



AMERICAN PUBLIC HEALTH ASSOCIATION

For science. For action. For health.

**Testimony of Georges C. Benjamin, MD, MACP, FACEP (E), FNAPA
Executive Director
American Public Health Association
House Committee on Homeland Security, Subcommittee on Emergency Preparedness,
Response, and Recovery
“Pandemic Response: Confronting the Unequal Impacts of COVID-19”
Friday, July 10, 2020**

Chairman Payne, Ranking Member King and members of the subcommittee, thank you for the opportunity to address you today on the impact of the COVID-19 pandemic on communities of color. I am Georges C. Benjamin, MD, executive director of the American Public Health Association in Washington, D.C. APHA champions the health of all people and all communities. We strengthen the public health profession, promote best practices and share the latest public health research and information. We are the only organization that combines a nearly 150-year perspective, a broad-based member community and the ability to influence policy to improve the public’s health.

The “outbreak of pneumonia of an unknown cause” was first reported in Wuhan, China on Dec. 31, 2019, and was in the U.S. by mid-January. The pneumonia was found to be caused by a novel coronavirus, which has been named and classified as SARS-2. This virus causes a disease, named COVID-19, which enters the body primarily through the respiratory route and causes a severe pneumonia as its major physiological impact. We now know the virus is able to attack many different organ systems, causing a range of clinical problems. To date it has stricken over 3 million individuals and caused over 131,000 deaths in the United States alone. We know that this virus is one of a family of coronaviruses that causes mild diseases like the common cold and also much more severe infections like Middle Eastern Respiratory Syndrome (MERS) and its less severe but also lethal cousin Sudden Acute Respiratory Syndrome (SARS-1). It remains infectious on a variety of surfaces from hours to days but degrades easily under certain environmental conditions. It is easily deactivated by common household cleaning and sanitizing products.

We currently have three co-occurring epidemics associated with this crisis: the infectious pandemic; an “infodemic” of misinformation and disinformation; and an epidemic of fear. The epidemic of fear is caused by a combination of things: fear of the virus, but also fear arising from the uncertainties around its spread and other unknown factors, and fear stoked by the poor and inconsistent risk communication from some political leaders.

The epidemiology of this virus shows it is actively spreading throughout the community and that each person can infect *on average* at least two other people. It is more infectious than most influenza strains and causes mild to no symptoms in about 80% of cases, with 15-20% having more severe disease. The case fatality rate in the U.S. is about 4.6% (39.6 deaths / 100,000 population). This rate will probably reduce as the number of asymptomatic and mild cases becomes clearer. We now know that at least 40% of infected people are asymptomatic or presymptomatic spreaders. The virus can spread in three main ways, most frequently from large particulate respiratory spread, fine

respiratory aerosols and fomites. Fomite spread occurs when a person contaminates their hand or another object with respiratory secretions.

People of all ages are at risk of getting this disease; however, children have been shown in general to have less severe symptoms. There is, however, a syndrome that is under investigation in a very small number of children and young adults of a hyper immune disease triggered by the virus. The impact on pregnant women and children is less well defined but appears at this time not to cause very severe disease. However, there needs to be much caution to interpreting these early observations as many clinical impacts on newborn children and pregnant women can be delayed.

The biggest impact from COVID-19 has been its disproportionate toll on communities of color. Early in the outbreak it became clear that African Americans and Hispanics were being impacted by both a higher incidence of this disease and a higher percentage of premature deaths when compared to the overall population. Data from a recently published paper in the *Annals of Epidemiology* reinforces the finding that African Americans are harder hit in this pandemic. The study from researchers at amfAR, The Foundation for AIDS Research, looked at county-level health outcomes, comparing counties with disproportionately Black populations to all other counties. Their analysis showed that while disproportionately Black counties account for only 30% of the U.S. population, they were the location of 56% of COVID-19 deaths. And even disproportionately Black counties with above-average wealth and health care coverage bore an unequal share of deaths.¹

Another analysis from the U.S. Centers for Disease Control and Prevention has also shown this disparity on a national basis, especially in hospitalized patients.²

The COVID Tracking Project has been tracing this phenomenon as well (<https://covidtracking.com/race>). They have found that 24% of the deaths where race is known are from African Americans, which comprises 13% of the U.S. population. More recently, CDC reported that as of June 12, 2020, age-adjusted hospitalization rates for non-Hispanic Blacks or American Indian / Alaska Native persons are approximately five times that of non-Hispanic whites and four times higher for Hispanic or Latino persons than that for non-Hispanic whites.³

A recent white paper by scholars at Harvard University found that Black Americans under the age of 65 have lost, collectively, 45,777 years of life as a result of COVID-19. Hispanics and Latinos lost 48,204 years of life, while white Americans under age 65 have lost, collectively, 33,446 years of life.⁴

This disparity in the impact of COVID-19 is not surprising in its presence, only in its scope. There are several reasons for this disparity. The first is greater exposure among communities of color due to their occupations. During this outbreak, more minorities have held public-facing occupations that put them at a higher risk of exposure as the nation moved to a stay-at-home posture. For example, grocery store clerks, transit workers, hotel workers, meatpacking plant workers, poultry workers and sanitarians were defined as essential workers and have continued to work and therefore have had higher risks of novel coronavirus exposures overall.

The second issue was a higher susceptibility to more severe disease should they get infected. Early evidence from the Chinese experience showed that the 15-20% of people with more severe disease tended to have pre-existing chronic diseases like heart disease, hypertension, lung disease and diabetes. This tendency to more severe disease for infected people with chronic diseases has played out similarly in the United States. We know that African Americans are 25% more likely to die from heart disease, 72% more likely to have diabetes, 20% more likely to have asthma and two times more likely to develop hypertension than non-Hispanic whites. We also know that many of these diseases develop at an earlier age as well. Hispanics have less heart disease and cancer than whites but have a 50% higher incidence of diabetes and are more likely to lack health insurance.

The third issue is the “infodemic” I earlier spoke about. We know misinformation is rampant in minority communities. Some of it is purposeful. Early rumors that African Americans were immune from the disease as well as rumors about false treatments and cures are widespread on social media and are even being spread via flyers and brochures. One example of a flyer that targeted the citizens of New Jersey in minority, Jewish and Muslim communities is shown in the link in this testimony. This flyer falsely included the logos of the U.S. Centers for Disease Control and Prevention and the World Health Organization shown here: <https://www.njhomelandsecurity.gov/covid19>. Similar flyers and disinformation more specifically targeting African Americans have been found in cities like New Orleans and on social media sites. In these cases people have been encouraged not to get tested or get the COVID-19 vaccine when it becomes available. The disinformation often tells people that testing is being done to track people to give them the disease. Another widely spread myth: the future vaccine will make one sterile. The anti-vaccine movement is amplifying these messages to others to discourage vaccine use. Many of these efforts are designed to build on existing mistrust of authority figures and create a sense of confusion and further loss of trust within the community.

The fourth reason for these health disparities is the presence of longstanding inequities in the social determinants of health that have created the conditions for ill health in minorities and disadvantaged people for years. A recent study by a team of noted researchers from the Harvard University Center for Population and Development Studies looked at the relationship between social determinants and excess mortality from COVID-19. It showed higher mortality from COVID-19 in cities and towns that had higher rates of poverty, household crowding, percentage of populations of color and higher racialized economic segregation.⁵

Finally, we know that place matters and can put individuals at higher risk for infection. Examples include nursing homes full of elderly individuals with chronic diseases and jails and prisons where confinement and limited access to handwashing and respiratory protections increase risk. Of course the nation’s prisons house a disproportionate number of men of color because of unjust criminal justice policies. Awareness about this longstanding injustice has contributed to recent efforts to deinstitutionalize nonviolent offenders and unadjudicated individuals in custody to reduce their risk of infection.

We can address these disparities through sound public health strategies. First, we need broad promotion of physical distancing, wearing masks and other respiratory protections, handwashing and following sound science in disease prevention and control as we reemerge from our homes back into public spaces. We have to ensure robust testing for symptomatic individuals and individuals at high risk due to occupation or place. Testing locations must be accessible to all communities. In the early roll out of testing when the availability of tests was limited, many testing sites were not available equally to all communities. This was a particular problem for the drive by testing sites, which were often not easy to get to and required the use of a car. These factors can play a huge role in determining who gets tested. Those making decisions about the location of testing sites should always vet these choices with representatives of the entire community to ensure they address any potential barriers.

Testing for the virus must be followed up by adequate contact tracing and sound programs for the isolation and quarantine of infected and exposed individuals. The use of culturally competent messages and messengers (including lay messengers, community health workers, faith community leaders, barbers, beauticians and social workers) is critical to address the misinformation and other issues of concern. Communities should use more radio, social media and age appropriate vehicles

for community health education. Materials should be prepared in a range of languages to reach people for whom English is not their first language (Spanish, Haitian, Chinese, Portuguese, etc.).

Importantly, we must adequately collect demographic and occupational data, including race and ethnicity, on who gets tested and where, the prevalence of the disease, comorbidities, hospitalizations and deaths from individuals tested for or diagnosed with COVID-19. This information is critical to ensuring that public health authorities and other decision makers can make data-driven decisions on where to place services and resources to reduce and ultimately eliminate health inequities.

Also, we must acknowledge how racism in all of its forms has created a legacy of unequal access to a range of health services, resulting in differences in the quality of care received, health-seeking behaviors and in the social factors that affect one's health. This must be addressed as a component of any solution to reduce the unequal impact of COVID-19 on communities of color.

There is a great deal of concern that the nationwide mass protests that occurred after the murder of George Floyd at the hands of Minneapolis police would result in disease spikes because, as I noted earlier, increased exposure is a risk factor for increased disease in communities of color, with higher morbidity and mortality. These increased exposures were complicated by police crowd control actions like the use of tear gas, pepper spray and corralling and detaining protesters into large groups. These actions further increase the risks of COVID-19 infection.

The presences of mass gatherings in the face of a severe pandemic do create a perceived health risk paradox. It raises the question, why would people choose to increase their risk of infection and get sick with COVID-19 in order to participate in mass protests, and what is the trade-off they are making? Many people believe the protesters are making a trade-off between the potential health risks of them becoming infected with COVID-19 with the real risk of them and their neighbors experiencing police brutality. For many, the magnitude of ending police violence, racial profiling and verbal harassment driven by racism overshadows the risk of getting COVID-19.

It remains to be seen if the protests will result in increased disease spikes. Nationally, we have begun to see increases in disease positivity and hospitalizations as the nation continues to reopen. It will be difficult to determine the relative roles the mass protests and reopening are playing in these exacerbations of the pandemic. However, it is clear that the health impact from COVID-19 has had a disparate impact on communities of color, and we must remain vigilant in our response.

I am concerned about how we plan for several potential health threats that could hit the United States during the pandemic over the next six months. This summer we are expecting a higher than normal hurricane season, and this fall we will have the seasonal return of influenza. Climate change has caused more severe storms, floods, wildfires and increased the spread of other climate-sensitive infectious diseases. All of these have been shown to have a disparate impact on communities of color when they occur. The increase in toxic air from wildfires and the increase in waterborne and mosquito-borne diseases all pose an increased risk to COVID-19 compromised patients. Finally, the traditional approach to managing emergencies will require more thought and planning as the ability to provide and use nonpharmacological interventions (masking, handwashing and physical distancing) is much more difficult in emergency shelters during heat waves or mass evacuations. I am aware the Federal Emergency Management Agency has begun to look into this, but the opportunity to begin educating the public on what to do differently in an emergency is now.

In order to ensure our states, cities and territories are better prepared for the next emergency, it is essential that Congress increase funding for CDC's Public Health Emergency Preparedness Cooperative Agreement and ASPR's Hospital Preparedness Program. Unfortunately, PHEP funding

has decreased from \$939 million in FY2003 to \$675 million in FY2020, while HPP has been slashed from \$515 million in FY2003 to \$275 million in FY2020. The COVID-19 pandemic has demonstrated how essential HPP and PHEP are to the public health and health care systems' ability to respond quickly and efficiently to emergencies. The investments from the Public Health Emergency Preparedness Cooperative Agreement created the response systems and infrastructure that enable states, cities and territories to respond to public health emergencies. PHEP has invested in capabilities critical to the COVID-19 response, such as incident management, epidemiological investigation, laboratory testing, community preparedness and recovery, and medical countermeasures and mitigation. By having staff in place and trained prior to an emergency, public health departments can respond without delay. Although supplemental funding is needed during this pandemic, base PHEP funding allows health departments to hire and retain expert staff. HPP is the only source of federal funding for regional health care system preparedness, minimizing the need for supplemental state and federal resources during a disaster. HPP provides funding and technical assistance to every state, four cities and US territories to prepare the health care system to respond and recover to events such as COVID-19. We are calling on Congress to provide at least \$824,000,000 for the PHEP cooperative agreement and at least \$474,000,000 for HPP in the FY2021 Labor, Health and Human Services and Education Appropriations bill.

A strong public health infrastructure and workforce are also essential to helping us reduce health inequities related to COVID-19 and other health threats. In order to better ensure our public health infrastructure is adequately prepared for addressing the current pandemic, future pandemics and other public health emergencies, we must seriously look at fixing our vastly underfunded public health system. APHA is calling on Congress to provide \$4.5 billion in additional long-term annual mandatory funding for CDC and state, local, tribal and territorial public health agencies for core public health infrastructure activities.^{6,7} This funding would support essential activities such as: disease surveillance, epidemiology, laboratory capacity, all-hazards preparedness and response, policy development and support, communications, community partnership development and organizational competencies. This funding is critical to ensuring our state and local health departments have broad core capacity to not only respond to the current pandemic but to better respond to the many other public health challenges they face on a daily basis. For far too long we have neglected our nation's public health infrastructure, and we must end the cycle of temporary infusions of funding during emergencies and provide a sustained and reliable funding mechanism to ensure we are better prepared to protect and improve the public's health, including our most vulnerable communities, from all threats.

Congress should also authorize and appropriate funding in fiscal years 2020 and 2021 for a public health workforce loan repayment program. This program was authorized, but not appropriated in the HEROES Act passed by the House of Representatives.⁸ Providing funding for this important program will help incentivize new and recent graduates to join the governmental public health workforce, encourage them to stay in these roles, and strengthen the public health workforce as a whole. The public health workforce is the backbone of our nation's governmental public health system at the county, city, state and tribal levels. These skilled professionals deliver critical public health programs and services. They lead efforts to ensure the tracking and surveillance of infectious disease outbreaks, such as COVID-19, prepare for and respond to natural or man-made disasters, and ensure the safety of the air we breathe, the food we eat, and the water we drink. Health departments employ public health nurses, behavioral health staff, community health workers, environmental health workers, epidemiologists, health educators, nutritionists,

laboratory workers and other health professionals who use their invaluable skills to achieve health equity and keep people in communities across the nation healthy and safe.

Finally, we should support and enact legislation that directly targets existing disparities and promotes health equity. This would include legislation that provides support and coordination at the federal level for addressing the social determinants of health that underlie many existing racial and ethnic health disparities. We also need legislation that addresses these disparities directly through promoting equity in health care access, workforce representation, data collection and other areas. Existing legislation that would further these efforts includes H.R. 6637, the Health Equity and Accountability Act of 2020, and H.R. 6561, the Improving Social Determinants of Health Act of 2020.

I thank you for the opportunity to testify before you on this important issue. I look forward to answering any questions you may have.

References

- 1) Millett GA, Jones AT, Benkeser D, Baral S, Mercer L, Beyrer C, Honermann B, Lankiewicz E, Mena L, Crowley JS, Sherwood J, Sullivan P, Assessing Differential Impacts of COVID-19 on Black Communities, *Annals of Epidemiology* (2020).
- 2) Garg S, Kim L, Whitaker M, et al. Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69: 458–464.
- 3) <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>, Accessed online July 5, 2020.
- 4) Bassett, MT, MD, MPH, Jarvis T. Chen, ScD, Nancy Krieger, PhD, The unequal toll of COVID-19 mortality by age in the United States: Quantifying racial/ethnic disparities, June 12, 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, Accessed online July 5, 2020
- 5) Jarvis T. Chen, ScD, Pamela D. Waterman, MPH and Nancy Krieger, PhD, entitled, COVID-19 and the unequal surge in mortality rates in Massachusetts, by city/town and ZIP Code measures of poverty, household crowding, race/ethnicity, and racialized economic segregation. https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1266/2020/05/20_jtc_pdw_nk_COVID19_MA-excess-mortality_text_tables_figures_final_0509_with-cover-1.pdf, Accessed online June 2, 2020
- 6) Organization letter to House and Senate leaders urging a significant, long-term investment in public health infrastructure in future legislation to speed the response to the COVID-19 pandemic. April 3, 2020. Available at: https://apha.org/-/media/files/pdf/advocacy/letters/2020/200403_ph_infrastructure_covid_stimulus.ashx.
- 7) Public Health Leadership Forum. Developing a financing system to support public health infrastructure. Available at: https://www.resolve.ngo/docs/phlf_developingafinancingsystemtosupportpublichealth636869439688663025.pdf.
- 8) Organization letter to House and Senate leaders supporting the inclusion of the Public Health Workforce Loan Repayment Program in the HEROES Act. May, 14, 2020. Available at: https://apha.org/-/media/files/pdf/advocacy/letters/2020/200514_ph_workforce_loan_repayment.ashx.