Disparities in the COVID Crisis

Prepared for Workplace Safety Issues and Workforce Issues

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CDC Study of adult cases in Georgia

- 305 patients from 7 hospitals in metropolitan Atlanta and one community hospital in southern Georgia over age 18 with laboratory-confirmed COVID-19 during March 1 – March 30, 2020
- Median Age 60
- 83.2% were Black (compared to 47% of all patients)
- 73.8% had conditions considered high-risk for severe COVID-19
Comorbidity factors in Georgia study

- Diabetes was documented in 39.7% of patients
  - BUT WAS NOT SIGNIFICANTLY MORE COMMON IN BLACK THAN NONBLACK PATIENTS
- Cardiovascular disease was documented in 25.6% of patients
  - PREVALENCE WAS SIMILAR IN BLACK AND NONBLACK PATIENTS
Only hypertension (not considered a high-risk condition) showed racial differences

- Chronic lung disease was documented for 20.3% of patients
  - Asthma in 10.5% of patients
  - Chronic obstructive pulmonary disease in 5.2% of cases
- NO SIGNIFICANT DIFFERENCES BY AGE OR RACE
- Severe obesity (BMI > 40) present in 12.7% of patients
  - DID NOT DIFFER SIGNIFICANTLY BY RACE
- Only Hypertension, 67.5% of patients, was more common among Black versus nonblack patients
Key outcome variable

- THE FREQUENCY OF Invasive Mechanical Ventilation AND FATALITY DID NOT DIFFER BY RACE
- 25% OF PATIENTS HAD NO HIGH-RISK CONDITIONS, BUT 5% OF THESE PATIENTS DIED

Blacks are more likely to get COVID is key

• COVID is more prevalent in the Black community
• But, in most states, while Blacks are a high share of COVID cases, they are a lower share of deaths compared to the share of cases
• If Black deaths were an issue of Blacks surviving COVID, then at worst they would be the same share of COVID cases as they are of deaths
• But, if Blacks are a smaller share of deaths from COVID than they are of those with the disease, that can only be because they are not more likely to die if they catch COVID
In states, like Kansas, Blacks make up a much higher share of those who die from COVID (above the white dashed line at 1.0) than among those who catch COVID, meaning they are more likely to die from COVID.

In states, like Pennsylvania, Blacks are a much lower share of those who die from COVID compared to those who catch COVID (below 1.0).

Source: https://covidtracking.com/race/dashboard
For Black and Latinos COVID is a worker problem

- COVID incidence is much greater among working age Black and Latino populations than among whites
- Black and Latino workers are over-represented in those professions at great risk because they interact with the public or work in close proximity of other workers
- And, because they are low wage workers who feel greater pressure to work, even if they are not well
- And, especially for Latino workers, the rise in unemployment has unearthed they lack access to health insurance as a safety-net
Laboratory-Confirmed COVID-19-Associated Hospitalizations
by Age and Race/Ethnicity as of May 23, 2020

Gould and Shierholz, Not everybody can work from home: Black and Hispanic workers are much less likely to be able to telework, Economic Policy Institute  
Black Healthcare Workers as COVID-19 Cases All Workers and Among Healthcare Workers

Source: Fermstad, Rho and Brown, MEATPACKING WORKERS ARE A DIVERSE GROUP WHO NEED BETTER PROTECTIONS, https://cepr.net/meatpacking-workers-are-a-diverse-group-who-need-better-protections/
An embarrassing lack of data

- Given the spread of COVID in workplaces, this from the Center for Disease Control is shocking.

  Among 315,531 U.S. COVID-19 cases reported to CDC during February 12–April 9, data on HCP occupational status were available for 49,370 (16%), among whom 9,282 (19%) were identified as HCP.

The findings in this report are subject to at least four limitations. First, not all states with COVID-19 cases in meat and poultry facilities submitted data for this report. Second, differences in case counts and percentage of workers with COVID-19 are affected by the testing strategies employed, with more infected workers identified in settings with more testing. As a result, data provided on worker infections should not be interpreted as the prevalence of infection for all meat and poultry facility workers. Third, lag time in reporting to the local and state health departments also affects the counts reported, as does the time from disease onset to death in fatal cases. Finally, widespread community transmission in some settings makes determining the source of exposure and infection difficult.
The dominant effect of rising COVID infections drove the spike in UI claims much more than school closure policies.

Panel A and Panel B of Figure 1 show time trends in new Unemployment Insurance (UI) claims grouped by state COVID-19 infection rates and school closures. The horizontal axis shows weeks since January 1st, 2020, and the vertical axis is the log number of unemployment insurance claims per 1,000 workers. Each panel reports time trends for three groups. In Panel A, states are divided into those with a low, medium, or high number of COVID-19 cases per capita as of March 21st. Panel B splits the states into low, medium, and high groups based on the share of school time students lost during the corresponding week due to school closures as of March 21st. The time trends, in both panels, spike in correspondence of the fourth week of March (22-28 March). The steepness of the spike appears sharpest for states with the earliest school closure and highest per capita COVID-19 cases.


https://www.nber.org/papers/w27127.pdf