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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 indelible impacts on our nation from the Coronavirus pandemic along with high fatality rates that disproportionately burden racial and ethnic minorities necessitate long-term coordinated federal, state and local action to improve critical determinants of population health, specifically important health and public health infrastructures as well as emergency and disaster preparedness systems. While our purview as the new pandemic epicenter should be a sufficient driver, coordinated health professionals bringing thoughtful attention to our historical context may be warranted. Prompting our advocacy should be the reality 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. Recent historic firsts on behalf of racial and ethnic minorities taken by U.S. Department of Health and Human Services, through the Health Resources and Services Administration, the Office of Minority Health and the Centers for Disease Control and Prevention in response to COVID-19, if proven effective, should be considered 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, the ultimate solution for improving the health and status Black Americans may look slightly different. Influenced by the 400th year anniversary of the first documented arrival of unfree Africans in North America in 1619, as well as the introduction of bills S.1080 and H.R.40 into Congress (The Commission to Study and Develop Reparation Proposals for African-Americans Act), some kind of reparations for Black Americans might serve as the 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. What is additionally needed is a thoughtful unification of efforts and a commitment to sustained progress with measurable results for as long as the need exists and certainly for the foreseeable future. Let us as humane clinicians and public health professionals capture this moment of challenge and follow through on this urgent call to action.

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

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All leading professional medical organizations and associations in the United States and especially those related to public health should feel secure taking bold action to measurably advance health equity within our country amid the current pandemic due to the virus that causes COVID-19. Prompting our efforts should be the reality that our collective ability as a nation to rebound from the coronavirus' devastation may ultimately hinge on protecting and equipping our most vulnerable racial-ethnic minority groups and any susceptible individuals within those populations.

Even 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 for Health (NIH), as well as the U.S. Health and Human Services (HHS) Secretary, Alex M. Azar II, J.D., have acknowledged as “unacceptable” the conditions underlying longstanding health disparities that remain unaddressed while they place some communities at disproportionate risk for death and disability from the coronavirus.^{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 as well as the advancement of our emergency and disaster preparedness systems.

We are seeing conclusive evidence that a powerful collective advocacy bringinh 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 have three times the rate of infections and almost six times the rate of deaths as counties where white residents are in the majority, noting that only a few jurisdictions publicly report coronavirus cases and deaths 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 and ethnicity when reporting on impact and case fatality due to coronavirus.^{5,6} By the end of that same month 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.⁷

Influenced by the 400th year anniversary in 2019 of the first documented arrival of unfree Africans in North America in 1619,⁸⁻¹¹ as well as the introduction of the bill S.1080-HR40 into Congress (The Commission to Study and Develop Reparation Proposals for African-Americans Act),^{12,13} 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 radical by some is the National Medical Association's (NMA's) long history of advocacy within health and medicine as well as throughout the nation whenever the cause was about fairness and equity for all, even when seemingly at odds with mainstream culture at the time. We are further 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 1965.¹⁴

The current coronavirus pandemic has been uniquely devastating and without recent precedent as a whole for the U.S., 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. (The occurrences of Ebola hemorrhagic disease, severe acute respiratory syndrome (SARS), H1N1 (also called swine flu) and Zika virus disease are examples). Reports show that as of end of May, the virus has been detected in nearly 180 countries, resulting in the infection of 5.6 million persons and more than 350,000 deaths, the most of which have occurred in the U.S. Now approaching 650,000 coronavirus infections in the U.S., just over four months after the first known case was confirmed, the number of coronavirus-related deaths in the U.S. has reached more than 100,000.¹⁵

Unfortunately, identification of a vaccine against coronavirus is predicted to take over one year at the least. Some noted potential challenges for vaccine development are as follows¹: antigen design for optimal immune response²; potential exacerbation of lung disease, either directly or as a result of antibody-dependent enhancement; and³ duration of immunity from single-dose vaccines.¹⁶ Furthermore, the virus' aggressive, highly transmittable behavior, lethality and distribution in the population is not fully understood by scientists and clinicians.

Inconveniently timed for all of our communities for a variety of reasons, the Coronavirus outbreak occurred swiftly and pervasively across the country with unexpected impact and with high fatality rates. The observed lack of coordinated testing capability and emergency preparedness

and response systems were predicted, given insufficient integration of our healthcare and public health infrastructures coupled with the social determinants of health yet to be at the forefront of our governmental decision-making process. Great geopolitical divides and broad distrust with the U.S. also 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.⁷ Along with older age and underlying health conditions such as cardiovascular disease or pulmonary conditions,⁷ certain environmental exposures and other factors such as nutritional status may heighten that risk.¹⁷⁻²⁰ 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-19 infected individuals as well as wider availability of testing for viral infection are needed to mitigate this disparate impact.

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

In addition, 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 public are seldomly written with attention to the complexity of the 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.

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 Human 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.”²¹

Also notable is that HHS’ Office of Minority Health (OMH) in early May 2020 released a competitive funding opportunity to support linkages to services, information and education around COVID-19 for minority, rural and socially vulnerable communities called the National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities Initiative.²² 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 by¹: improving the reach of COVID-19-related public health messaging²; increasing connection to healthcare and social services³; decreasing disparities in COVID-19 testing and vaccination rates; and⁴ 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 to stimulate solutions on the community level need to be multiplied to have the desired impact.

The CDC is also undertaking laudable measures in response to COVID-19 that speak to the needs of racial and ethnic minorities. Noting that health differences between racial and ethnic groups are often due to economic and social conditions that differ from whites, they acknowledge 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.²³⁻²⁵

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.
- Providing on its website, guidance documents to navigate the impact of COVID-19 for individuals, families, healthcare systems and providers as well as public health professional.

However, we hope that with input from HHS as well as the work of CDC and its grantees, regulations are issued to implement laws and develop policies and guidance for state and local governments, industry, and other organizations with attention to vulnerable communities. 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.²⁶ 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. The language and intention of the guidance documents of the CDC under COVID-19 should also be enshrined to inform actions for the long-term and not just under the current pandemic.

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 financial support when there is economic disruption. Doing so will only help assure preparedness for subsequent public health emergencies the gross disruptions that we are currently observing for vulnerable groups and communities.

In addition to these generic and typical public health strategies, for Black Americans we strongly suggest that reparations may be the ultimate 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, the Cobb Institute remains

supportive allies for all concerned health professional organizations to focus upon all 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 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-19 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-19?

We believe that significant, well-documented scholarship on black reparations warrants serious consideration.²⁷⁻³¹ 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.³²⁻³⁴ 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 colleagues serving on the frontline in vulnerable communities,³⁵⁻⁴² 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 organizations 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 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 of these and other like-minded organizations and a commitment to sustained progress with 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 are group-specific, which inevitably involves coordinated federal, state and local policies and efforts to tackle the existing structural and social determinants of health. Ultimately, the benefits of this unified effort will influence the rest of our United States Society to seek improvement of 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 INTERESTS

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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