

Battered by the pandemic, communities of color experience sharp drop in life expectancies

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Introduction

The PBS NewsHour segment “Battered by the Pandemic, Communities of Color Experience Sharp Drop in Life Expectancies,” published in February 2021, examined early evidence that COVID-19 mortality was reducing U.S. life expectancy unequally. Dr. Reed Tuckson argued that the pandemic exposed longstanding differences in work, housing, chronic disease, access to care, and treatment within the health system. The event was current at the time, but it now belongs to a longer mortality record. Final data show that U.S. life expectancy later recovered as COVID-19 deaths declined, reaching 79.0 years in 2024. Recovery of the national average, however, does not erase the severe losses experienced during 2020 and 2021 or the structural inequalities that shaped them. (PBS NewsHour)

Summary of the PBS Interview

The interview emphasized that Black Americans and other communities of color faced disproportionate infection, hospitalization, and death. Exposure was not simply a result of personal choice. Many people worked in public-facing or essential occupations that could not be performed remotely. Crowded or multigenerational housing made isolation difficult. Unequal access to nutritious food, preventive care, paid leave, testing, and high-quality treatment increased vulnerability. Preexisting conditions such as hypertension and diabetes also raised risk, but those conditions themselves were patterned by social and environmental circumstances.

The segment also discussed distrust of medical institutions. It is inaccurate to call such distrust “inherent.” Mistrust can be a rational response to personal discrimination, unequal treatment, exclusion from decision-making, historical abuse, and inconsistent public communication. Health organizations cannot correct it merely by persuading individuals to behave differently. They must demonstrate trustworthiness through respectful care, transparency, community partnership, accountability, and equitable access.

What Life Expectancy Measures

Life expectancy at birth is a period measure derived from age-specific death rates observed in a particular year. It estimates how long a hypothetical newborn would live if those mortality conditions continued. It is not a prediction of the exact lifespan of an individual born that year. A sudden event that increases deaths, especially at younger ages, can reduce period life expectancy sharply. (Centers for Disease Control and Prevention, National Center for Health Statistics, “Life Expectancy U S Dropped”)

The pandemic lowered life expectancy because deaths increased from COVID-19 and from several other causes affected by delayed care, economic disruption, overdose, violence, and pressure on health systems. The measure is useful because it summarizes mortality across ages, but it does not explain why deaths occurred. Cause-specific mortality, excess deaths, disability, geography, sex, income, and race and Hispanic origin are needed for interpretation.

The Pandemic Decline

U.S. life expectancy fell substantially between 2019 and 2021. The decline was not evenly distributed. CDC reporting showed especially severe losses among American Indian and Alaska Native people, Hispanic people, and non-Hispanic Black people. In 2021, life expectancy was 65.6 years for the non-Hispanic American Indian or Alaska Native population, 70.8 for the non-Hispanic Black population, 76.4 for the non-Hispanic White population, 77.6 for the Hispanic population, and 83.5 for the non-Hispanic Asian population. These estimates must be interpreted with awareness of racial and ethnic misclassification in death records, particularly for American Indian and Alaska Native people.

The title’s phrase “communities of color” is useful for identifying unequal exposure to racism, but it can also conceal differences among populations. Black, Hispanic, Asian, Pacific Islander, and Indigenous communities have different histories, age distributions, occupations, migration patterns, geographies, and health risks. Aggregated categories may hide vulnerable subgroups.

Recovery After the Acute Pandemic Period

Mortality conditions improved after 2021. Life expectancy rose to 77.5 years in 2022, 78.4 in 2023, and 79.0 in 2024. The 2024 estimate was the highest U.S. national level reported by the National Center for Health Statistics. COVID-19 was no longer among the ten leading causes of death in 2024. These facts show that a pandemic decline is not necessarily permanent. (Centers for Disease Control and Prevention, National Center for Health Statistics, “Mortality United States 2024”; Centers for Disease Control and Prevention, National Center for Health Statistics, “Life Expectancy Increases However Suicides”)

Race-specific figures illustrate partial recovery but continuing inequality. CDC's 2022 estimates reported life expectancy of 67.9 years for non-Hispanic American Indian or Alaska Native people, 72.8 for non-Hispanic Black people, 77.5 for non-Hispanic White people, 80.0 for Hispanic people, and 84.5 for non-Hispanic Asian people. Every group gained from 2021, but the distance between the highest and lowest estimates remained large. A rising national average can therefore coexist with avoidable disparities.

Structural Racism as a Fundamental Cause

Link and Phelan's fundamental-cause theory argues that social conditions such as socioeconomic status repeatedly shape disease because they determine access to flexible resources: money, knowledge, power, prestige, and beneficial social connections. When one disease is controlled, groups with greater resources are often positioned to benefit first from new information, technology, and treatment. The mechanism changes, but the inequality persists. (Link)

Structural racism operates through institutions rather than requiring individual prejudice in every encounter. Residential segregation affects exposure to pollution, heat, crowding, and under-resourced services. Labor-market discrimination influences job security, wages, paid leave, and the ability to work remotely. Unequal wealth affects housing and the capacity to absorb a crisis. Transportation, broadband access, insurance, language services, and neighborhood health infrastructure shape whether testing, vaccination, and treatment can be obtained quickly.

Essential Work and Occupational Exposure

Many workers in transportation, food service, retail, cleaning, warehouses, agriculture, health support, and caregiving continued in-person work. Exposure increased when employers lacked adequate ventilation, protective equipment, sick leave, or predictable scheduling. Describing these occupations only as individual risk factors misses the policy choices that defined workplace protection.

Workers also carried risk home. A person living with older relatives or several wage earners could not always isolate. Crowding was often linked to housing cost rather than preference. Effective public-health protection therefore required workplace standards, paid leave, accessible testing, income support, and temporary isolation options, not simply instructions to stay home.

Health Care Access and Quality

Insurance status, facility location, transportation, language access, and previous experience influence when people seek care. During COVID-19 surges, overstretched hospitals and delayed treatment affected outcomes. Bias can influence pain assessment, diagnostic decisions, communication, and the seriousness with which symptoms are treated. At the same time, many clinicians and community

organizations worked intensively to reduce barriers. A balanced analysis evaluates systems and outcomes without portraying every health professional as intentionally discriminatory.

Community health centers, faith organizations, tribal health systems, local leaders, and culturally responsive messengers helped deliver information and vaccines. Partnership was most effective when communities were involved in design rather than approached only after distrust emerged.

Chronic Disease and the Life-Course Perspective

Hypertension, diabetes, kidney disease, obesity, and respiratory disease increased the risk of severe COVID-19. These conditions are sometimes described as “lifestyle diseases,” but life-course research shows that risk accumulates through nutrition, stress, environmental exposure, education, neighborhood opportunity, health care, and economic security. Individual behavior matters within constraints that are unequally distributed. (Jones)

The weathering framework further proposes that repeated exposure to social and economic adversity can accelerate physiological deterioration. The concept helps explain why mortality differences cannot be reduced to genetics or a single adult choice. Policy affecting children, families, housing, education, and work is also health policy.

Mental Health, Grief, and Social Loss

Communities with higher mortality experienced more bereavement, caregiving disruption, and economic loss. Funeral practices were interrupted, and many people grieved without normal social support. Essential workers faced fear and exhaustion, while children experienced school disruption and loss of caregivers. Mental-health consequences therefore followed the unequal distribution of illness and death.

Support should include accessible counseling, school-based services, community healing, and economic assistance. It should not pathologize understandable grief or treat resilience as a substitute for structural change.

Policy Implications

First, public-health data should be timely and disaggregated while protecting privacy. Broad racial categories should be supplemented by geography, occupation, income, disability, language, and tribal affiliation where appropriate. Second, emergency plans should guarantee paid sick leave, worker protection, accessible testing and vaccination, and support for isolation. Third, health systems should measure differences in access, treatment, and outcomes and act on those findings.

Long-term policy must address insurance coverage, primary care, maternal health, environmental exposure, housing, food security, education, wealth inequality, and criminal-justice harms. Emergency preparedness is strongest when the population enters a crisis with fewer preventable health disadvantages.

Conclusion

The PBS segment accurately recognized that COVID-19 did not strike an equal society. The pandemic produced major life-expectancy losses, with especially severe effects in several racial and ethnic populations. National life expectancy subsequently recovered to 79.0 years in 2024, but recovery should not be confused with equity. Occupational exposure, housing, health care, chronic disease, wealth, and structural racism shaped who was most likely to become ill and die. The enduring lesson is that trust and health cannot be created by information campaigns alone. Institutions must become demonstrably trustworthy and reduce the material conditions that repeatedly produce unequal mortality.

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