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Perspective

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Structural Racism, Social Risk Factors, and Covid-19 — A Dangerous Convergence for Black Americans

Leonard E. Egede, M.D., and Rebekah J. Walker, Ph.D.

Current protests throughout the United States are highlighting the history of marginalization of and discrimination against Black Americans, including 250 years of slavery, 100 years of Jim Crow laws, high rates of incarceration, and unanswered calls for action after police shootings of unarmed Black Americans. Simultaneously, disparities in Covid-19 infections and deaths are laying bare the underlying structural racism that protestors seek to disrupt.

Structural racism — the ways in which societies foster discrimination through mutually reinforcing inequitable systems — has received little attention as a determinant of population health, in part because there is a perception that limited empirical research has been done on the subject.[1] Yet a meta-analysis of 293 studies revealed that racism is significantly associated with poorer mental and physical health.[2] Structural racism exists because discriminatory practices in one sector reinforce parallel practices in other sectors, creating interconnected systems that embed inequities in laws and policies.[1] Consequently, education, employment, housing, credit markets, health care, and the justice system mutually reinforce practices that allow or encourage discriminatory beliefs, stereotypes, and unequal distribution of resources.[1,2]

These systems affect health through a variety of pathways, including social deprivation from reduced access to employment, housing, and education; increased environmental exposures and targeted marketing of unhealthy substances; inadequate access to health care; physical injury and psychological trauma resulting from state-sanctioned violence such as police brutality and chronic exposure to discrimination; and diminished participation in healthy behaviors or increased participation in unhealthy behaviors as coping mechanisms.[1,2] The relationship between structural racism and health is not moderated by age, sex, birthplace, or education, which suggests that efforts to address it must target the entire population.[2]

Though structural racism shapes the distribution of social determinants of health and social risk factors, action within the health care system has been hampered by a lack of understanding of how to keep such variables from influencing health.[1,3,4] In addition, the discourse about social determinants often frames them as negative factors experienced by only some groups, whereas in reality, nonmedical factors can confer health bene-

Recommended Action Items for Mitigating Structural Racism.

- Change policies that keep structural racism in place.
- Break down silos and create cross-sector partnerships.
- Institute policies to increase economic empowerment.
- Fund community programs that enhance neighborhood stability.
- Be consistent in efforts by health systems to build trust in vulnerable communities.
- Test and deploy targeted interventions that address social risk factors.

fits as well as risks, and they affect everyone.[3] We need to focus on addressing both social risk factors (adverse social conditions associated with poor health) and unmet social needs (immediate social conditions that individuals identify as most pressing for them).[3,4]

The Covid-19 pandemic clearly illustrates the intersection of structural racism, social risk factors, and health. Data from the Centers for Disease Control and Prevention on Covid-19 infection and mortality rates show high incidences in specific geographic regions. Further investigation within Louisiana revealed that rates of hospitalization and death in Black patients were twice as high as would be expected on the basis of demographic representation.[5] It has been hypothesized that increased exposure to Covid-19 among Black Americans is attributable to greater representation in service occupations and a greater likelihood of living in inner cities with high population density.[4,5] However, explanatory context is needed for the structural factors that lead to such statistics.

The history of inner cities has left Black Americans with fewer economic and educational opportunities than their White counterparts and has exposed them to social risks associated with more severe negative effects. A lack of financial resources resulting from years of structural racism confers a host of social risks, including food insecurity, housing instability, and limited access to transportation. In addition, people facing these risk factors are less likely to have insurance to pay for Covid-19 testing and are more likely to avoid using the health care system because of high costs. In part because of structural factors that limit disease prevention and treatment, Black Americans also bear a higher burden of chronic disease than White Americans and thus have a higher risk of premature death.

With a concerted effort that encompasses multiple sectors, however, we can change the fabric of structural racism and social risk that leads to disparities in health. To be effective, change must occur within federal, state, county, and city governments; within private and nonprofit businesses and in the health care, food, housing, education, and justice arenas; and at the individual level. If everyone took a stand to stop racism and found a way to participate in sustainable change in one of the following six areas (see box), the result could be transformational.

First, the policies that keep structural racism in place need to be changed. It will take consistent pressure to effect radical changes in the structure and components of policies, and evidence will need to be marshaled to guide ongoing revision. We believe that multiple sectors should participate in large-scale policy interventions, and evaluation should include measurement of health outcomes to clarify effective leverage points. Education for students in the health sciences and continuing medical education for physicians should incorporate information on how the health professions intersect with other areas, the history of racism and its impact on health, and how the health field perpetuates social inequality and its relationship to health disparities; it should also emphasize an understanding of internalized scripts regarding race and ongoing self-reflection and provide training in ways of supporting organizational change.

Second, we need to break down silos and create cross-sector partnerships. One promising option is multisector, place-based partnerships that reinvest in neighborhoods.[1] This process allows multiple sectors to participate in meaningful systems-level work, builds relationships across sectors, and identifies ways to leverage and share infrastructure and financing. Funding for pilot projects should require cross-sector partners, identify barriers to sustainable expansion, and incorporate health measures as outcomes.

Third, new policies are needed to increase economic empowerment. Covid-19 has led to high rates of job loss, high exposure to SARS-CoV-2 for low-wage workers, and fear of screening, since positive results could affect employment. Though short-term solutions such as stimulus payments are important, a comprehensive and coordinated long-term response focusing on economic empowerment is needed. Barriers to educational attainment for low-

income communities need to be removed, and more jobs need to be made available to inner-city communities. Unfair housing policies and limitations on student loans for formerly incarcerated persons also need to be revised. Policies that limit intergenerational economic mobility, especially among Black Americans, also require structural change.

Fourth, community programs that build stable and supportive structures should be considered part of pandemic-recovery efforts. The type of neighborhood people live in contributes to various health outcomes, usually by affecting their access to healthy foods, safety, and exposure to environmental pollutants. Funding for community programs should support structural interventions that build resilience and alter the structural context of health, rather than merely mitigating social risk.

Fifth, health systems will need to make consistent efforts to build trust in vulnerable communities. Lack of trust in the health care system owing to a history of mistreatment, unethical experimentation, and criminal neglect toward Black Americans has led to low screening rates in Black communities because of concerns about the possible uses of test results. Community engagement and expanded access provided only during a time of national crisis will not build lasting trust. Health systems must acknowledge the concerns of Black communities, increase access for all, and expand efforts to provide educational resources.

Sixth, targeted interventions addressing social risk factors are needed. Individual choice plays a role in health, but social factors shape barriers to lifestyle change. Programs should directly address social risk and culturally tailor interventions to incorporate the preferences and needs of vulnerable populations. Coupling individual-level interventions with community-based efforts can increase sustainability and mitigate behavioral decay over time.

Given the tragic effects of the convergence of racism, social risk, and Covid-19, we hope that the U.S. experience of the pandemic becomes a call for changing the systems that perpetuate poor health.

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From the Division of General Internal Medicine, Department of Medicine, and the Center for Advancing Population Science, Medical College of Wisconsin, Milwaukee.

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