Healthcare Ready's Comment on the United States House of Representatives Ways and Means Committee Hearing on the Impact of COVID-19 on Communities of Color

Introduction

Healthcare Ready would like to thank the United States House of Representatives Ways and Means Committee for the opportunity to provide comment on the Hearing on the Disproportionate Impact of COVID-19 on Communities of Color on May 27, 2020. This hearing did not come a second too early, as this conversation must be a critical part of the national dialogue on the COVID-19 pandemic, as well as inform policies and plans shaping government and community responses. Black, Latinx, indigenous, and Pacific Islander communities are grappling with the disproportionate impact of this outbreak and the absence of a sufficient and coordinated public response to reduce this harm. To counteract the effect of inadequate crisis management, it is not only necessary that we study, understand, and speak about these disparities, but that we listen to the voices of those who have faced the greatest consequences, the voices of their caretakers, the voices of their community leaders, and that we heed their calls for action. This hearing was a necessary and timely opportunity to create actionable solutions and listen to these voices, but the resulting conversation and action is only beginning.

Healthcare Ready: Context and Perspective

Healthcare Ready is compelled to submit comments to this hearing as equity and community resilience are pillars of our mission to support the US healthcare system and its patients during disasters. These are pillars of our work, because our unique position allows us to see the connectivity between the healthcare system and public health response to disasters and the impact of disasters on the most vulnerable in our society – impacts caused by systemic inequities within these spaces. We recognize that disasters do not create disparities, but rather exposes them. And to that end, we work to address, in preparedness planning and response coordination, the health disparities that will be exacerbated during a crisis.

Our organization was founded in the wake of Hurricane Katrina, a catastrophic event that brought lasting harm to communities in New Orleans, especially low-income black people. At that time, prominent members of the healthcare supply chain recognized the need for a coalition

to protect the healthcare system and ensure healthcare facilities are supported and supplied before, during, and after disasters. These organizations came together to create Healthcare Ready to fill this gap.

Healthcare Ready is a nationally focused non-profit organization that supports healthcare system and patient resilience against disasters and disease outbreaks like COVID-19. We have activated our Emergency Operations Center (EOC) in response to over one hundred disasters, facilitating information sharing and collaboration between the public sector and the healthcare supply chain in times of crisis. When not activated, we carry out research, training and exercise programs, and host convenings designed to foster partnerships needed to protect public health in a disaster environment.

Healthcare Ready began tracking the emerging novel coronavirus threat in Wuhan, China in early January and officially activated on January 21 for the response to the now global outbreak of COVID-19. Alongside coordination of the healthcare supply chain response to this pandemic[1], our efforts have focused on engaging community-based organizations, patient advocates, and civil rights leaders. We are creating resources to protect public health in communities dealing with overlapping medical and social vulnerabilities. These are the people most vulnerable to life-threatening outcomes from a disaster, like not being able to reach a treatment facility to manage a chronic condition, having medications damaged or lost while evacuating, or being more exposed to an infectious disease and its most severe outcomes, the impact we have seen from COVID-19 in communities of color. The disproportionate impact of COVID-19 on communities of color is a direct result of the existing disparities in poverty levels, chronic condition rates, healthcare access, and community infrastructure.

As an organization with a mission to protect patients during crises, we see how disasters disproportionately harm the most marginalized people within a community and within society at large. We put an emphasis on understanding what makes some more vulnerable to worse outcomes after disasters because of this. An equitable approach to disaster preparedness and response means learning about the unique challenges of those in marginalized communities,

[1] https://healthcareready.org/covid19/

understanding how these challenges reduce their capacity to recover from disaster, and accounting for this in our planning and in our day-to-day approach. We look at the impact of disasters with a lens focused on the health outcomes and long-term recovery of the individual (the patient) and the community. Disasters disrupt the healthcare routines for the most vulnerable by exacerbating existing challenges in their ability to get the treatment and medication they need. When a natural disaster disrupts public transportation systems and infrastructure, for example, those that rely most heavily on these systems to maintain their treatment have the greatest risk for health emergencies and death because they cannot as easily find and afford alternatives. Take the case of a hurricane that floods roads and takes out power in a dialysis clinic: people who are dependent upon dialysis treatment must find alternative methods that are sometimes costly and inaccessible to find another a clinic and get there. Without the intervention of emergency managers that are mindful of this need and the inequities that exist, they could be forced to miss the treatment that is keeping them alive. When a disease outbreak, such as COVID-19, strains hospital capacity and devastates the ancillary care and home health care system, those who rely on these systems will be hit the hardest because they do not have the luxury to opt out of care without taxing their health.

This is critical in understanding the impact of COVID-19, because people of color often make up a disproportionately higher portion of these medically dependent populations and often face the most barriers to safeguard their health even outside a disaster situation.[2] The disproportionality and severity of the impact of COVID-19 on Black, Latinx, indigenous, and Pacific Islander communities is another example of existing health disparities being made worse by disasters. From our vantage point as public health analysts and emergency managers, we recognize the COVID-19 outbreak is not unique from any other natural disaster, environmental hazard incident, or infectious disease outbreak, in its disproportionately harmful effect on communities of color.

From Katrina to COVID-19: Natural Disasters and Public Health Emergencies in Communities of Color

[2] https://www.ncbi.nlm.nih.gov/books/NBK425844/

Healthcare Ready is uncomfortably familiar with the 21st century crises that have brought destruction and death to communities of color, from Hurricanes Katrina and Maria to the scores of lesser known disasters in between that left a troubled legacy for COVID-19 to follow. This is a legacy in which Black, Latinx, and indigenous communities often fare worse than their white counterparts in time of disaster. This is indicated by worsened financial stability and increased racial wealth disparities[3], reduced housing security and the inability to "return home" as easily as white people[4], and a higher prevalence of mental health conditions like post-traumatic stress disorder[5]. The toll of disasters, whether directly or directly, impacts the health of people of color as it alters the social environments that play a critical role in health outcomes.[6]

In our research work and response coordination, Healthcare Ready studies the link between resilience against disasters and the health and wellness of a community, and what this means for communities of color.[7] In order for a community to be resilient against a crisis like COVID-19, it first requires they have the financial security to invest in safe, quality housing that is built to withstand disasters. People of color are more likely to live in poverty, and living in poverty often forces one to choose housing in the most crisis-prone conditions[8]. These include flood plains and coastal areas subject to dangerous tropical storms. In more urban communities, the poorest people are more likely to live in homes with hazardous foundations that threaten their health.[9] In the context of a pandemic such as COVID-19, the lack of safe and resilient housing means people are less easily able to practice social distancing by staying at home, a COVID-19 risk factor that is compiled with a higher prevalence of multi-generational homes in communities of color[10] where COVID-19 can be more easily spread to the elderly[11]. Black communities and low-income Latinx communities also more likely to be "healthcare deserts",[12] meaning these communities experiences shortages of healthcare professionals and thus live farther away from

[3] https://www.eurekalert.org/pub_releases/2018-08/ru-ndw082018.php
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862006/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386718/#R32
[6] https://www.cdc.gov/socialdeterminants/index.htm
[7] https://healthcareready.org/infographic-the-importance-of-resilience-to-communities-of-color/
[8] https://www.americanprogress.org/wp-content/uploads/2013/08/LowIncomeResilience-2.pdf
[9] https://www.nature.com/articles/s41591-019-0713-y
[10] https://www.pewsocialtrends.org/2011/10/03/chapter-3-demographics-of-multi-generational-households/#:~:text=The%20most%20likely%20groups%20to,%2Drace%20Americans%20(17.9%25).
[11] https://healthcareready.org/infographic-covid-19s-impact-on-black-and-latinx-people/
[12] https://www.cfah.org/hbns/2012/health-care-deserts-more-common-in-black-neighborhoods.html

robust healthcare systems that can protect them in crisis.[13] Higher rates of poverty and lower rates of car ownership[14] in Black, Latinx, and indigenous populations means these communities are also more likely to rely on public transportation that may either be overwhelmed or disrupted by a disaster and reduce their ability to flee a disaster, or in the case of this pandemic, lead to a higher rate of exposure to COVID-19.

Disaster resilience in a community also requires emergency systems built to protect critical infrastructure, like healthcare, transportation, and housing. Without adequate funding and personnel, these systems cannot mitigate the impact of natural events and disease outbreaks. They also fail to establish a partnership of trust between community members and the agencies from which they would request assistance and information during emergencies. Without these systems, people in a community would be challenged to identify trusted sources of assistance and information in a crisis, especially for their healthcare needs. With limited resources and strained finances, they may have to make decisions that deprioritize their chronic health needs for their daily survival. This is a reality for many Black, Latinx, and indigenous communities as they are more likely to live in poverty and in communities without these resources.[15] These impediments to disaster resilience explain the disproportionate impacts of COVID-19 in these communities.

We saw also this disparity after Hurricane Katrina, which impacted black communities in New Orleans worse than white communities as a direct result of these structural inequities. Black people in New Orleans were more likely to live in the least structurally sound neighborhoods in the most coastal wards of New Orleans that are most vulnerable to storm surge and flooding. An inadequate system of levees and dams failed to protect these people from the dangerous flooding brought by Hurricane Katrina. The destruction of homes caused a flight of black New Orleanians away from the coastal city, reduced the black population in New Orleans over the years by 7%, and increased the proportion of these black citizens living in poverty.[16] Meanwhile, white and Hispanic populations have been restored or grown in size, respectively, accompanied

[13] https://healthcareready.org/infographic-covid-19s-impact-on-black-and-latinx-people/
[14] https://nationalequityatlas.org/indicators/Car_access
[15] https://healthcareready.org/infographic-covid-19s-impact-on-black-and-latinx-people/
[16] https://fivethirtyeight.com/features/katrina-washed-away-new-orleanss-black-middle-class/

by an influx of young, white professionals.[17] The most impoverished people in New Orleans have been predominantly black since before the landfall of Hurricane Katrina, a disaster that only exacerbated this imbalance of wealth. Black people in New Orleans were not victims of a disaster that picked favorites, but people living in circumstances that could not prepare or protect them from the most devastating outcomes, much like the people of color across the country that have fallen victim to COVID-19.

Hurricane Maria as a case study of disparities in disaster response

Ten years after Healthcare Ready was founded in the wake of Hurricane Katrina, our organization found itself responding to yet another crisis that disproportionately harmed communities of color, Hurricane Maria. Our Emergency Operations Center (EOC) activated to support the response to healthcare needs in the majority Latinx community in Puerto Rico (PR) and the majority black population in the US Virgin Islands (USVI). We worked in partnership with supply chain and government partners to increase coordination and create solutions to protect public health and restore the healthcare system in both PR and the USVI. Among the other shortcomings documented in the federal response to this storm was a dearth of culturally competent resources for these communities. Put simply, the federal response was not prepared for the realities of a catastrophe in these territories and this remains an important area for investment, to this day.

Storms, and other acute natural disasters, are not the only crises plaguing communities of color more heavily than other. We also see disproportionate impacts of environmental hazards on the health and wellness of people of color. The four-year drought in California, spanning 2012 through 2016, is an example of this. Indigenous communities that rely more heavily on fishing and smaller water systems are not as resilient against drought. In the case of the California drought that caused a salmon decline among many other impacts, indigenous people in the Pacific Northwest that rely more heavily on salmon fishing as a lifestyle tenet and core component of their diet in comparison to their white counterparts were more severely impacted.[18] Their resilience against crisis was also challenged by existing threats against the

[17] https://fivethirtyeight.com/features/katrina-washed-away-new-orleanss-black-middle-class/
[18] https://pacinst.org/publication/drought-and-equity-in-california/

preservation of their lifestyle. These threats include water diversion, dam operations, and fishing rights issues and are the results of systemic disenfranchisement of indigenous communities and their way of life since the arrival of European settlers on this land.[19] This same reality has caused higher rates of chronic condition and weaker health systems in indigenous communities leaving them to fare worse in the wake of COVID-19.[20]

These events are just examples in a long history of disenfranchisement that leaves communities of color to fare worse in disaster. The COVID-19 outbreak is no hurricane, but it is a disaster, and its impact to society is as connected to existing inequities. The cases highlighted above demonstrate how critical infrastructure, including healthcare, transportation, housing, and water systems, and more, are less equipped to protect communities of color from crisis. This is why these communities were at a greater risk to COVID-19's most severe impacts and why we are now seeing more deadly outcomes in these communities. These systems have been designed in ways that position resources further away from predominantly black communities than their white counterparts.[21] These systems leave people of color with less access to culturally- and language-appropriate health information and education.[22] These systems lack public officials trained in the equitable approaches needed to combat an earned mistrust of healthcare systems in communities of color in order to be trusted sources of assistance in times of crises.[23] These factors have all played a role in the more dangerous and fatal outcome from COVID-19 in communities of color. The communities on the margin are the communities with the greatest journey to reach resilience against disasters. In the US, these are most often communities of color.

Emergency Management Is an Opportunity for Risk Reduction in Communities of Color

Policies that eradicate unjust systems promote our collective resilience against disasters. Tackling injustice in its many forms – racism, sexism, homophobia, and ableism, to name a few – is a requirement of public service, which aims to promote the well-being and security of *all*

[19] Ibid.
[20] https://www.ama-assn.org/delivering-care/population-care/why-covid-19-decimating-some-native-american-communities
[21] https://www.cfah.org/hbns/2012/health-care-deserts-more-common-in-black-neighborhoods.html
[22] https://www.ncbi.nlm.nih.gov/books/NBK19910/
[23] https://live-naacp-site.pantheonsite.io/wp-content/uploads/2018/09/NAACP_InTheEyeOfTheStorm.pdf

citizens. Systemic injustice, like racism, is in direct opposition to the well-being of all citizens, whereas truly equitable policies are a harm to none. As such, it is the task of emergency managers like Healthcare Ready, to lead with equity. Simply discussing and analyzing the imbalances brought to light in the wake of a disaster is insufficient but does serve as a critical step in the right direction. In our response to COVID-19 and in our steady preparation amid hurricane season, Healthcare Ready is working to support community based organizations, community advocacy organizations, and patient advocacy organizations that are run by and in direct support of communities of color. By empowering these organizations and leaders - these *de facto* experts in equity – and training them in disaster response and preparedness, we aim to bridge critical gaps in communities of color. We are helping to bridge the gap between people of color and the public health systems and healthcare entities that should protect them from crises like COVID-19.

Moving Forward

This hearing provided a unique opportunity for researchers and medical professionals to provide testimony on the impact they have seen in their work during the COVID-19 pandemic. After today, there are voices yet to be heard and conversations yet to be had. There are stakeholders that were missing from the hearing, including organizations directly supporting and engaging women of color, representatives of the lower-wage workers in retail and service industries deemed essential, and non-physician healthcare workers and caregivers. Nurses associations, unions, and advocacy organizations led by women of color could add a vital perspective to a discussion on the increased exposure risk of essential workers and the solutions they envision to protect these workers.

We recognize that COVID-19 is killing the elderly at much higher rates compared to other age groups.[24] This means elderly people of color are at a critical intersection of vulnerability to severe illness from COVID-19. To that end, we are disappointed this hearing failed to thoroughly examine how our response to COVID-19 neglected the needs of elderly people of color. It can be assumed that critical opportunities were missed to engage senior housing managers and caregivers of the elderly, anchor institutions trusted and utilized by the older adults, and the

[24] https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#AgeAndSex

faith-based organizations that find their most zealous followers within elderly communities of color. The continued response and impending recovery must account for our failure to protect the aging population from this disease, while acknowledging the severe levels of grief they may be experiencing in a post-COVID-19 world. We must also create solutions to promote life-saving information and battle misinformation for those with insufficient access to and familiarity with technology in the context of social distancing. We must create innovative partnerships between emergency managers, public health officials, and volunteer organizations trained to support the elderly and others with technological limitations to coordinate strategic outreach efforts to the elderly and to supply these volunteers with sufficient personal protective equipment.

It is important to note that this hearing was held as the nation was also beginning to erupt with protests sparked by the unjust killings of George Floyd, Breonna Taylor, Ahmaud Arbery, and a long outcry of the black community fighting against systemic racism and bias. We should acknowledge a stark reality in which George Floyd, who was determined to be COVID-19 positive but asymptomatic in the official autopsy by the Hennepin County Medical Examiner's Office, seemed on track to survive this novel disease pandemic but was instead the fatal victim of a racialized act of violence.[25] This fact does not take away from the impact of COVID-19 on people of color, but it forces us to acknowledge that COVID-19 is not the only crisis disproportionately impacting communities of color in 2020. That is to say, if we are to reduce the impact of COVID-19 on communities of color, we must concern ourselves with understanding the root cause that leads to so many deadly outcomes in communities of color. This root cause is racism that leaves people of color worse off in times of crisis, and often in everyday life. By recognizing the common cause of struggles facing communities of color, we can more accurately respond to and reduce future death and sickness from disasters and disease outbreaks like COVID-19.

Healthcare Ready will continue to acknowledge the impact of racist policies and discrimination on public health and community health outcomes from crises like COVID-19. We call on our colleagues within emergency management, public health, pharmaceutical supply chain

[25] https://www.hennepin.us/-/media/hennepinus/residents/public-safety/documents/Autopsy_2020-3700_Floyd.pdf

operations, and patient care to follow suit. We reiterate the necessity of equitable emergency management to protect citizens from natural disasters, environmental hazards, and disease outbreaks. This requires an intentional shift in how we determine the burden of responsibility. Community resilience must be managed at a community, not individual, level. We must instead implement equitable outreach, engagement, and analyses into federal, state, local, tribal, and territorial emergency management planning. The blame for COVID-19 disproportionate impact on communities of color is not the fault of the marginalized people facing severe health outcomes, but the systems built to serve the well-being of those across the United States.