Hearing on "The Disproportionate Impact of COVID-19 on Communities of Color"
Ways and Means Committee
United States House of Representatives

Hearing held May 27, 2020
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Testimony from Camara Phyllis Jones, MD, MPH, PhD submitted on behalf of myself

Thank you for inviting my testimony.

Qualifications: I am a family physician and epidemiologist whose work focuses on naming, measuring, and addressing the impacts of racism on the health and well-being of the nation.

I am the 2019-2020 Evelyn Green Davis Fellow at the Radcliffe Institute for Advanced Study at Harvard University. Past roles include President of the American Public Health Association (2015 to 2016), Assistant Professor at the Harvard School of Public Health (1994 to 2000), Medical Officer at the Centers for Disease Control and Prevention (2000 to 2014), Senior Fellow (2013 to present) and Adjunct Associate Professor (2003 to present) at the Morehouse School of Medicine, and Adjunct Professor (2004 to present) at the Rollins School of Public Health at Emory University.

My current service includes member of the Board of Directors of the DeKalb County (Georgia) Board of Health; member of the National Board of Public Health Examiners; faculty member for the Accreditation Council for Graduate Medical Education's *Quality Improvement: Health Care Disparities* Collaborative; and member of the National Academies of Sciences, Engineering, and Medicine *Roundtable on Black Men and Black Women in Science, Engineering, and Medicine.*

Testimony:

The root cause of the disproportionate impact of COVID-19 on communities of color in the United States is racism

- The COVID-19 pandemic has starkly revealed that access to opportunity and exposure to risk are deeply divided by "race" and ethnicity in the United States
- Racism is the name of the system that differentially structures opportunity and assigns value based on "race" in this country, where "race" is the social interpretation of how one looks in a "race"-conscious society (see Jones CP, *Phylon* 2003 and Jones CP et al, *Ethn Dis* 2008)
- Racism is foundational in our nation's history and continues to be alive and well in this country
- Racism unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources (see Jones CP, *Phylon* 2003 and Jones CP et al, *Ethn Dis* 2008)

- Racism is not only the root cause of the disproportionate impact of COVID-19 on communities of color in the United States, it is the root cause of all "race"-associated differences in health outcomes in the United States
- This is includes differences in infant mortality rates and maternal mortality rates, as well as differences in the prevalence of obesity, diabetes, high blood pressure, heart disease, and the other chronic conditions which are now putting people infected with SARS-CoV-2 at higher risk of death
- The nation is suddenly paying attention to the excess deaths from COVID-19 in communities of color because Black, Brown, and indigenous bodies are piling up so quickly that their excess cannot be ignored or normalized

How is racism specifically manifesting with COVID-19?

- There are three levels of racism that impact health: institutionalized (structural), personally-mediated, and internalized (see Jones CP, *AJPH* 2000)
- People of color are getting more infected with SARS-CoV-2 because they are more exposed (frontline jobs, incarceration, homelessness) and less protected (essential roles not seen or valued)
- Then once infected, people of color are dying more from COVID-19 because they are more burdened by chronic diseases (segregated into disinvested and unhealthy environments) and have less access to health care (insurance, placement of resources, quality of care)

Now that we know about these disparities, we need to act

- We need to continue collecting, analyzing, and disseminating COVID-19 data (testing, hospitalizations, and deaths) by "race" and ethnicity as well as by zip code, income level, primary language, disability status, and other axes of structured inequity
- We need to address the fact that people of color are more exposed, less protected, more burdened by chronic diseases, and have less access to health care. Here are some starting ideas for addressing each area:
- ***More exposed***
    - Enable a much larger group of people to safely shelter in place: Universal basic income, or at least equitable access to monies coming from the CARES Act including the one-time payment (needs to be made periodic), the Payroll Protection Act (needs to get to small businesses owned by "Black" and "Brown" people), paid sick leave, unemployment insurance supplementation, and moratorium on evictions
    - Decarcerate those locked away in prisons, jails, and detention centers
    - Find housing for those who are unhoused: Consider temporary housing in dormitories or hotels which have been emptied by the pandemic response
- ***Less protected***
    - Recognize the essential nature of a much broader swath of the workforce, folks still going to work to enable others to safely shelter in place (postal, sanitation,

warehouse, grocery, delivery, farm, meat packing, custodial, food service, home health, and many other workers)
    - Provide all essential workers with highly effective personal protective equipment
    - Provide all essential workers with hazard pay
    - Develop a mechanism so that workers can register and be protected as a "conscientious objector" if they do not feel safe being compelled to return to work or to stay on the job
- ***More burdened by chronic diseases***
    - Increase testing and monitored isolation-away-from-home resources in communities of color
    - Reject calls to use pre-existing chronic diseases as a factor in denying or deprioritizing access to life-saving therapies (intensive care unit beds, ventilators, emergency dialysis) in the event of local shortages
- ***Less access to health care***
    - Augment health care resources in communities of color including increased staff, intensive care unit beds, ventilators, and emergency dialysis capability in local hospitals
    - Institute local agreements between hospital systems so that NO hospital will have to implement crisis standards of care, including rationing of life-saving therapies, until ALL hospitals in a locality have to do so
    - Advocate for universal health coverage (like Medicare for All) since the insufficiency of employer-based health insurance has now been made manifest in this time of massive unemployment (ironically as a result of a health crisis!)

Health equity is a process in which government must play a central role (see Jones CP, *Med Care* 2014 and Jones CP, *Newsweek* 2020)

- Health equity is assurance of the conditions for optimal health for all people
- Achieving health equity requires:
    - Valuing all individuals and populations equally
    - Recognizing and rectifying historical injustices
    - Providing resources according to need
- Health disparities will be eliminated when health equity is achieved

In order to impact the course of the pandemic for all people, we need to shift from a medical care model of testing for SARS-CoV-2 to a public health model of testing for the virus

- ***Outbreak investigation:*** Conduct universal testing (of all persons, both symptomatic and asymptomatic) in settings experiencing local outbreaks, including prisons, jails, and detention centers; meat-packing plants, poultry plants, warehouses, and other workplaces; nursing homes and other senior congregate settings; and even hard-hit neighborhoods or zip codes
- ***Public health surveillance:*** Periodically (preferably weekly) test a different population-based probability sample of a borough, city, county, or region, including both

symptomatic and asymptomatic persons, to estimate with known precision the current prevalence of the virus in that population
    - This prevalence estimate is a much better measure of the current level of virus in the population than using the number of symptomatic persons testing positive (a one- to two-week old picture), or the number of persons hospitalized (a two- to three-week old picture), or the number of persons dying of COVID-19 (a three- to four-week old picture)
    - This present-day prevalence estimate will help guide resource allocation two weeks hence
- These population-based testing strategies will enable us to go beyond simply documenting the course of the pandemic (as we have done by only testing those with symptoms in order to confirm a diagnosis at the individual level) to actually altering the course of the pandemic
    - Need isolate all infected persons (both symptomatic and asymptomatic), preferably away from their families in COVID-19 isolation shelters which are staffed by nurses who will monitor temperatures, oxygen saturation levels, and vigor; be equipped with oxygen; and be able to transfer patients quickly to hospitals should the need arise
    - ***Note:*** Isolation of the asymptomatic positives may have an especially important impact on altering the course of the pandemic
    - Do contact tracing for all of the positives, especially the asymptomatic positives
    - Quarantine, monitor, and test all of the contacts
- Continue to offer widespread testing to all of those who are symptomatic, or on the front lines, or even just curious