

**Dr. Uché Blackstock, CEO and Founder, Advancing Health Equity
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Good afternoon, I am Dr. Uché Blackstock. Thank you for inviting me to speak at this critically important briefing on racialized health inequities in the COVID19 pandemic. I am an emergency medicine physician. I am also the founder of advancing health equity. The mission of my organization is to work with healthcare and related organizations to close the gap in racialized health inequities.

I originally founded this organization last year prior to the Coronavirus crisis because despite significant advances in healthcare and technology over the last decades, racialized health inequities in the US have been both profound and persistent.

Black men have the shortest life expectancy. Black babies - the highest infant mortality rate. Black women - the highest maternal mortality rate and this trend persists despite socioeconomic status and level of formal education. Even the chronic stress of living with daily racism results in “the weathering effect”, the premature physiologic aging of Black Americans’ bodies.

Also, I would like to acknowledge the pain and trauma that many Black Americans have experienced this year and are currently experiencing due to the recent killings of George Floyd and Breonna Taylor by police officers. Their murders, like racialized health inequities, are a symptom of the same deeply rooted disease in this country – structural racism and white supremacy.

Living in this country has essentially made Black Americans sick. And over the last 8 months, we have witnessed a crisis layered upon another a crisis as Black communities across this country have borne the greatest burden of deaths from the novel Coronavirus.

As of mid-November, according to American Public Media Research Lab, more than 1 in 875 Black Americans have died from Coronavirus.

Black Americans continue to experience the highest actual COVID-19 mortality rates nationwide—about two or more times as high as the rate for Whites and Asians, who have the lowest actual rates.

If Black Americans had died at the same rate as white Americans, about 21,200 Black Americans would still be alive today.

In mid-March, with my own eyes, I noticed the demographics of my patients in the urgent care clinic where I work rapidly shift from a racially and socio-economically diverse population to mostly Black patients. Many of them were essential workers – bus drivers, subway conductors, grocery store workers. Many with underlying medical problems, like diabetes, high blood pressure and asthma. Many with no other choice but to use public transportation. And many

displaying typical COVID19 symptoms. However, we did not have adequate testing supplies at the time to test them.

I've been a physician for 15 years and have worked in the emergency departments with the sickest patients. I have never been as scared for my patients as I have been these past few months.

In particular, I remember an elderly Black man who came in with shortness of breath and fever. His oxygen level was incredibly low. He lived by himself. I was very worried about him and told him I would like to call an ambulance to bring him from our urgent care to the closest Emergency Room. He told me he would not go. He did not want to die in the ER. He told me that he didn't think he would receive good care and he felt safer at home.

As you may know, this distrust among Black Americans for the healthcare system is not uncommon. It is based not only on a historical legacy of centuries of neglect, abuse and exploitation of Black communities, but also based on current-day discrimination and racism that Black patients face.

Black Americans have been placed at risk to the consequences of the COVID-19 pandemic because of manifestations of structural racism, including lack of access to testing, a higher chronic disease burden and racial bias within health care institutions.

One of the main solutions to combating COVID-19 is widespread testing that would allow us to cohort and quarantine groups of patients who test positive so as to restrict the spread of disease. However, COVID19 testing has had limited availability for a variety of reasons, including ineffective federal leadership, the bureaucracy of federal agencies and an uncoordinated health care system.

As a physician, I've found it upsetting that celebrities and government officials without symptoms have been able to access testing quickly with same-day results, while I've had to ration out testing to my patients with turnaround times of five, seven and sometimes 10 days as a result of backlogs.

Because we have been forced to carry relatively high chronic disease burdens—specifically diabetes, asthma and hypertension—we are at a higher risk for developing serious complications from the novel coronavirus.

Additionally, even when Black patients seek care for their COVID-19 symptoms, they will likely receive worse care than other patients since it's more likely we will seek care at minority-serving hospitals, which have been shown to provide lower quality care and are beset with a shortage of critical care physicians, personal protective equipment and ventilators for dealing with critically ill COVID-19 patients.

Given our health care system's lack of preparedness and capacity, health workers will likely need to ration care as well. That's another problem since research has shown that most health care workers appear to have implicit biases that result in relatively positive attitudes toward white patients and conversely negative attitudes toward Black patients. Recently, an algorithm widely used by health care systems significantly underestimated the needs of the most chronically ill Black patients, further reinforcing racial health inequities.

Structural racism, through social and economic policies that disadvantage Black people, has placed Black Americans at risk for illness and death. It has been the key driving force behind the factors that determine an individual's and communities' health outcomes.

Last June, I testified in front of the U.S. House of Representatives select subcommittee on the Coronavirus and I urged subcommittee members to act urgently and swiftly to mitigate widespread and appalling racialized health inequities that we still see today.

This unprecedented moment must be used for structural change and to address the key social determinants of health, including safe and adequate housing, gainful employment, access to quality education, access to healthy foods and health care for all, that influence the health of Black communities.

The United States desperately needs a truth and reconciliation process around the racist policies, economic systems and institutions that have left Black lives devalued. This is an opportunity to intentionally acknowledge unjustified past and ongoing wrongs, engage with Black communities, and rebuild them equitably.

And then maybe, just maybe, my patient that I described earlier could have had a fighting chance against the novel Coronavirus.

Thank you.