Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Health Care Inequality: Confronting Racial and Ethnic Disparities in COVID-19 and the Health Care System"
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Thank you for each of these thoughtful questions, I will answer each below the question stem.

The Honorable Eliot L. Engel (D-NY) and the Honorable Lisa Blunt Rochester (D-DE):

1. Even before the COVID-19 pandemic, the U.S. has been and is experiencing a maternal health crisis that disproportionately impacts Black and Indigenous women. Early data shows that COVID-19 is making this crisis worse, and that the same communities dying from preventable pregnancy-related complications are those at highest risk for dying from COVID-19. What can be done to make sure that the pandemic does not exacerbate the existing maternal health crisis?

Response: Across the US, Black women's maternal mortality is at least 3-4 times higher than white and Latinx women.[1] And the causes are often predictable complications associated with pregnancy and childbirth such as heart problems, blood clots or excessive bleeding. The root of this health inequity is racism, although it can take a number of forms. We know it is racism because evidence indicates that Black women suffer a more than 3-fold higher maternal mortality rate despite their income, education or geographical location.[2] Or as

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[1] CDC. First data released on maternal mortality in over a decade. Jan 2020. Available at: https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2020/202001_MMR.htm#:~:text=Some%20of%20the%20highlights%20in%20the%20new%20reports%3A&text=658%20women%20died%20of%20maternal,is%20consistent%20with%20earlier%20data.

[2] Martin N and Montagne R. Nothing Protects Black Women During Pregnancy and Childbirth. Propublica. December 2017. Available at: https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth

reproductive justice scholar Dr. Monica McLemore has said, "The factors that typically protect people during pregnancy are not protective for Black women."[3]

To ensure that the pandemic does not exacerbate these alarming gaps in maternal outcomes there are important steps Congress should take to protect Black mothers and, by safeguarding the population rendered most vulnerable within our health care system, to protect everyone.

Increase access to health care for Black women. Gaps in insurance coverage for Black women shape their healthcare utilization and may render Black women particularly vulnerable to untreated or undertreated illness and complications of pregnancy. Thus access to vital prenatal and post-partum care is critical to ensure healthy birth outcomes for mothers and babies.

Expand Medicaid. Currently Medicaid covers nearly half of all births, yet evidence indicates Black Americans disproportionately rely on Medicaid for health insurance and predominantly live in states that have yet to participate in Medicaid expansion.[4] In addition, for many mothers, their Medicaid coverage may end within 60 days of their delivery, leaving them uninsured during the most critical windows for complications related to childbirth. Expanding Medicaid, increasing the income thresholds for eligibility, and lengthening the windows for coverage can help narrow devastating care gaps that contribute to racial inequities in maternal mortality rates.

Institute a Universal Healthcare System. While expanding Medicaid will help close dangerous coverage gaps, the US continues to stand alone among wealthy, developed nations in failing to ensure access to healthcare for each and every person in our country. This failure portends future health inequities for all those excluded from the employer-based insurance pools and who lack eligibility for state-sponsored insurance. The prohibitively high costs of healthcare in the United States means buying into the system, out of pocket, is also unaffordable at the median salary of most Americans. To chart a path to universal healthcare, the Congress could begin by expanding eligibility for Medicaid (as discussed above) and Medicare programs.

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[3] McLemore M. To prevent women from dying in childbirth, first stop blaming them. Scientific American. May 2019. Available at: https://www.scientificamerican.com/article/to-prevent-women-from-dying-in-childbirth-first-stop-blaming-them/

[4] Artiga K and Orgera K. Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018. Kaiser Family Foundation. Available at: https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/

Desegregate US hospitals and clinics. The process to desegregate the US healthcare system began with federal mandates that accompanied the passage of Medicare in 1965.[5,6] And yet, racial segregation persists in healthcare delivery systems across the US. As a result, the quality of prenatal, post-partum, hospital-based and primary care in the US remains tiered by racial and ethnic groups. This is a major driver of Black-white differences in maternal morbidity.[7] Insurance is often the mechanism by which healthcare delivery becomes segregated. As such, legislation to enact universal health insurance would provide an opportunity to eliminate this driver of inequity.

Fund the experts doing the work. Incredible work is being done across the country to address maternal outcome gaps. One example is the Alliance for Innovation on Maternal Health (AIM) which is funded through the federal Maternal and Child Health Bureau.[8] "AIM is a national alliance to promote consistent and safe maternity care, with the initial goal of reducing maternal mortality by 1,000 instances—and severe maternal morbidity by 100,000 instances—between 2014 and 2018."[9] The work of our nation's leading Black scholars, health care providers and advocates in organizations like Sister Song[10] and Black Mamas Matter[11] have also contributed to effective recommendations including: increased access to midwifery, group prenatal care, and social and doula support.

The COVID-19 pandemic should be a wakeup call. Our reliance on insurance as a gatekeeper for healthcare leaves too many Americans, and particularly Black mothers, vulnerable to poor outcomes and early death. Our inadequate funding for public and maternal health renders our nation's preeminent scholars, providers and advocates ill-equipped to keep us all safe.

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[5] Smith DB. The politics of racial disparities: desegregating the hospitals in Jackson, Mississippi. *Milbank Q*. 2005;83(2):247-269. doi:10.1111/j.1468-0009.2005.00346.x

[6] NPR. 50 Years Ago, Medicare Helped To Desegregate Hospitals. Available at: https://www.npr.org/2015/07/30/427648586/50-years-ago-medicare-helped-to-desegregate-hospitals

[7] Howell EA, Egorova N, Balbierz A, Zeitlin J, Hebert PL. Black-white differences in severe maternal morbidity and site of care. *Am J Obstet Gynecol*. 2016;214(1):122.e1-122.e1227. doi:10.1016/j.ajog.2015.08.019

[8] Alliance for Innovation on Maternal Health (AIM) – Community Care Initiative. HRSA. More information available at: https://www.hrsa.gov/grants/find-funding/hrsa-19-109

[9] McLemore M. To prevent women from dying in childbirth, first stop blaming them. Scientific American. May 2019. Available at: https://www.scientificamerican.com/article/to-prevent-women-from-dying-in-childbirth-first-stop-blaming-them/

[10] Information available at: https://www.sistersong.net/

[11] Information available at: https://blackmamasmatter.org/

To make sure this pandemic does not exacerbate the maternal mortality crisis, Congress needs to take clear and decisive steps to increase access to healthcare, desegregate our health system and support the professions that help keep us well.

2. What are some of the barriers that Black women face in receiving quality, comprehensive, and respectful prenatal and postnatal care during the COVID-19 pandemic?

Response: Currently Medicaid covers nearly half of all births, yet evidence indicates Black Americans disproportionately rely on Medicaid for health insurance and predominantly live in states that have yet to participate in Medicaid expansion.[12] In addition, for many mothers, their Medicaid coverage may end within 60 days of their delivery, leaving them uninsured during the most critical windows for complications related to childbirth. Expanding Medicaid, increasing the income thresholds for eligibility, and lengthening the windows for coverage can help narrow devastating care gaps that contribute to racial inequities in maternal mortality rates.

In addition, too many Black women receive their care in segregated facilities. This contributes to Black women receiving lower quality prenatal, post-partum, hospital-based and primary care in the US. And it is a major driver of Black-white differences in maternal morbidity.[13] Insurance is often a mechanism used to segregate healthcare delivery. Universal health insurance provides opportunities to eliminate this driver of inequity.

The Honorable Lisa Blunt Rochester (D-DE):

1. How can cultural competency help address barriers in accessing mental health services and do you have any recommendations for how we can further use cultural competency as a pillar to advance health equity?

   Response: The American Psychological Association[14] recommends cultural humility as "one construct for understanding and developing a process-oriented approach to [cultural] competency." This approach includes "a lifelong commitment to self-evaluation and self-

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[12] Artiga K and Orgera K. Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018. Kaiser Family Foundation. Available at: https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/

[13] Howell EA, Egorova N, Balbierz A, Zeitlin J, Hebert PL. Black-white differences in severe maternal morbidity and site of care. *Am J Obstet Gynecol*. 2016;214(1):122.e1-122.e1227. doi:10.1016/j.ajog.2015.08.019

[14] Waters A and Asbill L. Reflections on cultural humility. American Psychological Association. Available at: https://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility

critique**,** a desire to fix power imbalances where none ought to exist, and an aspiration to develop partnerships with people and groups who advocate for others." These pillars can help address barriers to seeking mental healthcare that arise from stigma and power imbalances in society. At the provider level, practicing cultural humility can help patients across racial and ethnic groups equitably benefit from the resources our healthcare system has to offer.

2. There are a disproportionate number of underlying health conditions that makes COVID-19 more fatal among Black and Hispanic communities. Lung disease is a leading co-morbidity among COVID-19 patients, and smokers are more likely to have severe COVID-19 symptoms than non-smokers. there are huge disparities in our nation regarding who smokes. For example, Medicaid beneficiaries smoke at twice the rate of those on private health insurance, despite being just as likely to want to quit. That's why I introduced legislation that would expand tobacco cessation coverage to all Medicaid beneficiaries during this critical time. What role does tobacco use play in COVID-19 related complications and in health disparities more generally? How important is it to assist smokers who want to quit?

   Response: According to the World Health Organization (WHO), "There are currently no peer-reviewed studies that have evaluated the risk of SARS-CoV-2 infection among smokers. [However] Zhao et al.35 analyzed data from 7 studies (1726 patients) and found a statistically significant association between smoking and severity of COVID-19 outcomes amongst patients. At the time of this review [June 30, 2020], the available evidence suggests that smoking is associated with increased severity of disease and death in hospitalized COVID-19 patients." Based on these findings and the well-known harms of tobacco use and second and third hand tobacco exposure, the WHO recommends tobacco cessation to decrease the associated health risks.[15] The most effective interventions for tobacco cessation assist those seeking to quit. Evidence has shown minoritized groups are less likely to receive healthcare provider advice to quit[16] and less likely to use nicotine replacement therapy.[17] Expanding access to cessation therapy

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[15] World Health Organization. Smoking and COVID-19. June 2020. Available at: https://www.who.int/news-room/commentaries/detail/smoking-and-covid-19

[16] Landrine H, Corral I, Campbell KM. Racial disparities in healthcare provider advice to quit smoking. *Prev Med Rep*. 2018;10:172-175. Published 2018 Mar 13. doi:10.1016/j.pmedr.2018.03.003

[17] Trinidad DR, Pérez-Stable EJ, White MM, Emery SL, Messer K. A nationwide analysis of US racial/ethnic disparities in smoking behaviors, smoking cessation, and cessation-related factors. *Am J Public Health*. 2011;101(4):699-706. doi:10.2105/AJPH.2010.191668

through Medicaid may address barriers to participation in these programs and racial and ethnic gaps[18] in their impact.

3. Increasing workforce diversity is critical to achieving health equity. Why do you think it is critical that Congress enact legislation that aims to increase workforce diversity, like H.R. 3637, the Allied Health Workforce Diversity Act?

Response: The US healthcare workforce is predominantly white[19] at every level, from medical students and physicians to hospital CEOs, nurses and NIH grant recipients. The impact is two-fold. First, for areas across the country where the local healthcare system is the major employer, exclusion of non-white workers from the healthcare workforce can reinforce local racial and ethnic gaps in income and wealth.[20] Second, the lack of racial and ethnic diversity across the allied health workforce also means that patients of color are less likely to receive racially concordant care (or care from a provider of their same racial or ethnic group) than white patients. While having a race-matched provider should not be required for a patient to receive loving, dignified and quality healthcare, evidence indicates that racial concordance between providers and patients of color contributes to increased healthcare utilization,[21] improved communication between providers and patients, and potentially improved[22] patient outcomes. In fact, a recent study published by the National Academy of Sciences[23] found that racial concordance between Black providers and Black newborns can decrease Black infant mortality. In these ways, increasing workforce diversity remains important for health equity, as it may contribute to the economic development of communities near medical centers and it may improve the experiences and outcomes of patients of color.

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[18] Cokkinides VE, Halpern MT, Barbeau EM, Ward E, Thun MJ. Racial and ethnic disparities in smoking-cessation interventions: analysis of the 2005 National Health Interview Survey. *Am J Prev Med*. 2008;34(5):404-412. doi:10.1016/j.amepre.2008.02.003

[19] Boyd RW. The Case for Desegregation. The Lancet. 2019.

[20] Diamond D. How the Cleveland Clinic grows healthier while its neighbors stay sick. Politico. July 2017. Available at: https://www.politico.com/interactives/2017/obamacare-cleveland-clinic-non-profit-hospital-taxes/

[21] Ma A, Sanchez A, Ma M. The Impact of Patient-Provider Race/Ethnicity Concordance on Provider Visits: Updated Evidence from the Medical Expenditure Panel Survey. *J Racial Ethn Health Disparities*. 2019;6(5):1011-1020. doi:10.1007/s40615-019-00602-y

[22] Meghani SH, Brooks JM, Gipson-Jones T, Waite R, Whitfield-Harris L, Deatrick JA. Patient-provider race-concordance: does it matter in improving minority patients' health outcomes?. *Ethn Health*. 2009;14(1):107-130. doi:10.1080/13557850802227031

[23] Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns [published online ahead of print, 2020 Aug 17]. *Proc Natl Acad Sci U S A*. 2020;201913405. doi:10.1073/pnas.1913405117

The Honorable Ann Kuster (D-NH):

Dr. Boyd, in your testimony you discuss how Black, Latinx, and Indigenous populations are overrepresented in our incarcerated population, and how these crowded facilities also dramatically increase the risk for COVID-19 exposure.

In fact, 8 of the 10 largest clusters of COVID-19 infection have occurred in correctional facilities.

1. Dr. Boyd, can we determine the full extent of racial disparities related to COVID-19 in the incarcerated setting based on the currently available data? Is this data reporting on race, ethnicity, and sex for both the justice-involved population and staff that is infected?

Response: There are a number of outlets providing data on the rates of COVID-19 infections and deaths within US jails and prisons. A few of the publicly available sources for this data include the recent CDC report published in May 2020 entitled, COVID-19 in Correctional and Detention Facilities-United States, February-April 2020.[24] This report included data on justice-involved populations and staff but did not, to my knowledge, report on the race, ethnicity, sex or gender of affected populations.

UCLA has compiled a large national database[25] of COVID-19 cases and presumed or confirmed deaths among populations in US jails or prisons, youth correctional facilities, and immigration detention facilities. While this database includes information on justice-involved populations and staff, it also lacks important demographic data, like race, ethnicity, sex, and gender of those affected. The UCLA database was used in a recent study[26] that provided population-level data on COVID-19 cases and deaths within our Federal and State Prisons.

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[24] CDC. COVID-19 in Correctional and Detention Facilities — United States, February–April 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm

[25] UCLA. UCLA Law Covid-19 Behind Bars Data Project. Available at: https://law.ucla.edu/academics/centers/criminal-justice-program/ucla-covid-19-behind-bars-data-project

[26] Saloner B, Parish K, Ward JA, DiLaura G, Dolovich S. COVID-19 Cases and Deaths in Federal and State Prisons. *JAMA*. 2020;324(6):602–603. doi:10.1001/jama.2020.12528

Finally, the Vera Institute of Justice[27] and Prison Policy Initiative[28] have compiled data monitoring the burden of COVID-19 among justice-involved populations and tracking critical policy efforts to address it. They also lack demographic information for these populations.

The overall lack of available demographic data for justice-involved populations and staff affected by COVID-19 may stem from inadequate reporting requirements for departments of corrections.

So no, unfortunately, given the currently available data, we cannot determine the full extent of racial or gendered inequities related to COVID-19 in the incarcerated setting. Mandating departments of corrections report demographic data (including race, ethnicity, sex, gender) on COVID-19 cases and presumed or confirmed deaths may be an important start to obtaining this information.

2. Given this, do we know the true impact and racial disparities of Coronavirus within the justice system?

Response: Unfortunately no. Given the currently available data, we cannot determine the full extent of racial or gendered inequities related to COVID-19 in the incarcerated setting. Mandating departments of corrections report demographic data (including race, ethnicity, sex, gender) on COVID-19 cases and presumed or confirmed deaths may be an important start to obtaining this information.

3. Dr. Boyd, do you believe access to appropriate health care in the incarcerated setting would help address the many health inequities among the justice involved population, as we have seen exacerbated by this pandemic?

Response: Improved access to appropriate healthcare in the incarcerated setting would help address health inequities among the justice-involved population. Yet evidence

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[27] Vera Institute of Justice. Criminal Justice Responses to the Coronavirus Pandemic. Available at: https://www.vera.org/projects/covid-19-criminal-justice-responses/covid-19-data

[28] Prison Policy Initiative. COVID-19 and the criminal justice system. Available at: https://www.prisonpolicy.org/virus/

demonstrates incarcerated populations have decreased access[29] to most healthcare services, including some preventative care services. The current pandemic is likely to exacerbate these care gaps as the nation faces the limitations of our current care infrastructure.

The Honorable Jan Schakowsky (D-IL):

A New York Times report published on May 21, 2020 revealed that in my home state of Illinois, nursing homes in which Black and Latinx residents comprise at least 25 percent of the resident population are three times more likely to have COVID-19 cases than nursing homes in which Black and Latinx residents represent fewer than 5 percent of the population. Nursing home industry officials have waved off this disparity by saying it reflects the racial inequities we have unfortunately seen in COVID-19 cases and fatalities across the United States.

1. Do you agree with the assertion of the nursing home industry?

   Response: There is evidence to show that residential segregation[30] is a major driver of racial health inequities. The mechanism by which segregation impacts health often occurs through public divestment within communities of color and manifests in decreased access to health care services, high paying jobs, quality education, and quality healthcare within segregated areas. The concentrated of minoritized groups within certain nursing homes may reflect and contribute to these broader forms of residential segregation across the US and in Illinois specifically. As such, the quality of care delivered in these settings and ability to address COVID-19 outbreaks may be limited by critical resource shortages that are exacerbated by segregation in these settings.

2. Are there more specific issues around quality of care and Federal support for nursing homes caring for primarily Black and Latinx residents that may fuel this disparity?

   Response: The racial composition of nursing homes are also driven by public policies that shape access to the services nursing homes provide and may reflect population-level barriers to home-based services for minoritized groups.[31] Medicaid expansion and campaigns to enroll seniors who qualify for dual-eligibility in Medicaid and Medicare may enable more seniors, and particularly seniors from minoritized groups, to receive comprehensive long-term care and skilled nursing care within their homes or the homes

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[29] Cropsey KL, Binswanger IA, Clark CB, Taxman FS. The unmet medical needs of correctional populations in the United States. *J Natl Med Assoc*. 2012;104(11-12):487-492. doi:10.1016/s0027-9684(15)30214-5

[30] Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. *Annu Rev Public Health*. 2019;40:105-125. doi:10.1146/annurev-publhealth-040218-043750

[31] Luterman S. It is time to abolish nursing homes. The Nation. August 2020. Available at: https://www.thenation.com/article/society/abolish-nursing-homes/

of their loved ones. Congregate facilities like nursing homes carry elevated baseline risks for infectious disease exposure and spread. Extending the covered benefits and broadening the potential beneficiaries of programs that provided home-based care would help to address these COVID-19 inequities among Black and Latinx seniors.

The Honorable Greg Walden (R-OR):

1. We are seeing that COVID-19-related health disparities for racial and ethnic communities are not entirely unique to the U.S. Alarmingly, the death rates from COVID-19 appear to be higher for people of color worldwide:

   - On May 7, 2020, the Office for National Statistics in the U.K. found that COVID-19-related deaths for ethnic groups in England and Wales exceeded those of white ethnicity.[32] [33] Black males and females were reported to be 4.2 and 4.3 times, respectively, more likely to die from a COVID-19-related death than their white counterparts. This also proved similar for people of Bangladeshi and Pakistani, Indian, and mixed ethnicities.[34]

   - The Canadian Government does not release data on race and socioeconomic status, but a study from University of Western Ontario reported that like the U.S., COVID-19 has disproportionately affected black and immigrant communities in Canada.[35]

   - Norway's public health experts looked into the backgrounds of those infected by COVID-19 and found that people born in Somalia had infection rates more than ten times above the national average.[36]

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[32] *Coronavirus: Risk of death is higher for ethnic minorities*, BBC (June 2, 2020), (www.bbc.com/news/health-52889106).

[33] United Kingdom Office for National Statistics, *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020, Coronavirus (COVID-19) related deaths by ethnic group, England and Wales Articles* (Apr. 7, 2020) (www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020).

[34] *Id*.

[35] Kate Choi, et. al., *Studying the social determinants of COVID-19 in a data vacuum*, Department of Sociology, University of Western Ontario (May 10, 2020) (osf.io/preprints/socarxiv/yq8vu/).

[36] *Nations look into why coronavirus hits ethnic minorities so hard,* Financial Times (Apr. 29, 2020) (www.ft.com/content/5fd6ab18-be4a-48de-b887-8478a391dd72).

- Official statistics on COVID-19 deaths in France do not include a breakdown by race and ethnicity—or even by country of origin or nationality.[37] However, there have been abnormally high death rates in low-income neighborhoods such as Seine Saint-Denis.[38] According to five mayors and the head of the Seine Saint-Denis department, the network of urban doctors in Seine Saint-Denis is much smaller than in other places, and the population is more vulnerable due to pathologies that expose them to chronic diseases such as diabetes, hypertension and cardiovascular disease.[39]

  A. What do you think are the causes of these global disparities?

  Response: Racism, white supremacy and inequality make humans sick.[40,41,42,43,44,45] It is true here in the United States and it is true across the world. Forms of racism[46] and white supremacy are used to systematically structure access to resources and opportunities by race, globally. This results in major political economies that profit off of social hierarchies and create and

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[37] *France's data collection rules obscure the racial disparities of Covid-19*, QUARTZ (June 5, 2020) (qz.com/1864274/france-doesnt-track-how-race-affects-covid-19-outcomes/).

[38] *France is blaming the poor for their own deaths. But look at how it treats them.*, The Washington Post (Apr. 30, 2020) (www.washingtonpost.com/opinions/2020/04/30/france-is-blaming-poor-their-own-deaths-look-how-it-treats-them/).

[39] *Id*.

[40] Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. *Annu Rev Public Health*. 2019;40:105-125. doi:10.1146/annurev-publhealth-040218-043750

[41] Bassett MT, Graves JD. Uprooting Institutionalized Racism as Public Health Practice. *Am J Public Health*. 2018;108(4):457-458. doi:10.2105/AJPH.2018.304314

[42] Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;389(10077):1453-1463. doi:10.1016/S0140-6736(17)30569-X

[43] Krieger N. ENOUGH: COVID-19, Structural Racism, Police Brutality, Plutocracy, Climate Change—and Time for Health Justice, Democratic Governance, and an Equitable, Sustainable Future. American Journal of Public Health 0, e1_e4, https://doi.org/10.2105/AJPH.2020.305886

[44] Kumar A. White Supremacy in Global Health. Think Global Health. June 2020. Available at: https://www.thinkglobalhealth.org/article/white-supremacy-global-health

[45] Lewer D, Jayatunga W, Aldridge RW, et al. Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study [published correction appears in Lancet Public Health. 2020 Jan;5(1):e18]. *Lancet Public Health*. 2020;5(1):e33-e41. doi:10.1016/S2468-2667(19)30219-1

[46] Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215. doi:10.2105/ajph.90.8.1212

further racial inequity – in access to income, wealth, education, housing, information, insurance, safety, and health.[47,48,49,50] In addition, histories of chattel slavery, indigenous dispossession, and colonialism are transnational and in some cases, ongoing. As such, the legacies and current practices of these violent injustices have a profound and enduring global impact on the social positioning, economic mobility, and physical and mental health and well-being of non-white, minoritized, and poor populations across the globe. COVID-19 has exposed the extent to which human beings – whether because of their race, religion, ethnicity, nationality, gender, income status or intersection of these perceived identities – remain outside the purview of many society's collective investments and collective care. And it has illustrated, in alarming ways, just how many humans continue to be excluded from the opportunity to enjoy the bounty the planet Earth has provided, that too many wealthy nations continue to hoard.

B. Are the underlying causes of the disparities outlined above similar to what we are seeing in the U.S.?

Response: While similar, in that multiple countries have reported an emergence or exacerbation of racial health inequities amid the current pandemic, the US stands alone among wealthy nations, in the breadth and depth of such racial inequities. Overall, the current COVID-19 death toll is on pace to become the 3rd leading cause of death in 2020.[51] And as of August 18, 2020, 1 in every 1,125 Black Americans has died from COVID-19.[52] Among children, youth and young adults aged 5-29, Latinx populations make up the majority of cases and nearly 40% of COVID-19 related deaths.[53] In states like Mississippi, New Mexico, Arizona and Utah, Choctaw and Navajo Nation populations make up the vast

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[47] Hardeman RR, Medina EM, Boyd RW. Stolen Breaths. *N Engl J Med*. 2020;383(3):197-199. doi:10.1056/NEJMp2021072

[48] Phelan J and Link B. Is Racism a fundamental cause of inequality in health? Annual Review of Sociology 2015 41:1, 311-330. Available at: https://www.annualreviews.org/doi/abs/10.1146/annurev-soc-073014-112305

[49] Link BG, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav*. 1995;Spec No:80-94.

[50] Laster Pirtle, W. N. (2020). Racial Capitalism: A Fundamental Cause of Novel Coronavirus (COVID-19) Pandemic Inequities in the United States. *Health Education & Behavior*, *47*(4), 504–508. https://doi.org/10.1177/1090198120922942

[51] CDC. Leading Causes of Death. National Center for Health Statistics. Available at: https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm.

[52] APM Research Lab. The Color of Coronavirus: COVID19 Deaths by Race and Ethnicity in the US. August 2020. Available at: https://www.apmresearchlab.org/covid/deaths-by-race

[53] Unidos US. The Latino Community in the Time of Coronavirus. July 2020 Report.

majority of COVID-19 deaths and far outpace COVID-19 mortality rates among white populations in the same areas.[52] In fact, counties that are predominantly non-white have a COVID-19 mortality rate than is 6 times higher than predominantly white counties across the US.[54] Researchers at Harvard's School of Public Health also revealed that the Black Americans aged 35-44 have a 9 times higher COVID-19 mortality rate than that of their age-matched white peers.[55] And a report by the Brookings Institute found that, "In every age category, Black people are dying from COVID at roughly the same rate as White people more than a decade older."[56] These racial gaps are enormous and are an outlier among the wealthy world. They are also why some researchers have noted that "US racial inequality may be as deadly as COVID-19."[57,58]

So while the underlying histories, as outlined in my previous response, are shared in many ways between nations, the racial inequities emerging in the US are distinct and the US government's current response to the pandemic has worsened these inequities in critical ways.[59,60] In particular, the US lacks national mandated guidance regarding stay at home orders, school openings, masking protocols, distancing requirements, testing capacity and PPE distribution. Without this national guidance and federal support, many states and localities have taken conflicting approaches to managing a global infection, all without the level of resources necessary to bring this pandemic under control the way it has been demonstrated in other countries. Clear national guidance and federal support to enable broad adherence to masking and stay at home orders, indefinite

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[55] Bassett MT, Chen JT, Krieger N. The Unequal Toll of COVID-19 Mortality by Age in the United States: Quantifying Racial/Ethnic Disparities. *Harvard Center for Population and Development Studies Working Paper Series*, Volume 19, Number 3. June 15, 2020. https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1266/2020/06/20_Bassett-Chen-Krieger_COVID-19_plus_age_working-paper_0612_Vol-19_No-3_with-cover.pdf

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income and eviction relief to support those who have lost their jobs as a result of the pandemic, and an increase in the production and equitable distribution of rapid testing and PPE across the US would go a long way in closing these deadly inequities. Funding and supporting our nation's public health leaders and participating in global scientific communities like the World Health Organization are also important ways the US can collaborate with other nations to tackle similar racial inequities.

C. In your opinion, why haven't the health systems of the countries highlighted above been able to reduce these disparities?

Response: Thirty-two countries across the world have made one vital intervention which has assisted in controlling the spread of COVID-19 that the US has yet to do: They have implemented universal healthcare.[61] Universal healthcare systems provide the infrastructure[62] necessary to test, trace, and treat, at-scale, and to equitably deliver healthcare services at the population-level. The medical record infrastructure, workforce development, and national investments it takes to successfully implement universal healthcare also increase national capacity to respond to health crises rapidly and at-scale. Overall, the US healthcare system, led by selfless and dedicated providers and staff, has taken herculean efforts to stretch services to all those who need care. Yet these efforts remain limited by the configurations of our systems and the limitations of insurance.

That said, even with universal healthcare, many countries struggle to fully eliminate racial health inequities. Addressing and eliminating these inequities here in the US and abroad ultimately requires challenging our political economies and building equitable supports that benefit those with the greatest need, not only those who hold the most wealth and power. Effectively doing so will take courage and political will.

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