

Introduction

We all have been affected by the current COVID-19 pandemic. However, the impact of the pandemic and its consequences are felt differently depending on our status as individuals and as members of society. While some try to adapt to working online, homeschooling their children, and ordering food via Instacart, others have no choice but to be exposed to the virus while keeping society functioning. Our different social identities and the social groups we belong to determine our inclusion within society and, by extension, our vulnerability to epidemics.

COVID-19 is killing people on a large scale. As of October 10, 2020, more than 7.7 million people across every state in the United States and its four territories had tested positive for COVID-19. According to the *New York Times* database, at least 213,876 people with the virus have died in the United States.^[1] However, these alarming numbers give us only half of the picture; a closer look at data by different social identities (such as class, gender, age, race, and medical history) shows that minorities have been disproportionately affected by the pandemic. These minorities in the United States are not having their right to health fulfilled.

According to the World Health Organization's report *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, "poor and unequal living conditions are the consequences of deeper structural conditions that together fashion the way societies are organized—poor social policies and programs, unfair economic arrangements, and bad politics."^[2] This toxic combination of factors as they play out during this time of crisis, and as early news on the effect of the COVID-19 pandemic pointed out, is disproportionately affecting African American communities in the United States. I recognize that the pandemic has had and is having devastating effects on other minorities as well, but space does not permit this essay to explore the impact on other minority groups.

Employing a human rights lens in this analysis helps us translate needs and social problems into rights, focusing our attention on the broader sociopolitical structural context as the cause of the social problems. Human rights highlight the inherent dignity and worth of all people, who are the primary rights-holders.^[3] Governments (and other social actors, such as corporations) are the duty-bearers, and as such have the obligation to respect, protect, and fulfill human rights.^[4] Human rights cannot be separated from the societal contexts in which they are recognized, claimed, enforced, and fulfilled. Specifically, social rights, which include the right to health, can become important tools for advancing people's citizenship and enhancing their ability to participate as active members of society.^[5] Such an understanding of social rights calls

our attention to the concept of equality, which requires that we place a greater emphasis on “solidarity” and the “collective.”^[6] Furthermore, in order to generate equality, solidarity, and social integration, the fulfillment of social rights is not optional.^[7] In order to fulfill social integration, social policies need to reflect a commitment to respect and protect the most vulnerable individuals and to create the conditions for the fulfillment of economic and social rights for all.

Disproportional impact of COVID-19 on African Americans

As noted by Samuel Dickman et al.:

economic inequality in the US has been increasing for decades and is now among the highest in developed countries ... As economic inequality in the US has deepened, so too has inequality in health. Both overall and government health spending are higher in the US than in other countries, yet inadequate insurance coverage, high-cost sharing by patients, and geographical barriers restrict access to care for many.^[8]

For instance, according to the Kaiser Family Foundation, in 2018, 11.7% of African Americans in the United States had no health insurance, compared to 7.5% of whites.^[9]

Prior to the Affordable Care Act—enacted into law in 2010—about 20% of African Americans were uninsured. This act helped lower the uninsured rate among nonelderly African Americans by more than one-third between 2013 and 2016, from 18.9% to 11.7%. However, even after the law’s passage, African Americans have higher uninsured rates than whites (7.5%) and Asian Americans (6.3%).^[10] The uninsured are far more likely than the insured to forgo needed medical visits, tests, treatments, and medications because of cost.

As the COVID-19 virus made its way throughout the United States, testing kits were distributed equally among labs across the 50 states, without consideration of population density or actual needs for testing in those states. An opportunity to stop the spread of the virus during its early stages was missed, with serious consequences for many Americans. Although there is a dearth of race-disaggregated data on the number of people tested, the data that are available highlight African Americans’ overall lack of access to testing. For example, in Kansas, as of June 27, according to the COVID Racial Data Tracker, out of 94,780 tests, only 4,854 were from black Americans and 50,070 were from whites. However, blacks make up almost a third of the state’s COVID-19 deaths (59 of 208). And while in Illinois the total numbers of confirmed cases among blacks and whites were almost even, the test numbers show a different picture: 220,968 whites were tested, compared to only 78,650 blacks.

Similarly, American Public Media reported on the COVID-19 mortality rate by race/ethnicity through July 21, 2020, including Washington, DC, and 45 states. These data, while showing an alarming death rate for all races, demonstrate how minorities are hit harder and how, among minority groups, the African American population in many states bears the brunt of the pandemic's health impact.

Underlying health conditions

African Americans have historically been disproportionately diagnosed with chronic diseases such as asthma, hypertension and diabetes—underlying conditions that may make COVID-19 more lethal. Perhaps there has never been a pandemic that has brought these disparities so vividly into focus.

Doctor Anthony Fauci, an immunologist who has been the director of the National Institute of Allergy and Infectious Diseases since 1984, has noted that “it is not that [African Americans] are getting infected more often. It’s that when they do get infected, their underlying medical conditions … wind them up in the ICU and ultimately give them a higher death rate.”^[33]

One of the highest risk factors for COVID-19-related death among African Americans is hypertension. A recent study by Khansa Ahmad et al. analyzed the correlation between poverty and cardiovascular diseases, an indicator of why so many black lives are lost in the current health crisis. The authors note that the American health care system has not yet been able to address the higher propensity of lower socioeconomic classes to suffer from cardiovascular disease.^[34] Besides having higher prevalence of chronic conditions compared to whites, African Americans experience higher death rates. These trends existed prior to COVID-19, but this pandemic has made them more visible and worrisome.