

Reflections on the COVID-19 mortality among the Black population and racial inequality in Brazil

Reflexões sobre a mortalidade da população negra por covid-19 e a desigualdade racial no Brasil

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Abstract

This literature critical analysis reflects on the social, political, and historical background responsible for racial discrepancies in hospital mortality by COVID-19 among the Brazilian population. During the pandemic, the COVID-19 mortality among the Black population gained notoriety. Rather than an isolated fact, this finding has historical roots dating back to Brazil's foundation and draws on structural racism, which reveals degrading living and health conditions experienced by the Black population before the pandemic. This situation of vulnerability affecting the Black population is a recurring scenario that is treated with the neglect inherent to structural racism. COVID-19 mortality portrays one way in which racism impacts and reproduces itself in the life and death of Black people.

Keywords: COVID-19; Social Inequity; Racism; Health Services Accessibility.

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Resumo

Neste artigo, fazemos uma análise crítica da literatura que objetiva refletir sobre os antecedentes sociais, políticos e históricos que conduziram às discrepâncias raciais na mortalidade hospitalar da população brasileira pela covid-19. Com o advento da pandemia, a mortalidade da população negra pela covid-19 ganhou notoriedade. Muito além de um fato isolado, esse achado possui raízes históricas que datam da fundação do país e é orientado pelo racismo estrutural, que evidencia condições de vida e saúde degradantes experienciadas pela população negra antes da pandemia. Constatamos que a situação de vulnerabilidade da população negra se repete sistematicamente em múltiplos cenários, é tratada com o descaso inerente ao racismo estrutural, e que a mortalidade hospitalar por covid-19 retrata um dos modos como o racismo impacta e se reproduz na vida e na morte deste grupo.

Palavras-chave: covid-19; Iniquidade Social; Racismo; Acesso aos Serviços de Saúde.

Introduction

Brazil is the second leading country in the world in the ranking of deaths from covid-19. This is composed mostly by the Black population, and the country also has the highest hospital mortality from the disease within this group (Baqui *et al.*, 2020). The emphasis on the higher mortality of this population, however, goes far beyond a proportional increase resulting from the pandemic: it is the result of the systematic repetition of the degradation of the living and health condition of Black people, based on historical, social, and political events that fomented the structural racism rooted in the country (Almeida, 2018).

The disadvantage experienced by the Black population has roots in slavery, consolidated by religious, philosophical (philosophical racism) and scientific (scientific racism) conceptions that attributed to this population the idea of an inferior race, present in the 18th and 19th centuries (Almeida, 2018). This ideology remains in the 20th century, with the maintenance of the exclusion of this population in the socioeconomic cycles established after the “abolition” of slavery, by the ideology of racism and the practices of racial discrimination perpetrated in daily life and in the structure of society (Fernandes, 2008; Munanga, 2003).

In this way, racism presents itself as an ideology of inferiority, used to justify the derogatory treatment granted to members of racial and ethnic groups and contributes to the aggravation and maintenance of disadvantages of power, resources or opportunities among these groups. This phenomenon is an organic component of social relations and is reproduced and ensured through the institutions, policies, practices, and norms for maintaining the social structure. Thus, racism presents itself as structuring and structuring contemporary society, shaping itself politically, historically, and economically. (Almeida, 2018; Jones, 2002; Paradies; Troung; Prient, 2013).

In addition, the various dimensions of racism are recognized as structural determinants of the morbidity and mortality profile of the Black population, as they restrict access to goods, services, rights, opportunities, and neglect the needs of this

population and place it in various situations of disadvantage. Thus, the social lethality (precarious material living conditions) already present in this population was aggravated during the covid-19 pandemic (Dias, 2020; Werneck, 2016).

Thus, although the disease caused by the new coronavirus is a recent clinical manifestation, its manifestations can be analyzed from historical and political perspectives in order to bring out the consequences of the disease in populations in situations of social vulnerability and difficulty in accessing health.

Thus, considering the scientific and mass media evidence on the determinants of morbidity and mortality due to covid-19, this article seeks to reflect on the social, political, and historical antecedents that led to discrepancies in hospital mortality of the Brazilian population due to the disease. This is a critical analysis of the literature that discusses the intersection between structural and scientific racism and hospital mortality of the Black population due to covid-19. This analysis is an excerpt and is a continuation of the dissertation thesis of one of the authors, developed at the Federal University of Rio Grande do Norte (UFRN) in 2019.

Mortality of the Black population due to covid-19 and racial inequality in Brazil

A cross-sectional study conducted with data from the **Influenza Epidemiological Surveillance Information System**, which has information that characterizes the covid-19 pandemic in Brazil,

was published in a high-impact international journal and highlights: “Black people have higher hospital mortality due to covid-19”. The findings conclude that being brown and black¹ it is the second risk factor for mortality from the disease and is lower only than the risk of dying from covid-19 when one is of older age (Baqui *et al.*, 2020). What elements would subsidize the effect of race on covid-19 mortality? Would genetic conditions explain the severity of cases and the discrepancy in mortality between Black people and white people?

Despite the expressiveness of the self-declared Black or brown population contingent in the composition of Brazil², precariousness in quality of life, education, access to goods and services and in their health conditions is highlighted, when we compare them to another portion of the population contingent.

Moreover, the perpetuation of racial inequality in Brazil is translated into social indicators. In an analysis conducted from the data of the general characterization of the population of the National Health Survey (PNS) (2013) we observed that, the socioeconomic strata with the lowest incomes, “D and E”³ are composed of 59.95% Black people and 40.37% non-Black people. In contrast, the strata with the best incomes, “A and B,” are composed of 61.58% non-Black people and 38.42% Black people. Regarding schooling levels, we observed the same trends, 33.44% of the population without schooling is non-Black, against an alarming 65.56% of Black people in this group. When we look at higher education we identify the reverse, 65.87% of

1 The Brazilian population is classified as “white,” “black,” “brown,” “yellow/Asian” and “Indigenous.” “Black” and “brown” individuals can also be classified jointly as “black”; this subdivision of the Black population seeks to contemplate self-declarations of people with darker skin color and their gradations, resulting from the process of whitening the Brazilian population. In addition, the term “race/color,” with two words applied in a single sense, is used in Brazil because skin color is the way in which people most identify the ethnic or racial grouping to which they belong and it is through the reading of this phenotypic trait that racial discrimination is effective in the country (Petrucci; Saboia, 2013).

2 According to the last demographic census, in 2010, the Brazilian population is made up mostly of Black people; there are 15 million self-declared black individuals (7.6%), added to 82 million brown individuals (43.1%). In the other portion of the population are 91 million who classified themselves as white (47.7%), two million as yellow (1.1%) and 817,000 Indigenous (0.4%). Data from 2015, from the National Household Sample Survey (PNAD), already reveal an increase in the number of self-declared blacks in relation to the last census, as 53.9% of people declared themselves black or brown (IBGE, 2016).

3 The “Brazil criterion” is a socioeconomic classification standard used in Brazil that considers educational level, access to goods and public services considered essential to estimate family income. The population is classified into six socioeconomic strata, according to the estimated family income, called: “A” (estimated family income of R\$ 23,345.11), “B” (estimated family income of R\$ 10,386.52 for B1 to R\$ 5,363.19 for B2), “C” (estimated family income of R\$ 2,965.69 for C1 to R\$ 1,691,441 for C2) and “D and E” (estimated family income of up to R\$ 708.19) (Kamakura; Mazzon, 2016).

individuals with this level of education are non-black and only 34.3% of these are black (IBGE, 2014).

Another factor that implies the reduction of income is the existing wage distinction between Blacks and whites. The World Health Organization (WHO), in 2012, pointed out that, among workers with up to four years of study, blacks and browns had, respectively, 78.7% and 72.1% of the hourly income of white workers. However, with the increase in years of schooling, to 12 years or more, the differences worsen or remain; the hourly income of blacks is equivalent to 69.8% of the income of whites and in the case of browns with this schooling level it is 73.8% in relation to whites (Guimarães, 2012).

Thus, it is perceived that the ideology of racism permeates the most diverse spaces of society, including organizational ones, suppressing the opportunities for participation and growth of the Black population in the labor market. This phenomenon is materialized through the exclusion, improper remuneration, and segregation of Black people in organizational environments. Even by overcoming the precarious educational conditions available to this population, in situations where there is a dispute over positions or even in the search for employment, Black men or women are less likely than people with similar training, but who are not black (Ribeiro; Araújo, 2016).

In addition, the marks of racism reflect beyond the social and economic spheres and reach the epidemiological scenario of the health of the Brazilian Black population. The population with the highest number of people in a situation of extreme poverty, with the highest number of illiterates, the lowest number of young people in higher education, in addition to having the highest hospital mortality from covid-19, also has the highest prevalence of children in a situation of food insecurity, the highest number of victims of lethal violence, sickle cell anemia, neglected diseases, such as Chagas disease, in addition to the largest contingent with Acquired Immunodeficiency Syndrome (AIDS) (Brasil, 2017).

This being said, when considering the sociodemographic data of the Brazilian Black population, we observe, in addition to the deprivation of income, the multiple deprivations that compromise

their living and health conditions, which can put this population in a situation of multidimensional poverty (Silva; Bruno; Silva, 2020).

In the meantime, access to employment, food, decent housing conditions, and education directly impact the population's health condition, as they interfere with the way they live, learn, work, and play, contributing to their health (Alkire; Foster, 2008; Silva; Bruno; Silva, 2020). On the other hand, the deprivations of these elements, in force in multidimensional poverty, produce different levels of risks, needs and health outcomes and promote vulnerability to illness due to covid-19.

Thus, vulnerability can be considered as a product of the multidimensional relationship of individual, collective and institutional aspects that permeate the individual and their relationships (Ayres, 2002). Its individual component comprises the behavior of the subject, their knowledge and information about situations and problems and translate into attitudes, which can be protective or puts them in situations of risk to health. The social component concerns the themes experienced by the subject, which vary according to their economic relations, gender, ethnic/racial, and religious beliefs. The institutional component, though, relates to the way health services deal with mitigating situations and contexts of vulnerability, considering the political framework and its capacity to articulate with other sectors, such as education, justice, culture, and social security (Ayres, 2002; Oviedo; Czeresnia, 2015).

The deprivations experienced by the Black population and aggravated in the covid-19 pandemic have a direct impact on issues essential to the survival of the individual and their human dignity, thus hurting basic constitutional rights. In addition, they can direct, through their multidimensional relationships, knowledge, and practices in health, use and access to health services and determine exposure and/or protection to situations that increase the risk of becoming ill, transmitting, treating, and recovering from the disease. In other words, deprivations translate into vulnerability to covid-19 and consequently have an impact on the design of the morbidity and mortality profile of the Black population, as presented by Baqui *et al.* (2020).

The historical construction of racial inequalities and deprivations of the living and health conditions of the Black population

In Brazil, several events have fostered inequalities that are reflected in the living conditions of its population and are directly related to the color of the skin that its citizens have. The disadvantage experienced by the Black population has roots in slavery, in the religious and scientific elaboration of inferiority for Black people, but its maintenance is due to the exclusion of this population in the new socioeconomic cycles established after the abolition of slavery, by the ideology of racism and practices of racial discrimination (Fernandes, 2008; Munanga, 2009).

The Black population, brought to forced labor on Brazilian plantations, suffered the most diverse types of violence since their capture. Transported in subhuman conditions on slave ships, Black individuals were stripped of their culture, as well as social and family ties and became the driving force of the country's economy. These people were subjected to inhumane working conditions, lived huddled together, chained in putrid cellars, fed precariously, wore rags, and were subjected to physical punishment so extreme that it could lead to their death (Schwarcz; Starling, 2015).

This exploitation of man by man, contradictorily, found the necessary support in Catholic ethics. Plantation owners generously took responsibility for slaves by imposing social conditions and customs, in addition to granting them an activity; in this way, they minimized their characteristics, considered animalistic and brutal. In this context, racial marks, such as the phenotypic traits of Black people, functioned as a means to identify their degrading condition as slaves, the way they should be treated and their position in society (Fernandes, 2008).

Between the 18th and 19th centuries, several scientific theories were disseminated in order to reinforce the inferiority of this population: they were based on the valuation of characteristics of white people (considered as normality) and depreciation of the characteristics of Black people.

In this perspective, physical traits of Black people - such as the size and shape of their skull, aspects of the nose and lips - were associated with behavioral, moral, and cognitive characteristics, such as low intelligence, emotional instability, and behavioral deviations. This association is used to justify the exploitation of this racial group, which were considered individuals biologically destined to serve through slavery (Munanga, 2003).

Throughout the 19th century, slavery gradually lost its magnitude in Brazil. Resistance movements, individual and collective escapes and manumissions reduced the number of people subjected to this regime and called into question the political, economic, and social control by the ruling class, which made the future of the country doubtful (Silva; Trigo; Marçal, 2013).

In addition, the prohibition of the transatlantic slave trade and the rise in its cost made slave labor increasingly costly to plantation owners. Moreover, in the last decades of the 19th century and the beginning of the 20th century, with the advent of capitalism and industrial production modes, the economic importance of the slave decreased and related it to inefficiency. Thus, the servile relationship was not considered profitable to the development of the country and the skills of the enslaved were considered insufficient to act in the new competitive capitalist system (Hansemalg, 2005).

In this context, discussions emerge that put on the agenda the modernization, development and progress of an embryonic capitalist nation, and the concepts of work and ideal worker begin to be resignified. Thus, slaves became considered a useless type of workforce, backward, incapable, without discipline, without technical knowledge and associated with a system of low productivity. Such elements were considered immutable in this population, inherent in their biological characteristics and thus granting them inferiority. In this way, the European immigrant (efficient farmer) starts to occupy space in the new forms of production (Hansemalg, 2005; Silva; Trigo; Marçal, 2013).

The movement around abolition, more than a movement to guarantee dignity and social justice, included the search for the insertion of Brazil in

the world economy that, in the new frames, needed the proletariat and its income to drain production; in addition, it made possible the emancipation of the enslaved in a controlled way, without manifestos and revolts against the *status quo*, guaranteeing social order. In this context, most abolitionists saw the liberation of Black people as a way to rid the country of the stagnation brought by slavery (Fernandes, 2008; Maringoni, 2011).

After abolition, in order to occupy the jobs previously taken by slaves, there was a warming in the importation of the select European workforce, stimulated, and financed by the state. Thus, the strengthening of the immigration of these white individuals, considered biologically superior and capable of guaranteeing the desired progress, also favored the miscegenation of the Brazilian population, allowed its improvement through progressive whitening and, consequently, the disappearance of the Black population of the country, considered an evil for the nation (Hansembalg, 2005; Jaccoud *et al.*, 2008).

In view of this, to achieve the nation's whitening, the relationship between whites and Blacks was allowed, within certain limits. Miscegenation, in addition to purifying the Brazilian nation, becomes an individual goal, a valve of hope that reduces social discontent among blacks in the face of their social inferiority. This is because, even after abolition, race remains a criterion of distribution of people in the social class structure. As such, mixed-race people, with traits similar to whites, are allowed to move around and enjoy privileges destined for more valued strata of society. In addition to the phenotypic traits similar to those of the white population, better economic conditions, acquired by few Black individuals, also expanded the possibility of mixed-race people enjoying these privileges (Hansembalg, 2005).

Consequently, with the coexistence of different socioracial groups in the same spaces, caused by the change of socioeconomic *status*, by the miscegenation and social insertion of some Black individuals in spaces intended for non-Black people, the discourse that there is no racial problem in Brazil was proclaimed. However, in practice this phenomenon was configured as a means of

containing manifestations of nonconformity of the population considered inferior (Fernandes, 2009; Hansembalg, 2005).

In this way, the myth of racial democracy guarantees a relative pacification between two socioracial groups. The idea of the "good negro", who progresses socially and coexists with whites if his politeness and respect for the rules are maintained, reduces the disadvantages of Blackness, but intensifies institutional neglect in the face of the drama of the "colored population," which continues to live in degrading conditions. However, for racial democracy, the condition of misery experienced by Black people is disseminated as a result of the recent condition of enslaved, and their social ascent is presented as achievable, only requiring time (Fernandes, 2009).

Although Black people have been allowed a discreet social ascent, racism and discrimination become means of reminding this population of the space of inferiority destined for them, preserving the structure of society's privileges. Thus, racism, as an ideology of inferiority of one group to the detriment of the superiority of another, is presented as a systematic form of discrimination that is based on race and is practiced consciously or unconsciously. This ideology is used to justify the treatment and derogatory condition granted to members of racial and ethnic groups, acting as a mechanism that aggravates and maintains disadvantages or privilege among these groups (Almeida 2018; Fernandes, 2009; Paradies, 2013).

Thus, racial discrimination, one of the instruments of racism, acts through the interpersonal manifestation of discriminatory behaviors and practices, which exclude and inferiorize these groups, granting them lesser or worthless attributes, based on the characteristics valued in relation to another group (Brasil, 2017; Paradies, 2013; Werneck, 2016).

These tools maintain the inferiority of Blacks and privileges of whites, preserve inequality, sustain asymmetries between races and control the ascents achieved by the Black population, which, even though they are tiny and non-threatening to the privileges of non-Black people, are seen as potential for compromising the *status quo* and as a means to generate uprisings of this population.

In this context, the rejection of Black skin color and other phenotypic traits of the discriminated racial group are presented as tools to legitimize the place destined for it in society (Fernandes, 2009; Petrucelli; Saboia, 2013).

Therefore, discrimination and racism ensured that freed Blacks maintained condition similar to that of the enslaved, even after the abolition of slavery. On the other hand, regarding employment, European immigrants (even with scarce resources, similar to those of Black people), occupied spaces and chances of progression in the new productive mode, achieving privileges that were not met by blacks (Fernandes, 2009).

The increase in European immigration and its massive occupation in more valued spaces of the labor market, such as large-scale agricultural production and industry, led the Black population, now free, to find work in the most precarious and subordinate occupations (such as domestic services and informal jobs), activities performed mostly by this population to the present day. This occupation of subsistence and low-paid activities is the phenomenon that originates what we currently call the “informal sector” (Jaccoud, 2008; Silva; Trigo; Marçal, 2013).

In addition to the distribution of labor activities in the post-slavery period, there was also a spatial distribution of the freed Black population. With coffee production developed in the south-central region of the country and, consequently, with the dominance of this activity by immigrants, freed Blacks occupied the available jobs in the north and northeast of the country, regions of stagnant economy, where international immigration was not significant and educational and occupational opportunities were very limited. The vast majority of the Black population is kept outside the region where urban and industrial society develops and, even when they manage to occupy these spaces, they are located in peripheries, areas with little public investment and with great vulnerability (Abreu, 2013).

These historical, ideological, and social events promoted the devaluation of the Black population, delineated their exclusion, disadvantages, poverty and precariousness of their current

living conditions and caused significant marks, which directly impact their ability to integrate into society, putting barriers in the project of building a democratic country with equal opportunities for all, in addition to having repercussions on the health condition of this population.

The repercussions of institutional racism on access to health services and morbidity and mortality due to covid-19

Racism is a structural phenomenon. It is a system of institutions, policies, practices, and norms that fosters opportunities and assigns values to individuals based on race/color or appearance (Jones, 2002). This event is conditioned by the relations of society, reproducing racial patterns, and is repeated and naturalized in institutions to protect the current social order, becoming part of the *status quo* of everyday relationships in the most diverse spaces (Jones 2002; Almeida 2018).

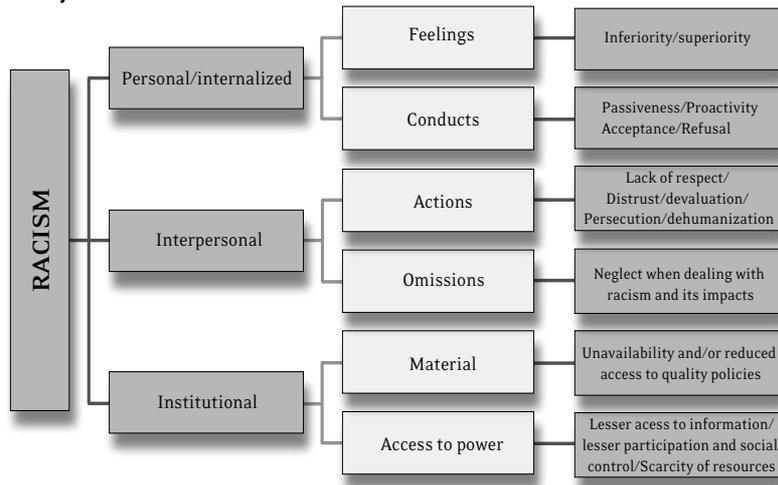
This phenomenon can be presented in three dimensions. The first composes **interpersonal racism**, manifested by prejudices, feelings, negative stereotypes, tied to racial or ethnic characteristics of a group. It can also be materialized by individual discriminatory practices, by the manifestation of derogatory or aggressive behaviors, whether intentional or not (Jones, 2002; Werneck, 2016).

The second dimension is that of **internalized racism**, defined as the acceptance of negative messages about one’s abilities and intrinsic worth by members of stigmatized racial or ethnic groups (Jones, 2002; Werneck, 2016).

The third dimension is **institutional racism**, manifested by its systemic component, perpetrated by organizations; policies, norms through inequitable treatment; negligence; disadvantage in access to benefits and slowness in the implementation of actions and policies, which results in failure to provide adequate services to people due to their color, culture, or ethnic origin (Jones, 2002; Werneck, 2016).

These dimensions of racism are outlined through a graphic resource (**Figure 1**) produced by Werneck (2016):

Figure 1 - Dimensions of racism



Source: Werneck (2016)

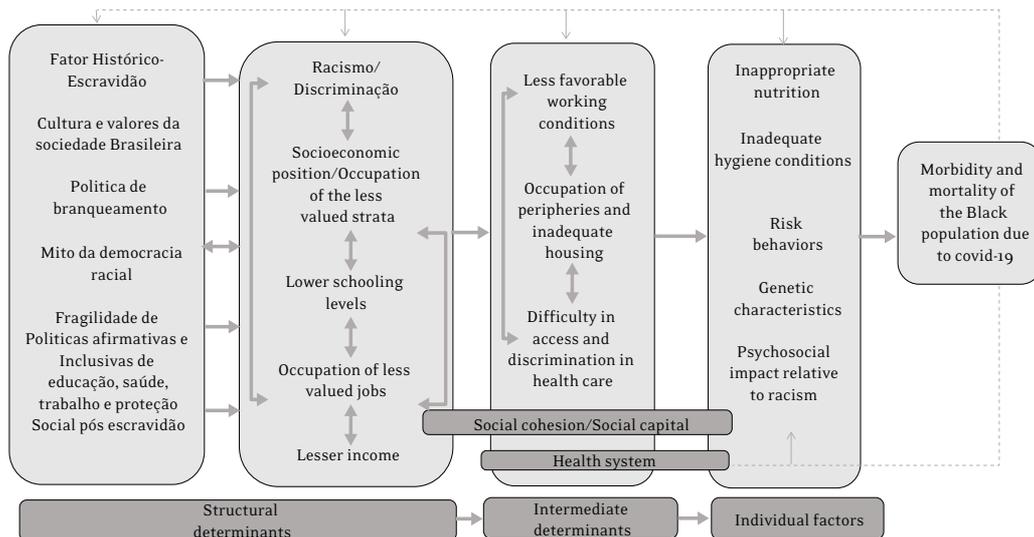
Thus, in health services, this event can materialize in all of its dimensions through the low quality of services provided to the Black population; through individual discrimination, practiced by professionals from the most diverse institutions and organizations; and through the difficulty to use health care, hiring for jobs, winning positions, access to education and in countless other situations.

Consequently, this social phenomenon, which is among the structural determinants of health

inequities, behaves as a producer of social hierarchy, which associated with health vulnerabilities, imposes barriers to access to rights and neglect the needs of the Black population (Brasil, 2017; Werneck, 2016).

Figure 2 presents a conceptual map of vulnerability to covid-19 of the Black population, based on the scheme of Solar and Irwin (2010), adopted by the World Health Organization (WHO), synthesizing the discussions of this work.

Figure 2 – Conceptual map with the determinants of morbidity and mortality of the Black population to covid-19



Source: Adapted from Solar and Irwin (2010)

As shown in the figure, the inequities in the morbidity and mortality of the Black population due to covid-19 reflect historical, social, and economic processes that are directly related to racism, a determinant of the precariousness of the living and health conditions of this population, limitations in the quality and access to services and health, and individual factors for vulnerability to coronavirus infection. Thus, racism, as a structural element, assumes a prominent position, and thus is configured as a base cause or priority root for the design of deprivations in the health of the Black population and in the involvement of the disease.

Furthermore, in addition to being relevant in understanding the determination of racism in the health of the Black population, it is essential to understand the role of the Brazilian National Health System (SUS) in this context.

In the meantime, it is known that health care free of discrimination and universal access to all citizens are prerogatives announced by milestones in the creation and regulation of SUS. However, even with the existence of a robust legal framework, from the creation of SUS to the present day, health disparities between racial groups and the inability to guarantee effective access to all Brazilian citizens in an equitable manner are identified, which indicates the non-effectiveness of the principles defended by this system (Brasil, 2017).

However, the National Policy of Integral Health to the Black Population (PNSIPN), implemented through Ordinance GM/MS No. 992, of May 13, 2009, and ratified in 2010 by the statute of Racial Equality, Law No. 12,288/2010, is presented with the objective of ensuring the promotion of integral health towards the black population, prioritizing the reduction of ethnic-racial inequalities, as well as the fight against racism and discrimination in SUS institutions and services (Brasil, 2017).

These efforts seek to understand health in a broader sense and the health system as a space to assist the complexity of the individual. In addition, they understand that health services should seek to minimize various forms of racism and provide access to all population groups, with a view to reducing disparities and situations of vulnerability.

In this perspective, we emphasize that access refers to the opportunity to use health services when necessary; it expresses characteristics of such offers and circumstances that facilitate or disrupt people's ability to effectively use them. Moreover, it is a complex phenomenon that can vary for each person or group, depending on a diverse range of variables related to the individual and the system, not only limiting the existence or not of the health service (Sanchez; Ciconelli, 2012).

Thus, numerous reasons are pointed out as intervening in access to health services, such as characteristics of the system, socioeconomic level of the population, schooling, cultural aspects, geographical characteristics of users and services, and belonging to specific groups. In addition, when we observe that these factors increase or decrease access to health services, we are faced with inequality in access to health services (Albuquerque *et al.*, 2017).

Therefore, disparities in access can generate or contribute to the structuring of health inequities. Consequently, groups that have impairment to use health services, such as the Black population, will have disadvantages that influence their morbidity and mortality profile, when compared to other groups with no difficulty of access (Arcaya; Arcaya; Subramanian, 2015).

We emphasize that, although the SUS has greater relevance for obtaining care among blacks and browns than for whites, we can find greater difficulty in access by the former group. Thus, it is evident a lower quantity of medical care and lower quality in the provision of this service for the Black population in relation to the white population. Thus, blacks and browns, in addition to having a higher probability of not being attended by these services, when attended to they declare themselves less satisfied with the service (Goes; Nascimento, 2013; Paixão *et al.*, 2010).

Moreover, the precariousness in access, in the quality of service and the increase in discrimination in health are aggravated when associated with multiple health conditions and other vulnerability factors, such as low education and income, elements present in the reality of this population group (Goes; Nascimento, 2013; Paixão *et al.*, 2010).

As such, the context of covid-19 exposed the geography of inequalities and ruthlessly reflected

past historical processes, especially for older people and the Black population (Teixeira *et al.*, 2020). Thus, the pandemic has widened racial segregation, showing that in the composition of those vulnerable to covid-19 in Brazil, the highest fatality rates are among blacks living in areas of lower socioeconomic status, a group formed by residents of favelas, peripheries, people on the street and even with a higher prevalence of specific morbidities (diabetes and hypertension, for example) (Teixeira *et al.*, 2020).

However, this discrepancy is reinforced because this population is affected by inequities in the geographical distribution of health services. This is because the regions with the lowest offer of these services are the ones that most concentrate the Black population: North, Northeast and Midwest, with 77.3%, 73%, 59% of its population consisting of Black people. (IBGE, 2016).

In addition, the Brazilian Black population finds yet another geographical barrier in guaranteeing the right to health, since this is the group that occupies most of the rural areas of the country, constituting 60% of the population in this situation of domicile (IBGE, 2016).

In this sense, we can observe that high rates of accessibility and satisfaction can be found in central areas of territories, where there is high urban density and high concentration of public services, including health services. Conversely, there is less access to services in less dense areas with fewer public services, such as rural areas (Towne Jr., 2017).

The advent of the covid-19 pandemic highlights other weaknesses related to the distribution of resources necessary to cope with it. In addition to having the lowest concentration of health services, the North and Northeast regions also have the lowest supply of intensive care unit (ICU) beds and mechanical ventilators (Noronha *et al.*, 2020).

In the current health context, the availability and access to hospital services, the number of public and private beds, the number of ICU beds and mechanical ventilators are determinants for the management of the most complex cases and for a favorable outcome. However, these resources are more available in the higher socioeconomic strata of society, which in Brazil are occupied mostly by white people (Rafael *et al.*, 2020).

In addition to interfering with the variability of access to health services, in the covid-19 pandemic, the race/color variable is related to the performance of diagnostic tests for the disease. This premise is corroborated by an ecological study conducted among neighborhoods in Rio de Janeiro, which points out that the performance of this type of test and a higher number of covid-19 cases occurs in neighborhoods where there is a higher income *per capita* and with a higher incidence of white residents, which reflects the greater access to these exams by people with better incomes. On the other hand, the neighborhoods with the largest Black population have the lowest number of tests and positive cases (Rafael *et al.*, 2020)

Although there is local evidence of greater diagnostic difficulty of the black contingent by covid-19, at the national level, the data presented in the epidemiological bulletin of the Ministry of Health show that the Black and brown population has higher morbidity and mortality overall by covid-19 in relation to the other racial groups in Brazil, which reiterates previous discussions (Brasil, 2020).

Although the data on hospital admission through the epidemiological bulletins of the Ministry of Health is not available, through the analysis of data from the **Influenza epidemiological surveillance information system**, Baqui (2020) identified that this event occurs in an approximate manner for the black and for the white populations; however, the study draws attention to the racial differences in the number of deaths of hospitalized black patients not admitted to ICUs.

This finding shows that the need for services with higher technology intensifies access disparities; even in this situation in which there is a similar hospital admission rate between whites and Blacks, there is a higher rate of hospitalization of white patients in ICUs. Thus, the mortality rate of Black Brazilians due to covid-19 is due, in part, to their non-hospitalization in ICUs, thus raising concerns about the organization of public and private health resources (Baqui *et al.*, 2020).

As such, it is estimated that because they belong to the highest social strata, the white population may have a greater chance of being admitted to private beds in ICUs, when there is unavailability of public beds due to saturation of the health system during the

pandemic. This opportunity favors the management of severe disease conditions and lower mortality from covid-19 (Noronha *et al.* 2020; Rafael *et al.*, 2020).

Despite drawing attention to the difficulty of access of the Black population to ICU beds and mechanical ventilators during the covid-19 pandemic, the loss of this population begins long before being in a hospital bed.

As presented in the first section of this manuscript, the Brazilian population, mostly black, is insidiously and widely subjected to multiple deprivations: in social activity, housing, sanitation, schooling, employment, and income (Brasil, 2016). These problems become even more serious and impactful in the context of the covid-19 pandemic.

The disease that was globalized through international travel, brought by people from the upper classes of Europe, found in Brazil this population deprived of the most elementary conditions of dignified life and health (Shadmi *et al.*, 2020).

In its rise, the covid-19 pandemic dictated the need for social distancing, to stay at home and avoid work; it also required extreme hygiene, through frequent hand washing and use of alcohol-based sanitizers. However, in a country where millions of Brazilians do not have basic sanitation, it is a challenge to adopt even the simplest measures (Shadmi). *et al.*, 2020).

These issues have raised multiple challenges, given the profile of the Brazilian population and the groups affected: a mostly black population, over 60 years old, multiple comorbidities, with difficulty in distancing or isolation, due to their housing conditions and intergenerational family arrangements, with a lack of material resources, low schooling levels and often with a lack of complete information about the disease and its severity, dependent on informal work *et al.*, 2020).

In addition to the deprivations experienced by most of the Brazilian population and the weaknesses in access to health services, in Brazil covid-19 has found fruitful soil through the systematic reproduction of structural racism, legitimized by the state. Our country, currently with the second highest number of cases and deaths, adopted a negative attitude and disregard for the recommendations of the World Health Organization (Shadmi *et al.*, 2020).

Thus, the emphasis on the disparities in hospital mortality of the Black population due to covid-19 reflects all the elements presented so far. The occupations of the lowest social strata by Black people and all the elements that permeate structural racism determine deprivations in their ways of life that translate into vulnerability to covid-19, which finds ways to expand through difficulty in accessing health services and ICU beds, resources necessary for the management of the disease and its complications.

Final Remarks

Understanding the roots of racial inequalities and the living condition of the Black population and confronting them with evidence on hospital mortality due to covid-19 presents us the ways in which structural racism impacts and reproduces itself in the life and death of the Brazilian Black population, in addition to revealing that the lifespan of the pandemic continues an already existing but ignored situation in Brazil.

We found that the situation of vulnerability to covid-19 by the Black population is systematically repeated in multiple scenarios and is treated with the inherent neglect of structural racism. We emphasize that it is imperative to improve Brazilian public policies, including health policies, with a view to correcting injustices and achieving more equitable access. We reinforce the need to make visible the situation of Black people in Brazil, to expand and implement existing affirmative policies so that they are in fact part of daily life, not only in the field of health, but in all areas, and that they produce a positive impact on the ways of living and dying of this population.

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Authors' contributions

Dantas conducted the conception, writing and critical review of the manuscript. Silva and Barbosa participated in the conception and critical review of the manuscript.

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