A Union of Professionals

Committee on Ways & Means

The Disproportionate Impact of COVID-19 on Communities of Color

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12 Noon

The AFT's 1.7 million members include 170,000 healthcare professionals, 200,000 retirees, hundreds of thousands of educators working in communities of color, as well as corrections officers and other public service professionals. Our members see the impact of COVID-19 on a daily basis throughout all aspects of society, with numerous AFT members having their lives taken by the virus. The following document* - COVID-19 and Racial Equity - *was developed by the AFT's Health Equity Working Group and we hope it will contribute to your discussions and policy proposals related to the Disproportionate Impact of COVID-19 on Communities of Color. Thank you, Chairman Neal and Ranking Member Brady, for organizing this important hearing.

How Did We Get Here? Structural Racism and Health Inequities

From the genocide of Native Americans, the brutality of enslavement, imperialism, colonialism and immigration exclusion acts, every system in the United States is built on and informed by structural racism. The COVID-19 pandemic has laid bare the resulting inequitable outcomes of healthcare in the U. S.

People of color experience more economic insecurity and poorer health outcomes than their white counterparts in myriad ways. The primary reasons we will discuss here:

1. **Poverty and low-wage work leave many people of color without access to routine medical care.**
2. **Inadequate and unstable housing exposes people of color to more environmental risks.**

1. Poverty and low-wage work leave many people of color without access to routine medical care.

Health care in the U.S. is prohibitively expensive even for many people with health insurance,[1] but many people still lack coverage entirely. Uninsured people are often forced to delay or forgo necessary medical care due to cost. This means they are less likely to receive a diagnosis or treatment in the early stages of a disease and are more likely to suffer from complications of chronic conditions that could otherwise be managed with routine care.[2]

Because of higher rates of poverty and low wages, the uninsured rate is much higher in communities of color than in white communities. In 2018, 8 percent of non-elderly white Americans were uninsured compared with 11 percent of black, 19 percent of Hispanic, and 22 percent of American Indian and Alaska Natives.[3]

2. Inadequate and unstable housing exposes people of color to more environmental risks.

Redlining in black communities and the systemic theft of tribal lands from Native people have created cities, neighborhoods and rural areas without access to the resources human beings need to thrive. The links between housing and health are innumerable. Here, we will focus particularly on asthma and diabetes because of their links to COVID-19.

Asthma

Households with children are more likely to have at least one child with asthma when they also report exposure to smoke, mold and leaks in their home. Renters are more likely to report exposure to these irritants, and people using rental assistance have higher rates of exposure to these triggers than renters not receiving government assistance.[4]

Data from the Department of Health and Human Services shows that 19 percent of non-Hispanic black children have been diagnosed with asthma compared with 12 percent of non-Hispanic white children. Black children are 4.5 times more likely than white children to be hospitalized for asthma and 10 times more likely to die from asthma.[5]

Diabetes

Among non-elderly adults, 7 percent of white Americans have diabetes, compared with 9 percent of Hispanic Americans, 11 percent of African Americans, and 14 percent of American Indian and Alaska Natives.[6] This is not surprising when the environmental risk factors for diabetes such as food access are taken into account.[7] This especially impacts Native Americans living on tribal lands. The Navajo Nation spans 27,000 square miles (about the size of West Virginia) but has only 13 grocery stores.[8]

In discussions of health disparities, the blame is often placed on communities of color for having higher rates of these chronic illnesses. This ignores the centuries of oppression and ways in which white supremacy have worked to keep people of color in poverty and far more exposed to risk factors that impact overall health.

Where Are We Now? Disparate Impacts of COVID-19 on People of Color

As a result of these existing inequities, COVID-19 infection and mortality rates have tragically and predictably hit communities of color the hardest. While acknowledging the impacts are far-reaching, we will focus on the following impacts:

1. **Overall, rates of COVID-19 fatality for people of color are higher.**
2. **People of color are disproportionately represented in essential service jobs and are therefore on the frontlines of the crisis without the protection they need.**
3. **People held at U.S. Immigration and Customs Enforcement (ICE) detention centers as well as those incarcerated in the U.S. prison system are at greater risk during the pandemic.**
4. **We lack appropriate data collection to fully understand the scope of the racial disparities of this pandemic, especially concerning Native American communities.**

1. Overall, rates of COVID-19 fatality for people of color are higher.

Due to all of the factors outlined in the previous section, people of color are being infected, hospitalized and dying from COVID-19 at higher rates than their white counterparts largely as a result of higher rates of exposure at work and underlying medical conditions.

Despite the limitations of the Centers for Disease Control and Prevention's data, which does not include information on race and ethnicity for many cases, the data that we do have is damning.

Race and Ethnicity	% of U.S. Population[9]	% of COVID-19 Deaths in U.S.
Non-Hispanic White	60.4%	52.1%
Non-Hispanic Black or African American	12.5%	21.2%
Non-Hispanic American Indian or Alaska Native	0.7%	0.3%
Non-Hispanic Asian	5.7%	6.1%
Hispanic or Latino	18.3%	16.5%
Other	2.4%	3.8%

Source: CDC data updated May 8, 2020 [10]

The data is even starker in many major cities and states with high concentrations of poverty in communities of color. Updated data from the CDC can be found here.

2. People of color are disproportionately represented in essential service jobs and are therefore on the frontlines of the crisis without the protection they need.

The industries where workers are least able to work from home (e.g., transportation, agriculture and hospitality) are largely industries that disproportionately rely on the labor of immigrant workers and people of color.[11] In a particularly salient example, an estimated 70 percent of farmworkers are undocumented.[12]

3. People held at ICE detention centers as well as those incarcerated in the U.S. prison system are at greater risk during the pandemic.

Current systems of mass incarceration and immigration enforcement are direct results and continuations of the foundational injustices previously discussed. This is clearly reflected in the demographics of the incarcerated population in the U.S. Compared with white people, black people are imprisoned at a rate that is 5.1 times higher, and Latinos are imprisoned at a rate 1.4 times higher.[13]

In a recent study, researchers estimated the rate of COVID-19 transmission within 111 ICE detention facilities and the impact on surrounding intensive care units. They modeled three scenarios: optimistic, moderate and pessimistic. They found that in the most optimistic model, 72 percent of individuals are expected to be infected by day 90 of an outbreak, while 100 percent are expected to be infected under the pessimistic mode. In 66 detention centers, a coronavirus outbreak would overwhelm local ICU beds within a 10-mile radius. In nine of these facilities, an outbreak would overwhelm local ICU beds within a 50-mile radius.[14]

4. We lack appropriate data collection to fully understand the scope of the racial disparities of this pandemic, especially concerning Native American communities.

On May 11, 2020, NPR reported, "If the Navajo Nation were a state, it would have the highest rate of coronavirus cases per capita after New York. At least 100 people have died from the virus, and 3,122 people have tested positive." In the Navajo Nation, 30 percent of residents lack access to running water; 30 percent do not have electricity; and before the pandemic, half of the residents were unemployed. The same conditions that routinely lead to poorer health outcomes for Native people have been exacerbated by the pandemic. [15]

While some tribes are able to collect data, many larger datasets in the U.S totally exclude Native Americans as a category, instead lumping them into an "other" catchall. Even in datasets that do include Native Americans, their numbers are likely dramatically underreported and misclassified.[16]

Where Are We Going? Policy Recommendations

In addressing the COVID-19 pandemic, it is not enough to seek solutions that will return the country to the status quo before the pandemic. Recognizing the need for both urgent response and systemic reform, we offer policy recommendations in the following categories:

1. **Addressing the immediate need for healthcare access**
2. **Addressing the immediate need for economic relief**
3. **Addressing the social determinants of health**
4. **Addressing the long-term need for reform of the U.S. healthcare system**

1. Addressing the immediate need for healthcare access

- Immediately increase federal funding for Medicaid, adjusted automatically to meet need throughout the crisis,[17] and immediately expand Medicaid in all states that have not already done so.
- Immediately increase federal funding for community health centers.
- Adopt the recommendation of the Congressional Black Caucus to waive Section 1905(a)(A) of the Social Security Act on an emergency basis until the COVID-19 crisis is over, allowing the use of Medicaid funding to provide healthcare to incarcerated people.
- Define testing and treatment for symptoms of COVID-19 as emergencies within emergency Medicaid, allowing anyone regardless of immigration status to access treatment.
- Use presumptive eligibility to provide testing and treatment through Medicaid, allowing care to be provided when needed and providing some stability for safety-net hospitals and community health centers.
- Suspend the public charge rule that is deterring immigrants and their U.S. citizen family members from seeking health and nutrition assistance.
- Permanently suspend ICE actions and activities in medical treatment and healthcare facilities.
- Reopen the Affordable Care Act insurance exchange for a special enrollment period lasting the duration of the crisis.
- Immediately increase funding to Indian Health Services by at least $3 million, in line with the proposed Equitable Data Collection and Disclosure on COVID-19 Act.[18]
- Fund 10,000 additional school nurses, in line with the recommendation of the National Association of School Nurses.[19]
- The Trump administration must immediately drop its lawsuit attempting to repeal the Affordable Care Act, which would result in 29.8 million Americans losing health coverage.[20]

2. Addressing the immediate need for economic relief

- Fund free child care for essential workers throughout the duration of the crisis.
- Fund direct payments of $2,000 per month to all Americans throughout the duration of the crisis, in line with the proposed Monthly Economic Crisis Support Act.[xxi]
- Immediately forgive all student loans of essential workers.
- Immediately suspend all evictions and foreclosures.
- Fund economic relief targeted for small businesses owned by people of color.

3. Addressing the social determinants of health

- Invest in safe public housing free from environmental hazards.
- Permanently increase funding for food assistance programs.
- Promote and fund the medical education of students of color and facilitate recruiting from inside the community. This should include significant investment in educational institutions that serve communities of color.
- Invest in national infrastructure and public transit, allowing easier travel between neighborhoods and easing the impacts of food deserts.

4. Addressing the long-term need for reform of the U.S. healthcare system

- In the long term, we must address the chronic underfunding of Indian Health Services that has created a crisis in Native communities. This investment must incorporate robust data collection, including tribal affiliations, and must be done in collaboration with Native leaders.
- In line with a resolution passed at the AFT 2016 convention:
  "The American Federation of Teachers and its affiliates call for improving—not destabilizing and destroying—our healthcare safety net, including protecting and improving Medicare, Medicaid and the Affordable Care Act. The AFT and its affiliates will continue to work to secure a healthcare system that puts patients before profits and recognizes every single person's right to access quality, affordable healthcare."

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