

**U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis
“An Unequal Burden: Addressing Racial Health Disparities in the Coronavirus Pandemic”**

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Chairman Clyburn, Ranking Member Scalise, and distinguished members of the House Select Subcommittee on the Coronavirus Crisis: thank you for convening this important conversation to address racial disparities during the covid-19 pandemic.

The numbers are clear. We can plainly see the devastating impact of covid-19 that disproportionately affects African-Americans and other communities of color. African-Americans are dying from covid-19 at nearly three times the rate of white Americans. In some states, Hispanics have more than four times the expected rate of infection based on their share of the population. In California, Pacific Islanders face a death rate from covid-19 that is 2.6 times higher than the rest of the state. In South Dakota, the rate of covid-19 among Asian Americans is six times what would be predicted based on demographic data, on a backdrop of surging racism and xenophobia directed toward Asian Americans across the country. Other minority communities are also disproportionately affected, including in New Mexico, where Native American people comprise about 11% of the population yet account for nearly 60% of COVID-19 cases. These harrowing numbers are only the tip of a tall iceberg; there are a lot of data missing that would more fully illustrate the impact of covid-19 on communities of color.

Today, I would like for us to acknowledge the urgency of the problem, then to address the solutions, both short-term actions that must be taken now and longer-term solutions that are also necessary.

“ACUTE ON CHRONIC”

I’d like to introduce a concept we in medicine know well: “acute on chronic”. In medical practice, this refers to a patient who has a long-standing medical condition that is exacerbated by an acute illness. This is the case for Covid-19: it is a new disease, a global pandemic, that has unmasked long-standing underlying health disparities.

Let me give you the example from a city I know well, my home city of Baltimore, Maryland, where I previously served as the Health Commissioner. A child born today can expect to live 20 years more or less depending on the neighborhood he or she is born into. There are racial disparities in just about every metric of health, whether it’s death from cardiovascular disease or maternal or infant mortality. In my city, and all across the United States, we live in a world where the currency of inequality is years of life.

This is the existing situation, of rampant health disparities. Now, we have a new disease that is rapidly transmitted from person-to-person. It is not surprising that areas with many individuals who are essential workers, that also have higher density and crowded living and working conditions, will have higher rates of transmission; after all, social distancing is a privilege that many people do not have. On top of that, covid-19 causes the most severe illness in people with

underlying medical conditions. Racial minorities who experience higher rates of high blood pressure, diabetes, and other conditions as a result of food deserts, lack of accessible care and other environment conditions will be disproportionately affected once again.

Add on to this that covid-19 has resulted in stopping key social programs that are lifelines in my community and all across the country, like schools and senior centers. Home visitation programs that have been instrumental to reducing infant mortality and lead poisoning have been put on hold. Many who have chronic conditions faced additional problems of accessing care. The acute impacts of covid-19 worsen the underlying conditions in individuals and communities. Our solutions must therefore focus on both aspects.

SHORT-TERM URGENT ACTIONS

(1) Target public health resources to minority and underserved communities. Key to containing covid-19 are public health measures of testing, contact tracing, and isolation/quarantine. Data/surveillance inform all of these efforts. I will address each of these four components in turn.

Testing: There must be free, widespread and easily accessible testing that's directed towards the most impacted communities—in this case, specifically communities of color that will experience the disproportionate impacts of covid-19. Not only should these tests be available at no cost, they must also be easy to obtain. Testing locations shouldn't just be at hospitals and doctor's offices; they should be in the community, where people live and work. This, indeed, is a tenet of public health, to go to where people are.

Reducing the racial disparities in covid-19 outcomes requires that public health officials be attentive to detecting covid-19 cases early to prevent a cluster from becoming an outbreak. Efforts must be made to increase testing sites throughout minority and underserved communities, including with creative outreach efforts: for example, testing drives at churches, community centers, and public housing complexes. Given existing disparities in accessing the healthcare systems, tests should be made available without a doctor's prescription.

(It goes without saying that these tests should also be accurate, with a very low false positive rate, and able to produce rapid results. Tests that do not give a result for 24 hours have limited utility to prevent disease transmission. There needs to be a national effort to secure these tests, which will be mentioned in the next section.)

Contact tracing: As efforts ramp up to recruit, train, and deploy contact tracers, there must be recognition that effective contact tracing depends on community trust. Every effort should be made to recruit contact tracers from the communities they serve, and to deploy contact tracers based on community need. Those who are the most "credible messengers" must also have language ability that reflects the needs of those they serve. This will also serve as an opportunity for employment in communities hardest hit by the economic impacts of covid-19 as well.

Isolation/quarantine: Individuals who test positive for covid-19 must be placed in isolation and those with significant exposure must be quarantined for the length of time that they are potentially infectious. Many may not be able to do so safely at home, if they live in close

quarters and multi-generational housing. Facilities should be made available free of charge to those who choose to isolate/quarantine elsewhere, including through the use of empty hotels and dormitories, and resources should be made available to reduce the economic impact of isolation and quarantine.

Previously, I joined a group of bipartisan leaders led by Andy Slavitt and Dr. Scott Gottlieb to put forth a proposal to establish such isolation/quarantine facilities and to replace wages with a small sum—equivalent to what is paid for jury duty—to incentivize individuals to isolate and quarantine. Such a proposal is particularly needed for those who face substantial barriers to housing and who experience economic hardship. Importantly, it addresses the needs of individuals for whom missing work or finding alternate housing could mean sacrificing food on the table or shelter for their families.

Data: There have been many calls to make publicly available racial demographic data for infections, hospitalizations, and deaths from covid-19. I agree with this, and add one more data point that's critical: the demographic data for testing. The other metrics are important too, but they measure what has happened with disease spread, as opposed to testing, which measures the actions that are in our control to prevent the spread in the first place.

Public health experts generally agree that sufficient tests are performed when the positive rate falls below 10%. That is to say, the net is cast wide enough when less than 10% in a population test positive. I would like to see this testing data broken down by race and zip code. That way, if we see the positive rate in the population in a community is at 10%, but African-Americans are still testing positive at a rate of 20%, that means African-Americans are under-tested compared to others. Similarly, neighborhood data would allow for better targeting of tests and resources to specific areas.

My ideal scenario is to have a dashboard that is updated in real-time, and that's coordinated by the CDC with data uploaded by state and local officials. This provides important information and also offers the transparency and accountability that are needed to ensure that communities most in need are receiving the resources they require. Federal funding can be tied to the availability of these data, adding a strong incentive for compliance.

(2) Establish clear, directive guidelines to protect workers and ensure that they are enforced. As a former local health official, I depended on the Centers for Disease Control and Prevention (CDC) for unambiguous guidance in the time of public health crises. At the beginning of the covid-19 crisis, the CDC held daily briefings that were informative and instructive. Unfortunately, these briefings stopped at the beginning of March. Subsequent guidance from the CDC was delayed, and the language used in the guidelines was not the specific, directive, and clear guidance that I am used to seeing from them.

What I would like to see from the CDC is, frankly, what I'm used to seeing from them in past administrations. For example, with states reopening, employees are told to go back to work. Exactly what standards must be met? People should not just be "encouraged" to do social distancing. What exact standards must be met in different types of workplaces, i.e. office environments vs meat-packing plants? Masks should not be worn, "if feasible". They should be

required. I want to see a clear statement, such as: If these fifteen criteria cannot be met, then reopening isn't safe and employees shouldn't be allowed back in these spaces. The Occupational Health and Safety Administration (OSHA) should then enforce these rules, as should local and state regulatory entities. If not, it is people of color and those who already face systemic disparities who will suffer the most.

There are those who might argue that directives should not come from the federal government, that local officials who know communities the best should put out this guidance. I can tell you as a former local official that we need as clear and specific of guidance from the CDC as possible. The CDC is the leading expert in synthesizing scientific information into actionable guidelines. No local official has the time nor the workforce capacity to wade through thousands of scientific studies. We depend on the CDC to review the studies and to come up with the guidelines. Local officials can then tailor the guidance and explain them in the local context that we understand. Specific guidance from the CDC gives the information we need to help local businesses. Contrary to it constraining us, federal guidelines actually empower local officials to do their work.

(3) Ensure that all who need it can receive care. Others have written extensively on the added pressures for people who will lose health insurance coverage following unemployment and the importance of reducing out-of-pocket costs given data showing that high cost of covid-19 care would deter some people from seeking care if they developed symptoms. Healthcare to treat covid-19 and related illnesses must be fully covered. We cannot discount the role of long-term recovery: many individuals who become sick from covid-19 may take months or even longer to recover.

Such coverage can be achieved through expanding Medicaid nationally and having open enrollment in state exchanges to assist those whose insurance are tied to jobs. There must also be paid sick leave, as well as facilities and mechanisms to properly isolate/quarantine as mentioned above.

These efforts have another dimension in the midst of the uprisings. I was the health commissioner in Baltimore during the 2015 civil unrest that followed the death of Freddie Gray while in police custody. Over a dozen pharmacies were closed after being burned down and/or looted. Clinics were closed due to safety concerns, and patients couldn't access life-saving treatments like chemotherapy and dialysis. Corner stores were shut, and people were unable to purchase food and other necessary supplies. These issues, as with all others, are exacerbated for African-Americans—for example, one in three African-Americans already lived in food deserts, compared to one in 12 whites.

This time, the uprisings are occurring in many communities around the country. As there are calls to address criminal justice reform and institutional racism, there must also be attention to the urgent needs of those struggling to access healthcare, food, medications, and other vital services.

LONGER-TERM SOLUTIONS

(1) Prepare for the next surge. In March 2020, our country faced a situation that I never thought I'd experience as a healthcare provider: that we'd run out of personal protective equipment (PPE) and have to put our frontline clinicians in harm's way without something as basic as masks. We also came to the brink of running out of ventilators and other critical equipment. States were forced to bid against each other for these and other critical supplies, such as swabs and reagents for tests.

There are a number of reasons why we were not prepared the first time around. Perhaps it was excusable then. But it is no longer. We know what is needed now, and we know that a second surge will almost certainly happen, especially with the convergence of covid-19 with the flu season.

Hospitals need to do their part to prepare for the second surge. Local and state policy-makers must gird for this too. The federal government needs to urgently develop and implement a national, coordinated effort to secure needed supplies and have a plan for procurement and distribution. PPE should not only be available to frontline hospital workers, but also to others who must interface with many people every day: why shouldn't grocery cashiers, bus drivers, and nursing home attendants all have protection for themselves? Lack of action will affect everyone, but in particular those in our society who are the most vulnerable and who already face the greatest brunt of disparities.

The federal government also needs to think now about issues that will come up in months to come. If there is an effective treatment developed, how will it be equitably distributed? If a limited supply of a vaccine becomes available, how can we ensure that it's not only those who are privileged who will access it? Lack of thoughtful planning will inevitably lead to a situation where those who are well-connected and well-resourced can obtain scarce resources, leaving many others to go without.

(2) Support safety-net public health systems. Primary care and community-based healthcare organizations have suffered substantially during the covid-19 crisis, and it is not at all certain that many will survive in its aftermath. Home visitation and other community outreach programs have also had to curtail their work; many others may not be financially sustainable either. Efforts must be made to support these community-based programs that serve as the safety net for many.

Already, local public health is chronically underfunded, with less than 3 percent of the estimated \$3.6 trillion in annual healthcare spending directed toward public health and prevention; CDC funding for public health preparedness and response programs has been cut by half over the last decade, forcing local public health officials to make impossible tradeoffs between critical, life-saving programs that serve communities in need. There is an urgent need to strengthen local public health infrastructure not only to ensure a robust response to covid-19 and future crises, but also so that those interventions do not come at the cost of health and well-being and thus further perpetuate racial disparities.

Flexibility is key in future funding. This pandemic has evolved quickly and local jurisdictions still best know the needs of their individual communities. They need to be able to adapt and

respond to the needs they have rather than having to find justification to meet Congressional spending mandates.

There must also be attention to previously marginalized areas of healthcare. Mental health is already a neglected area, and the need for behavioral health services can only be expected to rise with the convergence of health, economic, and societal crises. Any discussion of healthcare reform must take into account mental health as an equivalent need to physical health. There must be funding for programs to address trauma and build resiliency. And there needs to be recognition of the fact that racism is a public health issue—indeed a public health crisis in and of itself.

(3) Target resources to address social determinants of health, with a focus on areas of greatest need. Disparities in health are inextricably linked to housing instability, food deserts, and lack of transportation access. These are all issues that contribute to poor health broadly and to disparities associated with covid-19 specifically.

Any reform of the healthcare system must take into account that these social determinants contribute even more to health than the healthcare that one receives. For example, there needs to be examination of affordable housing through investment in the construction and repair of potential housing options and support of policies that extend debt forgiveness and prevent eviction. Food insecurity can be addressed by expanding eligibility and granting waivers for food assistance programs such as WIC and SNAP, investing in local food banks, and incentivizing food delivery for low-income and vulnerable neighborhoods, while education should be made a priority by ensuring access to books, technology, and Internet, all essential components of virtual instruction. As it relates to the aftermath of covid-19, resources provided in the wake of the pandemic should also be specifically targeted to areas of greatest need.

I'd like to end my testimony with a quote from the late Representative Elijah Cummings, the former Chairman of the House Oversight and Reform Committee and my Congressman from Baltimore. Representative Cummings would say, "Our children are messengers to a future that we will never see." He'd talk about how that world needs to be a better one, a more equal one, than the one that we have. That's the world that we are all striving for, one in which the currency of inequality no longer equals years of life. One in which where children are born and what race they happen to be no longer determines whether they live.