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Addressing Disparities and Inequalities in Healthcare: Disproportionate Representation of Minorities in COVID-19 Deaths as a Health and Social Injustice

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Abstract

Social inequalities exist around the world limiting a group's social, health, and economic advancement. These unfavorable conditions inhibit people from having access to essential resources such as healthcare, housing, education, employment, and transportation. Consequently, inequalities in accessing indispensable social goods generally affects diets and overall health and wellness of individuals negatively. Unfortunately, this systemic problem tends to inflict greater harm to lower-income groups disproportionately. These limitations usually result in poorer health and higher rates of health problems. Historically, existing inequalities in society are manifested in moments of crisis, and the COVID-19 pandemic (2019-2021) revealed overwhelming manifestation of this fact. The mortality rates for African Americans are more than triple the rates for whites after correcting for age, and the rates for Hispanic/Latinos are almost double the rates for non-Hispanic whites. According to the CDC's racial demographic information on COVID-19 cases and deaths, almost 23% of reported COVID-19 deaths in the U.S. are African Americans, even though blacks make up approximately only 13% of the U.S. population. This glaring revelation of the health inequities that exist in our society must be addressed. This paper examines the documented cases of significant health inequities in the U.S. including the underlying social determinants and implications that make minority groups vulnerable, contributing to their higher risk of morbidity and mortalities, and argued that healthcare is a fundamental human rights issue as stated in a 2017 WHO press release. This author contends that health inequity due to social inequity is unsustainable, and a detriment to sustainable development and provide

recommendations to address the health inequities.

Keywords: Social inequity, health inequity, health disparity, social determinants, social vulnerabilities, social justice, COVID-19

1. Introduction

1.1 Health Disparities and Social Inequalities in COVID-19 Infections and Deaths

Social inequalities exist around the world limiting a group's social, health, and economic advancement. These unfavorable conditions inhibit people from having access to essential resources such as healthcare, housing, education, employment, and transportation. Consequently, inequalities in accessing essential social goods such as healthcare, generally impacts diets and overall health and wellness adversely. Unfortunately, this systemic problem tends to inflict significant harm on lower-income groups disproportionately. Overall, Blacks and Hispanics in the USA have less access to basic needs such as medical care, health insurance, adequate housing, or sustainable employment. These limitations usually culminate to poorer health and higher rates of health problems such as high blood pressure, diabetes, cancer, depression, and other health pathologies. Historically, existing inequalities in society are manifested in moments of crisis, and the 2019-2021 pandemic revealed overwhelming evidence of this fact. The CDC adjusting for population age differences, reported that Native Americans, Latinos and Blacks are twice or thrice more likely than their White counterparts to die of COVID-19. Numerous research including CDC (2020), The Common Wealth Fund (2020), Johns Hopkins (2020), Gross et al. (2020), and Elflein (2021), show that minorities are disproportionately impacted by COVID-19 deaths. According to the racial demographic information on COVID-19 cases and deaths from the CDC's National Center for Health Statistics, almost 23% of reported COVID-19 deaths in the U.S. are African Americans, even though blacks make up approximately 13% of the U.S. population. A similar trend and evidence of racially/ethnically disproportionate infection and vaccination rates are revealed in the current Monkeypox infection data nationally. These are glaring and concerning revelations of the health inequities that exist in our society. It offers an opportunity for our society including governments, policymakers, social workers, human rights advocates and organizations across the world to address the significant health disparities and systemic social inequalities that continue to cause reduced life-expectancy and high morbidity and mortality rates among vulnerable, marginalized, and disadvantaged populations. The author contends that health inequity due to social inequity is unsustainable, and a detriment to sustainable development. Consequently, the author posits that strategic intervention measures to address the health inequities must be implemented in adherence to basic human rights, to attain sustainable health, social equity and justice to facilitate sustainable development, and that, as we mobilize resources to address the negative effects of COVID-19 and Monkeypox, we need to direct our attention to the broader structural and systemic inequities and its negative manifestations on minorities.

1.2 Importance of the Study

This study has significant relevance and implications. Understanding why there is major

racial inequalities in COVID-19 infection and mortality rates is essential to the sustainability of our society and the world. This is because it offers an opportunity for our society including governments, policymakers, human rights advocates, social workers, and humanitarian agencies and organizations across the world to address the health disparities and systemic social inequalities that continue to inflect reduced life-expectancy, and high mortality and morbidity rates among vulnerable, marginalized, and disadvantaged populations. The UN (2020), in reference to its 2030 Sustainable Development Goals #3 and #10 respectively, noted that COVID-19 has "deepened existing inequalities, hitting the poorest and most vulnerable communities the hardest...and that the pandemic is an unprecedented wake-up call, laying bare deep inequalities and exposing precisely failures..." As a result, it is an ethical and moral imperative that we study and identify the cause-and-effect factors and dynamics, the social, cultural, environmental, structural, and systemic forces that underlie and perpetuate social and health inequalities, in order to ameliorate them effectively. These include the development and implementation of strategic intervention measures to address the health and social inequities in adherence to basic human rights, by protecting and prolonging the lives of vulnerable groups while curtailing the high mortality cases.

2. Literature Review

2.1 Social Inequities

Social inequality refers to the social and structural factors in a society that impede a group's social and economic status, social class, and social circle (Science Daily, ND). Social inequality was described by Taylor (2004) as disparities between individuals in their "material well-being, their social position, cultural standing, or ability to influence others. It also refers to disparities in people's ability to ensure that they have a better future and that their children are secure, healthy, and have viable livelihoods" (Taylor, 2004, p. 1). Broadly defined, it is the disparities in the fair distribution of economic assets and income as well as the quality of life in a society as a whole. Social inequality is in existence due to the inadequacy of social and economic opportunities in certain areas that hinders certain groups of people (especially the less-privileged and marginalized) from leveraging their social and economic opportunities and capacities equitably, through access to and acquisition of the same social and economic opportunities such as housing, employment, and health care as compared to the wealthy. This is especially consequential, where accessibility to these social amenities are based on social determinants like income and wealth.

2.2 COVID-19 Pandemic, Disproportionate Representation, and Social Inequality

The COVID-19 pandemic exposed the vulnerabilities of less-privileged and most vulnerable in the world and revealed manifestation of endemic social inequalities. The Centers for Disease Control and Prevention (CDC), based on making an adjustment for population age differences, estimated that Native Americans, Blacks and Latinos are twice to thrice more likely to die from COVID-19 than white people (Johnson, Rodriguez & Kastanis, 2021). Brooks (2020) reported that African Americans struggle with disproportionate COVID-19 deaths, creating a deadly storm of illness and death. It is unleashing catastrophic effects on black communities across the US especially in urban centers and revealing the deadly legacy

of inequality. The common underlying factors that contribute to the severity of the problem include the environments and conditions of where most reside, the type of jobs they have, the frequency of debilitating health conditions and how they are treated by the medical establishment have created a lethal barrage of serious illnesses and deaths.

According to an article in the New York Times (2020) titled "As Coronavirus Deepens Inequality, Inequality Worsens Its Spread", the reporter stated that the pandemic is broadening social and economic disparities that add to the lethality of the virus. This is a self-reinforcing cycle that experts cautioned could have consequences for years to come. In societies where the virus strikes, it is worsening the effects of inequality, pushing many of the difficulties onto the losers of today's polarized economies and labor markets. Research shows that those in lower economic strata are likelier to catch the disease. They are also at a much higher risk to die from it. And, even for those who remain healthy, they are more prone to suffer loss of income or health care due to quarantines and other measures, potentially on a deeper scale. At the same time, inequality itself may be serving as a multiplier on the spread of the coronavirus and its deadliness. Lovelace (2020) reported that Black Americans continue to incur disproportionate number of COVID-19 deaths as the number of mortalities from the coronavirus pandemic reached more than 100,000 in the U.S., as shown by a review of the CDC's data. Conditions such as hypertension, asthma, and diabetes (Milam et al., 2020) that tend to afflict African Americans more than other groups could contribute to more COVID-19 deaths. Disparities and inequities in incomes and access to health care tend to injure minority and lower-income groups more than others.

Dr. Anthony Fauci, the nation's leading infectious disease expert said that the coronavirus outbreak is "shining a bright light" on how "unacceptable" the health disparities between blacks and whites are (Lovelace, 2020). The disproportionate number of African American deaths by COVID-19 is evidenced state by state. In Georgia, black Americans make up 32% of the state's population but account for roughly 47% of COVID-19 deaths, according to the CDC data. In Louisiana, black Americans make up nearly 33% of the population, but account for 54% of COVID-19 deaths in the state, according to the CDC. In New York City, the epicenter of the outbreak in the U.S., African Americans and lower-income communities are severely struck disproportionately by the coronavirus. In Michigan, black people are nearly 14% of the population but account for roughly 39% of deaths (Brooks, 2020; Einhorn, 2020).

Rayshawn Brooks (2020), a senior fellow at the Brookings Institute, stated that, in comparison, Whites are composed 25% of people diagnosed with COVID-19 and 26% of deaths, and they represent over 75% of the State of Michigan's population. In Illinois, Blacks make-up about 16% of the state, but account for 30% of people diagnosed with COVID-19. In Chicago, Blacks make-up 70% of individuals who have perished from the coronavirus, but are only 29% of the city's population (Einhorn, 2020). North Carolina and South Carolina reveals the same configuration, however with slightly smaller gaps. Gold and colleagues (2020), reported that disparities in COVID-19 cases and deaths among Hispanic people and other underrepresented racial and ethnic groups are well documented and might be associated with increased risk for exposure to SARS-CoV-2, the virus that caused COVID-19. Inequalities in the social determinants of health can cause increased risk for SARS-CoV-2

exposure among certain racial and ethnic groups. For example, underrepresented ethnic and racial groups might have a higher tendency to reside in multigenerational and multifamily households, stay in living environments that are congregated, have employment that requires an in-person work such as meatpacking, service, agriculture, and health care, have inadequate access to health care, or experience discrimination.

Disparities in the prevalence of underlying conditions such as diabetes and obesity among racial and ethnic groups might also be connected to increased susceptibility to COVID-19 related complication or difficulties and death. Elizabeth Gawthrop (2022) of the APM Research Laboratory whose ongoing project called Color of Coronavirus that monitors how and where COVID-19 mortality is inequitably impacting certain communities — to guide policy and community responses, based on a CDC data reported that the United States' official COVID-19 death toll has now surpassed 1 million deaths. Black, White, Asian, Indigenous, Latino Americans and Americans of more than one race all saw a sharp increase in deaths from December 2021 to January 2022, with January becoming the deadliest month for those groups since vaccines became widely available, however Black Americans are the only group to have seen the greatest loss at the beginning of the pandemic. The Commonwealth Fund report authored by Getachew, Zephyrin, Abrams, Shah, Lewis, & Doty (2020) stated that the effects of COVID-19 pandemic's in the United States has revealed persisting inequalities by ethnicity, race, and income. An analysis from April indicated that COVID-19 cases and deaths that were verified were excessively higher in areas with greater Black populations. Adding to these adverse results is the much greater likelihood that Black and Latino Americans reside in poverty and live in communities with congested households, air pollution, and insufficient access to health care. Beyond its impact on physical health, the pandemic had driven the U.S. economy into a recession, which usually severely affect people who are already disadvantaged more than the rest of society.

Highlights of the findings included the fact that over half of Latino and almost half of Black survey respondents stated experiencing economic difficulties related to the pandemic, considerably over the 21 percent of white respondents. Both Latino and Black respondents reported that they experienced mental health issues related to the pandemic at a rate that was approximately 10 points higher than whites. Almost one-third of all respondents experienced at least one economic hardship connected to the pandemic such as problems paying for necessities including rent, buying food, and taking out a loan or borrowing money just to make ends meet. The rate of having experienced any one of these economic difficulties was more than twice as high among Blacks and Latinos than for whites. These data confirmed national trends. While it is known that many people in the United States have historically experienced difficulties paying for basic necessities, the pandemic has worsened this problem. The U.S Census Bureau's coronavirus survey indicated that as of July 2020, almost 7 million more adults are encountering difficulties with food insecurity compared prior to the pandemic, with vast inequalities apparent between racial and ethnic groups.

Getachew and colleagues (2020) emphasized that these disparities may not surprising, in consideration of the fact that Black and Latino Americans have struggled for generations to acquire or achieve income levels, wealth, and assets that are at comparable level as white

Americans — even when the levels of education between these three racial groups are comparable. This challenging long-standing wealth disparity has left many households of color with an inadequate safety net or support system to assist them withstand the financial difficulties generated by the pandemic. Brooks (2020) argued that structural conditions that shape pre-existing conditions and health disparities are primarily responsible for the epidemic within the pandemic which is devastating Black communities across the U.S. He identified the structural conditions that cause racial health disparities by contending that, as compared to Whites, Blacks are more likely to live in neighborhoods where there are inadequacies of healthy food options, recreational amenities, green spaces, lighting, and safety. These substandard neighborhoods are embedded in the history of redlining. In addition, Blacks are more likely to live in areas that are densely populated, and this increases their potential contact with other people even further. They make-up about one-quarter of all public transit users. Blacks are also highly susceptible to not having access to equitable healthcare and are more likely to be part of the new COVID-19 "essential" workforce.

Brooks (2020) continued to contend that, they are approximately 30% of bus drivers and almost 20% of all food service workers, cashiers, janitors, and stockers. Rogers, Rogers, Gu, Yan, and Qeadan (2020) collaborated this, confirming their principal hypothesis that COVID-19 mortality was highest among Non-Hispanic (NH) Blacks compared with Non-Hispanic Whites due to the fact that Non-Hispanic Blacks hold more essential-worker positions such as food preparation, transportation, health care, and cleaning services. Notably, during a highly contagious pandemic like COVID-19, Black workers, and consequently their families, are highly exposed. In consideration of all these economic and structural issues, staying home during a quarantine is a privilege (Brooks, 2020), and this community is at a great disadvantage. As McLaren (2021) reported, the occupational configuration of employment likely matters for the transmission and contraction of the virus for multiple reasons. Obviously, occupations that require in-person contact with affected patients may be more susceptible to infection of the coronavirus. In broader terms, since physical distancing is an essential strategy for inhibiting the spread of the virus, workers who have the opportunity or are capable to work from home, may have an advantage in staying healthy.

Gross and colleagues (2020) find that the mortality rates for African Americans are more than triple the rates for whites after correcting for age, and the rates for Hispanic/Latinos are almost double the rates for non-Hispanic whites. Echoing this national public health concern, McLaren (2021) stated that the higher COVID-19 pandemic mortality rate for African Americans and other minority groups has been the subject of much public concern. Kim & Bostwick (2020) reported that although the current COVID-19 crisis is felt globally, at the local level, COVID-19 has disproportionately affected poor, highly segregated African American communities, in particular Chicago. Their research discovered significant "spatial clusters of social vulnerability and risk factors", both of which are greatly connected to the increased COVID-19-related death rate. They also found that a higher percentage of African Americans were linked to increased levels of social vulnerability and risk factors. They contended that the disproportionate impacts of COVID-19 in African American communities are an illustration of social exclusion and racial inequality that were in existence prior to the

COVID-19 crisis.

Kim & Bostwick (2020) continued to posit that social vulnerability illuminates economic, social, demographic, and geographic features that determine not only risk exposure, but also the capacity of the community to deal with, react to, and recuperate from natural catastrophes and dangers. Structural factors such as the uneven distribution of resources, social exclusion, poverty, and discrimination are endemic issues these communities face that exacerbates their suffering and perilous experiences. Natural disasters and pandemics, such as COVID-19, reveal the critical linkages between events occurring naturally and existing vulnerability of groups (Cutter, 2005; Kim & Bostwick, 2020). As shocking and agonizing as racial disparities in the COVID-19 death rates are, such racial inequality has been seen in innumerable health outcomes for decades (Arcaya & Figueroa, 2017). These endemic and persistent racial and ethnic economic, social, structural, and systemic inequalities have made communities of color vulnerable as their "capacity to deal with natural and man-made disasters" (Logan, 2009; Holifield, 2001; Kim & Bostwick, 2020) such as COVID-19 is compromised and debilitated.

Alcendor (2020) stated that the health inequities in the US that affect minority communities were pre-existing prior to the inception of the COVID-19 pandemic. The glaring evidence of these inequities have been exposed in some cities and states. Persistent health inequities evidenced among minority groups in the US such as diabetes, hypertension, and pulmonary disease, may contribute to the predisposal of these communities to the infection of SARS-CoV-2 and their greater risk for clinically severe COVID-19. This author posited that the fundamental social determinants of health and standards of care that minority communities receive must be enhanced to bring an end to these disparities and that improvements will involve changes in governmental policy coupled with an enduring dedication to minority communities that includes early interventions and prevention strategies to eliminate or reduce major health inequities towards the achievement of necessary health equity. Wrigley-Field (2020), based on her research posited that the estimates she reported make it conceivable that, even in the COVID-19 pandemic, the mortality rate of Whites will remain lower than the lowest recorded mortality rate of Blacks in the United States. The legal and structural environments that create racial inequality have radically shifted since the early twentieth century, generating a population of Blacks that are more economically heterogeneous. Yet, a century after the 1918 flu, the fundamental fact persists that the hardships experienced by Blacks are on the worst scale related to pandemics in modern US history. The real fact is that COVID-19 mortality experienced by Black Americans are highly disproportionate and will almost surely expand the racial mortality gap even further. Currently, age adjusted confirmed COVID mortality rates are more than 2.5 times higher for Blacks than Whites. These mortalities alone would upsurge the disproportion between the most recent White and the best-ever Black age-adjusted mortality rates and underscore the severe inequality in COVID deaths as layered on top of significant disparities that have existed every year.

Rogers, Rogers, Gu, Yan, and Qeadan (2020) stated that racial disparities are apparent in the effect of coronavirus disease in the U.S. and as COVID-19 death rates increases, existing

structural inequalities continue to characterize racial disparities in this pandemic. It is not surprising to some people that COVID-19 is unveiling health disparities in the U.S., which is outranked only by Portugal and Chile on income-based health inequities (Rogers et al., 2020; Hero, Zaslavsky, & Blendon, 2017). The disproportionate health impacts of the COVID-19 pandemic are representation of the unequal manifestations of chronic medical conditions among communities of color that is a consequence of a historical legacy of structural inequities. There are swamps of evidence indicating that racial/ethnic minority patients continue to get worse health care compared to Non-Hispanic White patients (Agency for Healthcare Research and Quality, 2020; Hostetter & Klein/The Commonwealth Fund, 2018; Cunningham, 2018; Satcher et al., 2005). These authors concluded from their study that structural disparities, not biology, continue to increase COVID-19–related racial inequalities. Hostetter & Klein (2018) reported that, most shocking was that their analysis discovered that even after taking into consideration income, comorbid illnesses, health insurance type, and neighborhood — factors that are usually considered to explain racial disparities and health outcomes among blacks, particularly, were still worse than whites.

Yaya, Yeboah, Charles, Otu, Labonte (2020) reported that as COVID-19 continues to inflict havoc around the globe and in its wake, data suggest that minorities in the US, especially black people, have been infected and died at a disproportionate rate across the country. They summarized that COVID-19 has further exposed the strong connection between race, ethnicity, culture, socioeconomic status and health outcomes and highlighted pivotal ethno-racialized disparities reflecting the ‘color of disease’. They continued to state that racism, segregation and inequality have been elusively and prevalently embedded in dominant cultures and social institutions for decades. The socioeconomic factors that shape health outcomes negatively within the underserved minority communities must be recognized and contextualized within historical, social, political, and economic spheres. Yaya and colleagues further contend that social determinants of health are key factors that influence the conditions characterizing how individuals are born, how they grow, how they live, work and age in specific environments. These social determinants are themselves shaped by the disparities in the distribution of resources, including money and power at the local and global levels, culminating into health disparities among groups of people. People who are disadvantaged socioeconomically, such as those who experience multidimensional poverty, have lower levels of education and reside in more dangerous neighborhoods, also tend to have underlying health conditions that increases their vulnerability for severe COVID-19 cases and issues. The compounding of the burden of racism which predisposes people to high-risk jobs and lower quality care has hastened the high rates of infections and death from COVID-19 among ethnic minorities. Cunningham (2018) reported that low incomes are linked to continuous cycle of insufficient access to good food and housing, financial strain, debilitating health behaviors, personal safety, and inadequate access to care. Consequently, these conditions, raise the health risk to low-income groups.

Mude, Oguoma, Nyanhanda, Mwanri, and Njue (2020) reported that racial minority groups in western countries experience inequitable socioeconomic and structural factors of health determinants. These detrimental determinants have resulted in disparities and inequities in

access to health care and related poorer health outcomes. These lop-sided disparities include frequency, hospitalization, and mortalities from COVID-19. Specifically, Black and Hispanic people have been impacted by COVID-19 at a disproportionate level. This very worrisome condition is an illumination of the deep-rooted systemic disadvantages (that underlie social, economic, and political systems) experienced by racial minorities in western countries. The identified racial disparities in prevalence, hospitalizations and mortality rate from COVID-19 is attributable to the fact that Blacks, Hispanics, and other racial groups encounter higher socioeconomic challenges that raises their risk level of COVID-19 infection. Conversely, individuals in higher socioeconomic status and living in wealthy communities have been identified to be less likely to be infected by the COVID-19 virus, whereas social and economic challenges have been linked to higher rate of COVID-19 virus contractions.

Furthermore, because racial minorities residing in urban environments have the propensity to live in more congested conditions and are more likely to have a job in occupations where they have in-person interaction with or come into face-to-face contact with the public, it makes it practically impossible to practice social distancing. Mude, Oguoma, Nyanhanda, Mwanri, and Njue (2020) also highlighted the fact that many Blacks were employed in the top nine essential jobs that predisposed them to the danger of contracting the COVID-19 virus, and thus increasing the risk of transmission of the virus to their families. Additionally, both Blacks and Hispanics are the major racial minority groups employed in frontline jobs and therefore prone to the risk factors to contracting COVID-19. The disturbing reality is that, despite the overwhelming evidence of racial minorities being at high risk of being exposed to the virus, they encounter mounting obstacles to accessing good health care such as testing and contact tracing, and these issues lead to delays in getting tested especially as a matter of life and public health exigency, until they are in a direr condition. This culminates in debilitating and undesirable health outcomes. Structural racism as an important factor in population health determination can also illuminate on the disparate problems of COVID-19 identified among racial minorities. Policies and forces that facilitate structural racism and health inequalities are embedded systems that make challenges experienced by racial minorities compound. Blacks, Hispanics, and other minority racial groups experience disproportionate higher rates of other underlying health conditions, making them more susceptible to COVID-19. Milam et al., (2020) echoed this observation when they reported that African Americans are overrepresented among reported COVID-19 cases and deaths in the U.S. There are multitude of factors that may explain the African American disparity in COVID-19 deaths, including higher rates of comorbid health conditions such as hypertension and cardiovascular disease, barriers to health-care access, and differences in cultural attitudes (Nelson, 2002). In countries such as the United States, challenges related to structural determinants of health are widespread and are disproportionately experienced by racial minorities, which lead to generational inequalities and struggles among this population (Credit, 2020; Walters, 2020).

A similar evidence and trend of racially/ethnically disproportionate infection and vaccination rates are revealed in the current Monkeypox inflection data nationally. For example, in Georgia blacks account for 81% of the number of people infected while they make up only

32% of the state's population. In North Carolina, blacks make up 21.3% of the population but 72.9% of the number of people infected in the state. According to The North Carolina Department of Health and Human Services (2022) report of the state's monkeypox infection and vaccination rates since July 2022, it shows that while 70% of cases are in Black/African American (AA) men, they have only received less than a quarter of the vaccinations administered so far. The data reveals that even though 70% of the MPX cases are in Black/African American men and 19% in White men, only 24% of vaccines have been administered to Black/AA recipients, while 67% have been given to White recipients.

The CDC's national-level data published on Monkeypox (MPX) cases reported in the U.S through July 22, 2022, reveal that there are racial and ethnic disparities, with Black and Hispanic people being disproportionately infected and burdened. Also, data on the vaccination rates across the nation indicate that the vaccination rates for Black and Hispanic groups are disproportionately much lower compared to Whites, despite accounting for the larger proportion of Monkeypox cases. Data reported from 43 states, DC, and Puerto Rico reveal that Blacks accounted for up 26% of Monkeypox cases compared to 12% of the population, and Hispanics made up 28% of cases compared to 19% of the population (Ndugga, Haldar, Pillai, Hill, & Artiga, 2022).

3. Methods

This research project was a secondary data analysis involving the author reviewing relevant literature on social and health inequalities in relation to COVID-19 morbidity and mortality across racial groups in the United States of America with a focus on racial/ethnic minorities. Key words such as COVID-19 and social inequity, health inequity, health disparity, social determinants of health, social vulnerabilities, COVID-19 and health disparities among minorities, as well as COVID-19 pandemic and minorities were searched on multiple search engines and academic journals and disciplines. The literatures/articles obtained from the search were rigorously reviewed through multiple filtration processes, and the most relevant literatures were selected, and a final review was completed. This was followed by the compilation and composition of the most essential information and the collation of relevant data.

3.1 Statistics and Data Analysis (Demographic Figures)

Table 1 below shows the mortality rates among the US population by race. This data was collated by the author using information from APM Research Lab, 2022.

Table 1. Percentage of US Population by Race & COVID-19 Deaths/Mortality Rates (National total: 1,031,241): August 10, 2022

Racial Group	**African American/Black**	**Hispanic/Latino**	**Asian**	**White**
Percentage of Population in US	13.6 %	18.9 %	6.1%	75.8%
COVID-19 deaths per 100 000 people	353 deaths per 100 000 (1 in 284)	267 deaths per 100 000 (1 in 375)	167 deaths per 100 000 (1 in 600)	340 deaths per 100 000 (1 in 294)
Number of COVID-19 deaths to US Population total deaths/mortality	146 108	163 477	32 285	669 083

Table 2 below shows the mortality rates among African Americans/Blacks and Hispanic Americans/Latinos. This data was collated by the author using 2020 figures from the CDC.

Table 2. African Americans and Hispanics/Latinos COVID-19 Deaths compared to Whites nationally

African A/Blacks Covid-19 deaths are 1.4 times that of whites
Hispanics/Latinos Covid-19 deaths are 1.2 times that of whites

Table 3 below shows the mortality rates of African Americans/Blacks in Georgia in relation to their population size in the state. This data was collated by the author using 2020 data from the CDC.

Table 3. Percentage of Blacks in Georgia compared to their COVID-19 deaths in the state

Georgia

Racial Group	African American
% of State's Population	32%
% of COVID-19 Deaths	47%

Table 4 below shows the mortality rates of African Americans/Blacks in Louisiana in relation to their population size in the state. This data was collated by the author using 2020 data from the CDC.

Table 4. Percentage of Blacks in Louisiana compared to their COVID-19 deaths in the state

Louisiana

Racial Group	African American
% of State's Population	33%
% of COVID-19 Deaths	54%

4. Discussion

The findings presented in this paper reveal overwhelming evidence that during the pandemic, racial minorities such as Blacks and Latinos, and individuals with lower incomes or socioeconomic status have experienced considerably greater challenges than other groups in the United States. These racial and ethnic groups make up disproportionately majority of the share of the essential workers vital to the functioning of our society and economy. If we are to consider an analogy where our nation is a vehicle made up of different key parts, including the engine and transmission that make the vehicle operational, if a key component of this vehicle is missing or malfunctions due to harsh conditions, it will affect the effective functioning or even potentially immobilize the vehicle. Essential workers are comparable to this essential component of the vehicle, therefore needs unfettered attention and support to function and thrive because it is for the ultimate wellbeing, efficiency, and sustainability of the whole system. The systems theory illuminates the interconnectedness and interdependence of components of the system and a harm to or malfunction in a part of the system can potentially inflict havoc to other parts of the system and consequently impact the whole system adversely. It is concerning that large numbers of racial minorities are struggling to pay for principal necessities and experiencing mental health problems related to

COVID-19. This is unsustainable, unjust, and in contravention of the UN human rights and Sustainable Development Goals. Such difficult situations and hardships require greater investments in the economic wellbeing and enduring security of these disproportionately affected groups.

As Getachew, Zephyrin, Abrams, Shah, and Doty (2020) suggested, there is a greater need for investments in these communities such as assistance with nutritional programs, increased access to behavioral health care and rent relief (financial assistance). In order to address this racial disparity, there is a need to apply a health equity framework in policy analysis, formulation, and implementation. From this social equity framework, there must also be disaggregate data collection specifically and unequivocally for African Americans and Latinos, as well as other at-risk groups who have experienced longstanding discrimination or bias treatment in the healthcare system. As noted earlier, historically, existing inequalities in society are manifested in moments of crisis, and the current pandemic revealed overwhelming manifestation of this fact. These manifestations include social and structural inequities. For example, the racial disparities among essential workers in the United States are consequence of longstanding systemic discrimination, implicit/explicit bias, racism and structural inequalities that include lack of access to and/or utilization of medical or healthcare systems and services. The systemic factors that compound the problem include the lack of public policy directed at safeguarding the precious lives of essential workers who put their lives on the line daily, to provide, protect, and serve others. Long-lasting systemic and structural failures and discrimination or inequalities must be critically examined from a social equity lens and corrective measures, or interventions must be introduced to remedy and end these endemic and inhumane practices and policies.

Gross et al. (2020), correctly stated that increased attentiveness to policy development and comprehensive strategies that requires the timely collection and public dissemination of state-and county-level data disaggregated by race and ethnicity is necessary. These measures are critical to enable timely modifications to response practices during public health crises. It is essential to implement targeted, contextually and culturally relevant governmental policies and community-based strategies and programs to protect minority groups who are at higher risk for sickness and death from the COVID-19 virus and other diseases. In agreement with Yaya et al., (2020), to prevent or reduce further ethno-racialized health disparities that has been unveiled by the COVID-19 pandemic, it will be necessary to carry out an intersectional analysis of the socioeconomic elements and social determinants of health (Cogburn, 2019; Otu, et al., 2020). Yaya and colleagues continued to elucidate an essential and relevant argument-which this author concurs with in the sense that, the socioeconomic issues that negatively affect health outcomes within the underserved minority communities must be found and contextualized within historical, social, political and economic spheres. Furthermore, the root causes of the differential treatment of racial and ethnic minorities such as African Americans, Hispanics and Asians in the context of healthcare, must be discovered and creative policies purported at closing access and treatment gaps implemented in ways that are efficient and acceptable.

4.1 Implications for Social Work Practice

In consideration of the fact that social workers, whether in the role of case worker, case manager, clinical therapist, or educator, are engaged with these affected populations through the varying services they offer, it is essential that they have pertinent knowledge and understanding of the social, cultural, structural, and systemic factors that inhibit and preclude these vulnerable, oppressed, disadvantaged, and marginalized groups from accessing essential healthcare and social services. Acquiring this relevant knowledge is a key component of information literacy, critical inquiry, and empowerment, that include understanding these marginalized group's social determinants and social vulnerabilities and addressing them effectively. The National Association of Social Workers (NASW) *Code of Ethics (2017) (updated, 2021),* Standard 1.05(b) highlights "a call to action" by stating that, "Social workers "must" take action against oppression, racism, discrimination, and inequities, and acknowledge personal privilege." In addition, one relevant NASW Ethical Principle states that social workers should "challenge social injustice" (NASW, 2017). In the same vein, it is necessary to bring into focus the mission of social work, which is to enhance human wellbeing and assist in meeting the basic needs of all people, with special attention to those who are vulnerable, oppressed, marginalized, and living in destitute. These core values and principles can be actualized through both action and advocacy to dismantle and reform discriminatory and oppressive systems, policies, and practices that are embedded in the nation's social, cultural, structural, economic, and political systems, as well as historical structures through which oppressive, unequal, unjust, unfair and racially prejudiced practices are perpetuated.

As many Blacks and Hispanics/Latinos have been impacted disproportionately by the rate of morbidity and mortality, this contributes to additional layer of stress to a population who are already disadvantaged. Some members of these group may be the primary breadwinners of their families and losing such an important figure or a loved one is profound and devastating. This is because the loss and grief lead to a profound emotional, mental, and physical disorientation. Studies from several sources including CDC (2021) have reported the alarming high rate of mental health issues among the US population during the pandemic. Unfortunately, the data also shows that minorities are impacted significantly. As social workers, it is important that we closely observe the mental health and well-being of these client populations. As clinicians, we should use relevant mental health diagnosis criteria and detection scales to facilitate assessment, early detection, and timely treatment/intervention. As the data reported in this paper shows that minority populations are not receiving vaccinations against the monkeypox epidemic as was the case with the COVID-19 vaccinations, social workers and other practitioners in the helping profession must redouble their efforts to engage this community in education and information literacy. This targeted community outreach action is critical to disseminating relevant information to facilitate the prevention, early detection, spread control, and treatment of this vulnerable population. Thus, diligent and proactive practices will facilitate the identification of risk factors and behaviors, as well as causes and effects, and allocation of necessary resources and intervention regimens.

5. Conclusion

Social inequities and health disparities continue to afflict minority populations in the United States and across different countries causing distressing social, economic, and health outcomes as manifested in the COVID-19 pandemic. These sets of socioeconomic deprivation and struggles, low income, challenging living conditions, deplorable healthcare experiences, poor access to adequate medical care, exacerbated by the lack of or no health insurance coverage contribute to high morbidity and mortality among racial/ethnic minorities. These persistent disparities are systemic, prevalent, deep-rooted in the cultural, social, economic, and political landscapes and detrimental to human decency, human rights, justice and sustainability, and therefore must be identified, uprooted, addressed and ended. Governments, policymakers, social justice/human rights advocates and patrons, as well as researchers must identify social determinants of these health disparities and institute appropriate prevention and response strategies and mitigation efforts. This can be achieved through sustainable and targeted policy formulation and implementation aimed at addressing and attaining social, economic, health, and structural equity and justice for racial minorities. Intervention programs could include governmental and private mitigation, testing, treatment, and funding efforts targeted to racial minorities and explicitly combating the prevalent disproportionate disparities. This will facilitate sustainable development, human rights, equity, and justice.

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