STATEMENT

of the

American Medical Association

for the Record

U.S. House of Representatives
Committee on Ways and Means

Re: The Disproportionate Impact of COVID-19
on Communities of Color

June 8, 2020

Division of Legislative Counsel
(202) 789-7426

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The American Medical Association (AMA) appreciates the opportunity to submit this statement for the record to the U.S. House of Representatives Committee on Ways & Means as part of its May 27, 2020 hearing on the "Disproportionate Impact of COVID-19 on Minority Communities." The AMA commends the Committee for focusing on this critically important issue. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is deeply committed to confronting and addressing the alarming health disparities and inequities that exist in communities of color across the United States.

Background

While it will take months, if not years, to capture and understand just how big of an impact COVID-19 is having on the U.S., the COVID-19 pandemic has revealed starkly the disproportionate impact of the virus on communities of color. The causes of the disproportionate impact are rooted in this country's historical and structural racism and the social, economic, and health inequities that have resulted, and continue to result in, adverse health outcomes. Throughout the public health emergency, the collection and reporting of racial data related to COVID-19 testing, hospitalizations, and mortality has been limited. The dearth of racially and ethnically disaggregated data reflecting the health of marginalized and minoritized persons and families underlies the struggles of the physician community and public health authorities to fully attend to, and be attuned to, the unique needs of their patients and populations, and for legislators to design well-informed policies that will preserve lives. Without collecting race and ethnicity data associated with COVID-19 (testing, hospitalizations, morbidities, and mortalities) these communities have been, and continue to be, at greater risk of disease and death, and physicians and hospitals will not be able to properly care for their patients. While the data remains incomplete, some data is being reported by 48 states and the District of Columbia, and overall, race or ethnicity is known in about half of all cases and 90 percent of deaths, according to National Public Radio and the COVID Racial Tracker. The data that has emerged on the racial and ethnic patterns of the COVID-19 pandemic show that the virus has disproportionately affected Black and Latinx, American Indian/Alaska Native—particularly in the Navajo nation—Asian-American, and Pacific Islander communities.

As widely noted in recent media reports and research studies, Black Americans have been among the hardest hit populations by the virus. Not only are they hospitalized and dying in disproportionate numbers, they also are more likely than White Americans to have lost income because of the pandemic. According to NPR's analysis, based in part on the COVID Racial Tracker, in 32 states plus Washington

D.C., Blacks are dying at rates higher than their proportion of the population, and in 21 states, it is much higher, more than 50 percent above what would be expected. For example, in Wisconsin, at least 141 African Americans have died, representing 27 percent of all deaths in a state where just 6 percent of the state's population is Black. In Minnesota, Black people make up only seven percent of the population, but they account for 16 percent of the 23,000 confirmed COVID-19 cases. And, as Ibram X. Kendi, Ph.D., stated in his Ways and Means testimony, Black Americans are dying at nearly two times their national population share, and in five out of the six counties with the highest death rates, Black Americans are the largest racial group. Underscoring the disproportionate toll on Black Americans, a study published in the *New England Journal of Medicine* found that Black corona virus patients made up three-fourths of those hospitalized and 70.6 percent of those who died in Ochsner hospitals, Louisiana's largest health system, whereas Blacks comprise only 31 percent of the Ochsner Health population. In the District of Columbia, according to the most recent data on the COVID Racial Tracker, Black or African Americans represent 52 percent of COVID cases and 75 percent of COVID deaths.

Why does the Black community seem to be at greater risk? There are three key factors: 1) pre-existing conditions, such as diabetes, hypertension and obesity that disproportionately impact the African American community; 2) essential jobs that are not in the health profession, including bus drivers, train operators and custodians, are overrepresented by communities of color; and 3) structural inequities and social determinants of health (SDOH) that are influenced by implicit bias and racial discrimination. In addition, there has been misinformation and disinformation, and myths that have had to be combated, particularly in the Black community. As AMA President Patrice A. Harris, MD, MA has noted, "We have to be grounded and rooted in the science and the evidence and the data, and decisions around this pandemic have to be data-driven decisions."

According to the COVID Racial Data Tracker, in the District of Columbia and 41 states, Latino Americans are disproportionately testing positive for the coronavirus, as well. The rates are two times higher in 30 states, and over four times higher in eight states. For example, in Virginia more than 12,000 cases—49 percent of all cases with known ethnicity—come from the Hispanic and Latino community, which makes up only 10 percent of the population. In Iowa and Wisconsin, the Latino case rate is five times their population share, according to the COVID Racial Data Tracker as of May 22, 2020. Overall, more than 28 percent of people diagnosed with COVID-19 in the United States are Hispanic, according to the Centers for Disease Control and Prevention (CDC). Despite that percentage and the fact that Latinx are the largest racial marginalized group in the United States, the effect of COVID-19 on this community has not been widely addressed, according to Aletha Maybank, MD, MPH, chief health equity officer and group vice president of the AMA.

American Indian communities in the U.S. have also suffered disproportionately higher rates of infection and death from COVID-19 during the pandemic. While the Navajo Nation has implemented a series of strict lockdown measures in an effort to protect its population, its health care facilities have been overwhelmed. Other tribes across the country are also suffering from high case numbers and severe economic fallout. In New Mexico, American Indian communities have accounted for 60 percent of cases but only 9 percent of the population, while in Arizona, at least 136 American Indians have died from COVID-19, accounting for 21 percent of deaths in a state where just 4 percent of the population are American Indian. The AMA recently sent a letter to U.S. Department of Health and Human Services (HHS) Secretary Alex Azar expressing the urgent need to address the dire situation that American Indians and Alaska Natives (AI/AN) are facing with respect to confronting the COVID-19 pandemic, particularly pointing out the problems in the Navajo Nation. We noted our concern that promised federal funding to AI/AN tribes has been either very slow to be released or has not reached many tribal nations at all. Such assistance is vitally important to ensure that the tribes have the resources they need to successfully address the numerous issues involved in fighting the COVID-19 health crisis and to save lives.

Inequity and Social Determinants of Health

As several of the witnesses before this committee testified, it should not come as a surprise that communities of color have been disproportionately impacted by COVID-19 in light of the historic and persistent health, social, and economic inequities experienced by them. The AMA defines health equity as "optimal health for all" and recognizes the importance and urgency of advancing health equity and addressing SDOH to ensure that all people and communities reach their full health potential. The World Health Organization (WHO) defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups." This definition clarifies that inequities and disparities do not have to exist, but that inequities are produced, they do not just happen, the people who are negatively impacted by experiencing the injustice are not to blame, and there is something that we can do to close the gap.

The pandemic has highlighted the importance of acknowledging the important role played by the SDOH. According to Healthy People 2020, the "social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risk." These social determinants include, but are not limited to, education, housing, wealth, income, and employment. We all experience conditions that socially determine our health. However, we do not all experience SDOH equally. The SDOH are impacted by larger and powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation. In this country, these historic and systemic realities are baked into structures, policies, and practices and produce, exacerbate, and perpetuate inequities among the SDOH, and, therefore, affect health itself. These larger, powerful systems of racism and gender oppression—also known as the root cause inequities—are "upstream" to the SDOH. In other words, racism and gender oppression are fundamental factors behind how SDOH affect individuals. They have shaped the social conditions in which men, women, and families live, and they work to produce inequities across society in complex ways, especially for those in communities of color.

At the provider and institutional levels, there is a growing body of evidence demonstrating that implicit and explicit biases exist that negatively impact the quality of health care equity and patient safety and drive these inequities. This was described originally in an Institute of Medicine (now the National Academy of Medicine) report, more than 15 years ago (Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/10260). The evidence shows that Blacks are more likely to receive poorer quality of care and less likely to receive the standard of care even when controlling for insurance status and income. This was linked with higher death rates for Blacks.

In addition, there has been a growing body of work examining the impact of structural racism on health in this country. In 2017, Dr. Zinzi Bailey et al. published a study in the *Lancet*, "Structural Racism and Health Inequities in the US: Evidence and Interventions," that explains structural racism to be 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. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources." And one key example of structural racism included how "residential segregation systemically shapes health care access, utilization, and quality at the neighborhood level, health-care system, and provider levels."

There is evidence that experiences of discrimination and racism have a "weathering" effect on the body. Dr. Arline Geronimus, who coined the "weathering" hypothesis, explained that "Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization" over one's life course. This physiologic pressure, also later described as allostatic load, can cause stress hormones, such as cortisol, and cause organ and

cardiovascular, metabolic, and immune systems damage over time. In addition, chronic stress and trauma due to discrimination that occurs as early as in-utero and early childhood, also known as adverse childhood experiences, have been associated with poor health outcomes and early death as an adult.

Additional SDOH considerations have also contributed to the disproportionate impact of COVID-19 on marginalized and minoritized communities, including poverty, lack of access to health care, nutritious food, affordable housing, and accessible transportation, as well as congregate living with multi-generational family members and the fact that many people of color work "essential" jobs that increase their exposure to the virus, such as in meatpacking plants, warehouses, supermarkets, hospitals, and nursing homes. Moreover, underlying chronic health conditions, including diabetes, obesity, and hypertension, have all played a role in increased COVID-19 cases and deaths in communities of color.

At the same time, the recent deaths of Breonna Taylor, a Black woman and emergency medical technician in Louisville who was shot and killed in her own home due to mistaken identity by law enforcement, and George Floyd, a Black man in Minneapolis killed in the custody of law enforcement, spotlight the linkages among violence, racism, and health disparities. As noted recently by AMA leaders Jesse M. Ehrenfeld, MD, MPH, Board Chair and Dr. Harris, "AMA policy recognizes that physical or verbal violence between law enforcement officers and the public, particularly among Black and Brown communities where these incidents are more prevalent and pervasive, is a critical determinant of health." Moreover, Drs. Ehrenfeld and Harris noted that "Recognizing that many who serve in law enforcement are committed to justice, the violence inflicted by police in news headlines today must be understood in relation to larger social and economic arrangements that put individuals and populations in harm's way, leading to premature illness and death. Police violence is a striking reflection of our American legacy of racism—a system that assigns value and structures opportunity while unfairly advantaging some and disadvantaging others based on their skin color…Importantly, racism is detrimental to health in all its forms." Research shows that racially marginalized communities are disproportionally subject to police force, and there is a correlation between policing and adverse health outcomes. An increased prevalence of police encounters is linked to elevated stress and anxiety levels, along with increased rates of high blood pressure, diabetes, and asthma—and fatal complications of those comorbid conditions.

What the AMA is doing to address SDOH and Health Equity

A commitment to health equity means we must address the SDOH and we must elevate and name the root causes of why health inequities exist and how they came to be—both in society and at the institutional level. The AMA demonstrates its commitment through addressing the social conditions that impact health, increasing health workforce diversity, advocating for equity in health care access, promoting equity in care, and ensuring equitable practices and processes in research and data collection. For example, over the last two years, the AMA has been actively involved in working with stakeholders and policymakers at the state and federal levels to support efforts to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity among Black women. Although the AMA and physicians cannot control all factors that need to change to achieve health equity, our organization understands its important role in identifying their importance and both urging and educating those who can have a direct role to act.

Last year, the AMA created the Center for Health Equity (CHE), led by our first Chief Health Equity Officer, Aletha Maybank, MD. This initiative aims to embed health equity across the AMA so that it becomes part of the practice, process, action, innovation, and organizational performance and outcomes. The CHE also strives to strengthen, amplify, and sustain the AMA's work to eliminate health inequities – improving health outcomes and closing disparity gaps – which are rooted in historical and contemporary injustices and discrimination. Under CHE's leadership, the AMA has recently partnered with notable hospitals, community health centers, and social organizations in Chicago in a $6 million collaborative

social impact investment pact called West Side United. The collaborative is a solid step forward toward closing health equity gaps and invigorating economic growth into neighborhoods of Chicago's west side.

Throughout the current pandemic, the AMA has compiled critical health equity resources from across the web to shine a light on the structural issues that contribute to and could exacerbate already existing inequities. The AMA has also sponsored a weekly Prioritizing Equity video series where health experts discuss how various communities of color have been impacted by COVID-19. And, on May 6, the AMA co-hosted a virtual town hall with the National Association of Black Journalists (NABJ). The conversation centered on COVID-19 and the Black community and was moderated by NABJ President Dorothy Tucker, an investigative reporter for CBS 2 Chicago (WBBM-TV).

To improve health equity, the AMA's strategic and focused approach includes a multi-pronged, multi-year investment, strategic partnerships, and advocacy. This approach includes having an explicit focus on racial and health equity, ensuring workforce diversity, educating the next generation of medical students on the structural and SDOH, and partnering with other organizations. The AMA supports efforts designed to integrate training in the SDOH and cultural competence across the undergraduate medical school curriculum to assure that medical students are prepared to provide patients with safe, high quality, and patient-centered care. In 2013, the AMA launched the "Accelerating Change in Medical Education" initiative. Today, the 37-member consortium, which represents one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to nearly 24,000 medical students—students who will provide care to a potential 41 million patients annually. One of the earliest innovations to come from the Consortium was the new and innovative curriculum on health systems science, which includes a chapter on the SDOH. Nearly all the 37 schools in the consortium are addressing the SDOH with a focus on ensuring that students recognize the impact of the SDOH and are working with inter-professional colleagues to address them.

In 2019, the AMA announced its Reimaging Residency Initiative, designed to transform residency training to best address the workforce needs of our current and future health care system. Many of the applications to the graduate medical education initiative have included health systems science training in their proposals, including one from New York-based Montefiore Health System to develop, implement and evaluate a multi-pronged curriculum in SDOH in four community-based primary care training programs—family medicine, internal medicine, obstetrics and pediatrics.

For practicing physicians, the AMA launched STEPSforward,™ an interactive practice transformation series offering innovative strategies that will allow physicians and their staff to thrive in the evolving health care environment by working smarter, not harder. This series includes a continuing medical education module on "Addressing Social Determinants of Health: Beyond the Clinic Walls." The interactive module helps physicians identify how to best understand the needs of their community, define a plan to begin addressing the SDOH, and explains the tools available to screen patients and link them to resources.

Suggested Solutions

As a leader in confronting and addressing both the COVID-19 pandemic and the public health crisis of health disparities and inequities, the AMA believes that we need to use this moment in time as an opportunity to move our country forward on health equity and racism. The recent attention in the media and among policymakers to the disproportionate impact of COVID-19 on communities of color has led to more conversations on the historical and structural racism, along with other factors, that have led to long-standing health disparities and social and economic inequities in communities of color. This is a conversation that is long overdue and it must continue after the current pandemic subsides. The AMA is committed to helping to lead the country forward to promote inclusion, equity, and diversity. This

requires a "whole-of-a-nation" approach, with multiple stakeholders, including government at all levels and public-private partnerships, promoting change.

The AMA recommends the following policies to promote equity and reduce health disparities:

Addressing Implicit Bias/Unconscious Bias. These biases are learned stereotypes that are automatic, unintentional, deeply engrained, universal, and able to influence behavior. Such biases contribute to racism in the health care system; both institutional and individual racism has been demonstrated to impact the care people of color, particularly pregnant Black women, receive and is, in turn, responsible for some of the differences in health outcomes. As mentioned above, programs at all levels of medical education are helping to address these biases and teaching about the SDOH, but such education needs to be expanded throughout the health care system and the broader society.

Data Challenges. Overall, issues with accurate, consistent, and complete data have been a continuing concern throughout the pandemic, including on the number of cases, testing results (e.g., the CDC and many states combined statistics on diagnostic tests and antibody tests), hospitalizations, and deaths. Without improvements in data collection at all levels of government, it is difficult to know where virus "hot-spots" are occurring, and where testing and other resources need to be focused. This is particularly important as the country lifts restrictions on physical distancing and businesses, schools, and government reopen. It is also critically important to fully understand the impact of COVID-19 on communities of color. That is why in April, the AMA and several other medical organizations called upon HHS to collect, analyze, and make available to the public, explicit, comprehensive, standardized data on race, ethnicity, and patients' preferred spoken and written language related to the testing status, hospitalization, and mortality associated with the novel coronavirus, COVID-19. In addition, the AMA supports H.R. 6585 (Kelly, D-IL), the "Equitable Data Collection and Disclosure on COVID-19 Act of 2020," which would require HHS to collect and report racial, ethnic, and other demographic data on COVID-19 testing, treatment, and fatality rates, and provide a summary of the final statistics and a report to Congress within 60 days after the end of the public health emergency. We urge support for this legislation. We note, however, that all data collection efforts must be culturally sensitive and appropriate and must respect patient privacy. Patients should not be compelled by the health care system or the government to disclose racial or ethnic information (including immigration status or country of origin) against their will.

Addressing SDOH. As noted previously, the SDOH can have a negative impact on health outcomes and have contributed to the disproportionate impact of COVID-19 on communities of color. Social risk factors, e.g., poverty, lack of access to health care, nutritious food, affordable housing, and accessible transportation, in addition to where people live and work, must be addressed beyond just the parameters of the pandemic. Congress is already working on numerous proposals to address SDOH, and the AMA supports a specific SDOH proposal, H.R. 4004, the "Social Determinants of Health Accelerator Act" (Bustos, D-IL), which is aimed at providing local communities with the funding and planning tools to implement solutions to the SDOH. Most importantly, improved access to health care—specifically related to the pandemic but also more generally—must be addressed. The pandemic has starkly revealed that it is critically important that every individual has access to health care, and we support expanding health insurance to those individuals who remain uninsured, both through the private market and Medicaid.

Investment in Professional Diversity. We need to increase the pipeline of racially and ethnically diverse, practicing physicians. This need extends to medical school, residency, and physicians in teaching and academic settings. For example, we support continuing the development of a more diverse physician work force by supporting programs such as the Health Careers Opportunity Program (HCOP). The purpose of this grant program is to assist individuals from disadvantaged backgrounds to enter a health profession through the development of academies that will support and guide them through the

educational pipeline. We also support increased funding for Title VII health professions programs and the National Health Service Corps.

Language diversity among practicing physicians, medical students, and residents is an equally important component of professional diversity. As highlighted by many of the witnesses who testified before the Ways and Means Committee, physicians who can speak the native languages of minority populations are more adept at gaining patient trust and that, in turn, can lead to greater adherence to courses of treatment and improved health outcomes.

Conclusion

It will take all of us working in partnership—and the AMA is committed to doing so—to build and continue on a path forward to address not only the specific health disparities that the COVID-19 pandemic has revealed, but also the underlying structural and institutional racism and SDOH and to advance health equity. The AMA looks forward to working with members of this Committee and in Congress to advance these critical goals.