novel coronavirus, a zoonotic virus that had passed from animal to human.¹

Half a world away, Jason Hargrove, an African American bus driver for the city of Detroit, was likely spending New Year's Eve with his family, unaware of the emerging threat to his very life. Almost exactly three months later, Jason died from complications from COVID-19, the disease caused by the coronavirus.² While the rapid transmission of the disease, its unpredictable lethality and lack of coordinated mitigation are all incredibly tragic, Jason's death was likely a result of compounding inequities that leave many communities of color disproportionately susceptible to harm from pandemic.



Jason Hargrove and wife Desha Johnson-Hargrove³

The Disproportionate Impact on African American Communities

By the beginning of April, Americans had a tragic view of the toll COVID-19 was taking across the country. New tallies of infections and deaths, unthinkable three months ago, arrive with jarring regularity.

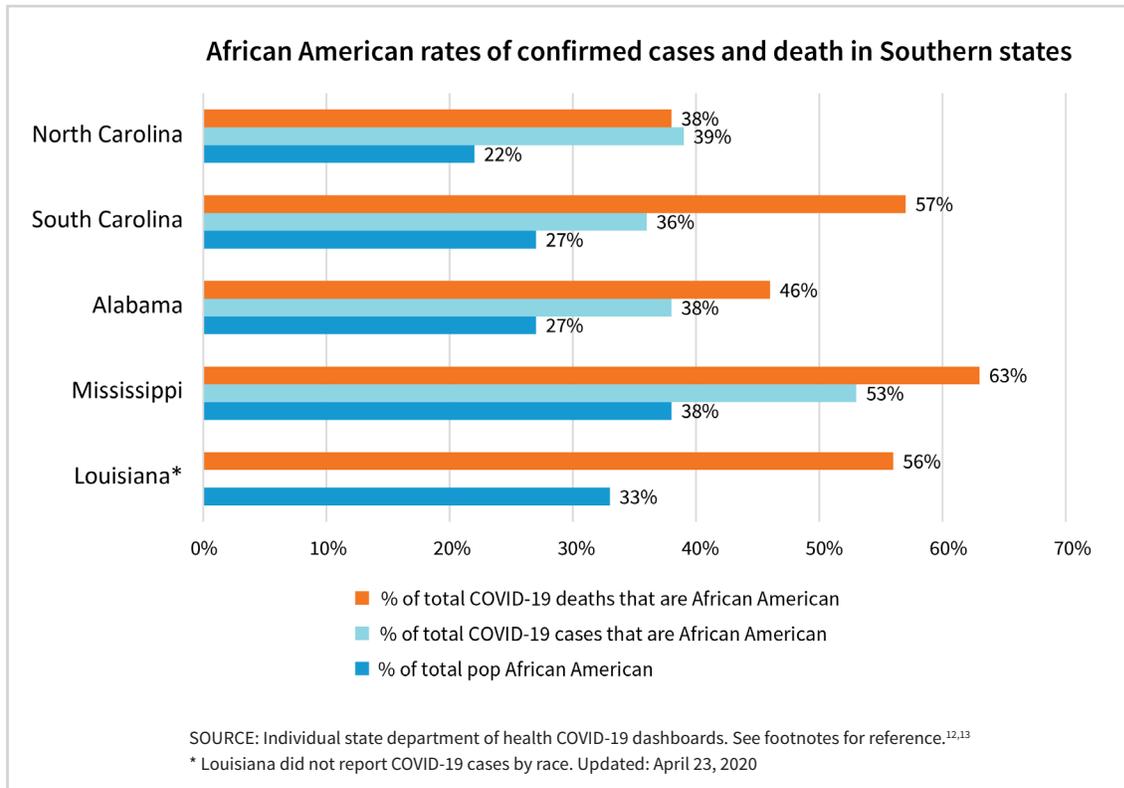
In many places throughout the country, people of color are contracting and dying from COVID-19 disproportionately. The Centers for Disease Control and Prevention is not currently tracking racial and ethnic data for COVID-19 cases across the country, so it could be weeks before the agency is able to report on and formally acknowledge the depths of this problem.⁴ However, data from states and cities paint a disturbing picture of the coronavirus's impact on African American communities.

In Jason Hargrove's home state of Michigan, African Americans make up 14 percent of the population, but they account for 33 percent of confirmed COVID-19 cases and 40 percent of deaths.⁵ Tragically, this disparity is evident in other states and cities:

- In Illinois, African Americans are 15 percent of the state's population but make up 26 percent of the infections and 42 percent of the deaths.⁶ In Chicago specifically, African Americans account for 40 percent of COVID-19 cases and 62 percent of deaths, even though they comprise only 30 percent of the population.⁷
- In New York City, where the population is nearly 24 percent African American, 33 percent of COVID-19 related deaths are attributed to the group.⁸
- In St. Louis, Missouri, the health director reported on April 8, 2020 that all 12 of the city's

residents who had died of COVID-19 (100 percent) were African American.⁹

- Alabama reported on April 11, 2020 that African Americans, who make up 27 percent of the state, accounted for 37 percent of COVID-19 cases and 54 percent of deaths.¹⁰
- In Louisiana, 59 percent of COVID-19 deaths are attributed to African Americans, who make up 33 percent of the state.¹¹



Here in North Carolina, African Americans, who are 22 percent of the state’s population, make up 38 percent of COVID-19 cases and 37 percent of infection-related deaths.¹⁴ According to a University of Washington model, deaths in North Carolina could reach 416 by August 4, 2020.¹⁵ If racial disparity trends hold, African Americans in NC could make up 162 of those deaths—70 more than would be expected if COVID-19’s impact were consistent with the state’s demographic makeup.

Current and Historic Policies Creating Today’s COVID-19 Crisis in African American Communities

As a society we are having a national conversation about why Black people are dying from COVID-19 at higher rates than peer groups. This conversation, however, should not be undertaken without first acknowledging the ever present and insidious role of white supremacy: the ideology necessary to justify bondage of human beings, exploitation of their labor, implementation of Jim Crow and the denial of the compounded impact these systems have had on every facet of present-

day African American life, to include health.¹⁶ This ideology has produced a legacy of intentionally harmful health policy; from the under-resourced medical division of the Freedman's Bureau in the late 1860s which only deployed 120 doctors across the post-Civil War South to the present-day decision of many southern states to refuse expansion of Medicaid although many of their residents would have benefitted.¹⁷ Research holds that these and other far reaching policy decisions were motivated by racial resentment which affects present day African American employment outcomes, neighborhood health care infrastructure, patient experience, community access to healthy foods and environmental quality.^{18,19} All of these factors contribute to differential access to quality health care, clean air and water, and nutritious food which by extension, lead to severe health conditions for African Americans in the context of COVID-19.

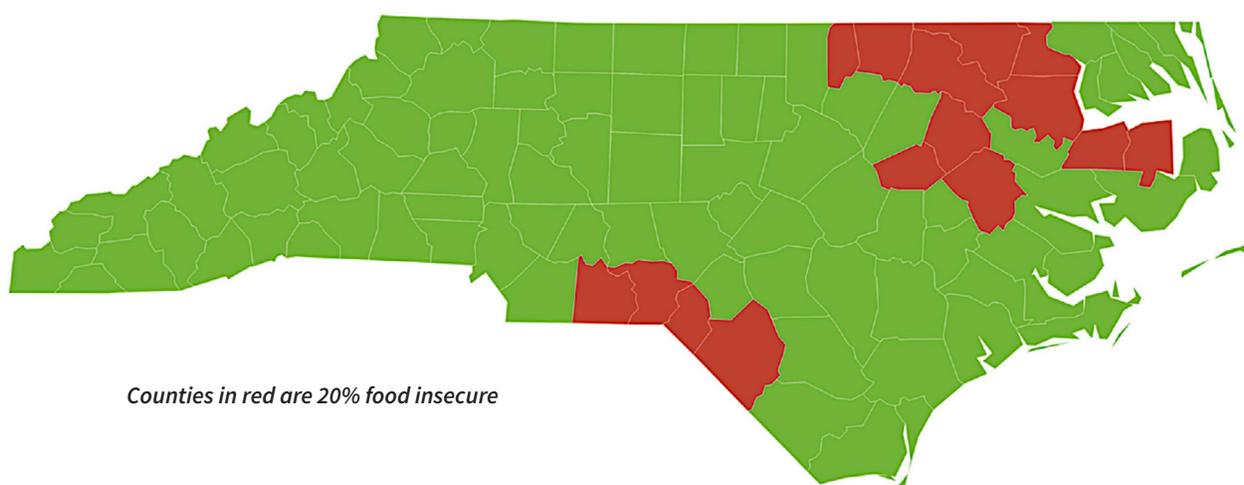
Differing employment outcomes and higher rates of being uninsured. Most nonelderly adults get their health insurance through an employer.²⁰ But African Americans make up a disproportionate share of the country's unemployed or underemployed population, so they are less likely to receive employer-sponsored health insurance.²¹ Nine years after the peak of the Great Recession, the unemployment rate for African Americans (6.6%) was twice that of Whites (3.3%).²² Additionally, because the African American underemployment rate is higher than other groups, they are more likely to work multiple low- to medium-wage jobs that do not offer health insurance.²³ Because legislative leaders in North Carolina have refused to expand Medicaid, these workers often fall in the coverage gap—they make too little to qualify for financial assistance on the Affordable Care Act (ACA) marketplace but too much to qualify for Medicaid.

Isolation from health care providers. Lack of health insurance in the African American community is compounded by the paucity of neighborhood comprehensive health centers. For communities of color hospitals and specialty centers are simply farther away and not supported by robust public transit options. This is particularly an issue for rural, northeastern North Carolina counties where African Americans often make up the majority of the population. Since 2010, seven rural hospitals in North Carolina have closed, three of them in the eastern part of the state.²⁴ North Carolina now has 17 counties without a state-licensed hospital, 11 of which are in eastern North Carolina, and 7 of those counties have populations that are more than 30 percent Black.²⁵ This, coupled with higher rates of uninsurance, means it is less likely that African Americans in rural North Carolina are able to maintain regular check-ups, attend follow-up visits or fill prescription medications. This puts them at greater risk for complications from easily treatable and preventable diseases and potentially catastrophic illnesses, like COVID-19.

Poor patient experience. When African Americans do receive medical care, providers often ignore or downplay their symptoms and concerns, putting them at risk of misdiagnoses and other deleterious implications. In the tragic case of Jason Hargrove, three days before his death and during his second trip to the hospital, he and his wife raised serious concerns about his cuticles turning blue from lack of oxygen. They were told there was “no reason to do anything” and sent him home.²⁶ Taken on its own this can be seen as poor medical advice, but put in the context of the plethora of other examples of racial bias in health care it demonstrates a damaging pattern. The medical field's long-standing bias toward minimizing and discounting the health concerns of African Americans is so embedded that even an algorithm designed to predict when patients would benefit from extra care was found

to “dramatically and consistently” underestimate when sick black patients needed specialized attention.²⁷

Food insecurity and chronic illness. For decades, Black neighborhoods have struggled with food insecurity, defined as when families lack access to nutritious foods.²⁸ The intersection between concentrated poverty and the absence of capital investment for grocery stores in neighborhoods of color have left thousands of North Carolinians relying upon fast food and convenience stores for sustenance. In North Carolina, there are 15 counties where food insecurity strikes more than 20 percent of their population every night.²⁹ With the exception of Robeson County, these 15 communities all have African American populations significantly higher than the state average.³⁰ Neighborhoods without access to fruits, vegetables and fresh meat put families at greater risk to developing hypertension, obesity and heart disease. Diabetes, chronic lung disease, hypertension and cardiac disease have emerged as the most common underlying risk factors contributing to death from COVID-19.³¹



Environmental racism. Compromised air and water quality in African American communities due to industrial pollution are often a byproduct of lack of regulatory oversight and environmental racism.³² Industries that generate potentially life-threatening pollutants are often located in or near communities of color. According to the UNC Center for Civil Rights, nearly 25 percent of North Carolinians live within one mile of a major pollution site listed on the Environmental Protection Agency’s Facility Registry, but 44 percent of residents of African American clusters live within one mile of these pollution sources.³³ Royal Oak located inside Supply, NC (Brunswick County) has had water and sewer infrastructure denied by county leadership while having to fight a landfill expansion within the community.³⁴ While Royal Oak was successful in their fight against landfill expansion, many other Black communities are not and as a result are exposed to more pollutants. In turn, this exacerbates the risk for the development of chronic diseases such as cancer and asthma, conditions that undermine survival from COVID-19 infection.

Essential workers. African American workers are much more likely to be deemed “essential” putting them at risk to exposure to COVID-19. Throughout the country they are overrepresented in occupations such as food service and production work, which have less flexibility to “work

from home” and effectively quarantine.³⁵ In fact, research show that only 20 percent of African Americans work jobs that allow them to work from home, compared to 30 percent of Whites.³⁶ The Bureau Labor Statistics reveals African Americans have high employment rates in postal service, home health aides, correctional officers and jail guards – all occupations that often require physical proximity to others.³⁷ Employment trends, driven by historical precedent and inequity, have created tough choices for African Americans across the state, many choosing to risk infection in order to maintain employment.

Potential Solutions

While there are numerous policy prescriptions that can address both the racist legacy undergirding health disparities and the immediate response to COVID-19, the obvious first step is the expansion of Medicaid. It would immediately provide health insurance to more than 500,000 North Carolinians, create jobs and provide a much-needed boost to urban and rural hospitals.^{38,39}

African Americans make up 34 percent of uninsured adults eligible for Medicaid with universal expansion.⁴⁰ Additionally, expanding Medicaid in North Carolina would help narrow health disparities as coverage would provide access to early detection for diseases like prostate and cervical cancer, both which offer positive prognosis when detected early.⁴¹ For low income, uninsured African Americans facing possible symptoms of COVID-19, access to Medicaid would eliminate the fear of cost sharing, making it more likely they would seek treatment, obtain medical advice and prevent potential spread.⁴²

Lastly, Medicaid expansion would do much to address the challenge rural hospitals face with uncompensated care. In North Carolina, expansion would generate more than \$1.8 billion yearly in hospital reimbursements, \$665 million in Medicaid payments annually for rural hospitals.⁴³ For rural hospitals on the precipice of closure this could bolster their viability in the face of COVID-19.

Another strong step in the right direction is addressing food deserts. It is far past time to rely on the market to address the public health good. If private capital does not find it profitable to serve food deserts like the Murchison Road corridor in Fayetteville, then a solution might be for city, county and/or state leaders to establish cooperative-based grocery stores. These food centers could serve the community with fresh produce, meat and seafood sourced by farmers, fishermen and producers of color. The benefits would be far-reaching and would position generations for healthier futures. This is not without precedent. In Baldwin, Florida the last commercially owned grocery store closed in 2018, leaving roughly 1,600 residents in a food desert.⁴⁴ The municipal government recognized the need for its residents and established the Baldwin Market, a publicly operated grocery store, which is resourced and staffed by the town. To date the model has served the community well.⁴⁵

In 2020, no worker in this country should be relegated to an essential status and not be compensated for potential exposure to a disease for which there is no cure. Essential status should come with hazard pay, particularly in the context of a pandemic. US Senate Democrats have introduced a proposal called the “Heroes Fund” for the next stimulus package which would

position the federal government to finance premium pay of \$25,000 for frontline workers.⁴⁶ This is an important first step, but a societal reevaluation of how workers are deemed “essential” and their own role in that determination is long overdue. Furthermore, should an “essential” worker not find it in their health interest to work in the midst of a pandemic, either due to a compromised immune system or the preservation of their mental health, they should not be adversely affected by their decision to stay healthy and stay home.

Conclusion

This brief has provided three simple public policy suggestions and there are many more that address health disparities in North Carolina, the South and across the country.⁴⁷ What may matter more in this fight against COVID-19 and the disproportionate toll it is having on African Americans is a recognition of the interconnectedness we all share as human beings in the social and economic fabric of the state. When policymakers oppose Medicaid expansion, its impact is not only felt by the uninsured and rural hospitals, but also by the attorney who takes his coffee at his favorite diner in the morning. If the uninsured waitress serving him is feeling ill from early symptoms of COVID-19 but does not seek treatment because of out-of-pocket costs, then the attorney who has coverage is also at risk for infection. Industrial bad actors belching airborne pollutants into the atmosphere or leaking carcinogens in river systems cannot ensure their byproducts stay in the communities of color in which they often reside. These chemicals travel for hundreds of miles putting all North Carolinians at greater risk for asthma and cancer, both comorbidities for COVID-19.⁴⁸

Americans in general are far too comfortable dismissing the full impact that structural and institutional racism has wrought on communities of color. These structures of marginalization reinforce and amplify each other creating a dystopian reality, one that perpetuates health disparity which in this moment in time is literally killing Black and Brown people.

As North Carolinians we are all truly in this together. Being comfortable with the adage “when this advantaged group catches a cold, this disadvantaged group catches the flu”, isn’t just guidance for bad public policy, it’s bad human nature.

It also means, that eventually, we are all more likely to catch the flu.

Endnotes

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