AYANNA PRESSLEY
7TH DISTRICT, MASSACHUSETTS

Congress of the United States
House of Representatives
Washington, DC 20515

WASHINGTON, DC OFFICE
1108 LONGWORTH HOB
WASHINGTON, DC 20515
(202) 225-5111

BOSTON OFFICE
1700 DORCHESTER AVENUE
BOSTON, MA 02122

WWW.PRESSLEY.HOUSE.GOV

CONGRESSWOMAN AYANNA PRESSLEY
HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
HEARING TESTIMONY
June 24, 2021

Thank you Chairman Pallone, Ranking Member McMorris Rodgers, Subcommittee Chairwoman Eshoo, and Subcommittee Ranking Member Guthrie for the opportunity to provide testimony to the House Committee on Energy and Commerce Subcommittee on Health. I am encouraged by today's focus on legislation to advance equity in public health, and I am honored to have my bill, the Anti-Racism in Public Health Act (H.R. 666), included in this hearing.

I introduced the Anti-Racism in Public Health Act, in partnership with Representative Barbara Lee and Senator Elizabeth Warren, to invest in robust, comprehensive research on the public health impacts of structural racism and policy solutions to bring an end to racial health disparities once and for all. Structural racism is a public health crisis that continues to ravage Black, Brown and indigenous communities, deny us quality health care, and exacerbate the longstanding disparities in health outcomes. My legislation currently has 56 cosponsors and more than 30 organizational endorsements ranging from the Leadership Conference on Civil and Human Rights to the National Medical Association to UnidosUS.

The legislation would create a National Center for Anti-Racism at the Centers for Disease Control and Prevention (CDC) and a Law Enforcement Violence Prevention Program. The newly created Center would recognize racism as a public health crisis and provide dedicated resources to support local and state efforts to educate the public and advance antiracist public health interventions.

The same way the CDC provides guidance to health officials and policymakers related to coronavirus, this legislation would require the CDC to publish and promote anti-racist health policy. We need a robust, multidisciplinary, intersectional, and race-conscious approach that acknowledges decisions on social determinants of health, like housing justice and transportation equity, are major factors in public health outcomes.

In alignment with today's hearing title, "Empowered by Data," the bill puts a premium on data collection that is rooted in community. We need to continue to learn how entrenched structural racism is in our everyday life so that we can fully transform our approach to public health and eradicate racial disparities. Funding is appropriated to conduct research, award grants, and provide leadership and coordination on the science and practice of anti-racism in the provision of health care, the public health impacts of systemic racism, and the effectiveness of interventions to address these impacts. Further, the Anti-Racism in Public Health Act calls for the creation of at least 3 regional centers of excellence in anti-racism under the CDC.

But make no mistake, we already have sufficient data, spanning centuries of research, to treat structural racism like the public health crisis it is. And we must.

Racial disparities in health outcomes exist at alarming rates. Compared to their white counterparts, people of color are more likely to suffer from chronic health conditions, such as diabetes, asthma, and hypertension.[1] Black Americans bear a disproportionate share of the cancer burden, having the lowest survival rate among racial groups for most cancers.[2] Black, American Indian, and Alaska Native women are two to three times more likely to die from pregnancy-related causes than white women.[3] The experiences of countless Black and brown women , including four-time Olympic gold medalist Serena Williams, demonstrate how race, not education or income, determine health outcomes like maternal morbidity.

The nation's current crises underscore how structural racism is contributing to the mortality rates in communities of color, particularly Black people. Due to COVID-19, people of color are dying at higher rates than white people. Black people, across all ages, are at least twice as likely to die from the disease compared to their white counterparts.[4] The Massachusetts 7th Congressional District, which includes most of Boston, Cambridge, and Chelsea, has been among the hardest hit areas throughout the Commonwealth of Massachusetts. Despite accounting for just 25 and 20 percent of the city's population, Black and Latinx residents made up 65 percent of COVID-19 infections.[5] These disparities are a direct reflection of how pervasive structural racism and inequality have predisposed communities of color to co-morbidities that heighten the risk of COVID-19 hospitalization and death.

Furthermore, inequitable access to quality health care disproportionately burdens communities of color. Among similarly situated nations, the United States is unique in its failure to guarantee health care as a human right and ensure all people have affordable and comprehensive coverage.[6] People of color and immigrants are less likely to be insured,[7] and health care providers are scarce

---

[1] *See* Sofia Carratala & Connor Maxwell, *Fact Sheet: Health Disparities by Race and Ethnicity*, CTR. FOR AM. PROGRESS (May 7, 2020), https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/.

[2] *See* Carole. DeSantis et al., *Cancer Statistics for African Americans, 2019,* AM. CANCER SOC'Y (Feb. 14, 2019), https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21555.

[3] *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*, CTR. FOR DISEASE CONTROL AND PREVENTION (Sept. 5, 2019), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html.

[4] *See* Tiffany Ford et al., *Race gaps in COVID-19 deaths are even bigger than they appear*, BROOKINGS INST. (June 16, 2020), https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear/.

[5] *See Racial Data on Boston Resident COVID-19* Cases, CITY OF BOS. (July 15, 2020), https://www.boston.gov/departments/mayors-office/racial-data-boston-resident-covid-19-cases.

[6] *See* Max Fisher, *Here's a Map of the Countries That Provide Universal Health Care (America's Still Not On It)*, ATLANTIC (June 28, 2012), https://www.theatlantic.com/international/archive/2012/06/heres-a-map-of-the-countries-that-provide-universal-health-care-americas-still-not-on-it/259153/.

[7] *See* Samantha Artiga et al., *Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018*, Kaiser Family Found. (Mar. 5, 2020), https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/.

in many Black and brown communities, making it difficult to access quality care.[8] Lack of routine and preventive medical care exacerbates the aforementioned racial disparities of chronic health conditions.

Racial inequity in public health is a result of government-sanctioned policies and practices. People of color are not predisposed to poorer health outcomes due to our race. Racist historical, cultural, institutional, and interpersonal dynamics directly and indirectly affect our health. The long history of codifying racism throughout the United States has lasting health effects.

The Anti-Racism in Public Health Act is a first-of-its-kind bill. It is bold, progressive policy that meets the scale and scope of the crisis we are living in. It is not enough to simply call out racism. In this moment of national reckoning, the federal government has a moral obligation to actively pursue anti-racist policies and dismantle systemic racism once and for all.

This Committee has an opportunity to be intentional and precise in legislating justice and equity by collecting data and taking action on racial disparities in health outcomes. As we begin to turn the page on the COVID-19 pandemic, we cannot simply return to the status quo normal that allowed these inequities to exist because the status quo was never good enough. We must do all that we can to root out racism everywhere it exists, including in our public health system.

A more just and equitable nation is possible.

[8] *See* Amelia Goodfellow et al., *Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review*, ACAD. MED. (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5007145/.