U.S House of Representatives Homeland Security Subcommittee on Emergency Preparedness, Response & Recovery

"Pandemic Response: Confronting the Unequal Impacts of Covid-19"
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Chairman Payne, Ranking Member King, and distinguished members of the Subcommittee on Emergency Preparedness, Response & Recovery: 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, Latino-Americans, Native Americans, and other communities of color. According to new data published in the New York Times this week, Latino and Africa-Americans are three times as likely to be infected as their white neighbors. They are twice as likely to die from the virus.

A Brookings Institution report found that in some age groups, African-Americans have six times the mortality than whites. 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 the iceberg; there are lot of data missing that would more fully illustrate the impact of covid-19 on communities of color.

Why are there such rampant health disparities? 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: not only care for physical health conditions but also mental health as well. The acute impacts of covid-19 worsen the underlying conditions in individuals and communities. Our solutions must therefore focus on both aspects.

In this testimony, I emphasize ten actions that Congress can take now to reduce the disproportionate impact of the pandemic on people of color. When possible, I emphasize (in the underlined text) the agencies and entities that are directly under the jurisdiction of the Homeland Security Committee.

(1) Target testing to minority and underserved communities.

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.

State and local officials cannot do this work alone; it's estimated that we need ten times the amount of testing that we currently have. Congress must instruct FEMA to ramp up testing and to set up testing facilities all across the country. Existing hotspots should be the priority, but emphasis should be placed to ensure that community spread is detected early on to prevent clusters from becoming outbreaks and outbreaks from becoming epidemics. In addition, FEMA must coordinate efforts to ensure that the supply chain remains intact, and that surges in infections do not result in swabs and testing reagents from becoming limiting factors.

(2) Track demographic information to ensure equitable resource allocation.

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 federal government 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.

The CDC would be the ideal entity to coordinate such a dashboard. FEMA can also play a role in tracking this information, especially if it becomes instrumental (as I hope it does) in ensuring widespread testing.

(3) Hire contact tracers from minority communities.

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.

While contract tracers should come local communities, the coordination can be done nationally. It makes no sense to have 50 different protocols for recruitment, training, and deployment. A national strategy for contact tracers could, in theory, come under the purview of the Department of Homeland Security, which has experience in mass deployment for critical infrastructure and security needs.

(4) Provide free facilities for isolation and 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 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.

Establishing these facilities, rapidly, is something that should be led by FEMA. FEMA has shown that it can rapidly set up field hospitals. Isolation and quarantine facilities are just as critical for controlling the outbreak, and Congress should urgently request FEMA to oversee these efforts.

(5) Suspend immigration enforcement for those seeking medical assistance for covid-19.

Public health hinges on public trust. Undocumented immigrants who fear deportation will be scared to seek help if they exhibit covid-19 symptoms, thereby posing a risk not only to themselves but their families and communities. Congress should prohibit ICE from accessing records of those seeking care for covid-19 or in any way having access to facilities that offer testing and care for patients. This should also be made clear through public education campaigns in minority communities.

Congress should also ask for temporary cessation of the Trump administration's public charge rule. This rule will serve to further delay legal immigrants from seeking necessary healthcare. It should be suspended for a two-year period given the immediacy of the covid-19 pandemic.

(6) Institute stronger worker protections.

As a former local health official, I depended on the 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.

Congress must instruct CDC and OSHA to return to their mandates of protecting the health of the public and specifically workers. It should also do its part through agencies in the immediate purview of its committees. The Homeland Security Committee can, for example, ensure that all workplace protections are followed for TSA employees. This includes universal masking for all passengers in airport facilities, as this will protect the employees as well as the public. Such policies can set an example for not only the federal government but also private industries to secure protections for workers and the public—and in so doing, protect those most vulnerable including minorities.

Furthermore, there must be stronger protections to limit the spread of covid-19 in DHS-run immigration detention facilities. This includes ensuring access to PPE, appropriate protocols for isolation and quarantine, and criteria for release of detainees if cases reach a certain point determined by public health experts. As with all other workplaces, protecting the staff will also protect those they come into contact with and reduce community spread.

(7) 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.

Congress must take prompt action to urge the Trump administration to have a national coordinated strategy. This includes activating the Defense Production Act to ensure PPE, ventilators, and other critical supplies are produced in sufficient quantity.

(8) 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.

As the Homeland Security Committee considers threats to critical infrastructure, I urge that you also consider the public health safety net to be part of national security and the backbone of critical infrastructure in the U.S. and around the world.

(9) Increases health insurance coverage

More than 45 million people have lost their jobs during the pandemic, and with those jobs, many of them lost health insurance. That's on top of 27 million who were previously uninsured. Lack of insurance leads to a delay in treating underlying medical problems, which increases the likelihood of severe illness and death from covid-19. Since minorities constitute a higher percentage of the uninsured, increasing coverage will prevent further amplification of disparities. States can do this through expanding Medicaid and allowing open enrollment in exchanges.

Congress must ensure healthcare coverage for all Americans, starting with frontline federal

workers. It should also press for national policies around evidence-based public health practices that reduce infection risk, including universal mask-wearing.

(10) 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.

Conclusion

To some, the ten steps outlined here will seem too small in scope. I agree that there must be attention to longer-term issues like housing instability, income inequality and structural racism that are inextricably linked to health disparities. But the covid-19 pandemic is the life-or-death threat facing communities of color right now. The perfect cannot be the enemy of the good when there are specific actions that policymakers can take that will reduce disparities in covid-19 outcomes and, in so doing, improve health for all. The world that we strive for should be 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.