Testimony by Daniel E. Dawes, J.D.
Committee on Ways and Means
Hearing on "Overcoming Racism to Advance Economic Opportunity"
April 6, 2022

Good Morning. Chairman Neal, Ranking Member Brady, and Members of the Committee on Ways and Means, I sincerely appreciate the opportunity to testify today. My name is Daniel Dawes and I am the Executive Director of the Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine in Atlanta, Georgia. Built upon the legacy and vision of our founder, the 16th U.S. Surgeon General, Dr. David Satcher, the Satcher Health Leadership Institute aims to be a leading transformational force for health equity in policy, leadership, development, and research. It is because of Dr. Satcher's vision and many years of public service, coupled with our Mission and commitment to the communities that we serve, that I am so honored to be here today.

Before I begin Mr. Chairman, I want to say that your public acknowledgment that insidious racism and discrimination negatively and pervasively affect *every* aspect of the lives and livelihoods of racial and ethnic minorities has helped move the health, economic, and racial equity dials forward in the right direction. And so, I thank you for calling this hearing and issuing this long-overdue call to action – not only to this powerful committee, but to every member of Congress – to weigh the role that systemic racism and discrimination play in our nation's persistent health, economic, and racial disparity and inequity epidemics.

I was invited to testify about the effects that systemic racism and discrimination have on the health care, health outcomes, and thus life opportunities of a growing segment of the U.S. population. It is certainly not lost on me that we are addressing this critical topic both during the first week of National Minority Health Month, as well as while we are still in the midst of a global pandemic. What a fitting time to draw attention to and call for action on the effects of systemic racism and discrimination *in* health care and *on* health outcomes.

I came here this morning in the spirit of your own words, Chairman Neal, when you recently said, "as the oldest committee in Congress, it is our responsibility to work tirelessly toward achieving a more perfect Union for *all* Americans, including those often overlooked and left out." I applaud you for using the power of your gavel to shine a brighter light on the need for Congress to demonstrate a commitment to identifying and rooting out the key drivers of racial disparities and inequities in our society.

I also want to acknowledge Representatives Sewell, Gomez, and Horsford for their collective work in leading the Committee's Racial Equity Initiative (REI). Much of the work at the Satcher Health Leadership Institute focuses on the political determinants of health, which we define as the systematic processes of structuring relationships, distributing resources, and administering power through policies and practices which either advance health equity or exacerbate health inequities. We consider these political determinants of health to be the fundamental drivers or the most upstream factors that give rise to the social determinants of health that have largely been identified and accepted as the root causes of health disparities and inequities.

I hope that as this committee moves forward with its REI efforts in the policies that you consider, you apply the lens of the political determinants of health, and consistently address the role of systemic racism, to help ensure that the transitional racial equity and justice that you seek to achieve through all policies is not minimized or lost in the opportunity of this moment in time. Now more than ever, it is important to consider the social and political climate within which so many policies and programs within this committee’s purview were drafted and ultimately passed. And, it is equally pertinent to weigh how those factors influenced how policies and programs were structured and funded *then*, yet are administered *today*. While we cannot right the wrongs from the past – specifically those that occurred upstream – we can and must apply lessons learned as we work towards repairing the past and advancing health and other equities downstream today. Through this committee’s REI, you are doing just that by charting a new path to ensure meaningful *in*clusivity in Ways and Means policies – a path that I hope all of your colleagues in Congress follow as we move forward to achieve racial equity within and throughout society.

As a nation, we have made some significant strides in advancing racial equality and justice. I use the word equality, as opposed to equity, very intentionally. This is because, while those successes certainly indicate a trend in the right direction, over the past several years, those successes have been marred by horrific incidents of often-deadly police brutality against unarmed Black men, women and children; and senseless acts of physical violence against and verbal abuse toward men, women and children of Asian, Hispanic, and Arab descent. It is impossible to deny that they – together – confirmed that racism in this country is alive and well. Further, I think we all know that the racial inequities and inequalities that have been exposed in the last couple of years are not new. In fact, they date back to well over 400 years ago. As a nation, we are coming to stronger grips with how these inequities – many of which were born centuries ago – remain lingering, embedded and entrenched in many of the systems, institutions, policies and laws that affect us *today*.

In fact, the impact of slavery has been associated with long-term effects on contemporary mortality, poverty, heart disease, maternal and infant mortality, among others. Beginning in 1641, Massachusetts became the first colony to legalize slavery under the passage of the Body of Liberties law, which was later used as a template for other colonies and ultimately became part of the Articles of New England Confederation. In 1670, the fate of these “captives” was sealed when the Body of Liberties laws were amended to include a slave woman’s offspring to be a “legal slave” meaning that the offspring would have the same legal status in society as their mother - a slave.

Moreover, as if this were not enough to harm the health and well-being of Black enslaved people, policies were also developed, negotiated, passed, implemented, and enforced across the colonies limiting Black and Indigenous populations’ ability to address their social determinants of health needs. Public policies were enacted which explicitly prohibited Black and Native American groups from

raising their own food, earning their own money, learning to read and write, moving beyond a certain mile radius and requiring passes to move around or lanterns to move around at night.

From a political determinants of health lens, it is here when the roots of inequity began to enroot and incubate in America – when the commercial interests wanting to sustain their business model of slavery, worked with the policymakers to codify this evil institution into law. It is here where our moral compass, strayed from its true north, through the aid of policy and continued to be recycled from one generation to the next. After the American Revolutionary War in 1789 when the U.S. government was formally established as a constitutional republic and getting settled, with the aid of Benjamin Franklin, the first attempts were made to take action against slavery, address the social determinants of health, and advance health equity for vulnerable and marginalized groups. Those efforts were ignored and it would take 75 years later under the Abraham Lincoln administration to finally pass the country’s first comprehensive and inclusive health policy affording newly freed Blacks and poor Whites an opportunity to address their food, clothing, housing, education, employment, medical, and security needs - all critical social determinants of health factors which play an outsize role in a person’s health outcomes and life expectancy. Unfortunately, less than seven years later that policy was dismantled and so were the health and economic opportunities afforded Blacks and other vulnerable populations.

Modern day research studies now show a direct correlation to the intergenerational trauma created in these same populations, all stemming back to the early adoption of racist policies and practices from pre-colonial times. But the early 1900s were no different than colonial times in major ways. We saw this trend continue even further despite the federal government recognizing that we could no longer continue to develop, implement or enforce explicitly racist policies.

Instead, what we observed were racist advocates coming together creatively and nefariously constructing, not overtly exclusionary and discriminatory policies, but rather “facially neutral” ones, including the Social Security Act that intentionally excluded domestic workers and agricultural works who were largely African American and immigrants at the time. Additionally, another facially neutral policy that has had a disproportionately negative impact on communities of color is the Homeowners Loan Corporation Act, which yellow-lined and red-lined over 200 of America’s cities. And like so, racism and discrimination continued to shape America in many other ways.

Structurally, the Highway Act of 1956, which authorized the construction of a 41,000-mile network of interstate highways that would span the nation, routed highways directly and purposely, through Black and Brown communities sparing white, affluent, and middle-class neighborhoods. We saw the placement of railroad tracks and disproportionate placement of bus depots in communities of color by acts of policy. In some instances, the government took homes by eminent domain with the passage of the Housing Act which displaced over 500,000 African Americans, Latinos, and Asian Americans. Tearing through the heart of these vibrant communities, this massive effort came during a time when

courts nationwide were striking down traditional forms of racial segregation and during a time when racial rezoning was on the rise, stopping all efforts dead in its tracks

Today, we can more clearly see the effects that these infrastructures have on the health of racial and ethnic minority communities. Higher rates of asthma owing to the smog and polluted air they are forced to breathe in. Higher rates of diabetes, cancer, heart disease, lupus, etc. owing to the structural conditions these communities find themselves in. But as we think about these social determinants of health, we need to think about how they came to be in the first place. Similarly, the poverty tax is a vehicle to exploit low income households disguised through sophisticated methods such as higher interest rates on their loans and mortgages, higher homeowners and auto insurance costs for those living in neighborhoods with a median income of $30,000 or less, and in some parts of the country - even higher costs for groceries, according to a Brookings Institute study, which leads us down a whole other path of food deserts, hospital and pharmacy deserts.

The United States is in the midst of a moment of heightened awareness where greater attention is being paid to racial injustice. And so, I look forward to working with the members of this committee to leverage this unique time in history to achieve equity in a very real and meaningful way. It is important to remember that most of the recent incidents I just mentioned happened against the backdrop of the ongoing COVID-19 pandemic and its stark, disproportionate, and disparate impact on Black, Latino, American Indian, Asian, Native Hawaiian, and Pacific Islander individuals and communities. In fact, Latino, Black, American Indian and Alaska Natives are *four times* more likely than Whites to be hospitalized for COVID-19 and *three times* more likely than Whites to die from COVID-19.

It is hard for me to overstate the reality that these COVID disparities were brought to light *as* racial and ethnic minorities *continued* to suffer from less access to affordable, quality health care, and disproportionately higher rates of incidence and prevalence, as well as premature death, across *every* chronic and acute disease and condition. This includes cancers, diabetes, hypertension, heart disease, asthma, depression and anxiety, and overweight and obesity, just to name a few.

For example, today, the maternal mortality rate among Black women is *two to three times higher* than that among White women. In fact, a Black woman with an advanced degree is more likely to die from pregnancy-related complications in the United States than a White woman with only a high school degree. Unfortunately, their babies do not fare much better: African-American newborns, overall, are *three times* more likely than White newborns to die. In some communities, the number is even higher. Study after study confirms that racial and ethnic health disparities and inequities are so pervasive that they have – in some cases – widened over time and become the norm in the United States. Further adding insult to injury is a recent report from the Commonwealth Fund that found that racial and ethnic health inequities not only are pervasive in this country, but some of the starkest and widest disparities are actually in states known for having high performing health care systems.

We know that health disparities and inequities are symptoms of broader social and economic inequities that directly reflect systemic and structural racial biases and barriers across all sectors in our society. In fact, according to the Centers for Disease Control and Prevention, structural racism and unconscious racial bias in healthcare are among the root causes of the racial and ethnic disparities we continue to see today. It is no wonder, then, that nearly one year ago to the day (April 8, 2021), CDC Director, Dr. Rochelle Walensky declared “racism is a serious public health threat.”

Now, the health disparity and inequity statistics I just mentioned get a lot of attention, not only because they are so persistent and pervasive, but because they cost so much from a human health perspective. In fact, they directly result in African-American and American Indian men, women and children living for far fewer years than their White cohort at nearly every age.

That said, what typically does not receive nearly as much attention is the fact that these disparities also carry a hefty economic cost. Research shows that health disparities amount to nearly $93 billion in excess medical care costs and another $42 billion in lost productivity each year. In a study I am leading to determine the economic burden of mental health inequities, preliminary findings show that over a five-year period, $278 billion could have been saved and reinvested into the economy, and over 116,770 lives could have been saved had mental health inequities become more equitable - and this is a conservative estimate.

To better illustrate how some of these inequities in healthcare impact Americans economically and vice versa, our literature review revealed the following: American Indian/Alaska Native people experience both lower economic and lower behavioral health outcomes when compared with all other Americans (Indian Health Service, 2016). Low-income Latin(o)(a)(x)/Hispanic families had highest numbers of full families in poor health, followed by Black/African-American low-income families (Braveman & Barclay, 2009). Lack of health insurance is often flagged as one of the most statistically significant determinants of depression, low educational attainment, and poor self-rated health (Lee et al., 2016). Han & Ku (2019) reported that over two-thirds of rural counties had no psychiatrists and almost half of rural counties had no psychologists.

I know that thinking about the impact of racism on people of color is uncomfortable. I know that we – as a nation – have long had a difficult time reckoning with our ugly history of racism, which today is *starkly at odds* with most of our *publicly professed* ideals and values. I also know that it is imperative to provide some context about what the word “racism” means and is, and why it continues to impact every aspect of the lives of Black and brown people in this country today.

A journal article published in 2020 by the American Psychological Association noted that, “people often define racism as disliking or mistreating others on the basis of race.” That is a small part of it. However today, during this historic moment of profound public awareness of racial injustice, we know

more. According to the authors, we now know, “racism is *a system of advantage based on race*. It is a hierarchy. It is a pandemic. Racism is so deeply embedded within U.S. minds and U.S. society that it is virtually impossible to escape.” It includes not only overt racial discrimination, but – more commonly seen today – implicit and subconscious racial bias that lives and breeds out of the public eye, yet is embedded throughout the fabric of this country and felt very profoundly by people of color. We also know that the U.S. healthcare system is no exception. Systemic racism and implicit racial bias not only affect the healthcare quality and health outcomes of racial and ethnic minorities, but also the very policies that govern – and practices that occur within – our nation’s system of care.

Dr. David R. Williams, an esteemed professor and researcher at the Harvard T.H. Chan School of Public Health has spent his life’s work illuminating the wide-reaching damage that systemic racism and discrimination cause to the health and lives of African Americans, Asian Americans, Latinx, and Indigenous people. His decades of work and countless articles published in peer-reviewed journals led him to once conclude, “racism affects health in profound ways that are over and beyond any of the measures…. through systems that have been built up over the years and are now locked in place, replicating social inequality.” Through his work, which included the landmark IOM *Unequal Treatment* report, we know that across similar income and education levels, insurance status, age and even disease type and severity, racial and ethnic minorities, when compared to their white counterparts, often are diagnosed later, and consistently have less access to the most advanced treatments, suffer worse health outcomes, and die prematurely.

Now, I realize that for some here today, the thought of racism in health care can be galling and even a downright difficult concept to consider, let alone believe. I know that some tend to blame persistent racial and ethnic health disparities on the personal lifestyles and choices of those who are most harmed by them. I am here today to tell you that that underscores the severity of the systemic causes and the impact of the political determinants on health outcomes and inequities.

That it is as pervasive a problem today – in 2022 – as it was hundreds of years ago is both stunning and telling. Afterall, let’s consider the facts: not only does the United States have one of the most sophisticated and advanced healthcare systems in the world, but healthcare providers who practice in this country take an oath “to do no harm.” However, the evidence is undeniable. In September of 2015, there was a systematic review of data from 293 studies that focused *specifically on racism as a determinant of health*. They found that racism and discrimination permeate the entirety of our nation’s health care system, from its policies and practices, to interactions between the most well-intentioned healthcare providers and administrators, and their patients.

This is where the thought of racism in health care is uncomfortable. No one wants to think of or believe that the very persons who are charged with and promise to “do no harm” could hold implicit and subconscious racial biases that affect how they provide care to their patients. However, the

evidence is in and the reality is that it happens. For example, in 2016, a study of medical school students and residents found that a shocking percentage of them – 40 percent, in fact – believed that "black people's skin was thicker than that of a white person"; and that "black people's nerve endings are less sensitive than that of white people." This study – which is among several – found that the implicit racial biases held by rising and current healthcare providers led to their African-American patients being *less likely* than White patients to receive adequate pain medications and treatments.

Similar studies that investigated the impact of explicit and implicit racial biases held by healthcare providers found similar findings. Racial biases held by healthcare providers often is implicit, but its impact on the health and wellness of racial and ethnic minorities is demonstrative, catastrophic and leads to poor health quality and even premature death. Other studies have found that systemic racism is directly associated with the onset of mental health disorders, and poorer mental health outcomes – specifically anxiety, depression, and stress – among racial and ethnic minorities compared to Whites. Countless studies confirm that when an individual experiences racism and discrimination, it leads to higher rates of unhealthy eating, smoking, and alcohol and drug use – all of which negatively affect a person's overall health and wellbeing.
Further, racism also is directly associated with more deleterious physical health outcomes among racial and ethnic minorities when compared to Whites. For example, a 2019 study found that racist experiences literally increase inflammation in African Americans, increasing their risk of developing kidney and heart disease.

Noting these statistics and empirical realities of the role that race places in health, it is a true honor to be speaking before a committee that has jurisdiction over so many programs and policies that very often affect the most vulnerable and marginalized individuals and communities in society: low-income communities, working families, and people of color. The opportunities to advance health equity, in my mind, are endless, and the impact that this committee can have in doing so is unimaginable.

So, the obvious question is this: given all that we know about the impact of racism *in* health care and *on* health outcomes, where do we go from here? To your credit, this committee already has taken bold steps to achieve health equity that I believe are worthy of noting. In 2020, you requested information from medical specialty societies and individuals about the use of clinical algorithms that erroneously – and sometimes dangerously – relied on race. And, among the 19 responses you received, there was consensus that race is often *mis*used in risk assessments and diagnoses in healthcare settings. In fact, race-based formulas often propagate the false narrative that race is a biological, rather than a social and political, construct. As a direct result, they not only create and sustain, but grossly exacerbate racial and ethnic health disparities and inequities.

For example, two formulas that used race to estimate how well someone's kidney's function reported that Black patients had better functioning kidneys than White patients, even though both sets of

patients had the same creatinine levels. While this may sound harmless, the end result was devastating because Black patients, with deteriorating kidneys, were referred later than White patients to specialist care and transplants, affecting their overall quality of life and health outcomes.

In fact, the recent misuse of race in medicine has led to:

- Expecting Latina and Black women being systematically categorized as “high risk” pregnancy cases. This directly resulted in higher rates of cesarean section births; and
- Gross *under*diagnosis of cystic fibrosis in people of African descent because the disease was considered a “white” disease.

That this committee is holding various segments of the current U.S. healthcare system accountable for the misuse of race in medicine is a giant step forward in the right direction.

Together, though, we can, should, and frankly must do more, and this is how:

1. It is important to ensure that every person in this country has consistent access to affordable, quality health care. I do not think that anyone would downplay the vital role that health care access plays in all efforts to eliminate health disparities and inequities. Medicare and Medicaid have played an incredible role in addressing racial and ethnic disparities in un- and under-insurance. However, it is equally important to ensure that there are accountability frameworks in place that keep racial equity at the forefront.

2. Across every policy and program that falls under this committee’s purview, there is a desperate need for stronger data collection and disaggregation by race and ethnicity, *as well as systematic and consistent reporting* of that data. Without this data, it is nearly impossible to truly understand the magnitude of our health disparity and inequity epidemic. Additionally, any health equity researcher will tell you that if you are not counted, it sends the message that you do not count. So, supporting stronger data collection and reporting is vitally important to all efforts that seek to achieve health equity.

3. Examine all policy proposals that come before this committee through the lens of racial equity, paying particular attention to the political determinants of health that tend to either reduce health disparities or exacerbate them. As I noted earlier, today, structural racism and discrimination in health care operates not only through the actions of an individual, but also through the policies, programs and laws that allocate resources, make judgments and assign priorities in a manner that marginalizes, devalues, and disempowers racial and ethnic minorities who seek care in today’s U.S. healthcare system.

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Chairman Neal, Ranking Member Brady, and the rest of the committee members, thank you for allowing me to share my testimony on the effects of racism in and on the health care and health outcomes of racial and ethnic minorities. I am appreciative of all of your leadership on this effort and I welcome any questions.

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