National Medical Association

8403 Colesville Road, Suite 820
Silver Spring, Maryland 20910
(202) 347-1895
www.NMAnet.org

Testimony of Oliver Brooks M.D.,
President of the National Medical Association (NMA)
House Committee on Energy & Commerce -Subcommittee on Health
June, 17, 2020

Good afternoon Chairwoman Eshoo, Ranking Member Burgess, and Members of the Committee.

Thank you for the opportunity to appear before the committee to discuss confronting racial and ethnic disparities in COVID-19 and the health care system.

I am testifying today as a physician practicing in south Los Angeles, and as the President of the National Medical Association (NMA), which is the largest and oldest national organization representing the interests of more than 50,000 African-American physicians and the patients that they serve.

As the nation's only healthcare organization devoted to the needs of African American physicians and their patients, we are disturbed by the vast health inequities for vulnerable populations. We have been and are on the frontlines advocating for patients who face numerous and often insurmountable obstacles to receiving quality health care. Black patients experience differences in access to health care, the affordability of these services, implicit biases by some providers, and limited participation in clinical research, which has consequences around viable medical treatments. We have been studying and reporting on this for decades.

As a result of the Coronavirus pandemic, a bright light has recently been shown on the health disparities that have always existed in America. What the world is witnessing is that Black patients are severely overrepresented among those who have suffered the morbidity and mortality of COVID-19. This pandemic is a painfully fresh reminder of these disparities in our healthcare system that leave minorities behind.

COVID-19 has killed more than 115,000 Americans - with the Black community accounting for a disproportionate number of deaths. An example of this phenomenon is starkly chronicled in a Washington Post article published on June 12th. The death toll in Washington D.C. from the novel coronavirus surpassed 500 in the nation's capital on June 10th. District health officials report that 375 of the 506 fatalities have been African American, 65 have been Hispanic and 54 have been White. Blacks and Whites each account for about 46 percent of the city's population, according to Census Bureau data, while about 11 percent are Hispanic. Yet Blacks account for 74 percent of COVID-19 deaths, and the wards of the city with the largest Black populations have suffered the heaviest losses.

The disparity shows up not in terms of who gets diagnosed and infected with the virus, but in who is dying from the disease.

Data from the 40 states that collect race and ethnicity data show that White Americans are dying from COVID-19 at a rate of 22.7 per 100,000 in the population, whereas African Americans die at a rate 54.6 deaths per 100,000, Hispanic Americans at a rate of 24.9 deaths per 100,000, and Asian Americans at 24.3 deaths per 100,000. Though the data are sparse for Native Americans, in New Mexico they die from the COVID-19 disease at a rate that is eight times that of the White population, and in Arizona they die at a rate that is five times that of all of others in the population. For Native Hawaiians and Pacific Islanders, the available data in ten states show percentages of COVID-19 cases and deaths that are two to three times greater than their percentage of the population.

The question is WHY are we seeing such glaring differences in who is dying from COVID-19?

The CDC has noted that those with hypertension, diabetes and obesity are more likely to have an adverse outcome if they contract COVID-19. Blacks are 2.2 times more likely to have diabetes, 20 percent more likely to have high blood pressure, and 30 percent more likely to be obese. Right there you see a problem. However underlying health conditions alone cannot be viewed as the predominant factor in COVID-19 mortality.

Social determinants of health (SDOH), defined by the Centers for Disease Control and Prevention (CDC) as conditions in the places where people are born, live, learn, work, and play, are as important a role in a person's health as genetics or medical treatment. They include intangible factors such as socioeconomic, political, and cultural structures, as well as place-based conditions including education systems, accessible and affordable healthcare, healthy food availability, environmentally safe living surroundings, and well-designed communities.

The World Health Organization (WHO) states that SDOH are shaped by the distribution of money, power, and resources at global, national and local levels. These social circumstances create societal stratification and are responsible for health inequities among different groups of people based on social and economic class, gender, and ethnicity.

Social determinants of health are an underlying cause of today's major societal health dilemmas including obesity, heart disease, diabetes, and depression. Moreover, complex interactions and feedback loops exist among the social determinants of health. For example, poor health or lack of education can impact employment opportunities which in turn constrain income. Low income reduces access to environmentally safe communities, healthcare, nutritious food and increases hardship. Hardship causes stress which in turn promotes unhealthy coping mechanisms such as substance abuse and overeating of unhealthy foods.

A Washington Post article on June 3, 2020 entitled, "How U.S. cities lost precious time to protect black residents from the coronavirus", reported that "interviews with nearly 60 public health experts, lawmakers and community leaders show that many of the first coronavirus testing sites went up in areas that happened to be whiter and more affluent, despite the requests of black leaders. Local governments — sometimes ignoring the pleas of community activists — targeted few of their education campaigns about prevention and social distancing specifically to African Americans, even as conspiracy theories spread that black people were immune to the disease, a message that needed to be dispelled.

Poor reporting of data, which initially masked the fact that the disease was disproportionately affecting black communities, remains a problem even as states move to reopen their economies. Today, Americans living in counties with above-average black populations are three times as likely to die of the coronavirus as those in above-average white counties, according to an analysis of census and other data by The Washington Post.

The American Academy of Pediatrics last year published a policy statement on how racism is a core cause of health problems in children and adolescents. What wasn't? Race itself. The paper drove home a crucial point: Racism, not race, affects health, and race shouldn't be used to explain away disparities caused by racism.

Simultaneously, we are facing another deadly pandemic of police brutality which is also caused by the common thread of systemic racism found in COVID-19. We have witnessed the killing of Ahmaud Arbery, Breonna Taylor, George Floyd, and most recently, the shooting this past Friday of Rayshard Brooks in Atlanta. These deaths, that have taken place just in the first six months of 2020, are added to countless other blacks who have become victims of the other pandemic within the United States. Blacks are 3 times more likely than Whites to die at the hands of the police. More unarmed Blacks were killed by police last year than Whites even being only 14 percent of the population. In other words, African Americans are experiencing a pandemic within a pandemic and are dying in unprecedented numbers as a result. The unifying factor between COVID-19 deaths and police brutality deaths is racism.

The current climate of social unrest in the U.S. and the thousands of people protesting against systemic racism and in support of the Black Lives Matter movement is bringing these inequities into even sharper focus, adding more political and emotional weight to the longstanding issue.

So, where do we go from here?

We must address the underlying issues that create the disparities and vulnerabilities in the health and wellbeing of our communities, from racial injustices to the healthcare system. How do we fight America's perpetual pandemic? How do we dismantle hundreds of years of oppression and change the systemic inequities that got us to where we are today?

There will never be a simple answer. But as doctors and health advocates, we will continue to examine how racism is embedded in our health care system and fight to expand access to affordable, quality health care for Black Americans.

We will advocate for a public health system that protects all people and inherently provides access to equitable housing, healthy food, health care services, employment opportunities, community centers, justice, and every other basic tenet of life.

We call on universal healthcare coverage. The uninsured rate among African Americans is 11 percent versus 8 percent for Whites. More insurance leads to better health outcomes.

We call on the federal government to embrace policies that address food insecurity, where 22 percent of African Americans are food insecure versus 12 percent of Whites, by expansion of SNAP. Better food leads to better health outcomes.

We call on policies that increase the number of African American physicians; African Americans are 1 in 8 in the US but only 1 in 15 doctors. Studies show that Black patients have better outcomes when treated by Black doctors.

We call for policies that decrease the digital divide; 20 percent of African American homes have no internet access. Learning, remote health services, and research in 2020 is internet-based. Improved access will lead to better health outcomes.

We call on the federal government to require more data regarding the racial and ethnic disparities in COVID-19 outcomes.

We also call upon Congress to take note of a letter sent on June 11th, from The Alliance of Multicultural Physicians (the Alliance) urging FDA Commissioner Stephen Hahn and members of Congress to make diversity in clinical trials a greater priority in order to address disparities in COVID-19 cases and deaths in racial/ethnic minority communities, and to address a longstanding lack of diverse participation in clinical trials.

We call for implicit bias training for the physicians and other health providers. Some of the bias that leads to poorer outcomes is subconscious and can only be addressed by conscious attention to it. This training also needs to be mandated for all law enforcement personnel.

We call on Congress to make funds available to African American small businesses. Currently, access to capital is the number one challenge for these businesses. However, only 3 percent are being financed through Small Business Administration loans.

The National Medical Association, Rainbow PUSH Coalition and the National Bar Association released a joint statement that proposes actionable steps to reduce the disproportionate impact of COVID-19 on the African American community.  It addresses many other concerns, including protection for vulnerable populations and a global perspective on the pandemic.

Our fight for a better public health system in the United States must center on ending violence against Black people and fighting for a public health system in which Black lives truly do matter. Our fight must center on ending the deprivation of state resources to Black communities that is endemic to this country's politics. Without that, there will be no change.

Thank you.