Commentary

Structural racism and social distancing: Implications for COVID-19

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The COVID-19 pandemic is not the first pandemic in which we have witnessed health inequities [1], whether it will be the last is dependent on how well we identify, understand, and address the fundamental causes of these inequities. Few studies have examined the association between fundamental causes of health inequities, such as structural racism, and COVID-19 health outcomes. These studies have found that greater racial residential segregation, a measure of structural racism, is associated with higher county-level case and mortality rates [2–4]. However, even fewer studies have examined the ways in which structural racism influences the ability to prevent these outcomes. In this issue of EClinicalMedicine, White and colleagues [5] begin to address this gap in the literature by reporting their findings of a national study in the United States of the association between racial residential segregation and social mobility under different mobility-related government policies: lockdown orders and reopening. The results of their longitudinal analysis were that county-level racial residential segregation was associated with decreased social mobility under lockdown orders and slightly increased social mobility after reopening.

These results have important policy implications, given that social mobility is associated with increased risk of COVID-19 transmission. The authors speculate that increased social mobility may lead to increased risk of COVID-19 health outcomes among Black people, although, they were unable to directly demonstrate this in their analysis. The use of de-identified, aggregated social mobility data precludes the ability to determine which racial groups in segregated counties may benefit from reduced social mobility during lockdown orders or may be harmed when social mobility increases after reopening. Improving the measurement of social mobility disaggregated by sociodemographic factors, including race, is an important next step.

While White and colleagues [5] are to be applauded for taking on this important topic and complex analysis, more research is urgently needed to: determine whether structural racism influences different types of mobility (i.e. for employment, retail, or recreation); identify other modifiable intermediary factors between structural racism and COVID-19 health outcomes; determine whether social mobility or other intermediary factors are associated with increased risk of COVID-19 case and mortality rates; and examine whether there are any differences in these associations by racial group. Results from such studies are needed to inform pandemic-related policy decisions by identifying potential levers to reduce the impact of structural racism on health inequities.

Racial residential segregation, one of the ways in which structural racism is operationalized, is correlated with housing, educational, and economic resources and opportunities, and has been associated with multiple health outcomes as well as racial inequities in health outcomes. It is therefore unsurprising that racial residential segregation is implicated in COVID-19 outcomes. However, demonstrating associations will not be enough to address the root problems. Ultimately, reducing racial inequities in COVID-19 health outcomes will require interventions to effectively address the fundamental causes of these inequities. Addressing structural racism is to address the “totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice” [6]. Potential solutions include place-based, multisector, equity-oriented, community redevelopment initiatives, which have been shown to improve the social determinants of health, although additional research is needed to examine any concomitant improvements in health [6]. Funding commitments from private and public sources will be required to test and implement additional interventions to address structural racism.

In response to the police killings of George Floyd, Breonna Taylor, and numerous other Black men and women in the United States, the Lancet journals have pledged to advance racial equality in part by publishing issues related to racial equality [7]. For the Lancet journals’ commitment to racial equity to be meaningful, researchers need to conduct high quality studies and report them prudently so as not to perpetuate harms. Researchers can perpetuate racial bias and victim-blaming by focusing exclusively on associations between COVID-19 health outcomes and individual factors, especially those that are unscientifically-constructed factors such as race [8]. Instead, researchers must make greater effort to examine the structural factors and indicators of racism that constrain people to be at higher risk of poorer COVID-19 health outcomes. Moreover, centering the voices, research, and recommendations of communities who are
most impacted by the COVID-19 pandemic will be an important part in achieving health equity [9,10]. Approaching the COVID-19 research agenda in this manner will provide needed evidence for the larger policy changes to effectively address structural racism and reduce racial health inequities – hopefully averting future public health crises.

Declaration of Competing Interest

The authors have nothing to disclose.

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