



TEXAS LEGISLATIVE STUDY GROUP

An Official Caucus of the Texas House of Representatives

Dear Members and Supporters,

I'm sure most of you know, but this issue is very personal to me because of how long I've worked on public health issues and because I am a black diabetic, I am at risk of becoming one of the statistics mentioned in this report. Because of that, I am very proud to be the Chair of the Legislative Study Group, which has always had a dedicated group of members who have fiercely worked towards the elimination of health disparities caused by social determinants.

During the Clinton Administration, I and fellow LSG members worked to implement Surgeon General David Satcher's vision of zero disparities and 100% coverage. We worked to create the Office of Minority Health and Cultural Competency, and through the Budget required state health agencies to keep track of racial and ethnic data on diseases, including diabetes, hypertension, and heart disease. I also passed the bill in 2001 to create the Health Disparities Task Force to ensure that all the different health agencies and authorities in Texas would work together towards eliminating health disparities.

In 2005—after the 2003 consolidation and reorganization of Texas' health agencies by the Republicans—LSG members worked together to put the Health Disparities Task Force back together as the Interagency Council for Addressing Disproportionality. LSG members worked through the budget process to keep the Council—which was renamed The Office of Minority Health Statistics and Engagement (OMHSE) —together until 2018, three years beyond its 2013 expiration date. All LSG members should be proud of the work the OMSHE and its predecessors did to reduce health disparities. Regrettably, it has taken the COVID-19 pandemic to wake up some in this state and country to the fact that it still is sorely needed.

To help the LSG and its members work on this important issue, I have sent a letter to Commissioner Hellerstedt requesting that DSHS collect all data related to COVID-19 by race and ethnicity, including infection rates, hospitalization rates, ICU rates, death rates, and other relevant data.

Rep. Garnet F. Coleman
Chair, Legislative Study Group

LSG Report: COVID-19 Reveals Racial Health Disparities

It is well known that communities of color have worse health outcomes, and now COVID-19 is making that fact undeniable, even to members of the Trump administration. On Tuesday, April 7th the Director of the National Institute of Allergy and Infectious Diseases [Dr. Anthony Fauci said](#):

"It's not that [Blacks] are getting infected more often. It's that when they do get infected, their underlying medical conditions...wind them up in the ICU and ultimately give them a higher death rate . . . [COVID-19 is] shining a bright light on how unacceptable [the disparity] is . . . when all this is over -- and as we said, it will end, we will get over coronavirus -- there will still be health disparities which we really do need to address."

One thing Dr. Fauci got wrong in his statement on Tuesday was saying African Americans are not getting infected by COVID-19 at a higher rate. According to [the New York Times](#), **whites have an infection rate of 39.8 cases per 100,000 population compared to a rate of 137.5 per 100,000 for African Americans.**

Session after session, LSG members have authored, worked on and [passed legislation](#) to direct state agencies to study and eliminate racial disparities in health outcomes. Those efforts include but are not limited to:

- HB 757 (2001) by **Rep. Garnet Coleman** created the **Health Disparities Task Force** to help ensure that all the different health systems were sharing data and approaches to eliminating health disparities.
- LSG members made sure the Child Protective Service collected data on racial disparities during a CPS crisis that led to a CPS overhaul in 2005.
- SB 501/HB 945 (2005) by **Senator Royce West** and **Representative Dawnna Dukes** put the Task Force back together after the Republicans consolidated and reorganized the state's health agencies in 2003 and renamed it the Interagency Council for Addressing Disproportionality, which would later be renamed The Office of Minority Health Statistics and Engagement (OMHSE).
- LSG members fought to keep the OMHSE that was originally set to expire in 2013 in existence until 2018.
- During the 2017 regular and special session, **Rep. Armando Walle** and **Rep. Shawn Thierry** fought to make sure disparities involving mothers of color were addressed by the Maternal Mortality Board.

Essential Data Collection is Needed

Regrettably, it has taken a pandemic to make it clear to some that communities of color face different and more difficult health challenges that need to be addressed by our state and federal government. The mishandling of the COVID-19 pandemic has made it clear that data collection and tracking is an essential tool for public health professionals and policymakers. The fact that this virus is having such a severe impact on the Black community—when compared to other populations—underscores the need to collect more data based on race, ethnicity, age, gender, and other factors to improve public health and prepare for the next public health crisis.

Race/ethnicity fields are often left blank in public health records because local agencies are “[under a tremendous amount of strain to collect and report case information](#)” said Scott Pauley, a Center for Disease Control (CDC) spokesman. **Neither the CDC nor many national databases provide data based on race and only a few states, municipalities or private labs release their data by race**, according to [the Atlantic](#). Thankfully, due to some dedicated journalists, there is an increased demand for racial information, new data is being collected, and new insights are being gleaned. Rep. Garnet Coleman has also sent a letter to DSHS Commissioner Hellerstedt requesting that DSHS collect all data related to COVID-19 by race and ethnicity, including infection rates, hospitalization rates, ICU rates, death rates, and other relevant data.

Death and Infection Rates Show Racial Disparity

As the deadly spread of COVID-19 has accelerated in the United States, it has become painfully clear that Blacks are inordinately being affected by the virus. One of the hardest-hit cities is Milwaukee, Wisconsin; [ProPublica did some of the first in-depth research](#) into how the virus has impacted the black community there. In Milwaukee only 26% of the population is Black yet [81% of the cases](#) and [73% of the deaths](#) are Black. This is particularly disturbing when you consider the virus did not start there. “[The](#)

[coronavirus entered Milwaukee from a white, affluent suburb. Then it took root in the city's black community and erupted](#)".

In addition to Milwaukee, Blacks are accounting for a majority of the COVID-19 deaths in other cities including [Chicago](#), [Louisiana](#), and [Washington, D.C.](#) Sadly, [all 12 who have died in St. Louis](#) have been Black (as of April 8th). Nationwide, Blacks are nearly 6 times more likely to die of COVID-19 than Whites. According to [the New York Times](#), the Black death rate from this virus is 6.3 per 100,000 compared to 1.1 per 100,000 for Whites.

A recent analysis done by the UTHealth School of Public Health maps the areas in [Dallas](#), [San Antonio](#), [Austin](#), and [Houston](#) that they believe will have the highest number of COVID-19 cases. Their analysis shows that the areas of our major cities where people of color reside stand a greater chance of being impacted by COVID-19. Preliminary data shows Houston has recorded 1,380 coronavirus cases and [of the 12 that have died, 8 were Blacks, 2 Latinos, and 2 Whites.](#)

The reasons why COVID-19 is inordinately affecting the Black community are two-fold, the obvious one being that Blacks and all people of color generally have less access to care. The second one can't be seen and is the link science has shown between stress, the body's production of Cortisol, and how the [increased amounts of stress in Black lives lead to cortisol](#) increases that then increases the number of cases of [hypertension](#), [diabetes](#), and [heart disease](#). As Charles Blow lays out in [the New York Times](#), COVID-19 is more deadly among people who have high blood pressure, diabetes and/or heart disease. High blood pressure is most common in Blacks; Black people have the highest death rate from heart disease and the risk of diabetes is 77% higher for Black than Whites.

African Americans by percentage of population and share of coronavirus deaths

Only a few jurisdictions publicly report coronavirus cases and deaths by race.



Source: Johns Hopkins University, state health departments and American Community Survey
Chart Created by the Washington Post

Impact on Latino Communities

Much of the early analysis has been focused on COVID-19's impact on the Black community. But that does not mean other communities of color are not badly impacted by the coronavirus. On Wednesday, April 8th the [New York Times](#) reported that data from New York City's health department indicated that New York's diverse Latino population — about 29% of the city's population — represents nearly 34% of the patients who had died of COVID-19 as of Monday. Black people accounted for almost 28% of the city's COVID-19 deaths and 24% of the population. White people — about 32% of the city's population — made up only 27% of its COVID-19 deaths. Perhaps more telling is the [rate of deaths per 100,000 population](#), which indicates both Latinos and Blacks must deal with racial health disparities in the epicenter of the pandemic in the U.S. [The Boston Globe reports that the Coronavirus may be hitting harder in both Black and Latino populations](#) in Massachusetts as well.

In other parts of the country where data is preliminary, including states along the Mexican border, we have not seen coronavirus peak yet. However, the threats of the Trump administration's immigration policy could make many Latinos hesitant to seek medical help. [Public health experts say fears of seeking out care are very real among immigrants](#) and that could impact immigrant families, the clinicians who serve them, and the general population.

For example, [early data from Los Angeles](#) shows that Latinos, who make up almost half of the city's population, only account for 28% of the deaths, while Blacks - 9% of the population – represent a higher death rate, with 17% of the deaths. However, these numbers represent only 57% of the deaths for which there is racial and ethnic data, which is a persistent problem in analyzing racial disparities.

Former LSG member, Congressman Joaquin Castro, explained why Latinos will likely be heavily impacted by COVID-19, to [the Hill](#):

“Locally, we are already seeing evidence that communities of color, including immigrant communities, have higher rates of coronavirus cases, even though testing is still not widely available...We also know that Latino communities are especially vulnerable since they are more likely to be un- or underinsured, do not have equal access to health care services and less than 1 in 5 Latino workers can work from home.”

Disparities in Economic Impact

We must remember that our economy will only recover when people are safe and healthy enough to go back to work. Public health and scientific experts have warned us that the Coronavirus will still be around until a vaccine and treatments are developed. Trying to get back to “normal” too quickly could cause the number of cases of COVID-19 to spike again. Regrettably, getting back to normal will be more difficult for communities of color. Many people of color have still not fully recovered from the 2008 Great Recession, which hit people of color [worse](#) than Whites. And now, we are [almost certainly in a recession](#).

Additionally, more needs to be done at the Federal level to provide racial equity when helping businesses through the coming months. For example, in the 2.2 trillion-dollar CARES Act, minority businesses were overlooked. The Act only allocated [\\$10 million](#) to the Minority Business Development Agency (MBDA).

Congressman Castro, chairman of the Congressional Hispanic Caucus, said to [The Hill](#), “If just 16% of Latinos can work from home, that means that the vast majority of Latino workers are either being forced to risk their health and keep working through the crisis, or have lost their income or their job.

Conclusion

The LSG and its members will continue working, as we have for more than a quarter of a century, to eliminate health disparities in the state of Texas. We worked to establish the Health Disparities Task Force and the Interagency Council for Addressing Disproportionality, which would later be renamed The Office of Minority Health Statistics and Engagement (OMHSE). LSG members fought to preserve the OMHSE, and given the impact that the COVID-19 pandemic has had on people of color in our communities, we must work to address this life and death issue next session, reinstate OMHSE, and

more. As always, the LSG will provide evidence-based policy recommendations to its members, and when it comes to public health, we are demanding that the state collect and provide more accurate and complete data related to health disparities. Together, the LSG will continue our work on this most important issue, and through our efforts, we can and will ensure the COVID-19 response and recovery are carried out in an equitable way.