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On Answering the Call to Action For COVID-19: Continuing a Bold Legacy of Health Advocacy

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Abstract: The disproportionately high burden of death and disability observed for racial and ethnic minorities under the Coronavirus pandemic necessitates sustained advocacy by the medical and public health communities around critical determinants of population health. Prompting our advocacy should be the understanding that our collective ability to rebound from such crises may ultimately hinge on protecting and equipping our most vulnerable racial-ethnic minority groups and any susceptible individuals within those populations. If proven effective, recent historic firsts by the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), the Office of Minority Health (OMH) and the Centers for Disease Control and Prevention (CDC) in response to COVID-19 should be championed for permanency within policy, practice and funding. In addition, given the complex history of Black Americans in this country and persistent and substantial Black-white disparities on health and economic measures across the board, some kind of reparations for this group may serve as a logical starting point for further advocacy. Nevertheless, we remain supportive allies of all organizations concerned with communities who suffer the weight of this pandemic and any future world health disasters. Let us as human clinicians and public health professionals capture this moment of challenge and engage in thoughtful unification of effort and commit to measurable progress for as long as the need exists and certainly for the foreseeable future.

Keywords: Coronavirus pandemic ■ Racial and ethnic health disparities ■ Structural and social determinants of health ■ Emergency and disaster preparedness ■ Reparations

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All respected U.S. medical societies and associations representing physicians and public health professionals should feel secure taking bold action to measurably advance health equity within our country amid the current Coronavirus (or COVID-19) pandemic. Prompting our efforts should be the reality that our collective ability as a nation to rebound from the devastation due to this virus may ultimately hinge on protecting and equipping our most vulnerable racial-ethnic minority groups and any susceptible individuals within those populations. Highlighted here for immediate championing are commendable historic firsts initiated by the U.S. Department of Health and Human Services (HHS) in response to COVID-19 that hold significant promise if made permanent. In addition, support for a comprehensive reparations package may be warranted in order to fund the kind of in depth and informed policies that can effectively target persistent health inequities.

Indeed, the pressing need for us to remedy the unacceptable conditions that underlie disproportionate burden of death and disability from the coronavirus and that undoubtedly drive observed health disparities more broadly, has been echoed by the U.S. Surgeon General Jerome Adams, M.D., M.P.H., Anthony Fauci, M.D., Director of the National Institute of Allergy and Infectious Disease (NIAD) of the National Institutes of Health (NIH), as well as HHS Secretary, Alex M. Azar II, J.D.^{1,2}

However, only thoughtful attention to our historical context as we develop tailored, group-specific measures and interventions will help us effect larger improvements in critical determinants of population health. Federal coordination of response strategies and recovery from this pandemic that can be tailored and implemented locally may also be necessary.³ An added benefit will be the overall strengthening of health and public health infrastructures in the U.S. as well as the advancement of our emergency and disaster preparedness systems.

We are seeing conclusive evidence that a powerful collective advocacy bringing that kind of thoughtful and deliberate intent can effectively sway action of the federal government as it relates to health crises like the current pandemic, which is deeply encouraging.

In early April 2020, a *Washington Post* analysis of nine counties showed that majority-black ones have three times the rate of infection and almost six times the rate of deaths as counties where white residents are the majority, noting that only a few jurisdictions publicly report coronavirus cases and death by race.⁴ Additionally, a letter from The Lawyers' Committee for Civil Rights Under Law as well as an appeal from several national physician organizations formally called upon HHS Secretary Azar to direct federal agencies to collect and release information including statistics by race-ethnicity when reporting on impact and case fatality due to coronavirus.³⁻⁵ By the end of that same month the first such report by the Centers for Disease Control and Prevention (CDC) published a Morbidity and Mortality Weekly Report (MMWR) containing some of that information as available from hospitalization records.⁶

Influenced by the 400th year anniversary in 2019 of the first documented arrival of unfree Africans in North America in 1619,^{6–9} as well as the introduction of the bills S.1080-HR40 into Congress (The Commission to Study and Develop Reparation Proposals for African-Americans Act),^{10,11} we strongly urge that some kind of reparations for Black Americans serve as the logical starting point for further advocacy.

Informing our assertion of an approach that could be perceived as radical by some is the National Medical Association's (NMA's) long history of advocacy within health and medicine throughout the nation whenever the cause advanced fairness and equity for all, even when seemingly at odds with mainstream culture at the time.

We are emboldened by the knowledge that former NMA President and NAACP President, Dr. William Montague Cobb, for whom the W. Montague Cobb/NMA Health Institute (Cobb Institute) is named, helped orchestrate the National Hospital Desegregation Movement as well as championed passage of the Civil Rights Act in 1964 and Medicare in 1965.¹²

The current coronavirus pandemic has been uniquely devastating and without recent precedent for our country, the new epicenter for the outbreak. While other similar global occurrences created action abroad, they usually created little panic at home given their smaller scale and relatively limited geographical spread compared to the current crisis. (The occurrences of Ebola hemorrhagic disease, severe acute respiratory syndrome, H1N1 (also called swine flu) and Zika virus disease are counter examples). The statistics are shocking as of early June — just six months after the emergence of the first cluster of cases in Wuhan, China and only five months after the identification of the first U.S. case. The virus has been detected worldwide in nearly 180 countries, resulting in the infection of almost 7 million persons, over 2 million of whom are in the U.S., and nearly 400,000 coronavirus-related deaths, 100,000 of them occurring in the U.S.¹³

Unfortunately, the identification of a vaccine against coronavirus is predicted to take over one year and the full spectrum and natural history of the clinical disease, transmission dynamics, pathogenesis and duration of viral shedding has not been determined. Since the initial report of the first identified U.S. case, scientists and clinicians have stated that the virus exhibits an aggressive, highly transmissible behavior, lethality and distribution in the population that is not fully understood.¹⁴ Some noted potential challenges for vaccine development are as follows: antigen design for optimal immune response; potential exacerbation of lung disease, either directly or as a result of antibody-dependent enhancement; and duration of immunity from single-dose vaccines.¹⁵

Although inconveniently timed for all of our communities, the swift and pervasive outbreak of the Coronavirus across the country might have been predicted when considering a variety of factors. Our ongoing lack of coordinated testing capability and emergency preparedness and response systems are widely acknowledged. Contributors are insufficient integration of our healthcare and public health infrastructures coupled with the fact that important social determinants of health are resigned to the periphery of our governmental decision-making processes. In addition, great geopolitical divides and broad distrust within the U.S. continue to delay and hamper a coordinated emergency response at the federal, state and local levels.

The immense burdens placed on the most vulnerable racial and ethnic groups complicate this picture to a greater extent, as revealed by relevant epidemiologic data.

Growing evidence indicates excessively high rates of death and disability due to coronavirus for Black American communities and other racial-ethnic minorities, and at alarmingly disproportionate levels given similar transmission rates across populations and our significantly smaller representation in the general population as a whole.¹⁶ Along with older age and underlying health conditions such as cardiovascular disease or pulmonary conditions,¹⁶ certain environmental exposures and other factors such as nutritional status may heighten that risk.^{13,14,16} In fact, the impact and fatality rate from this virus may likely correlate most closely with vulnerable groups and even more so with biologically susceptible individuals within those populations. Collection of additional data on the demographics of COVID-infected individuals as well as wider availability of testing for viral infection are needed to confirm and mitigate any disparate impact.

The full extent of the economic and other impacts from the coronavirus are still uncertain but may likely mirror the population distribution of the human health aspects of this tragedy once better documented.

Even though pandemic-related preparation and planning have regularly occurred in U.S. public health circles since the 1918 Influenza Pandemic, interventions accepted as public health standards historically lack scope and vision when applied to vulnerable racial-ethnic minorities. Plans to address public health emergencies like an epidemic may be drafted and possibly rehearsed for the general public but seldomly geared toward the complexity of needs and barriers for specific populations. Nor do comprehensive plans, preparations or budgetary set asides when implemented transfer well between government administrations, whether they be Congressional, Presidential, state-level, county-level or local governmental transitions even in the presence of admirable leadership in this area.

Prior to these recent efforts, highly concerning to us was that even through 2017 the HHS National Pandemic Influenza Plans developed to prevent, control and mitigate the effects of influenza viruses fails to provide strategies for limiting or eliminating racial and ethnic disparities in vaccination, treatment access or contact tracing, although it does call for attention to vulnerable and at-risk individuals.¹⁷ If not already done so by the time of this article, that plan may need to be revisited and updated with the language of concern and guidance around reaching vulnerable racial-ethnic minority groups that is reflected in current funding HHS efforts.

Now that we are beginning to observe federal agencies more readily heeding the plight of vulnerable groups and populations under the current crisis, we hope that these historic interventions, if proven effective, can be made permanent within policy, practice and funding as they relate to racial and ethnic minorities.

In early April, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA) awarded \$1.3 billion to federally qualified health centers (FQHCs) to support their ability to detect, prevent, diagnose, and treat COVID-19 as well as maintain or increase health center capacity and staff.

STATES HHS

“Health centers deliver care to the nation’s most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and our nation’s veterans. Led by patient-majority boards, these health centers provide affordable, accessible, and quality primary health care to over 28 million people a year, regardless of their ability to pay.”¹⁸

Also notable is that HHS’ Office of Minority Health (OMH) in early May released a competitive funding opportunity called the National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities Initiative to support linkages to services, information and education around COVID-19 for minority, rural and socially vulnerable communities.¹⁹ The 3-year initiative seeks to develop and coordinate a strategic and structured information network of national, state/territorial/tribal and local public and community-based organizations who will mitigate the impacts by: (1) improving the reach of COVID-19-related public health messaging; (2) increasing connection to healthcare and social services; (3) decreasing disparities in COVID-19 testing and vaccination rates; and (4) enhancing capacity and infrastructure to support response, recovery, and resilience. OMH plans to fund one awardee for a period of up to 3 years at \$40 million total.

These efforts may need to be multiplied to have the desired impact.

The CDC is also undertaking commendable laudable measures in response to COVID-19. Noting that health differences between racial and ethnic groups are often due to economic and social conditions that differ from whites, the CDC acknowledges in new recommendations and guidelines that living conditions, work circumstances, underlying health conditions and lower access to care, can affect their preparation and response to public health emergencies such as an influenza outbreak.²⁰

Thus, in response to the many challenges presented by the current coronavirus pandemic, the CDC is:

- Collecting data to monitor and track disparities that will be used to improve the clinical management of patients, allocation of resources, and targeted public health information.
- Supporting partnerships between scientific researchers, professional organizations, community organizations, and community members.
- Providing clinical guidance and guidance to schools, workplaces and community settings.^{21,22}
- Providing on its website, guidance documents to navigate the impact of COVID for individuals, families, healthcare systems and providers as well as public health professionals.

The language and intention of the guidance documents of the CDC under COVID should be enshrined to inform actions for the long-term and not just under the current pandemic. Along those lines, we hope that HHS and, in turn, the current work of CDC and its grantees with attention to vulnerable communities under COVID, deeply influences policymaking at the various levels of the federal, state and local governments as well as guides the efforts of industry and other entities.

As clinicians and public health practitioners we understand that best public health practice entails continuously targeting the most vulnerable groups and communities for chronic and infectious disease prevention, intervention, distribution of resources and even financial support when presented with economic disruption. Doing so will only help assure preparedness for subsequent public health emergencies and the gross disruptions that we are currently observing for vulnerable groups and communities.

Beyond these generic and typical public health prescriptions, for Black Americans we strongly suggest that reparations may be the eventual answer.

Note that whereas this particular solution centers on the history of Black Americans given our expertise on Black-

white disparities and informed by the work of the NMA since its founding in 1895, we at the Cobb Institute remain supportive allies of all health professional organizations concerned with the communities who suffer the weight of this pandemic and any future world health disasters.

With this fact in mind, two logical questions appear worth asking U.S. society at large:

How can dedicated government funds be allocated in the long term for an extended period toward initiatives for populations in the U.S., whether rural or urban who because of structural and social determinants of health bear the greatest burden of death and disease from public health emergencies such as the COVID pandemic?

Given this pandemic's magnification of longstanding racial inequities in health and healthcare in the U.S. that date back to slavery, would reparations of some kind to Black Americans be appropriate for correcting the foundational Black-White racial inequalities in housing, working conditions, climate challenges and the lack of access to quality education that have created specific health-vulnerabilities to COVID?

We believe that significant, well-documented scholarship on black reparations warrants serious consideration.^{23–27} The long historical underpinnings exacerbating this crisis for Black Americans adds a strong moral imperative as well as a valid social justice claim. Black Americans, consisting of populations acknowledged as being present in the country since its founding, have made immeasurable contribution to the early, rapid development and subsequent central global economic positioning of the U.S.^{28–30} Yet this group has also been marginalized historically and left economically and socially disadvantaged intergenerationally and with high, disproportionate health burdens overall.

In fact, as we reflect on several solutions worthy of implementation offered by physicians and other clinicians serving on the frontline in vulnerable communities,^{31–39} we submit that each proposal could be easily funded as part of a reparations package. Already numerous calls by these health professionals for widespread, no-cost diagnostic testing and collection of demographic data on who is being affected are being appreciated. Even hints of measures to address the broader inequities that drive current social and environmental conditions for health inequality are present in the latest efforts by HHS as well as its OMH and the CDC. Such efforts should be funded in the long term and with attention to a variety of conditions and illnesses. Direct monetary compensation specifically designated for Black Americans, given the economic consequences of racism and discrimination, has also been mentioned and should be respected.

Every one of our allied professional organization with a part of its mission and agenda to improve the health status of racial and ethnic minorities, including the National

Medical Association (NMA) and its many affiliates, the American Medical Association (AMA), the National Hispanic Medical Association (NHMA), and the American Public Health Association (APHA), have all demanded action to address remedy persistent inequities laid bare by the impact of COVID-19.

The present, promising unity of purpose is deeply felt. What is additionally needed is a thoughtful unification of efforts and a commitment to sustained progress and evidenced by measurable results for as long as the need exists and certainly for the foreseeable future.

However, we must be urged to use this tragic opportunity to set the stage for long-term disaster planning for socially vulnerable communities that is group-specific, which inevitably involves coordinated federal, state and local policies and efforts to address defined structural and social determinants of health. Ultimately, the benefits of this unified effort will spill over into the rest of U.S. society thereby improving the health status and wellbeing of all.

We are of the belief that now is not too late to save lives and halt the progression of this virus throughout the communities, both urban and rural, of our great nation.

Let us as humane physicians and public health professionals capture this moment of challenge and follow through on this critical call to action.

CONFLICT OF INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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