



STUDENT NATIONAL MEDICAL ASSOCIATION

From the Desk of the National President

FOR IMMEDIATE RELEASE

Tuesday, May 5, 2020

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SNMA & ANAMS Urge Actions Be Taken to Address Inequitable COVID-19 Outcomes Experienced by Communities of Color

The **Student National Medical Association (SNMA)** was founded in 1964 by medical students from Howard University School of Medicine and Meharry Medical College and is the nation's oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians. The **Association of Native American Medical Students (ANAMS)** was founded in 1975 by a small group of American Indian medical students and represents Native American health professions students and those interested in promoting Native American health. The ANAMS supports Native American medical students in the successful completion of their curricula, provides a forum for the interchange of ideas and cultural support, and assists American Indian and Alaska Native Tribes, Villages, and Pueblos with the recruitment and retention of American Indians into health professions. Given the profound and disparate impact that the novel coronavirus disease 2019 (COVID-19) has had on the health and wellbeing of Black, Latinx, and Native communities, the SNMA and ANAMS strongly urge federal and state legislators and health departments to take immediate action to combat this disparity in health outcomes.

Limited COVID-19 Data Available Demonstrates Stark Racial/Ethnic Health Disparities

Although the statistics are still being assessed, current data as of May 4, 2020 shows that there is a significant disparity in the burden of illness and death among communities of color, particularly among Black/African Americans and American Indians and Alaska Natives (AI/AN). A Center for Disease Control and Prevention (CDC) study of 14 states demonstrated that during the month of March, Black/African Americans and AI/ANs accounted for 33% and 7.9% of COVID-related hospitalizations, respectively, despite Black/African Americans making up 18% of the population in those states (the AI/AN population was not reported by this study, however, the average AI/AN population for 4 out of the 14 states is 5.7%, with these states having the 2nd, 4th, 7th, and 10th highest AI/AN population in the US).[1][2] The Indian Health Service (IHS) has reported 3,974 confirmed cases of COVID-19 across Indian health programs.[3] The Navajo Nation alone has the



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3rd highest per capita COVID-19 infection rate behind the states of New York and New Jersey.[4] In New Mexico alone, AI/ANs represent 55.27% of COVID-19 cases, despite making up around 10% of the state's population.[5] Additionally, according to the American Public Media (APM) Research Lab, the COVID-19 mortality rate for Black/African Americans is 27% despite making up only 13% of the United States (US) population. In Washington, DC and 10 out of the 38 states reporting, Black/African Americans are 3-7 times more likely to die from COVID-19 than Whites.[6] In Chicago and Louisiana alone, Black/African Americans account for 70% of COVID-19 deaths, yet only about a third of the state population.[7] Unfortunately, not all states are collecting and/or releasing comprehensive racial/ethnic data on COVID-19 outcomes, and data that is available is not consistently collected across states, particularly for Native Americans, thus inhibiting the scope of the problem from fully being captured.[6] For example, county and regional data from county and state health departments is not readily available to the 12 Tribal Epidemiology Centers across the nation, which slows surveillance efforts. Sharing of COVID-19 data between states and Tribes also varies greatly from state-to-state.[8]

Similarly to maternal mortality rates, the COVID-19 pandemic has rapidly brought to the forefront the racial divide in the health of the nation: with the average life-expectancy of a person of color in the US at 3.5 years less than that of their White counterparts, in more ways than one, the health outcomes of a person of color in the US can be likened to that of emerging nations with much less developed medical systems and technology.[9] While COVID-19 did not create the circumstances that brought about health care disparity and inequity in the US, it has and will continue to aggravate the existing disproportionate differences in the social determinants and health outcomes between racial/ethnic groups.

Historical and Societal Context that Drives These Racial/Ethnic Inequities

It shouldn't come as a surprise that Black, Latinx, and Native communities are experiencing poorer COVID-19 outcomes when compared with their White counterparts given the extensive data and research that exists on racial/ethnic health disparities: the risk factors for poorer COVID-19 outcomes include diabetes, cardiovascular disease, and asthma, which are all comorbid medical conditions that disproportionately impact Black, Latinx, and Native communities.[7] Unfortunately, COVID-19 has only exaggerated the excess barriers to health among Black, Latinx, and Native communities that historical and structural racism has created: elements that are protective and contribute to positive COVID-19 outcomes (access to healthcare for prompt testing and diagnosis; wide-spread contact tracing, frequent handwashing, self-isolation, and quarantine to minimize the spread) are placed further out of reach for communities of color.[10][11] Even with proper healthcare access, reports of racial discrimination against Black/African Americans seeking care for COVID-19 being turned away multiple times, then subsequently dying from the disease have only grown.[12][13][14] However, this doesn't begin to contextualize the damage that COVID-19 has and



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will continue to have on these communities if action isn't taken on their behalf by the government and healthcare systems.

The US federal government has an obligation to provide health services to the citizens of the 574 federally recognized Tribes in the US, born out of treaties signed between the US and Tribes. This obligation is commonly referred to as the trust responsibility, and is upheld through the Indian Health Service (IHS), a federal agency within the US Department of Health and Human Services.[15] Despite this obligation, the IHS is not funded to need, and has the lowest per capita healthcare expenditures (\$4,078) compared to other federal health programs like Medicare (\$13,185).[16] This chronic underfunding has exacerbated the disparities seen within AI/AN communities where individuals die at higher rates than the average American from chronic lower respiratory diseases, diabetes, liver disease and cirrhosis, assault/homicide, and unintentional injuries.[17]

The chronic underfunding of the IHS is in large part due to the discretionary nature of appropriations to the IHS through the Interior/Environment Appropriations Act, not the Labor, Health and Human Services Appropriations Act.[18] Every year, the IHS consults with Tribes to determine a proposed budget of total need which is then reviewed by the House and Senate Committees on Appropriations.[19] The ongoing trend is for these committees to approve only partial funding of IHS such as in 2016 when the IHS was only funded at 59% of total need.[20] Furthermore, IHS dollars are then distributed based on the Census Bureau estimations of AI/AN populations, which has been known to undercount those living on reservations or in Native villages. Often these tribal communities are more rural, low-income, geographically isolated, and/or linguistically isolated, and their underrepresentation in the census numbers means that they do not receive adequate IHS funding.[21] This even further exacerbates the health and social inequities faced by these communities.

Even with proper access to healthcare, people of color are more likely to live and work in settings that expose them to increased risk of infection from coronavirus. Black, Latinx, and Native individuals are more likely to live in large, multigenerational households, making them unable to self-isolate or quarantine away from the rest of their household.[22] The disproportionately higher rates of incarceration of Black, Latinx, and Native people, including within detention centers at the US-Mexico border, also places them in close quarters settings and further increases their risk of infection from coronavirus.[23][24] Lack of access to basic amenities such as clean running water further exacerbates the vulnerability to infection. This is especially true in Indian Country where twice as many homes lack running water when compared to other Americans.[25][26] Furthermore, many of these patients either are essential workers or live with an essential worker, and thus cannot stay or work from home.[27] Even more are employed in the service industry and thus more vulnerable to job loss and loss of income, as demonstrated by the racial/ethnic disparity in unemployment rates change since COVID-19, as well as exposure to the virus.[7][28][29]



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Inaction and/or Poor Action by the US Government

On March 27, 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act, a \$2 trillion stimulus package to provide aid and relief to American individuals, families, and businesses in need. Unfortunately, immigrants, individuals experiencing homelessness, and individuals experiencing reduced employment (vs unemployment) due to COVID-19, many of whom are people of color, were not accounted for by the provisions of the CARES Act.[30] Additionally, by providing only a one-time impact payment for individuals and families, the Act does not account for the fact that economic precarity and need for relief and aid amongst US residents will continue to impact Americans until the pandemic ends and the economy stabilizes.[31] The same can be said for the Families First Coronavirus Response Act (FFCRA) passed by Congress on March 18, 2020, which allocated approximately \$104 billion to expanding paid sick leave, unemployment benefits, and food assistance for children and families. Additionally, no provisions were made within any of the legislature passed in response to COVID-19 to safeguard Americans from continuing to fall into financial precarity and/or housing insecurity.[32]

From the CARES Act relief fund, \$8 billion was allocated for distribution amongst tribal governments to aid in efforts to combat COVID-19 as well as provide economic stability. To date, none of these funds have been disbursed. This has been attributed in part to the US Department of the Treasury, in conjunction with the US Department of the Interior, not knowing how to allocate the funds.[33] Complicating the matter, Assistant Secretary of Indian Affairs Tara Sweeney has drawn criticism from Congressional Leaders for allowing for-profit Alaska Native Corporations (ANCs) to be eligible for these funds, despite them not constituting a tribal government.[34] Tribal leaders are concerned that Sweeney's actions will divert necessary funding to respond to the pandemic. As of May 1, 2020, several Tribes are suing the Treasury Department for failing to provide the allocated funds by the April 26 deadline. District Judge Amit Mehta of the US District Court for the District of Columbia recently ruled in favor of the tribal governments, barring the federal government from disbursing funds to ANCs as the lawsuit proceeds.[35] Members of Congress have also written to the Secretaries of the Treasury and the Interior to immediately disburse the much needed funds. In what has been described as a "perfect storm," the untimely delay of federal relief has put an increased burden on tribal governments who are disproportionately impacted by the current pandemic.[36] Tribal gaming and lending operations have been shuttered for weeks, which has had a downstream effect on health, employment, education, and social services for these Tribes.[37][38] While not all Tribes have gaming enterprises, those who do are in more remote areas and often employ the majority of Native American and non-Native American residents in the area. Initially, these programs were excluded from the Small Business Administration's \$349 billion Paycheck Protection Program, which immediately led to employee furloughs.[39][40] Additionally, despite the United Nations urging Member States to include the specific needs and priorities of Indigenous peoples in addressing the global outbreak of COVID-19, the White House has failed to include appropriate AI/AN representation on its COVID-19 Task Force.[41]



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Recommendations

As future health professionals, we have a duty to advocate for equitable protection and care for our most vulnerable patients, particularly in times of crisis. Each minute of delay in taking action is not worth the lives lost to this pandemic that could have been prevented. The SNMA and ANAMS call for the following recommendations to counteract the existing and perpetuated burdens that will disproportionately impact the populations we serve:

1. Increase wide-spread access to COVID-19 care, including testing, management, and treatment, regardless of insurance and documentation status.
2. Collect comprehensive race/ethnicity data for COVID-19 at the local, state, and federal level and make all data publicly available on a monthly basis during the pandemic.
3. Launch local and/or state health department-level investigations to detect failures within healthcare systems that have led to practices of discrimination that have resulted in patients receiving inadequate care and instate procedures for reporting, remediating, and preventing such incidences of discriminatory care.
4. Economic Impact Payments and other funding provided through the CARES Act and FFCRA must be extended to continue on a monthly basis until the national “curve” has flattened.
5. Eligibility for Economic Impact Payments and other funding provided through the CARES Act and FFCRA must not be limited by occupation type or documentation status (e.g., H.R. 6437 - Coronavirus Immigrant Families Protection Act).
6. Steven Mnuchin (US Secretary of the Treasury) and Tara Sweeney (Assistant Secretary of Indian Affairs) must immediately disburse funds allocated to tribal governments by the CARES Act.
7. Uphold the federal government’s trust responsibilities to Tribes by appointing Rear Admiral Michael Weahkee, Director, Indian Health Service to the White House COVID-19 Task Force.[41]
8. Expedite review of policies, such as the Federal Immigrant Release for Safety and Security Together (FIRST) Act,[42] which call for release of people detained within ICE detention centers for non-violent offenses, or their placement in Alternatives to Detention (ATD) Programs. Additionally, create and expedite review of policies aimed at releasing all other inmates incarcerated for non-violent offenses and halting the further detainment of non-violent offenders.

Sincerely,



Student National Medical Association (SNMA)
Association of Native American Medical Students (ANAMS)



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References

1. https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w
2. <https://www.cdc.gov/tribal/tribes-organizations-health/tribes/state-population.html>
3. <https://www.ihs.gov/coronavirus/?CFID=184597571&CFTOKEN=61564418>
4. <https://www.npr.org/2020/04/24/842945050/navajo-nation-sees-high-rate-of-covid-19-and-contact-tracing-is-a-challenge>
5. <https://cvprovider.nmhealth.org/public-dashboard.html>
6. <https://www.apmresearchlab.org/covid/deaths-by-race>
7. <https://www.kff.org/disparities-policy/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/>
8. <https://indiancountrytoday.com/news/ready-or-not-warnings-for-tribes-as-covid-19-epidemic-spreads-cmAg0kyHi0iHmBtFHIWYA>
9. <https://www.nytimes.com/2020/04/29/magazine/racial-disparities-covid-19.html>
10. <https://www.cdc.gov/coronavirus/2019-ncov/faq.html>
11. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>
12. <https://www.bostonglobe.com/2020/05/01/opinion/beloved-teacher-dies-coronavirus-unconscious-bias-health-care-may-have-hastened-her-death/>
13. <https://www.theroot.com/black-woman-dies-from-coronavirus-after-being-turned-aw-1843091288>
14. <https://abcnews.go.com/Health/covid-19-exposes-mistrust-health-care-inequality-back/story?id=70370949>
15. <https://www.ihs.gov/newsroom/factsheets/basisforhealthservices/>
16. <https://www.gao.gov/assets/700/695871.pdf>
17. <https://www.ihs.gov/newsroom/factsheets/disparities/>
18. <https://www.everycrsreport.com/reports/R44040.html>
19. <https://www.ihs.gov/aboutihs/annualbudget/>
20. http://www.ncai.org/policy-issues/tribal-governance/budget-and-appropriations/07_FY2016_Health_NCAI_Budget.pdf
21. <http://www.ncai.org/NCAI-FY20-BudgetReport-PREVIEW.pdf>
22. <https://www.cdc.gov/coronavirus/2019-ncov/community/tribal/social-distancing.html>
23. <https://www.prisonpolicy.org/profiles/US.html>
24. <https://www.kpbs.org/news/2020/apr/14/otay-mesa-detention-center-now-largest-immigration/>
25. https://www.democracynow.org/2020/4/15/covid_19_navajo_nation_native_americans
26. <https://indiancountrytoday.com/news/coronavirus-risk-is-compounded-by-the-rural-DC-rMTUzzE6WDGee8jbENQ>
27. <https://www.theguardian.com/commentisfree/2020/apr/16/black-workers-coronavirus-covid-19>
28. https://www.bls.gov/web/empstat/cpsee_e16.htm
29. <https://www.americanprogress.org/issues/race/news/2020/04/14/483125/economic-fallout-coronavirus-people-color/>
30. <https://thehill.com/opinion/white-house/493458-where-the-cares-act-went-wrong>
31. <https://www.epi.org/blog/despite-some-good-provisions-the-cares-act-has-glaring-flaws-and-falls-short-of-fully-protecting-workers-during-the-coronavirus-crisis/>
32. <https://www.cbpp.org/research/economy/cares-act-includes-essential-measures-to-respond-to-public-health-economic-crises>
33. <https://www.indianz.com/covid19/wp-content/uploads/2020/05/04517803454.pdf>
34. <https://www.politico.com/news/2020/04/16/trump-indian-affairs-funds-191622>
35. <https://www.nytimes.com/2020/05/01/us/politics/coronavirus-native-american-tribes-treasury-stimulus.html>
36. https://www.huffpost.com/entry/tribes-covid-19-federal-relief-treasury-deb-haaland_n_5ea9decac5b633a8544487d9?guccounter=1
37. http://www.indiangaming.com/istore/Aug07_SpeakOut.pdf
38. <https://www.americangaming.org/sites/default/files/Economic%20Impact%20of%20Indian%20Gaming%20in%20the%20U.S.%20September%202017.pdf>
39. <https://www.indianz.com/IndianGaming/2020/04/14/we-keep-getting-left-out-tribal-gaming-r.asp>
40. <https://home.treasury.gov/system/files/136/PPP%20-%20Overview.pdf>
41. https://www.nihb.org/docs/05012020/NIHB%20Letter%20_Weahkee%20and%20COVID-19%20Task%20Force4.29.2020.pdf
42. <https://www.booker.senate.gov/imo/media/doc/MDM20356.pdf>