



STATEMENT

of the

American Medical Association

to the

**U.S. House of Representatives
Committee on the Budget**

**Re: Health and Wealth Inequality in America:
How COVID-19 Makes Clear the Need for Change**

**Presented by Patrice Harris, MD, MA
Immediate Past President of the American Medical Association**

June 23, 2019

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The American Medical Association (AMA) appreciates the opportunity to provide testimony to the U.S. House of Representatives Committee on the Budget as part of its June 23, 2020 hearing on “Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change.” 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 minoritized and marginalized communities across the United States.

Disproportionate Impact of COVID-19 on Minoritized and Marginalized Communities

As our nation confronts the dual crises of a deadly pandemic that has triggered joblessness unseen since the Great Depression, the pandemic has revealed starkly the disproportionate impact of the virus on minoritized and marginalized communities. While the data remains incomplete, the data that have emerged on the racial and ethnic patterns of the COVID-19 pandemic show that the virus has clearly disproportionately affected Black and Latinx, American Indian/Alaska Native—particularly in the Navajo nation—Asian-American, and Pacific Islander communities. An April 2020 report from the Centers for Disease Prevention and Control (CDC) found that 33 percent of hospitalized patients with COVID-19 were Black, despite only comprising 18 percent of the community being evaluated, while amfAR, the Foundation for AIDS, found that 22 percent of US counties are disproportionately Black and those counties account for 52 percent of COVID-19 infections and 58 percent of COVID-19 deaths.

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. The latest data from the [COVID Racial Tracker](#) shows that while Black Americans account for 13 percent of the U.S. population, they account for 24 percent of the deaths where race is known: this means Black people are dying at a rate nearly two times higher than their population share. According to [NPR’s analysis](#), based in part on the COVID Racial Tracker, in 32 states plus Washington D.C., Black Americans 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. Preliminary data from the [APM Research Lab](#) shows that the overall mortality rate for Black Americans is 2.3 times as high as the rate for Asian-Americans and Whites. In analyzing the most recent CDC data, a recent report from the [Brookings Institution](#) found that death rates among Black people are much higher than for White people. In addition, according to Brookings, these disparities can be seen more clearly by comparing the ratio of death rates among Black people to the rate for White people in each age category. Among those aged 45-54, for example, Black death rates are at least six times higher than for whites. Underscoring the disproportionate

toll on Black Americans, a [study](#) published in the *New England Journal of Medicine* found that Black coronavirus 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 data on the COVID Racial Tracker, Black or African Americans represent 52 percent of COVID cases and 74 percent of COVID deaths.

Why does the Black community seem to be at greater risk? There are [three key factors](#): 1) structural inequities that are a consequence of long time racist policies, practices, and procedures that determine access to comprehensive health care and social determinants of health (SDOH) that are influenced by bias and racial discrimination; 2) pre-existing conditions, such as diabetes, hypertension, and obesity that disproportionately impact the African American community; and 3) an increased likelihood of working essential jobs, such as bus drivers, train operators, custodians, and in supermarkets, meatpacking plants, hospitals and nursing homes. In addition, there has been major mistrust of medical institutions, misinformation and disinformation, and myths that have had to be combated, as a consequence of historical abuses of science and experimentation by medical institutions. Aside from deeply evaluating fissures of communal trust in historically White institutions, our nation has to reckon with the role of social and biological sciences to ensure our future care decisions reflect the unique needs of historically marginalized and minoritized communities. As AMA Immediate Past 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, the Hispanic and Latinx community, which makes up only 10 percent of the population, represent 45 percent of all cases with known ethnicity. In Iowa and Wisconsin, the Latinx 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 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](#) and Alaska Native (AI/AN) communities in the U.S. have also suffered disproportionately higher rates of infection and death from COVID-19 during the pandemic. The [Navajo Nation has been severely affected by the pandemic with at least 322 confirmed deaths, more than 16 states including Kansas, Nebraska, and South Dakota. The death toll equates to a death rate of 177 per 100,000, higher than any single U.S. state.](#) Other tribes across the country are also suffering from high case numbers and severe economic fallout. As reported by the [Albuquerque Journal](#), America Indians across New Mexico, the majority of whom live on remote tribal lands, are dying of COVID-19 at rates 19 times that of all other populations combined, according to data provided by the state Department of Health. They account for 57 percent of the state’s cases—despite only being 11 percent of the population—and have infection rates 14 times that of the rest of the population. 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 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.

There is also a striking racial and ethnic divide in how COVID-19 has hit nursing homes. Of the U.S.'s more than 116,000 COVID-19 deaths, over 50,000 died in nursing homes or other long-term care facilities, according to a recent [analysis](#) by The Wall Street Journal. And, according to the [New York Times](#), nursing homes where Black American and Latinx individuals make up a significant portion of the residents—no matter their location, no matter their size, no matter their government rating—have been twice as likely to get hit by the coronavirus as those where the population is overwhelmingly White. According to the New York Times, “The nation’s nursing homes, like many of its schools, churches and neighborhoods, are largely segregated. And those that serve predominantly black and Latino residents tend to receive fewer stars on government ratings. Those facilities also tend to house more residents and to be located in urban areas, which are risk factors in the pandemic.” The analysis found, however, that the five-star rating the government uses was not a predictor; even nursing homes that had predominantly Black or Latinx residents were more likely to be affected by the coronavirus than were predominantly White nursing homes with low ratings.

Primary Factors behind Minoritized Populations being Disproportionately Impacted by COVID-19

Minoritized and marginalized communities experienced inequities in health and economic outcomes long before the COVID-19 pandemic. Thus, it should not come as a surprise that these communities have been disproportionately impacted by COVID-19 in light of the historic and persistent health, social, and economic inequities experienced by them. As pointed out recently by the [Kaiser Family Foundation](#), despite reductions in health inequities since the passage of the Affordable Care Act, people of color continue to fare worse disproportionately to Whites in terms of health access, coverage, and utilization. These long-term health disparities made people of color more vulnerable to being afflicted by, hospitalized, and dying from COVID-19. In turn, COVID-19 has exacerbated the underlying, long-term health and economic disparities and inequities experienced by minoritized and marginalized communities.

The AMA defines health equity as “optimal health for all” and recognizes the importance and urgency of advancing health equity and addressing structurally determined factors of health 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 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 structural factors of health and 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 the U.S., 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 minoritized and marginalized communities.

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 (ACEs), 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 and lack of access to health care, nutritious food, affordable housing, and accessible transportation, as well as a stronger likelihood of living in congregate living with multi-generational family members and the fact that many people of color have a greater probability of working in essential jobs that increase their exposure to the virus, such as in meatpacking plants, warehouses, supermarkets, hospitals, and nursing homes. From an economic perspective, minoritized populations serving in many types of essential jobs receive lower wages, which increases susceptibility to market forces. The high rates of job losses in minoritized communities stemming from COVID-19 also has resulted in a decline in employer sponsored health coverage and the loss of income exacerbates financial challenges for patients interested in and who can afford purchasing insurance policies through the individual market. The structural inequities built into the U.S. health system—inequities measured and documented for decades—explain why communities of color have higher rates of chronic heart disease, diabetes and obesity, the underlying conditions that make these individuals significantly more vulnerable to complications and death from COVID-19.

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 inequities. As noted recently by AMA [leaders](#) Jesse M. Ehrenfeld, MD, MPH, Immediate Past Chair of the Board 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 disproportionately 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 Structural and SDOH by Centering Health Equity

The AMA is deeply committed to helping achieve greater equity by raising awareness about its importance to patients and communities and by working at the system-level to identify and eliminate inequities. 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 physicians cannot control all factors that need to change to achieve health equity, the AMA 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 launched the Center for Health Equity (CHE), led by our first Chief Health Equity Officer, Aletha Maybank, MD. The CHE’s goal is to embed health equity across the AMA so that it becomes part of the organization’s practice, process, action, innovation, and organizational performance and outcomes. The CHE’s mission is to: 1) identify and address inequities in how care is delivered; 2) advocate for equitable access to care and research; 3) increase diversity and inclusion in the medical workforce; 4) influence determinants of health; and 5) elevate the AMA as a recognized leader and a model for equity across health care and in our society. As part of this work, earlier this year the AMA announced a \$2 million investment in a community collaborative focused on improving economic conditions for residents on Chicago’s West Side, neighborhoods where life expectancy is far below the national average, and significantly lower than in communities just a few miles away. Investing in neighborhoods and ensuring improved and equitable distribution of resources can help begin to tackle these complex challenges and improve the health prospects for individuals and entire communities.

Long-term Effects of the COVID-19 Pandemic and the Economic Fallout on Health Inequities

While the combined impact of the pandemic and economic fallout on minoritized and marginalized communities has been devastating, one positive result is that there is more awareness, especially outside the health care and academic communities, about health inequities and health disparities. More people (i.e., White people) are talking about these issues, and expressing their concern and the need for change to happen and for that change to be centered in an anti-racist and structural justice lens, particularly within our health system. This also is applicable to racial justice, policing reform, and justice reform. It is critical that these conversations continue, especially after the pandemic subsides.

Without a doubt, an influx of mental health issues is coinciding with the COVID-19 pandemic and will continue in its immediate aftermath. The combined toll of the pandemic, economic downturn, and incidents of police violence on our collective mental health is not yet known, but people are angry, tired, and frustrated – and in nearly every community, people are demanding change in a system that is unjust

and that has historically treated the Black community and other groups unfairly. Long before COVID-19, a mental health crisis existed in the Black community, created by a lack of mental health resources, unequal distribution of and access to other resources, and a host of other factors including determinants of health. New data culled from this spring's [Household Pulse Survey](#) conducted by the U.S. Census Bureau suggests that COVID-19 is widening mental health challenges for communities of color, which as a group has less access to mental health services than Whites. According to the survey, nearly one-fourth of respondents show signs of major depressive disorder, while nearly one-third report symptoms of generalized anxiety disorder. The findings were significantly higher for adults under age 30, among women, and those with low incomes. Overall, levels of anxiety and depressive disorders were three to five times higher than those measured in the first half of 2019, echoing findings from other polls and studies, including the Kaiser Family Foundation.

The COVID-19 pandemic is inherently a trauma event. Stress and anguish can affect a variety of individuals. Patients who personally contract and recover from COVID-19 may suffer from the impact of the illness and fear of acquiring the virus in the future. Individuals caring for patients afflicted with the virus, especially those who may not have been able to be with their loved-ones as they ultimately succumbed to COVID-19, will experience tremendous grieving and loss. On a more macroeconomic level, individuals that experience financial setbacks from the impact of the virus, including salary cuts or loss of employment, will experience added stress from the changes in their personal fiscal situation.

The need for physical distancing during the pandemic – combined with major disruptions such as unemployment and the risk posed by attending religious services or other large gatherings – serves to heighten the sense of isolation and anxiety many are experiencing. The effects can be even more profound among adolescents and the elderly, those dealing with substance abuse, and individuals who have struggled previously with behavioral disorders. The fear and anxiety triggered by the COVID-19 pandemic will remain long after the last cases are diagnosed.

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 through anti-racism reflected in our policies, practices, protocols, and performance metrics. The recent attention in the media and among policymakers to the disproportionate impact of COVID-19 on minoritized and marginalized communities has led to more conversations on historical and structural racism, along with other factors, that have led to longstanding health disparities and social and economic inequities. 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, and anti-racism. 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 inequities:

Addressing Implicit Bias/Unconscious Bias and Structural Racism. 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 structurally 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 tests, the number of positive results, testing results (e.g., 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 governments reopen. It is also critically important to fully understand the impact of COVID-19 on minoritized and marginalized communities. That is why in April 2020, 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. 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. 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.