Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

COVID-19 in Racial and Ethnic Minority Groups

The effects of COVID-19 on the health of racial and ethnic minority groups is still emerging; however, current data suggest a disproportionate burden of illness and death among racial and ethnic minority groups. A recent CDC MMWR report included race and ethnicity data from 580 patients hospitalized with lab-confirmed COVID-19 found that 45% of individuals for whom race or ethnicity data was available were white, compared to 55% of individuals in the surrounding community. However, 33% of hospitalized patients were black compared to 18% in the community and 8% were Hispanic, compared to 14% in the community. These data suggest an overrepresentation of blacks among hospitalized patients. Among COVID-19 deaths for which race and ethnicity data were available, New York City identified death rates among Black/African American persons (92.3 deaths per 100,000 population) and Hispanic/Latino persons (74.3) that were substantially higher than that of white (45.2) or Asian (34.5) persons. Studies are underway to confirm these data and understand and potentially reduce the impact of COVID-19 on the health of racial and ethnic minorities.

Factors that Influence Racial and Ethnic Minority Group Health:

Where We Live, Learn,
Work, and Play Affects Our Health

The conditions in which people live, learn, work, and play contribute to their health. These conditions, over time, lead to different levels of health risks, needs, and outcomes among some people in certain racial and ethnic minority groups.

Health differences between racial and ethnic groups are often due to economic and social conditions that are more common among some racial and ethnic minorities than whites. In public health emergencies, these conditions can also isolate people from the resources they need to prepare for and respond to outbreaks.[1,13, 14]

Living conditions

For many people in racial and ethnic minority groups, living conditions may contribute to underlying health conditions and make it difficult to follow steps to prevent getting sick with COVID-19 or to seek treatment if they do get sick.

- Members of racial and ethnic minorities may be more likely to live in **densely populated areas** because of institutional racism in the form of residential housing segregation. People living in densely populated areas may find it more difficult to practice prevention measures such as social distancing.
- Research also suggests that racial residential segregation is a fundamental cause of health disparities. For example, racial **residential segregation** is linked with a variety of adverse health outcomes and underlying health conditions.[2-5] These underlying conditions can also increase the likelihood of severe illness from COVID-19.
- Many members of racial and ethnic minorities live in neighborhoods that are **further from grocery stores and medical facilities**, making it more difficult to receive care if sick and stock up on supplies that would allow them to stay home.
- **Multi-generational households**, which may be more common among some racial and ethnic minority families[6], may find it difficult to take precautions to protect older family members or isolate those who are sick, if space in the household is limited.
- Racial and ethnic minority groups are **over-represented in jails, prisons, and detention centers**, which have specific risks due to congregate living, shared food service, and more.

Work circumstances

The types of work and policies in the work environments where people in some racial and ethnic groups are overrepresented can also contribute to their risk for getting sick with COVID-19. Examples include:

- **Critical workers:** The risk of infection may be greater for **workers in essential industries** who continue to work outside the home despite outbreaks in their communities, including some people who may need to continue working in these jobs because of their economic circumstances.
    - Nearly a quarter of employed Hispanic and Black or African American workers are employed in service industry jobs compared to 16% of non-Hispanic whites.
    - Hispanic workers account for 17% of total employment but constitute 53% of agricultural workers; Black or African Americans make up 12% of all employed workers, but account for 30% of licensed practical and licensed vocational nurses.[7]
- **A lack of paid sick leave:** Workers without **paid sick leave** might be more likely to continue to work even when they are sick for any reason. This can increase workers exposure to other workers who may have COVID-19, or, in turn, expose others them if they themselves have COVID-19. Hispanic workers have lower rates of access to paid leave than white non-Hispanic workers.[8]

Underlying health conditions and lower access to care

Existing health disparities, such as poorer underlying health and barriers to getting health care, might make members of many racial and ethnic minority groups especially vulnerable in public health emergencies like outbreaks of COVID-19.

- **Not having health insurance:** Compared to whites, Hispanics are almost 3 times as likely to be uninsured, and African Americans are almost twice as likely to be uninsured.[9] In all age groups, blacks were more likely than whites to report not being able to see a doctor in the past year because of cost.[10]
- Inadequate access is also driven by a long-standing distrust of the health care system, language barriers, and financial implications associated with missing work to receive care.
- **Serious underlying medical conditions:** Compared to whites, black Americans experience higher death rates, and higher prevalence rates of chronic conditions.[10]
- **Stigma and systemic inequalities** may undermine prevention efforts, increase levels of chronic and toxic stress, and ultimately sustain health and health care disparities.

What Can Be Done

History shows that severe illness and death rates tend to be higher for racial and ethnic minority groups during public health emergencies.[12] Addressing the needs of vulnerable populations in emergencies includes improving day-to-day life and harnessing the strengths of these groups. Shared faith, family, and cultural institutions are common sources of social support. These institutions can empower and encourage individuals and communities to take actions to prevent the spread of COVID-19, care for those who become sick, and help community members cope with stress. For example, families, churches and other groups in affected populations can help their communities face an epidemic by consulting CDC guidance documents for their organization type.

The Federal government is undertaking the following:

- Collecting **data to monitor and track disparities** among racial and ethnic groups in the number of COVID-19 cases, complications, and deaths to share broadly and inform decisions on how to effectively address observed disparities. These data will be translated into information to improve the clinical management of patients, allocation of resources, and targeted public health information. Supporting **partnerships** between scientific researchers, professional organizations, community organizations, and community members to address their need for information to prevent COVID-19 in racial and ethnic minority communities.
- Providing clinical guidance and guidance to support actions to slow the spread of COVID-19 in schools, workplaces and community settings, including those serving racial and ethnic minorities.

Public health professionals can do the following:

- Ensure that **communications** about COVID-19 and its impact on different population groups is frequent, clear, transparent, and credible.
- Work with other **sectors**, such as faith and community education, business, transportation, and housing organizations, to share information and implement strategies to address social and economic barriers to implementing steps to slow the spread of COVID-19.

- **Link** more people among racial and ethnic minority groups **to healthcare services** for serious underlying medical conditions — for example, services to help them obtain necessary medications, follow treatment plans, or get testing and treatment if they have COVID-19 symptoms.
- **Provide information for healthcare professionals and health systems** to understand cultural differences among patients and how patients interact with providers and the healthcare system. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.
- Use **evidence-based strategies** to reduce health disparities. Those most vulnerable before an emergency are also the most vulnerable during and after an emergency.

Community organizations can do the following:

- **Prepare community health workers** in underserved racial and ethnic minority communities to educate and link people to free or low-cost services.
- **Prioritize resources** for clinics, private practices, and other organizations that serve minority populations.
- Leverage effective **health promotion programs** in community, work, school, and home settings to disseminate recommendations and information about COVID-19.
- **Work across sectors** to connect people with services, such as grocery delivery or temporary housing, that help them practice social distancing. Connect people to healthcare providers and resources to help them get medications they may need.
- To prevent the spread of COVID-19, **promote precautions** to protect individuals in your community, including the correct use of cloth face coverings and equip communities with supplies to make them.
- Help combat the spread of rumors and misinformation by **providing credible information** from official sources.

Healthcare systems and healthcare providers can do the following:

- Implement **standardized protocols** in accordance with CDC guidance and quality improvement initiatives, especially in facilities that serve large minority populations.
- Identify and **address implicit bias** that could hinder patient-provider interactions and communication.[11]
- Provide **medical interpretation services** for patients who need them.
- Work with communities and healthcare professional organizations to **reduce cultural barriers to care**.
- **Connect patients with community resources** that can help older adults and people with underlying conditions adhere to their care plans, including help getting extra supplies and medications they need and reminders for them to take their medicines.
- **Learn about social and economic conditions** that may put some patients at higher risk for getting sick with COVID-19 than others — for example, conditions that make it harder for some people to take steps to prevent infection.
- Promote a trusting relationship by **encouraging patients to call and ask questions**.

What Individuals Can Do

- **Follow CDC's Guidance for seeking medical care** if you think you have been exposed to COVID-19 and develop a fever, cough or difficulty breathing. Follow steps to prevent the spread of COVID-19 if you are sick.
- If you or someone you care for is at higher risk of getting very sick from COVID-19, **take steps to protect them and you from getting sick**.
- **Take precautions** to protect yourself, your community, and others.
- **Cope with stress** to make yourself, the people you care about, and your community stronger.
- **Find ways to connect** with your friends and family members and engage with your community while limiting face-to-face contact with others.

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Resources

Schools, Workplaces & Community Locations

CDC's Office of Minority Health and Health Equity

Healthypeople.gov: Social Determinants of Health

Health System Transformation and Improvement Resources for Health Departments

Strategies for Reducing Health Disparities

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