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ON BEHALF OF THE
AMERICAN SOCIETY OF NEPHROLOGY**

**WRITTEN TESTIMONY ON THE DISPROPORTIONATE IMPACT OF
COVID-19 ON COMMUNITIES OF COLOR**

PREPARED FOR THE HOUSE COMMITTEE ON WAYS AND MEANS

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On behalf of the more than 37 million Americans living with kidney diseases, the more than 21,000 nephrologists, scientists, and other kidney health care professionals at the American Society of Nephrology (ASN) welcome the crucial focus on racism and disparities not just during the COVID-19 pandemic, but in the health care system as a whole. As Black, Hispanic and Latinx, South Asian, Asian, Indigenous, and White clinicians of US and international origin who are committed to advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients, we reflect the ethnic and racial make-up of the communities that we serve and are acutely aware of the needs of our communities and the disparities among them.

ASN is actively working on numerous fronts to promote equity within kidney health care and among kidney health professionals. However, the growing prevalence of kidney disorders, brought into sharp relief by the COVID-19 pandemic, has provided a fierce sense of urgency that more must be done to dismantle systemic racial and socioeconomic barriers to kidney health, and to address the root cause behind these disparities: racism.

Kidney diseases are non-communicable diseases, increasingly [burdening health systems globally](#), with the consequence of a domestic public health crisis, effecting 15% of US adults – [37 million Americans](#) – with 750,000 Americans suffering kidney failure requiring ongoing kidney replacement therapies and costing Medicare [\\$36 billion annually](#). Racism, another public health crisis that America is battling, is not without its influence on kidney disease. Despite advancements in the management of hypertension and diabetes – the two risk factors accounting for [over 70%](#) of all cases of kidney disease, Black Americans (16.5%) and Mexican Americans (15.3%) are [more likely](#) to have kidney disease than White Americans (13%). These disparities are even more marked in the rates of progression to kidney failure, with a prevalence [3.5 times higher](#) in Black Americans and 1.5 times greater in Hispanic Americans.

Disparities in healthcare, particularly as it pertains to kidney disease and kidney failure, cannot be addressed without addressing racism on a systemic and institutional level. Disparities in kidney disease prevalence and progression extend beyond kidney disease risk factors. Health status is closely [correlated with](#) institutional racism and socioeconomic status (SES) – status that is further stagnated by a lack of social upward mobility through multiple generations.

These factors can further be understood by examining [Social Determinants of Health \(SDOH\)](#), key of which include economic stability, education, social and community contexts, health including access to health care, and neighborhood and built environments. The disparities within each of these contexts, a societal dysfunction that has not been remedied, has led to a cascade of devastating consequences in the realm of kidney disorders. Nutrition, which is often framed as a personal choice, would be better understood as a lack of access to optimal choices for individualized health. [Low income and food insecurity](#) have been shown to be associated with diabetes and hypertension, both leading causes of kidney disease, as well as obesity and kidney disease itself. To compound this situation, food insecurity within diabetics and those with hypertension [increases the risk for kidney diseases](#).

Socioeconomic status, social determinants of health, and contextual poverty have continually been proven to be the [driving force of the factors](#) linked to kidney disease outcomes, and can even be seen at play in the geographic environment through kidney disease [“hotspots,”](#) areas with higher than average incidence of kidney diseases as compared with the country or region. Any serious attempt to address the increasing prevalence and mortality related to kidney diseases must include dismantling racist geographic and environmental structures that lead to disparities in kidney diseases.

In addition to racial and socioeconomic disparities in the prevalence of kidney diseases, significant racial and socioeconomic inequities extend into the access to health care services and therapies for kidney diseases and kidney failures. Disparate access to preventative healthcare for kidney diseases, hypertension, diabetes, and obesity have contributed to the increasing numbers of these chronic conditions in the population, as well as the worsened outcomes. Black patients are more than [three times as likely](#) than white patients to progress to kidney failure, blacks and minorities are [less likely to be insured](#), and are at increased risk for losing coverage during crises such as COVID-19. Lack of access to care even expands risk factors for kidney disease by exposing further difficulties during pregnancy, with lack of access leading to adverse pregnancy outcomes that may [increase the lifelong risk](#) of kidney diseases.

In 2020, the best therapy available for kidney diseases and kidney failure remains kidney transplantation. Sadly, kidney transplantation may be the clearest example of compounding and systemic racism in kidney health care. Patients with kidney failure are typically identified as candidates for transplantation by their providers, and are then referred to transplantation, a process that involves completing extensive assessments by various providers, placement on a waiting list if the preferred option of living donor is

not available, and are then tasked with continued follow up to maintain the transplanted graft and afford maintenance therapy.

However, Black patients are less likely to be [identified as transplant candidates](#), [referred for evaluation](#) to receive a transplant, and to [complete the transplant evaluation](#). Black patients are also less likely to have the preferred [living donor](#) and less likely to be [placed on the waiting list](#), while also being more likely to [receive lower quality kidneys regardless of the age of the patient and length on the kidney waitlist](#), and have [poorer transplant graft survival](#) for a multitude of reasons that may include difficulties in access to care – a cyclical and compounding struggle that is nearly impossible to defeat without real identification and solution to racism.

While awaiting transplantation, Americans with kidney failure undergo dialysis treatments. However, residential areas where there are more Black residents are more likely to have dialysis centers that are [less likely to meet performance targets and have higher-than expected mortality](#). Home dialysis modalities are associated with a higher quality of life and [lower mortality](#) compared to in-center modalities particularly for Black patients, and present a care choice that may provide better outcomes for many patients. However, minority patients of multiple backgrounds, including Black Americans, are [less likely to be candidates for home dialysis](#) due to biases as well as SDOH that include housing, access to childcare, and limitations in employment that would prohibit proper dialysis modality training.

Kidney failure, a consequence of failed prevention the progression of kidney diseases, is associated with [lower employment](#) in Black and Hispanics, further exacerbating the SES of vulnerable groups and reinforcing the systemic structure of racism. Clinical practice and studies continue to elucidate the depths of the disparities within kidney disease and healthcare as a whole, but it is clear that disparities are clearly traced to structural racism and will not be adequately addressed in the absence of dismantling these racist structures.

The COVID-19 pandemic has further exposed the ethnic and racial disparities in the existing generational structure and exacerbated its effects in healthcare outcomes, including within kidney diseases. Among patients, a higher prevalence of kidney disease based on health disparities intersecting with a higher risk of -19 exposure leads to an [increased risk of death](#). In fact, one of the [first COVID-19 fatalities](#) in the United States was a hemodialysis patient, a loss that demonstrates the particular vulnerability of our patient population to the unknowns of the pandemic – and further reinforcing the risks and disparities associated with social determinants of health.

Analogous to the associations of kidney diseases “hotspots” and race, there are similar associations between COVID-19 and race: 4 of the top 5 counties with the highest death rates in the nation are predominantly Black, with disproportionately Black counties accounting for more than one [half of COVID-19 cases and almost 60% of COVID-19 related deaths](#). Black Americans comprise 13% of the US population, but [account for 33% of COVID-19 hospitalizations](#) to-date and 24% of deaths where race is known– in

many states and localities, demographic data has not been systematically recorded. Where there is recorded data, we have seen that Black Americans are dying from COVID-19 at a rate [nearly two times higher than their population share](#) in multiple recorded regions: in Michigan, Blacks make up 15% of the state population but represent 35% of COVID-19 diagnoses; in Illinois Blacks represent 16% of the state but 30% of COVID-19 diagnosis; in Louisiana they represent about 30% of the population but a devastating [70% of COVID-19 deaths](#).

The disparities are currently being explored at length and have been described as [“the color of COVID,”](#) but the common link increasingly appears to be the structural disadvantages posed by a system based on race. Minorities are more likely to be essential workers and have increased contact with COVID-19 but are also more likely to become unemployed. Essential jobs in [food manufacturing, agriculture, and grocery stores](#) are more likely to be held by Black, Hispanic, or Latinx individuals. Black Americans represent nearly 30% of bus drivers and nearly 20% of all food service workers, janitors, cashiers, and stockers. During a highly contagious pandemic like COVID-19, Black workers, and consequently their families, are over-exposed.

In this regard, staying at home during quarantine is a privilege. Who [can and cannot socially distance or work from home](#) is a function of underlying socioeconomic factors prevalent in minority communities, including but not limited to the inability to socially distance due to housing conditions, lack of access to personal protective equipment to costs or local shortages, locally escalated costs of household cleaning supplies, and shelter in place orders leading to massive layoffs and unemployment, made all the more devastating as health care benefits necessary to receive care for COVID-19 and kidney diseases are closely tied to employment.

[Housing, income, and race have also been demonstrated to lead to mortality differences](#) in COVID-19. [Minority groups are more likely to live with numerous members in a household](#), further increasing risk during a highly contagious pandemic. Telehealth, the modality of health care most readily adapted to bridging gaps in care, may in fact be exposing more disparities by leaving out those with limited or no access to broadband internet connections or telephonic devices. In addition, [children in low-income households](#) are less likely to have telephonic devices, further exacerbating SDOH including education and access to care. [School closures](#) have additionally impaired access to nutrition and education, particularly with limited technologic capabilities in low-income households.

Much is left to learn about COVID-19. But, as of now, we are aware that risk factors for worsened outcomes from COVID-19 include underlying respiratory diseases –which often result from environmental factors that disproportionately impact individuals of lower socioeconomic class – and obesity – which often results from the same dearth of nutritional resources that can lead to kidney diseases and kidney failure. Therefore, race is not a risk factor for COVID-19 prevalence, but rather the negative consequences of institutionalized and structural racism that has led to an increased risk of COVID-19 in minority communities. The convergence of racism with factors including environmental

conditions, housing, SES and employment, and access to health care and treatment has led to deep racial disparities in the prevalence of COVID-19. Addressing the disproportionate impact of COVID-19 necessitates the acknowledgement and intervention at the root cause: racism.

Racism is a public health crisis with profound manifestations in the kidney community. It is difficult to isolate the social disparities in the kidney community from the unsustainability and immorality of racism, because they cannot be separated. The root cause of disproportionate health outcomes is, in fact, systemic and institutionalized racism. Addressing gaps in housing and food insecurity, technology solutions, nutrition, and the environment – all social determinants of health – is a mandatory part of dismantling institutional and systemic racism in health. Addressing these social determinants alone is not enough, and we are not doing even this sufficiently. We must act swiftly – to systemically undo racism and the underlying maladaptive structure of disparities in social determinants of health. All Americans want to be able to access care for their health and to ensure that they receive equal and equitable health care. Institutionalized racism must be abolished.

As a result, ASN calls on Congress to pass the Health Equity and Accountability Act of 2020, comprehensive and broadly supported legislation to address disparities in health care. In addition, ASN urges Congress to consider other measures – such as elements of the Advancing American Kidney Health Initiative – that address social determinants of health, in particular social determinates that disproportionately lead to the development of kidney diseases, and more broadly to dismantle the systems of oppression that impact the 37 million Americans living with kidney diseases, their families, and all Americans.

Thank you for your consideration of this important request. Should you have questions or need additional information, do not hesitate to contact Zach Kribs, Senior Government Affairs Specialist of the American Society of Nephrology, at (202) 618-6991 or zkribs@asn-online.org.

ABOUT THE AMERICAN SOCIETY OF NEPHROLOGY

The American Society of Nephrology is a 501(c)(3) non-profit, tax-exempt organization that leads the fight against kidney disease by educating the society's more than 21,000 nephrologists, scientists, and other healthcare professionals, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. For more information, visit www.asn-online.org.