Moving Toward
A National Black Health Agenda

What African Americans Want from The Democratic and the Republican Party in Healthcare

ADDRESSING SOCIAL DRIVERS of HEALTH

NATIONAL BLACK CHURCH INITIATIVE
www.naltblackchurch.com

The National Black Church Initiative (NBCI)
Rev. Anthony Evans, President
Dr. Joseph Webster, Chief Clinical Officer

AMERICAN CLINICAL HEALTH
DISPARITIES COMMISSION INC.

Power concedes nothing without a demand. It never did and it never will. Find out just what any people will quietly submit to, and you have found out the exact amount of injustice and wrong which will be imposed upon them, and these will continue till they are resisted with either words or blows or with both. The limits of tyrants are prescribed by the endurance of those whom they oppress."

Frederick Douglass

The National Black Church Initiative would like to thank our churches and supporters for their continuous belief in our mission and the revelation of God through Christ. We would like to thank Mr. William Joseph, Dr.. Joseph Webster, Dr. James McCoy, Ms. Christina Epperson, the Rev. Thomas L. Hart, the Rev. Sheldon Williams, and the Rev. Lawerence Acker

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"Bringing people together to serve humanity"

July 22, 2024

Honorable Joe Biden
President, United States of America
1600 Pennsylvania Avenue NW
Washington, DC 20500

Honorable Kamala Harris
Vice-President, United States of America
1600 Pennsylvania Avenue NW
Washington, DC 20500

Honorable Donald Trump
Former President, United States of America
Republican National Committee (RNC)
310 First St SE
Washington, DC 20003

Honorable Senator JD Vance
288 Russell Senate Office
Washington, DC 20510
Republican VP Nominee
US Senate

Honorable Senator Charles E. Schumer (D-NY)
Majority Leader
US Senate
Hart Senate Office Building, 322
Washington, DC 20510

Honorable Mike Johnson (LA-04) Speaker of the United States
House of Representatives
U.S. House of Representatives
217 Ford House Office Building.
Washington, DC 20515

Chairman Jaime Harrison
Democratic National Committee (DNC)
430 South Capitol Street SE
Washington, D.C., U.S.

Chairman Michael Whatley
Republican National Committee
310 First Street SE
Washington, D.C., U.S.

Honorable Sen. Kay Granger
Chairwoman
House Appropriations Committee
Republicans
H-307 The Capitol
Washington, DC 20515

Honorable Sen. Patty Murray Chairwoman
Senate Appropriation
Appropriations Committee Democratic 154
Russell SOB
Washington, D.C. 20510

Honorable Steven Horsford
Chairman
Congressional Black Caucus
House of Representatives
406 Cannon HOB.
Washington, DC 20515

THRU

African Methodist Episcopal Church
African Methodist Episcopal Zion Church
American Baptist Churches, USA
Berean Missionary Baptist Association, Inc.
Bible Way Church World-Wide, Inc.
Christian Methodist Episcopal Church
Church of God in Christ
Full Gospel Baptist Church Fellowship International
Greater Mount Calvary Holy Church
House of God International Bible Way Church of Jesus Christ
International Council of Community Churches
Mt. Calvary Holy Church of America
Christ Holy Sanctified Church
Mount Sinai Holy Church of America, Inc.
National Baptist Convention, USA, Inc.
National Baptist Convention of America International, Inc.
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National Primitive Baptist Convention, USA, Inc.
Pentecostal Assemblies of the World, Inc.
Progressive National Baptist Convention, Inc.
The Potter's House Church
The Union of Black Episcopalian
Full Gospel Baptist Church Fellowship International

Dear President Biden and Members of the 119th Congress,

NBCI is a coalition of 150,000 churches with 27.7 million members excited to share with you and the United States Congress our National Black Health Agenda. This agenda lays out a budgetary priority to eliminate African American morbidity and mortality.

According to the Washington Post article titled, Black Communities Endured a Wave of Excess Deaths in the Past 2 Decades, America's African American communities experienced an excess of 1.6 million deaths compared with the White population during the past two decades. This devastating loss comes at a cost of hundreds of billions of dollars, as highlighted by recent studies, encompassing a generation of research into health disparities and inequity (JAMA Network Open. 2024;7(1):e2353626. doi:10.1001/jamanetworkopen.2023.53626, JAMA. 2023;329(19):1662-1670. doi:10.1001/jama.2023.7022).

Reducing the negative impact on quality of life and the psychosocial, and economic burden caused by lack of access to high-quality affordable healthcare is a main concern of forty-two million African American voters. We will vote according to our health interests irrespective of political party.

Our nation must ask the critical question: Do Black lives truly matter? Why is the United States unwilling to spend the necessary money to curtail and eliminate health disparities and death and dying after 500 years in this country? What is the central question here? Racism is the primary reason for the unfolding of this American tragedy. The Black Church demands that the US Congress does something to fix this problem, immediately.

The Black Church will not sit by and allow this to happen without a fight. We are willing to utilize all of our moral power and authority through the exercise of the vote. We will force this issue of the value of African American humanity at the ballot box in 2024 if necessary. Over the next ten years, we will apply multiple strategies to awaken the congress to the urgency of this crisis.

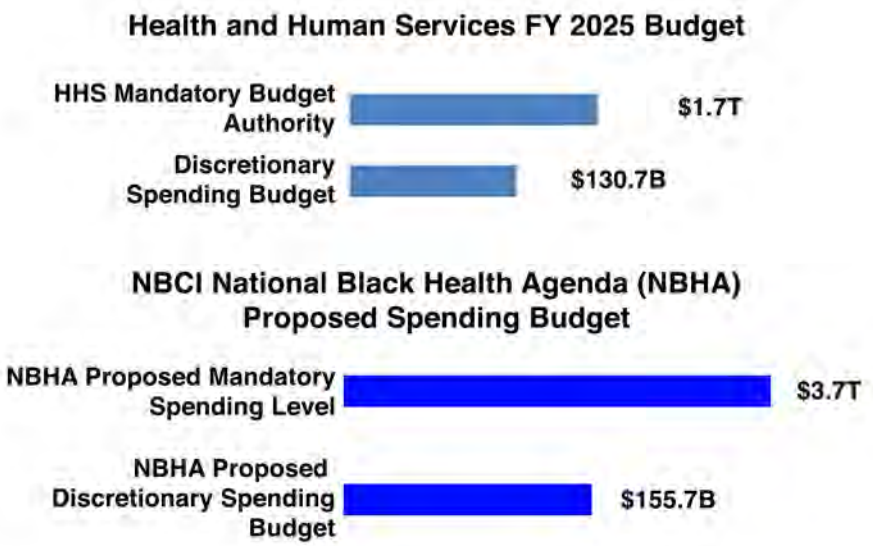
Every leading expert in health disparities, including the Center for Budgetary Priorities, has said that this investment will strengthen our nation and produce huge savings in the future. Dr. David Satcher, former Director of the Health Leadership Institute and Center of Excellence on Health Disparities at Morehouse School of Medicine and the 16th Surgeon General of the United States, and Dr. Thomas LaVeist, Dean of the Tulane University School of Public Health and Tropical Medicine both came to the realization that an enormous investment into African American health is critical to the moral economic future of our nation. These two leading African American experts, with a combined expertise of over 100 years in addressing health equity, have created a blueprint for our country to drastically curtail the negative health outcomes and start us on a path to eliminating health disparities over the next 10 years. They agree that the efforts put forth in this report by Reverend Anthony Evans and leading African American clinicians, is not only a good start, but also a critical gesture of commitment to the health and well-being of the African American Community by turning 50 years of government reports on health disparities into concrete action.

Since the Heckler Report in 1985, issued by then Secretary of Health, Education, and Welfare Margaret Heckler, there have been mainly only words and studies. With input from community stakeholders and clinical experts, for the first time since the Heckler Report, the National Black Health Agenda has moved to change those words into solid, concrete action, starting in 2025. We believe that a $2.25 trillion down payment is a good starting point.

The President's Fiscal Year (FY) 2025 Budget supports the Department of Health and Human Services (HHS) mission to promote the health and well-being of all Americans. However, we believe the budget does not include sufficient fundings for African Americans given the health inequities previously identified. HHS proposes $1.7 trillion in mandatory budget authority with an additional $130.7 billion in discretionary spending for FY 2025.

The 2025 HHS budget is woefully inadequate to address any of the issues concerning health disparities and the disproportionately high rates of morbidity and mortality among African Americans.

NBCI's National Black Health Agenda (NBHA) is calling for an additional $2.25 trillion increase in mandatory spending for enrollment at the (FY 2021-2024 COVID) level for Medicaid and Medicare in the mandatory budget, bringing the total mandatory budget to $3.7 trillion and an additional $25 billion in discretionary spending which will bring the discretionary budget to $155.7 billion. By increasing the mandatory spending to COVID levels, we will avoid tens of thousands of exacerbated illnesses and premature deaths among African Americans, saving an average of between$280-$300 billion a year, as cited by leading healthcare experts.



This will address and, ideally, eliminate health disparities among African Americans, significantly reducing morbidity and mortality and generating prolific annual healthcare savings. It has been reported in the Washington Post article, "Black Communities Endured Wave of Excess Deaths in Past 2 Decades", studies find that the aforementioned health disparities gap translates into 80 million years of potential life lost — years of life that could have been preserved if the gap between African American and White mortality rates had been eliminated.

This means, all those individuals could have been paying taxes and contributing to the wealth of the nation. Our report determined that the price society pays for failing to achieve health equity and allowing African American people to die prematurely was $238 billion in 2018 alone, without measuring the inflationary impact.

According to the Center on Budget and Policy Priorities June 2024 report titled, "More Revenue is Required to Meet the Nation's Commitments, Needs, and Challenges",

"*policymakers should use the scheduled expiration of most provisions of the 2017 tax law in 2025 as an opportunity to bolster the revenue base." To meet our commitments to seniors, make high-value investments that will improve well-being broaden prosperity, and improve our fiscal outlook, we must raise more revenue. Simply put, we cannot meet 21st-century needs with past levels of revenue.*"

All of this corroborated by Dr. Thomas LaVeist's argument in his books Race, Ethnicity, and Health: A Public Health Reader and Minority Populations and Health: An Introduction to Health Disparities in the United States, on financing healthcare.

Allowing President Trump's tax cuts to expire would allow for significant room and savings to tax corporate earnings that have experienced a 10-year revenue boom through today. President Trump's and Reagan's concepts of trickle-down economics have been memorialized in a catchy phrase by economists. However, in reality, the trickle-down economic theory does not work. Simply put, corporations do not, as a matter of policy, tell the federal government that they are paying too little taxes. The savings we propose from eliminating President Trump tax cuts should be used as a down payment to eliminating African American morbidity and mortality as cited in this report.

Additionally, these savings are never passed down to the poor. The rich keep them. Thus, corporations experience a windfall with little to no taxes and maximum profits. Health experts argue that these extra revenues that can be taxed by the federal government can pay for the additional $2.25 trillion requested by NBCI to drastically curtail the morbidity and mortality of African Americans in this country.

We are requesting an increase to the budget by $2.25 trillion to restore the healthcare of the 15-20 million uninsured who received temporary coverage under the pandemic emergency. authorization. The current budget does not address that priority. The fulfillment of our request will give us as a nation a fighting chance to finally create a foundation to address and begin to eliminate health disparities over the next ten years. As cited above, we have been discussing this since 1985, and there have been thousands of health disparities reports on how to do it with no concrete progress being made. Today that changes with this bold request.

In figure 1, we have outlined what we believe should be the spending priorities with the additional $25 billion requested in the discretionary budget.

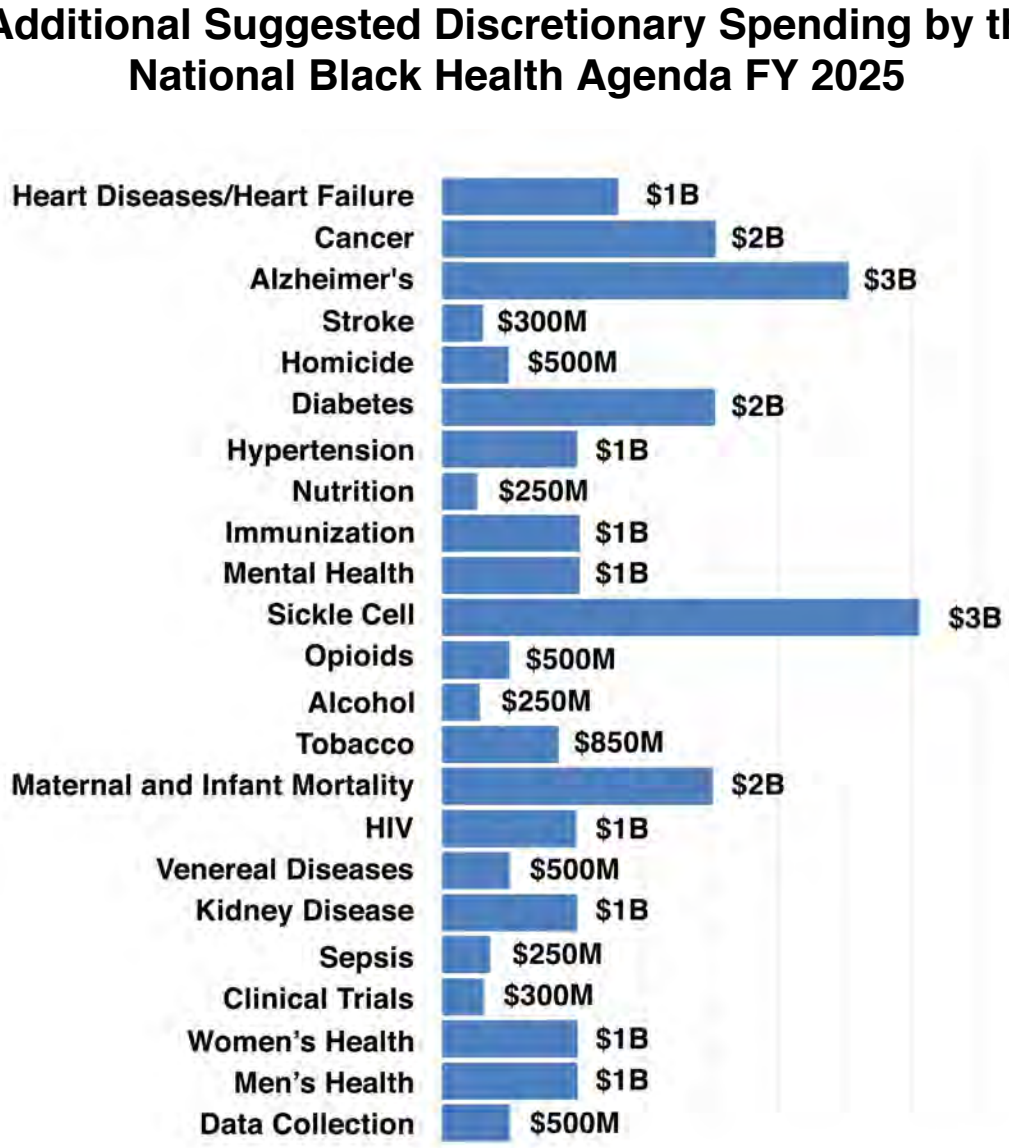


Figure 1

Finally, NBCI's NBHA requests that Congress establishes the American Clinical Health Disparities Commission as an independent agency under the Office of the Secretary of HHS with independent spending authority of one-third of the HHS discretionary budget with the mandates of strategic spending to help eliminate health disparities in under-represented communities.

NBCI's purpose is to partner with major organizations and officials whose main mission is to reduce racial disparities in the variety of areas cited in Figure 1. NBCI offers faith-based, cutting- edge solutions to effectively address economic and social issues. NBCI's programs are governed by credible statistical analyses and, evidence-based strategies and techniques that improve health outcomes. Through this proposal, you will see that our plan is researched, thoroughly calculated, and reviewed by some of the top health disparities experts in the country.

We look forward to working with you and the 119th Congress on this issue.

Rev. Anthony Evans
President
National Black Church Initiative

Rev. Edwin L. Jones, Ph.D.
Faith Christian University Church

Rev. Amos Ballenger
Mt. Zion Baptist Church

Rev. John Norman
Mt. Zion Baptist Church

Rev. Everett Harris
Mt. Zion Baptist Church

Rev. Winston C. Ridley, Jr.
The Greater First Baptist Church

Rev. Gerald L. Martin
Morning Star Baptist Church

Bishop Ode H. Hines
Greater Good Samaritan Baptist Church

Rev. William Calvert
Heavenly Bound Baptist Church

Rev. Virgil Murphy
Temple Missionary Baptist Church

Bishop Robert Wilson
Word Of Truth Church

Rev. Alex L. Lambert
St. Paul Baptist Church

Dr. A.H. Mark Dean
All For Jesus Scripture Art

Rev Marcus Tillman
First Baptist Church

Rev. Dr. Cynthia T. Turner
Dayspring Community Church

Rev. Luetilla Rodgers
Mt. Zion Baptist Church

Rev. Omar Buchanan
Mt. Zion Baptist Church

Rev. Harry Strong
Mt. Zion Baptist Church

Rev. Jeff Eddy
National Lay leader

Rev. Dr. Tom A. Bailey
Victory Temple Missionary Baptist Church

Bishop Scottie D Jackson
River of Life Pentecostal Church

Rev.. Robert Lawrence Earls, Sr.
St. John Baptist Church

Bishop Thomas P. Beale, Jr.
Church of the Way

Rev. Rodney Blackmon
Christian Unity Baptist Church

Bishop Harry Carter, Jr.
Zion Baptist Church

Dr. Anthony Mays
Breakthrough Bible College

Elder Willie R. Hunt
New Community Church of God In Christ

Rev. Aubrey C. Lewis, Pastor
St. Luke Baptist Church

Rev. Dr. Rudolph White, Pastor
New Southern Rock Baptist Church

Rev. Queen Shepherd, Pastor
Powerhouse Ministry International

Rev. Darrell Lewis, Pastor
Family Fellowship Church

Rev. Elijah Sutton, Pastor
Guildfield Baptist Church

Rev. Lloyd Fennell, Assistant Pastor
Guildfield Baptist Church

Rev. Dr. Cleophus W. Atkins, Pastor
Restoration Christian Fellowship Church

Rev. Arafa Speaks
New African Church

Rev. Anthony White, Youth Minister
New Southern Rock Baptist Church

Rev. Edward Cole
Associate Minister

Rev. Milton R. Baker
Christian Faith Center Ministry, Inc

Rev. Ruth Sutton
Guildfield Baptist Church

Rev. Ronald Patterson
Guildfield Baptist Church

Rev. Lanier C. Twyman, Sr.
St. Stephens Baptist Church

Rev. Betty Crawford
Guildfield Baptist Church

Rev. Alan Horton
Guildfield Baptist Church

Rev. Antonio Lowery
Guildfield Baptist Church

Guildfield Baptist Church

Rev. Tommy Lee Gilbert
Guildfield Baptist Church

Rev. Denise Mills
Guildfield Baptist Church

Rev. Teresa Blanks
Guildfield Baptist Church

Rev. Richard Winston
Guildfield Baptist Church

Rev. Matthew Robinson
Guildfield Baptist Church

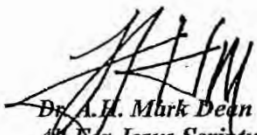
Rev. Eugene W. Wilson, Sr.
Wilson Ministries

Rev. Walter A. Pettiford, Sr.
New Beginning Ministries

Rev. Wilbert & Dolores Gray
PG Sheriff Office Chaplin

Rev. Larry Phillip McCray
Mt. Calvary Missionary Baptist

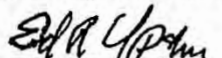
Rev. Jerome Williams
Williams Ministries



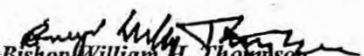
Dr. A.H. Mark Dean
All For Jesus Scripture Art

Rev Marcus Lamman
First Baptist Church

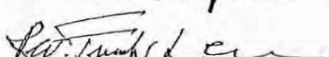
Rev. L.D. Williams
Divine Prosperity Baptist Church



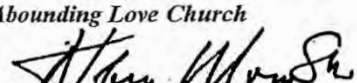
Dr. Edrick R. Upshur
New Generation Baptist Bible Church



Bishop William H. Thomason
Greater Praise Temple Ministries

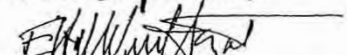


Frank A. Lee, Sr.
Abounding Love Church

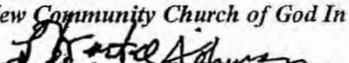


Rev. Albert W. Montgomery, Sr.
Agape Missionary Baptist Church

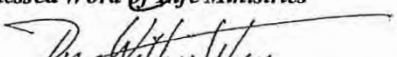
Dr. Anthony Mays
Breakthrough Bible College



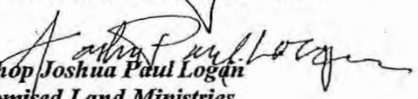
Elder Willie R. Hunt
New Community Church of God In Christ



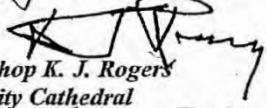
Bishop Dekontee L. Johnson
Blessed Word of Life Ministries



Dr. Williams Wright
Emmanuel Bible Fellowship Church



Bishop Joshua Paul Logan
Promised Land Ministries



Bishop K. J. Rogers
Unity Cathedral

Bishop M. Preston Stancil
Providence Harvest Church

Cc:

Rev. Tony Evans
Bishop T. D. Jakes
Dr. Frederick Douglass Haynes, III
Dr. Jamal Harrison Bryant
Bishop Rudy McKissick
Bishop W. Darrin Moore
Bishop Talbert Swan
Dr. Wendell Anthony
Dr. Traci Blackmon
Dr. Amos C. Brown
Pastor Corey Brown
Bishop John R. Bryant
Dr. Iva Carruthers
Dr. Delmon Coates
Dr. Jawanza Karriem Colvin
Dr. Marcus Cosby
Dr. Wayne Croft
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Rev. Leah Daughtery
Dr. Marcus Davidson
Bishop James Davis
Rev. Jacques D. Denkins
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Dr. John Faison, Sr.
Drs. Elaine and Floyd Flake
Rev. Willie D. Francois, III
Bishop Sam Green
Dr. Neichelle Guidry
Dr. Cynthia Hale
Pastor Victor T. Hall
Rev. J.C. Howard
Rev. Alexander E.M. Johnson

Dr. Jeffrey Allen Johnson, Sr.
Dr. Marcus D. King
Bishop Vashti McKenzie
Pastor Breonus Mitchell
Dr. Joshua L. Mitchell
Bishop Paul S. Morton
Dr. Otis Moss, III
Dr. James Perkins
Dr. Zina Pierre
President Welton Pleasant, II
Bishop Dennis Proctor
Dr. Nelson B. Rivers, III
Bishop Marvin Sapp
Drs. J. Alfred Smith Sr. and Jr.
Dr. Gina Stewart
Dr. Warren H. Stewart, Sr.
Dr. Alyn Waller
Dr. Lance Watson
Dr. Maurice Watson
Dr. Howard John Wesley

Dr. Ralph Douglas West, Sr.

Note additional signatures

Parks Chapel AME Church
Ever Increasing Faith Ministries
New Hope Baptist Church
Atherton Baptist Church
City of Refuge Church
City of Refuge UCC
Faithful Central Bible Church
Shiloh COGIC
Trinity Baptist Church
McCoy Memorial Baptist Church
Mt. Sinai Missionary Baptist Church
Tabernacle of Faith Baptist Church
Full Gospel Baptist Church
Greater True Light Missionary Baptist Church
Bryant Temple AME Church
According To Prophecy Ministries
Bethel Baptist Church
Christian Life Center
Grand Avenue Church of Christ
Faith Tabernacle COGIC
Grace Covenant Christian Church of the Harvest
Antioch C.O.G.I.C.
Rising Star Baptist Church
Front Land Church
Pilgrim Rest Baptist Church
Roosevelt Community Church
Immanuel Temple Apostolic Church
Integrity Christian Fellowship
Mesa View Baptist Church
New Paradise Baptist Church
Nu-Way International Christian Ministries
St. Stephen's Cathedral COGIC
Total Deliverance Worship Center
Voices of Victory Christian Ministries
Witness of the Word
Word for Life Ministries
Greater Victory Church
Third Baptist Church
Jones Memorial United Methodist Church
Providence Baptist Church
Calvary Hill Community Church
Rock of Ages Baptist Church

Community Baptist Church
First AME Church
Allen Temple Baptist Church
Paradise Baptist Church
Greater St. Paul Church
Temple Missionary Baptist Church
Life COGIC
Center of Praise Ministries
Christ Our Redeemer Church
Evergreen Missionary Baptist Church
Beth Eden Baptist Church
Harmony Missionary Baptist Church
St Andrew Missionary Baptist Church
Cornerstone Missionary Baptist Church
Bethany Baptist Church
Saints Rest Missionary Baptist Church
Victory Baptist Church
Greater St. John Missionary Baptist Church
Cosmopolitan Baptist Church
Crossroads Baptist Church
United Ministries
Bible Fellowship Missionary Baptist Church
Taylor Memorial United Methodist Church
Moriah Christian Fellowship Baptist Church
7th Avenue Baptist Church
Ephesian Missionary Baptist Church
Brookins Community AME Church
Greater Cooper AME Zion Church
St. Paul AME Church
New Vision Ministries
St Paul AME Church
St. John Missionary Baptist
Glorious Day Apostolic Church
St. Paul Baptist Church
Bethel Ministries
Victory Life Bible Church
St. Andrews AME Church
Antioch Progressive Church
Mount Calvary
New Hope Baptist Church
Del Paso Union Baptist Church
New Home Missionary Baptist Church
First AME Church

Into the World Ministries The Biblical Alternative
Friendship Baptist Church
Zoe Christian Fellowship of Long Beach
Community of Faith Bible Church
Saint Reed Missionary Baptist Church
Holy Name of Jesus Catholic Church
First Baptist Church of LA
Grace Baptist Church
The Resurrection Life Fellowship Missionary and Evangelistic Church
Bread of Heaven Ministries
Macedonia Christian Fellowship Church
Holy Deliverance Pentecostal Church
Second Baptist Church
New Creation Church of San Diego
West Angeles Church
Mt. Zion Baptist Church
Second Mt. Zion Baptist Church
Tabernacle Baptist Church
Sixth Episcopal District Headquarters
New Bethel AME Church
Behold the Light Christian Ministries
Beulah Missionary Baptist Church
Friendship Community Church
New Hope Baptist Church
New Life Ministries
Same Like Faith Family Christian Center Church
Triumphant Community Church
Friendship Baptist Church
Good Hope Missionary B.C.
Greenforest Community Baptist Church
Lovejoy Baptist Church
Mount Zion AME Church
Shaw Temple AME Church
St. James United Methodist Church
Greater Travelers Rest Baptist Church
Life Abundantly Christian Church
Blooming Lighthouse Ministries
Fully Rely on God Christian Min.
New Testament Christian Church Center
Nazareth Baptist Church
New Unity Christian Fellowship Church
Turner Chapel AME
Vison For Souls Family Worship Center
Word of Faith Family Worship Cathedral
The Enon Church
Word of Faith Love Center
World Changers Church International
Peace Baptist Church
New Beginnings Full Gospel Baptist Ministry
Big Bethel AME Church
New Birth Missionary Baptist Church
Salem Bible Church
Destiny Metropolitan Worship Church
Faith Christian Center
The Greater Piney Grove Baptist Church
Changing A Generation Full Gospel Baptist
Church Elizabeth Baptist Church
Cascade United Methodist Church
Jackson Memorial Baptist Church
Hillside International Truth Church
Berean Christian Church
Impact Church
Mount Zion Baptist Church
United for Christ Church
New Birth Community AME Church
Antioch Missionary Baptist Church
Bethel AME Church
Ebenezer Baptist Church
Evangel Fellowship C.O.G.I.C.
Lumberton First Baptist Church
Friendship Missionary B.C.
Lincolnville AME Church
Little Rock AME Zion Church
Night Light Missionary Baptist Church
Greater Salem Church
St. James AME Church
Saint Paul AME Church
The Park Church
Trinity AME Zion
Watts Chapel Missionary Baptist Church
Nehemiah Christian Center COGIC
Shiloh COGIC
New Restoration Community Church
Powerhouse COGIC
Macedonia New Life Church
The Fountain of Raleigh
Oberlin Baptist Church
Elevation Baptist Church
First Baptist Church
First Cosmopolitan Baptist Church
Tupper Memorial Baptist Church
Christian Faith Baptist Church
Oak City Baptist Church
Wake Chapel Church

St. Matthew AME Church
Living Waters AME Church
Union Hill AME Church
Emmanuel AME Church
Gaines Chapel AME Church
Holland Chapel AME Zion Church
Fair Promise AME Zion Church
Greater Bethel AME Church
Macedonia Baptist Church
First Baptist Church-West
St. Paul Baptist Church
Greater Mount Sinai Baptist Church
New Zion Missionary Baptist Church
Reeder Memorial Baptist Church
Greater Providence Baptist Church
New Hope Missionary Baptist Church
New St. John Baptist Church
Trinity Park Baptist Church
Second Calvary Baptist Church
Greater Galilee Baptist Church
Tabernacle Baptist Church
Walls Memorial AME Zion Church
New Covenant AME Church
Steele Creek AME Zion Church
Orange Grove Missionary Baptist Church
New Bethel Missionary Baptist Church
Simon Temple AME Zion Church
Piney Grove A.M.E. Zion Church
Harrison Chapel A.M.E. Church
St. Joseph AME Church
Mt. Zion AME Church
St. Luke AME Church
St. Julia AME Zion Church
Rockwell AME Zion Church
Reeves Temple AME Zion Church
Metropolitan AME Zion Church
Mayfield Memorial Missionary Baptist Church
Chapel Memorial Baptist Church
Springfield Baptist Church
St. Matthew Baptist Church
Baptist Grove Church
Morning Star Missionary Baptist Church
New Breed Community Church
First Calvary Baptist Church
Mount Vernon Baptist Church
Ebenezer Missionary Baptist Church
Peace Missionary Baptist Church
Community Baptist Church
North East Baptist Church
Greater New Birth Baptist Church
St. Johns Missionary Baptist Church
Lincoln Memorial-Baptist Church
Mt. Gilead Baptist Church
West Durham Baptist Church
New Metropolitan Faith Winners Baptist Church
Mount Level Missionary Baptist Church
Henderson Grove Missionary Baptist Church
First Baptist Church
New Ebenezer Baptist Church
New Hope Missionary Baptist Church
Emanuel AME Church
7th District AME Church
Bethel AME Church
Francis Burns United Methodist Church
Friendship Baptist Church
Union AME Church
Cumberland United Methodist Church
Progressive Church
New Light Beulah Baptist Church
Silver Bluff Baptist Church
First Providence Baptist Church
Friendship AME Church
Bible Way Church
Brookland Baptist Church
Genesis Church of God in Christ
Zion Baptist Church
First Nazareth Baptist Church
Second Nazareth Baptist Church
Greater St. Luke Baptist Church
New Ebenezer Baptist Church
Saint John Baptist Church
Ridgewood Missionary Baptist Church
Trinity Baptist Church
Gill Creek Baptist Church
Antioch Baptist Church
Cornerstone Baptist Church
Reid Chapel AME Church
Pine Grove AME Church
Columbia District AME Church
Bethel AME Church
Allen Temple AME Church
Morris Street Baptist Church
Morris Brown AME Church
St. Peter's AME Church

Pleasant Grove Missionary Baptist Church
Mt. Prospect Baptist Church
Corinth Baptist Church
Royal Missionary Baptist Church
Spring Hill AME Church
Greater Saint James AME Church
Moncks Corner AME Church
Mt. Olive AME Church
Campbell Chapel AME Church
Mount Carmel AME Church
Adams Chapel AME Church
Mt. Lebanon AME Church
Beulah AME Church
Magnolia AME Church
Greater Saint Paul
Spring Hill AME Church
Mount Moriah Missionary Baptist Church
Union Baptist Church
Jerusalem Baptist Church
Victory Missionary Baptist Church
Mount Zion Baptist Church
First Mount Zion Baptist Church
Bethel AME Church
First AME Church
First Baptist Church
Allen Chapel AME Church
Ebenezer Baptist Church
New Mount Zion AME Church
Sixth Mount Zion Baptist Church
First Baptist Church
Breakforth Ministries and Consulting Inc.
High Street Baptist
Double Anointing COGIC
Bethel AME Church
Mount Zion African Baptist Church
Trinity Missionary Baptist Church
Pilgrim Baptist Church
Hill Street Baptist Church
First Baptist Church
Mount Zion AME Church
Chapman Grove Baptist Church
First Baptist Church
Ebenezer Baptist Church
Jerusalem Church Inc.
First Timothy Baptist Church
Centurion Apostolic International Ministries
New Birth Baptist Church
Southern Heights Church of Christ
Sweet Home Missionary Baptist Church
United Christian Church of God
Antioch Missionary Baptist Church
Greater St. Paul AME Church
Parkway Baptist Church
Logos Baptist Church
93rd Street Community Baptist Church
Mt. Hermon AME Church
Mt. Zion AME Church
Saint Paul AME Church
Bethel Naples AME Church
Bethel Punta Gorda AME Church
Martin Memorial AME Church
Universal Truth Center for Better Living
New Jerusalem Primitive Baptist Church
Allen Temple AME Church
St. Paul AME Church
Wayman Chapel
Saint Stephen AME Church
Mount Olive AME Church
Greater Grant Memorial AME Church
First Baptist Church
Bethel Baptist Institutional Church
Bible-Based Fellowship Church
Grand Central Progressive Missionary Baptist Church
Love Fellowship Christian Church
St. Joseph Missionary Baptist Church
Zion Hope Primitive Baptist Church
Greater Payne AME Church
Saint Mark AME Church
Mount Olive AME Church
New Bethel AME Church
Mount Olive AME Church
Carter Tabernacle CME Church
Greater Mt. Zion AME Church
St. James AME Church
Shekinah Glory Church of God in Christ
Mt. Zion Progressive Missionary Baptist Church
Turner Chapel AME Church
Greater Faith AME Church
Mt. Zion Primitive Baptist Church
Allen Chapel AME Church
Mount Zion Commandment Keeping Church of the First Born
New Mount Zion AME Church
Bethel Missionary Baptist Church
Greater Bethel AME Church

Temple of Praise Assembly
St. John AME Church
St. Paul AME Church
Scott United Methodist Church
Allen Chapel Ame Church Care
Bethel African Methodist Episcopal Church
Eastern Star Church
Greater Galilee Institutional Missionary Baptist Church
Holy Angels Catholic Church Indianapolis
Jones Tabernacle AME Church
Providence AME Church
Robinson Community AME Church
St. Philips Episcopal Church
Mount Zion Missionary Baptist Church
Mount Olivet Baptist Church
3rd Episcopal District
McKinley United Methodist Church
Omega Baptist Church
Higher Ground Always Abounding Assemblies, Inc.
Liberty Hill Baptist Church
Mega Church
New Jerusalem Baptist Church
Quinn Chapel AME Church
St. Paul AME Zion Church
Wayman AME Church
Antioch Baptist Church
Morning Star Baptist Church
Mt. Hermon Baptist Church
Olivet Institutional Baptist Church
East Mt. Zion Baptist Church
Providence Baptist Church
Mount Sinai Ministries
Affinity Missionary Baptist Church
Shiloh Baptist Church
Mt. Pleasant Baptist Church
Mount Olive Missionary Baptist Church
Good Shepherd Baptist Church

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Introduction

The United States is in an extreme state of emergency when it comes to the public health crisis of the African American population. As noted in the 2008 paper titled, "The Public Health Approach to Eliminating Disparities in Health", reducing and eliminating health disparities is a matter of life and death. Dr. David Satcher, former director of the Health Leadership Institute and Center of Excellence on Health Disparities at Morehouse School of Medicine and 16th Surgeon General of the United States in partnership with Eve J. Higginbotham, Vice Dean of Inclusion, Diversity, and Equity at the University of Pennsylvania's Perelman School of Medicine wrote the paper that served as a blueprint in approaching how to eliminate health disparities in the United States. Although written over a decade ago, the paper stands as a strong model by which we will utilize in our approach.

This is the impetus for the National Black Church Initiative and issuing to this nation the National Black Health Agenda. Satcher and Higginbotham lay out the basic operational blueprint in realizing the approach to drastically address and eliminate health disparities.

A PUBLIC HEALTH FRAMEWORK FOR HEALTH DISPARITIES

Public health is defined as "what we, as a society, do collectively to assure the conditions for people to be healthy."[6](p19) These "conditions" relate to the determinants of health and play a critical role in disparities: environment, biology and genetics, human behavior, and access to quality health care. We see access disparities evidenced by minorities being most likely to be uninsured, underinsured, under-served, and underrepresented in our national health care system.

Major disparities exist in different physical and social environments in the United States, and these factors account for 20% to 25% of the variations in outcome in morbidity and mortality[1]. For example, African American and Hispanic children are far more likely to grow up in communities near toxic waste sites compared with White children.[7] The impact of some environmental toxins has been well documented, and the general removal of lead from the environment was a great public health achievement of the past century[8]. Asthma, on the other hand, is a rampant epidemic largely environmental in nature that disproportionately affects minority children in emergency department visits, hospitalizations, and deaths, even though there is little difference in prevalence when compared with Whites[9].

Another recent study showed that urban children exposed to severe violence, including murder, were much more likely than children who had not been exposed to such violence to become victims or perpetrators of the same kind of violence later in life, even when controlling for socioeconomic status[10]. Furthermore, natural and human-made disasters such as Hurricane Katrina[11] or battlefield combat[12] increase the risk for posttraumatic stress disorder in both children and adults. To implement aggressive, targeted interventions, much more rigorous research is needed to fully understand the mechanisms by which environmental disparities influence behavior later in life and the impact that they have upon the brain.

The most sensitive of the determinants of health are biology and genetics, and because of histories of eugenics and other approaches that label and blame individuals, many stay away from this area. Genetics is responsible for 20% to 25% of variations in morbidity and mortality[1]. With increasing understanding of the human genome and the relationship between genetics and health outcomes, we see greater opportunities to intervene. As we move toward personalized health care, this area will increase in importance on the basis of knowledge of genetics and the ability to target interventions.

Human behavior is the most important determinant of variations in health outcomes. Lifestyle practices such as tobacco use, level of physical activity, nutritional habits, sexual behavior, and stress-coping mechanisms are key factors affecting health and account for more than 40% of variations in health outcomes[1].

Smoking is still the leading cause of preventable death in the United States, accounting for more than 430 000 deaths annually. The Surgeon General's Report on Tobacco Use Among U.S. Racial/Ethnic Minority Groups highlighted variations in smoking behavior and its impact on minority groups[13]. African American men have the greatest rate of lung cancer from smoking, and both African American men and African American women suffer disproportionately from cardiovascular disease. American Indian women have the highest rate of smoking during pregnancy, a major contributing factor in the high rate of infant mortality in that population. American Indian infants are twice as likely to die in their first year of life compared with their majority counterparts[2]. The impact of physical activity was highlighted in the Surgeon General's Report on Physical Activity and Health[14]. Another comprehensive study examined the impact of programs of physical activity and nutrition on the onset of diabetes among high-risk populations and demonstrated that they could significantly reduce the onset of diabetes, even in high-risk populations[15].

Today, the obesity epidemic in the United States disproportionately affects American Indians, African Americans, and Hispanics. For African Americans and American Indians, these effects are major concern, given the disparities that already exist for overweight and obesity: diabetes, cardiovascular disease, and cancer. Access to nutritious food and safe places to be physically active are critical for these groups.

THE PUBLIC HEALTH APPROACH TO ELIMINATING DISPARITIES

Given these determinants of health and their varying impacts on different groups in the United States, what is the public health approach to the elimination of disparities in health? The public health approach involves defining and measuring the problem, determining the cause or risk factors for the problem, determining how to prevent or ameliorate the problem, and implementing effective strategies on a larger scale and evaluating the impact[16]. In order to eliminate disparities in health, the public health approach must take place in the context of a balanced community health system, which includes health promotion, disease prevention, and early detection, moving towards universal access to health care.

Measuring the magnitude and distribution of a problem in different populations, generally through surveillance or screening, not only defines the problem but also helps to define the success or failure of the intervention. Analyzing surveillance data and distributions determine associations or risk factors for the identified problem. Surveillance may include laboratory research to identify a virus or bacteria causing a problem or community-based research to evaluate the role of environment or behavior.

We must next determine what works to prevent or ameliorate the problem. If dealing with an infectious disease, the search for a vaccine may be critical. Many examples of success exist—one of the most dramatic was the development of the polio vaccine in the early 1950s. However, other problems such as obesity, hypertension, and diabetes require more complex solutions based on behavioral and environmental interventions. Once we have determined what works to prevent or ameliorate a problem, we then have the burden of implementing solutions on a larger scale and evaluating and replicating their impacts.

How then would we apply a balanced community health system to disparities in health? First, we must more aggressively target programs to groups suffering disproportionately from chronic diseases and their risk factors. Two key examples are the Action for Healthy Kids program and the 100 Black Men Health Challenge.

Former Surgeon General David Satcher and First Lady Laura Bush started the Action for Healthy Kids program in 2002. The goal of the initial conference was to follow through on The Surgeon General's Call to Action to Prevent and Reduce Overweight and Obesity, released in 2001[17]. More than 250 community leaders, legislators, and school system representatives attended a 2-day conference on the potential role of schools in combating obesity by helping children develop healthy lifestyles. The conference ended with a commitment to develop a nationwide program to fight obesity.

Volunteers worked with schools and school boards to implement programs of support for physical education in grades K–12 in an environment that modeled good nutrition. Within 1 year, all 50 states and the District of Columbia had Action for Healthy Kids programs. Schools were appropriate settings for such an effort because 53 million children attend school each day, schools provide opportunities for children to improve their lives and futures regardless of socioeconomic background or ethnicity, and schools may provide the opportunity for children to adopt healthy lifestyles of nutrition and fitness even when family and community cannot.

How could schools struggling with the No Child Left Behind Act and other efforts be expected to take on the added challenge of helping children develop healthy lifestyles? Many schools throughout the country raised this question, and a 2004 publication, The Learning Connection, answered that question[18]. Several studies showed that children who ate breakfast and were physically fit generally performed better on standardized exams, attended school more regularly, and concentrated on their work better, whereas children who were overweight and obese had a higher prevalence of depression and school absenteeism.

Many schools and districts throughout the nation are enhancing the content, frequency, and quality of their physical education programs and are developing model nutrition programs, including changing the content of vending machines and altering school meals. This effort received a major boost when Congress passed the Wellness Act of 2004, mandating that all schools or districts receiving federal funds for school meals implement wellness policies within 1 year[19].

Schools have begun to reach out to parents and communities with targeted programs supporting healthy lifestyles. According to Action for Healthy Kids reports, more than 70% of school districts have developed adequate policies to comply with the Wellness Act, and most other schools are working diligently to develop such policies[20]. Not only are minority and lower-socioeconomic-status children overly represented in public schools, especially those receiving federal support for meals, they also benefit disproportionately through school programs because they may not have adequate family and community support or resources for healthy lifestyles.

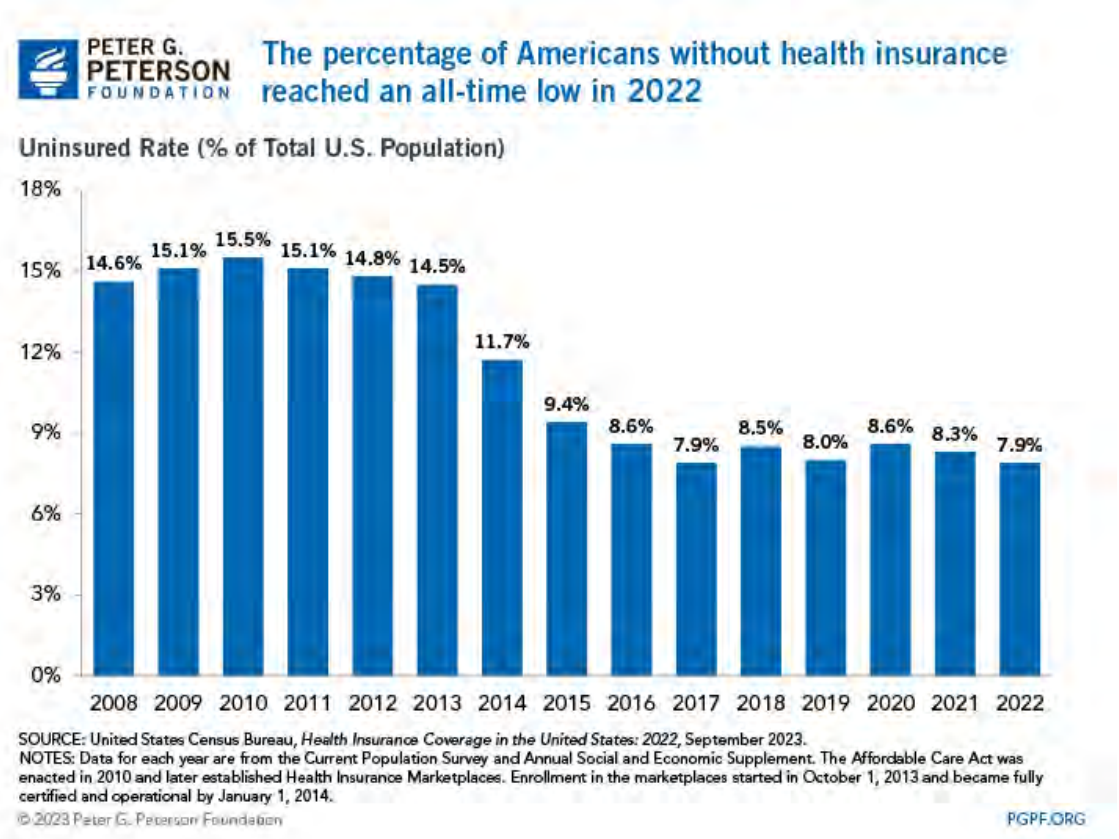
In a separate focus on adults, the 100 Black Men Health Challenge program started in 2002 with the Atlanta chapter of 100 Black Men out of concern that many African American men were becoming ill and dying well before the age of 70 (given that the national average life expectancy was over age 77 years), even in higher socioeconomic groups[21]. The 100 Black Men of America Inc is an organization of professional men who are of higher socioeconomic status and are committed to mentoring, tutoring, and supporting children and their families in lower socioeconomic communities; encouraging children to succeed academically; and guaranteeing scholarships for college. The success of this program is well documented in Project Success: Doing the Right Thing for the Right Reason and has been widely touted in the media[22].

In the pilot center for the study, our concern was first with the members of 100 Black Men themselves. Despite their career success, they suffered highly from health disparities, especially in cardiovascular disease, diabetes, and cancer. The 100 Black Men Health Challenge targeted these men with 3 major personal health goals. First, we wanted each man to get regular physical activity and good nutrition—especially increasing fruit and vegetable intake and reducing unhealthy calories. Second, we offered a smoking cessation program, and third, we wanted each man to regularly visit a primary care provider. We screened the men quarterly for weight, nutrition, physical activity, and prostate health when indicated. This program has been praised as one of the most successful interventions targeting African American men[23]. These men are now incorporating healthy lifestyle modeling and education for their mentees and increasingly are able to improve their community environments and support opportunities for healthy lifestyles.

Action for Healthy Kids and the 100 Black Men Health Challenge are quite different in location, style, target, and approach, yet each has the potential to reduce disparities and risk factors while also improving learning among children. The public health approach to eliminating disparities in health is being well modeled in these two programs and in others beginning to take place throughout the country. Given overwhelming evidence for the problems in disparities and the major risk factors involved, we develop programs to prevent or ameliorate the risks. Although Action for Healthy Kids is already being implemented nationally,

the 100 Black Men Health Challenge has primarily been modeled and evaluated in Atlanta. We will soon move our monitoring to other cities with chapters of 100 Black Men, and ultimately, to the more than 100 chapters nationwide. Strong support and funding for the national leadership of 100 Black Men has helped us to plan for the broad implementation of this program.

Each year in the United States, thousands of individuals die unnecessarily from easily preventable diseases and conditions. The reasons for the excess deaths and resulting economic toll are many, including mass incarceration, but the root is the same. According to the reports published in the influential medical journal JAMA, the unequal nature of how American society is structured is the origin of the issue (JAMA Network Open. 2024;7(1):e2353626. doi:10.1001/jamanetworkopen.2023.53626, JAMA. 2023;329(19):1662-1670. doi:10.1001/jama.2023.7022). This includes access to quality schools, jobs with a living wage, housing in safe neighborhoods, racism, health insurance and medical care — all of which affect health and well-being. Health experts call the summation of these issues and conditions the social drivers of health.



Thomas A. LaVeist, PhD
Dean of the Tulane University School of Public Health and Tropical Medicine

For centuries, Black people were legally deprived of these benefits, and researchers said we have yet to fully ameliorate the effects.

"Just to illustrate the issue, one of the clearest examples of structural racism was in 1935 when the Social Security Act was passed," said Thomas LaVeist, dean of the Tulane University School of Public Health and Tropical Medicine and the lead author of the study on the economic implications of health disparities. "They intentionally left out domestic workers and farmworkers who were disproportionately Black. That hasn't been fully unraveled."

The shorter life expectancy of Black Americans means they do not derive what they have invested in Social Security. People born in 1960 can start receiving their full Social Security benefits at age 67, but according to the Centers for Disease Control and Prevention, Black men born that year had an average life expectancy of just 61 years.[1]

Not only is that person paying into a system they are not fully benefiting from, but society is also losing "because that person isn't there as part of the economy," LaVeist said. "We've paid for schooling for this person, who gets a job and pays taxes and dies prematurely. The investment in that person is never recovered by society."

Per the aforementioned information, reducing and eliminating disparities in health is a matter of life and death. It is critical that we approach this problem from a broad public health perspective, attacking all the determinants of health: access to care, behavior, social and physical environments, and overriding policies of universal access to care, physical education in schools, and restricted exposure to toxic substances. We describe the historical background for recognizing and addressing disparities in health, various factors that contribute to disparities, how the public health approach addresses such challenges, and two successful programs that apply the public health approach to reducing disparities in health. Public health leaders must advocate for public health solutions to eliminate disparities in health.

This is why the request from the National Black Church Initiative in its National Black Health Agenda makes sense. It advocates for critical financial resources toward all the root causes toward the issue of health disparities as articulated by Dr. Satcher, who is viewed as the foremost authority on health disparities. By making such a substantial downpayment, you have begun to correct the problem and move toward the solution toward health equity and management.

As the COVID-19 pandemic made glaringly clear, our country does not prioritize the health of its citizens of color, more specifically the African American community. Many African American health experts believe that the country's error in allowing the dismissal of COVID-19 benefits was the root of many missteps as it pertained to the way the country handled the pandemic (Unwinding the Medicaid Continuous Coverage Requirement). The National Medical Association's President Dr. Yolanda Lawson noted that the lack of aid will continue to exacerbate health disparities. "

[1] United States 2018, H. (2018). HUS 2018 Table. Washington; Center for Disease Control and Prevention.

The number of Medicaid enrollees disenrolled since the end of the COVID-19 public health emergency has already surpassed the 15 million count initially projected by the federal government; yet about 40% of the eligibility redetermination process remains to be completed." notes Dr. Lawson. This view is also shared by Dr. Satcher and Dr. LaVeist. Recently, healthinsurance.org explained how the Medicaid disenrollments that began on April 1, 2023, are affecting health coverage and has affected the nation's health insurance landscape heading into the Medicaid unwinding a year ago. "It was clear the country was facing a monumental shift in healthcare, and the impact has been even larger than anticipated,"[2] said Louise Norris, a health policy analyst for the site.

It is important to remember that these aren't just numbers. Each disenrollment represents a person who experienced a significant change in their health coverage situation over the past year. And there are still hundreds of thousands of additional people likely to be impacted in the coming months. The question we must ask is what nation would allow two million of its citizens to die in twenty years with the most sophisticated healthcare system in the world and there is no public outcry or strategy? Can we call ourselves a humane society while continuing to allow the African Americans citizens to die at that dramatic rate?

Historically, the Black church has often been at the forefront of societal change. The National Black Church Initiative (NBCI) is a coalition of 150,000 African American churches that have a commanding presence in the life and culture of African Americans. As a leader in the community that plays a vital role in bringing every segment of the African American population together to rally around key social issues, it is paramount to not only speak on this crisis but construct a plan to move forward. NBCI has adopted an approach based on its recently launched National Clinical Trails Strategic Plan[3] and vows to implement the core principles of Dr. Stacher's vision in its faith-based communities all around America. NBCI churches are in every congressional district in the country and have urged their members to vote like their lives depend on it– because it does!

Dr. James A McCoy MD, FACS
Morehouse School of Medicine

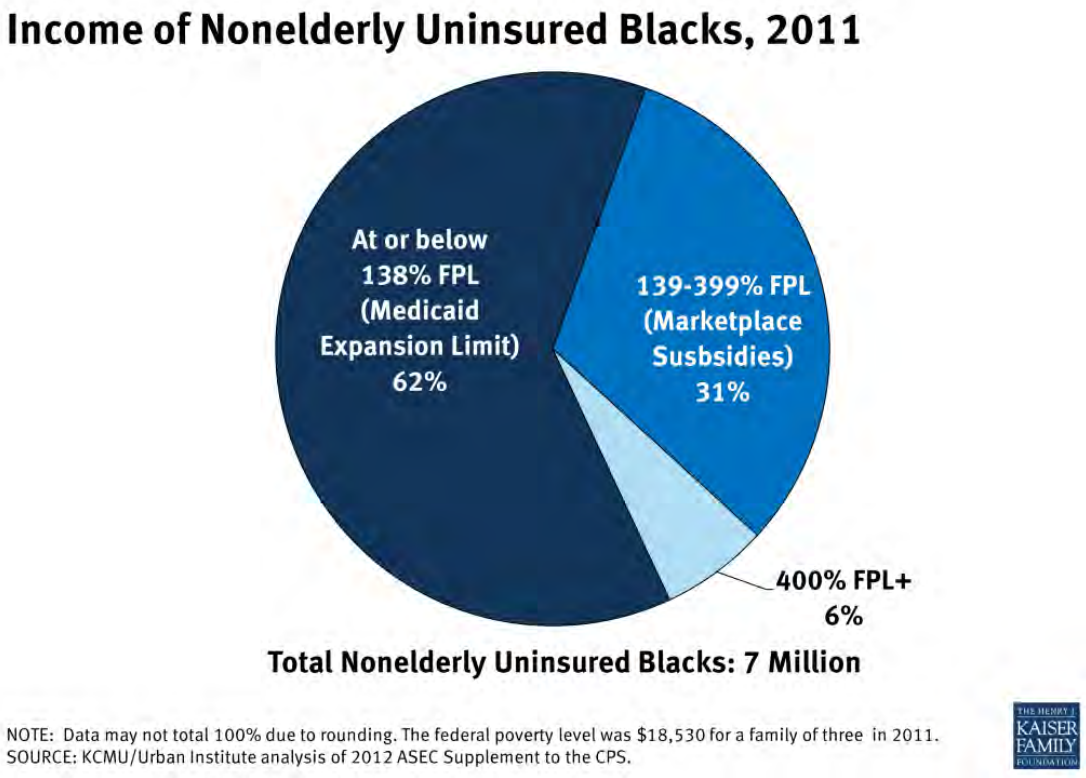
On a local and national level, the Black vote is extremely powerful. NBCI members alone constitute 27.7 million American voters. Both Democrats and Republicans recognize the significance and power of the black vote and how it can strongly impact political outcomes. NBCI has been preaching the good news of eliminating health disparities with your vote. Put simply, we are voting for the party and candidates who prioritize and vote to improve black lives and help NBCI eliminate health disparities. Disparities in health among different racial, ethnic, and socioeconomic groups in the United States are real and present a serious threat to our future as a nation. It is time for our leaders and communities to get serious about prioritizing the elimination of health disparities.

[2] "Medicaid Unwinding Approaches One-Year Mark: Disenrolled Count Surpasses Initial Expectations, Continues to Climb." *Healthinsurance.org*, 21 Mar. 2024, www.healthinsurance.org/newsroom/press-releases/medicaid-unwinding-approaches-one-year-mark-disenrolled-count-surpasses-initial-expectations-continues-to-climb/. Accessed 6 June 2024.

[3] https://blackchurchclinicaltrials.com

Much of the national discussion, reporting, and research on disparities in health focus primarily on differences in access to quality health care. Although critical to eliminating disparities, access only accounts for 15%-20% of the variation in morbidity and mortality that we see in different populations in this country.[4] According to the US Department of Health and Human Services (HHS), there are five key components that contribute to human beings being able to have an adequately healthy lifestyle. The social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[5] It is crucial for the success of any health-related initiative to look at it from this public health approach. Not only is it the only approach that is comprehensive and science-based enough to succeed in reducing and ultimately eliminating disparities, but it focuses on health promotion and disease prevention, which are not only more cost-effective but also more humane. It is imperative that public health leaders are ethically bound to promote and advocate for this approach. We propose a public health-oriented (preventive) strategy for eliminating health disparities that is more comprehensive and more likely than a biomedical (curative) approach to be successful in the long term.

NBCI has added real budget numbers that, according to health experts, if those spending levels are reached and maintained over ten years, it will go a long way in helping to build the framework in eliminating health disparities in our lifetime. There must be a regular overall commitment that will cover the cost of Medicaid and Medicare with each year having a supplement budget for not only shortfall but real growth to provide innovative and new drugs and therapies.



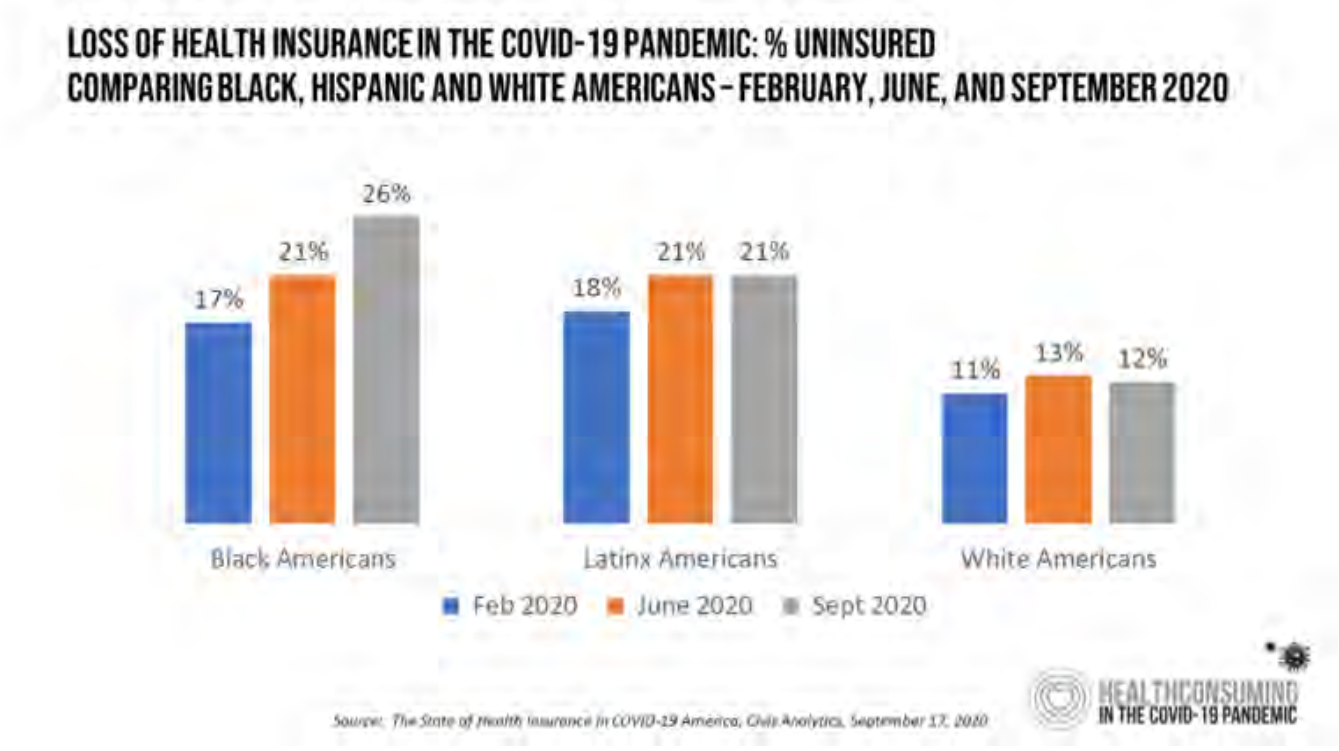
* Federal Poverty Level

https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-for-the-black-population-today-and-under-the-affordable-care-act/

[4] Satcher, David, and Eve J. Higginbotham. "The Public Health Approach to Eliminating Disparities in Health." *American Journal of Public Health*, vol. 98, no. Suppl 1, 1 Sept. 2008, pp. S8–S11, www.ncbi.nlm.nih.gov/pmc/articles/PMC2518593/#r1. Accessed 6 June 2024.

[5] https://health.gov/healthypeople/priority-areas/social-determinants-health

Transforming the American healthcare system is no small undertaking. We understand that this is a large task, requiring funding and other forms of support, however, through research and planning, we can ultimately prove to save the country money. According to Dr. Thomas LaVeist, in the article, “Estimating the Economic Burden of Racial Health Inequalities in the United States”, he lays out a strategic structure on how the nation can save tens of billions of dollars by forthrightly addressing the health disparities issue– an economic feat that could consequently allow funding to be allocated in other areas. The primary hypothesis of this study is that racial/ethnic disparities in health and health care impose costs on numerous aspects of society, both direct health care costs and indirect costs such as loss of productivity. The authors conducted three sets of analyses, assessing: (1) direct medical costs and (2) indirect costs, using data from the Medical Expenditure Panel Survey (2002-2006) to estimate the potential cost savings of eliminating health disparities for racial/ethnic minorities and the productivity loss associated with health inequalities for racial/ethnic minorities, respectively; and (3) costs of premature death, using data from the National Vital Statistics Reports (2003-2006). They estimate that eliminating health disparities for minorities would have reduced direct medical care expenditures by about $230 billion and indirect costs associated with illness and premature death by more than $1 trillion for the years 2003-2006 (in 2008 inflation-adjusted dollars). We should address health disparities because such inequities are inconsistent with the values of our society and addressing them is the right thing to do, but this analysis shows that social justice can also be cost effective.



https://www.healthpopuli.com/2020/09/17/only-in-america-the-loss-of-health-insurance-as-a-toxic-financial-side-effect-of-the-covid-19-pandemic/

Dr. Joseph Webster
NBCI Chief Clinical Officer

The President's Fiscal Year (FY) 2025 Budget supports the HHS' mission to promote the health and well-being of all Americans. HHS proposes $130.7 billion in discretionary and $1.7 trillion in mandatory proposed budget authority for FY2025. NBCI National Black Health Agenda (NBHA) is calling for an additional 2 trillion dollars with free enrollment at the FY2021-2024 COVID level for Medicaid and Medicare in the mandatory budget an additional $25 billion in discretionary spending which will bring the figure to $155.7 billion.

NBCI is requesting that the 2 trillion be used to restore the healthcare of the 15-20 million uninsured who received temporary coverage under the pandemic emergency authorization. Therefore, NBCI HBHA is requesting that spending levels for the HHS mandatory budget be capped at $3.7 trillion for FY 2025-2026 and the discretionary spending rise to $155.7.
NBCI is open to a discussion about reallocation/better use of existing funds as a way of resourcing this unmet need as opposed to suggesting raising taxes as the only option. Adoption of more Value Based payment models that reward outcomes versus simply paying for processes.

According to the Center on Budget and Policy Priorities June 2024 report entitled, More Revenue is Required to Meet the Nation's Commitments, Needs, and Challenges, "policymakers should use the scheduled expiration of most provisions of the 2017 tax law in 2025 as an opportunity to bolster the revenue base. To meet our commitments to seniors, make high-value investments that will improve well-being and broaden prosperity, and improve our fiscal outlook, we must raise more revenue. Simply put, we cannot meet 21st-century needs with past levels of revenue." All of this echoed Dr. Thomas LaVeist's argument on financing healthcare, further corroborating what we have addressed. By allowing President Trump's tax cuts to expire, it would allow for significant room to tax corporate earnings who have experienced a 10-year revenue boom through today. President Trump's concept of trickledown economics has been memorialized into a catchy phrase by conservative economists.

However, in reality, the trickledown economic theory does not work. Simply put, corporations do not, as a matter of policy, tell the federal government that they are paying too little taxes. Additionally, they never pass lower prices onto the consumer for their goods and services. Thus, corporations experience a windfall of little to no taxes and maximum profits. We strongly argue that these extra revenues that can be taxed by the federal government can pay for the additional $2 trillion requested by NBCI to drastically curtail the morbidity and mortality of African Americans in this country.

Furthermore, the Center on Budget and Policy Priorities makes its strongest case by stating, "Underinvesting in people, communities, and the building blocks of the U.S. economy increases poverty and hardship, worsens racial and ethnic inequities, shortchanges opportunity, and restrains economic growth." This argument further illuminates Dr. Thomas LaVeist as well as former surgeon general Dr. David Satcher's stance in their declaration of solving the economic issues surrounding health disparities.

Reverend Anthony Evans, president of the National Black Health Initiative and his 27.7 million members also give concrete evidence to these arguments. So, it doesn't become an issue of whether the argument is sound and makes economic sense, what it clearly says is that this nation refuses to spend the money needed to repair the health and wellness of African Americans. The Black church will not tolerate this and as such, we will use the full force of the Black church to make this a reality. This is why we're headed to the ballot box come November 2024.

We understand that our request is a large cost to bear, however, according to leading experts like Dr. LaVeist and Dr. Satcher, there will be a greater cost should we continue to ignore these needs. The health of African American citizens in this country can no longer go unprioritized. We believe you can offset this additional cost through 14 saving strategies, all listed and articulated in the heart of our proposal. We cannot estimate in real terms the cost savings that we know will be a result of the implementation, however, we must include and engage all major stakeholders to make sure that whatever is agreed upon is sustainable.

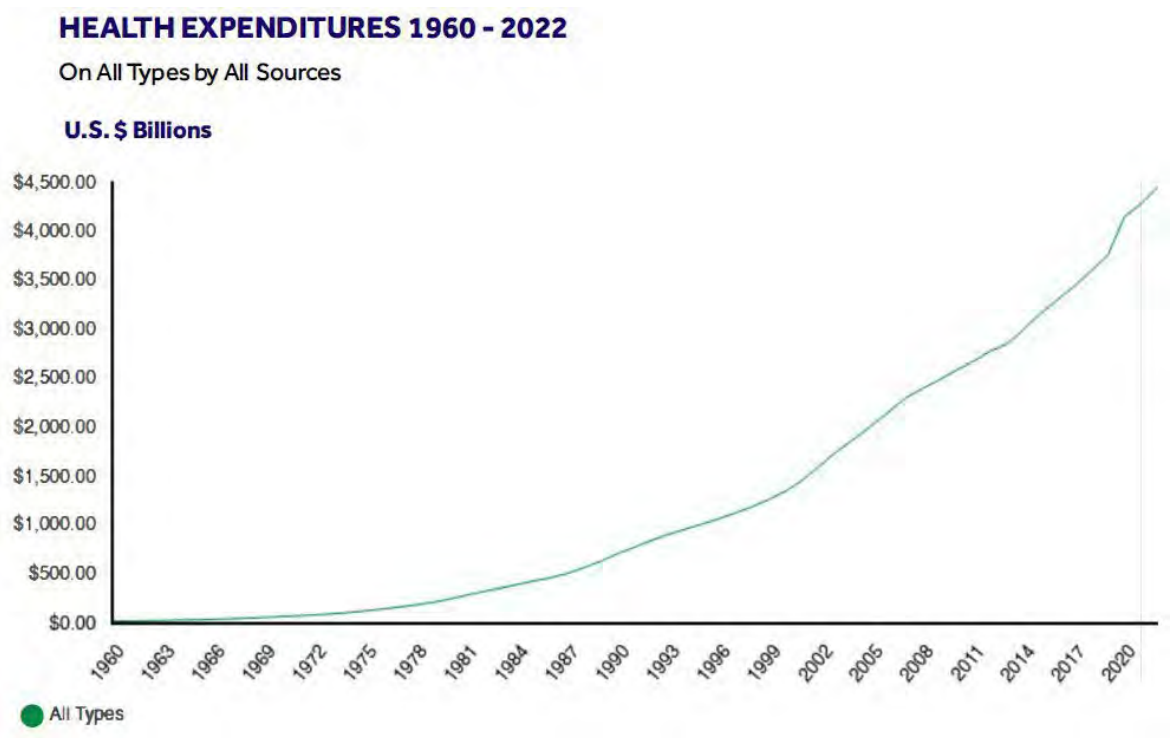
1. Allowing President Trump's tax cuts to die in order to have sufficient revenue to fund the ask of the $2 trillion. An additional $4.6 trillion including the cost of debt service would be saved over the next decade, according to the Congressional Budget Office.
2. The US Congress should ban private equity firms' investment to no more than 10% ownership of any patient delivery services including hospitals. Private equity is a direct threat to achieving any health disparities goals because of their sole profit motive objective. FRONTLINE and NPR investigate the growing inequities in American healthcare exposed by COVID-19. The Healthcare Divide examines how pressure to increase profits and uneven government support are widening the divide between rich and poor hospitals, endangering care for low-income populations.
3. The USA 'sick-based' healthcare delivery model needs to be transformed into a preventive health' model.
4. Deduct the Federal Assistance to the States dollar based on the Opioid Payout unless the state agrees to spend at least 99% of the dollars for Opioid care.
5. Center for Medicaid Services (CMS) hospital supplements should only go to those hospitals – rural or urban – that has a hospital based patient population that is at least 50% poor as defined by FPL. This figure is based on the current formula used by CMS. We are arguing that there will be a major realignment in CMS rules and regulations or the Congress to achieve the desirable outcomes.
6. Reform health insurance companies and reduce the 'automatic denial rate' for service to less than 75% and increase requirements for justification of denial
7. Place a moratorium on healthcare insurance premium increases for at least five years
8. Restore Rural and Critical Urban Hospitals that were closed within the last 7 years
9. Reform Urgent Care Centers and modernize them and their role in outpatient healthcare services.
10. Promote Alternative and Holistic Medicine and incorporate the Faith-based Community in re-envisioning a holistic design that amplifies preventive medicine.
11. Completely Reform and Restructure CMS including implement a plan to reduce waste, abuse and fraud in CMS by at least 75% by hiring an additional 5,000 'loss officers'
12. Implement a minimum of 17% or higher for people making more than $5 million annually.
13. Implement a 0.7% increase in Leisure Tax on guns, tobacco, alcohol, lottery tickets and travel.
14. Cancel two proposed new weapon systems from DOD budget that are projected to cost over $1TRILLION over the next 5 years.

Leading healthcare experts and the Center on Budget and Policy Priorities in their article "More Revenue is Required to Meet the Nation's Commitments, Needs and Challenges" agree that if the items listed above are fully implemented the federal government will save more than $3 – 5 TRILLION over the next 10 years.

To meet our commitments to seniors and underserved communities and make high-value investments that will improve well-being and broaden prosperity, and improve our fiscal outlook, we must raise more revenue. Simply put, we cannot meet 21st-century needs with past levels of revenue. As a first step, policymakers should use the scheduled expiration of most provisions of the 2017 tax law in 2025 as an opportunity to bolster the revenue base, not erode it by failing to pay for any tax cuts that are extended and potentially adding still more tax cuts for corporations and high-income households on top1.

Conclusively, we have a list of five primary requests that we are seeking to achieve in order to obtain our goal. This list is not the only way to achieve health equity, but it is a well-curated, thought-out plan to begin the journey to eliminating health disparities. It is our hope to begin to work on these together to see a better future for our country and African American citizens

1. The request of 2 trillion for the purpose of curtailing the morbidity and mortality of African Americans for the reasons previously stated + for the nation to finally address health disparities as it's costing us more money to ignore the issue
2. The NBCI Black health agenda is asking for consistent spending within discretionary spending on an average of $25 to specifically attack and in some cases eliminate health disparities through efficiency, technology, and additional funding
3. Spendings at level of a cure that directly impact African Americans for Hep-C and Sickle Cell with the crisper approach (we need the economics to cure African Americans of these problems)
4. 60% of discretionary spending will be for outreach and education– because we know they work and are effective. It will also include pre-diagnosis, immunization, and accurate statistical data to include that additional spending is vital to solving the problem (if you want to know if it works, here's the data to prove it)
5. In addition to prevention and increase spending, which we know will reduce the death and dying but the long-range health costs; If you spend now, you will save long-term in the future. Additionally, we have over 14 credible ways you can pay for this program over the next 10 years.



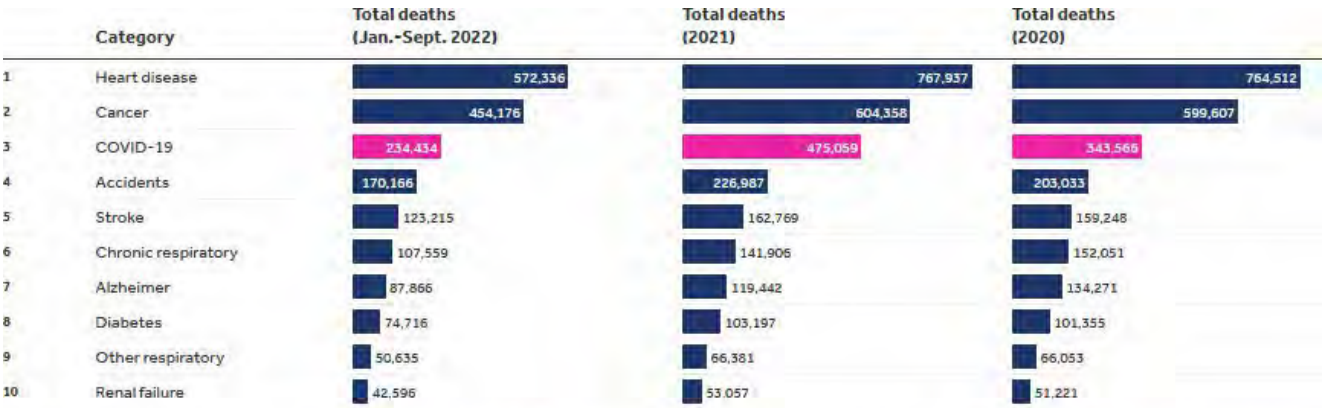
https://www.healthsystemtracker.org/health-spending-explorer/

We must work to eliminate all social determinants to give the African Americans in this country a fair and fighting chance. This will not be easy. It will take careful budgeting strategies and the will of the President, the Congress, and the American people to be serious about this fight and treating African Americans as citizens with their full rights as Americans. The cost saving of such an approach according to The Congressional Budget Office will save the country between 1.7 and 2.7 trillion dollars over 5 to 10 years when adjusted for inflation in 2024. NBCI believes it is the right of African American citizens to be afforded the same level of healthcare as every other citizen of this country. In order to achieve true health equity, we implore you to partake in this plan to eliminate health disparities in the United States.

Year	All Types	Total National Health Expenditures	Year	All Types	Total National Health Expenditures
1960	$27.12	$27.12	2004	$1,894.68	$1,894.68
1961	$29.06	$29.06	2005	$2,026.58	$2,026.58
1962	$31.77	$31.77	2006	$2,165.10	$2,165.10
1963	$34.56	$34.56	2007	$2,305.53	$2,305.53
1964	$38.25	$38.25	2008	$2,402.36	$2,402.36
1965	$41.63	$41.63	2009	$2,492.75	$2,492.75
1966	$45.75	$45.75	2010	$2,589.64	$2,589.64
1967	$51.19	$51.19	2011	$2,676.55	$2,676.55
1968	$58.02	$58.02	2012	$2,783.26	$2,783.26
1969	$65.42	$65.42	2013	$2,855.70	$2,855.70
1970	$74.08	$74.08	2014	$3,001.74	$3,001.74
1971	$82.38	$82.38	2015	$3,163.76	$3,163.76
1972	$92.39	$92.39	2016	$3,305.35	$3,305.35
1973	$102.65	$102.65	2017	$3,443.65	$3,443.65
1974	$116.34	$116.34	2018	$3,601.21	$3,601.21
1975	$132.67	$132.67	2019	$3,756.37	$3,756.37
1976	$152.03	$152.03	2020	$4,156.32	$4,156.32
1977	$172.65	$172.65	2021	$4,289.12	$4,289.12
1978	$193.96	$193.96	2022	$4,464.57	$4,464.57
1979	$219.69	$219.69	1999	$1,273.21	$1,273.21
1980	$253.23	$253.23	2000	$1,366.00	$1,366.00
1981	$293.57	$293.57	2001	$1,483.42	$1,483.42
1982	$330.94	$330.94	2002	$1,631.02	$1,631.02
1983	$364.81	$364.81	2003	$1,770.38	$1,770.38
1984	$401.90	$401.90	2004	$1,894.68	$1,894.68
1985	$439.88	$439.88	2005	$2,026.58	$2,026.58
1986	$472.28	$472.28	2006	$2,165.10	$2,165.10
1987	$514.47	$514.47	2007	$2,305.53	$2,305.53
1988	$576.65	$576.65	2008	$2,402.36	$2,402.36
1989	$642.18	$642.18	2009	$2,492.75	$2,492.75
1990	$718.73	$718.73	2010	$2,589.64	$2,589.64
1991	$785.97	$785.97	2011	$2,676.55	$2,676.55
1992	$852.20	$852.20	2012	$2,783.26	$2,783.26
1993	$914.87	$914.87	2013	$2,855.70	$2,855.70
1994	$966.37	$966.37	2014	$3,001.74	$3,001.74
1995	$1,020.28	$1,020.28	2015	$3,163.76	$3,163.76
1996	$1,073.56	$1,073.56	2016	$3,305.35	$3,305.35
1997	$1,132.95	$1,132.95	2017	$3,443.65	$3,443.65
1998	$1,198.44	$1,198.44	2018	$3,601.21	$3,601.21
1999	$1,273.21	$1,273.21	2019	$3,756.37	$3,756.37
2000	$1,366.00	$1,366.00	2020	$4,156.32	$4,156.32
2001	$1,483.42	$1,483.42	2021	$4,289.12	$4,289.12
2002	$1,631.02	$1,631.02	2022	$4,464.57	$4,464.57
2003	$1,770.38	$1,770.38			

COVID-19 is on track to be the third leading cause of death in the U.S. in 2022

Total deaths in the United States from COVID-19 and other leading causes, 2020-2022



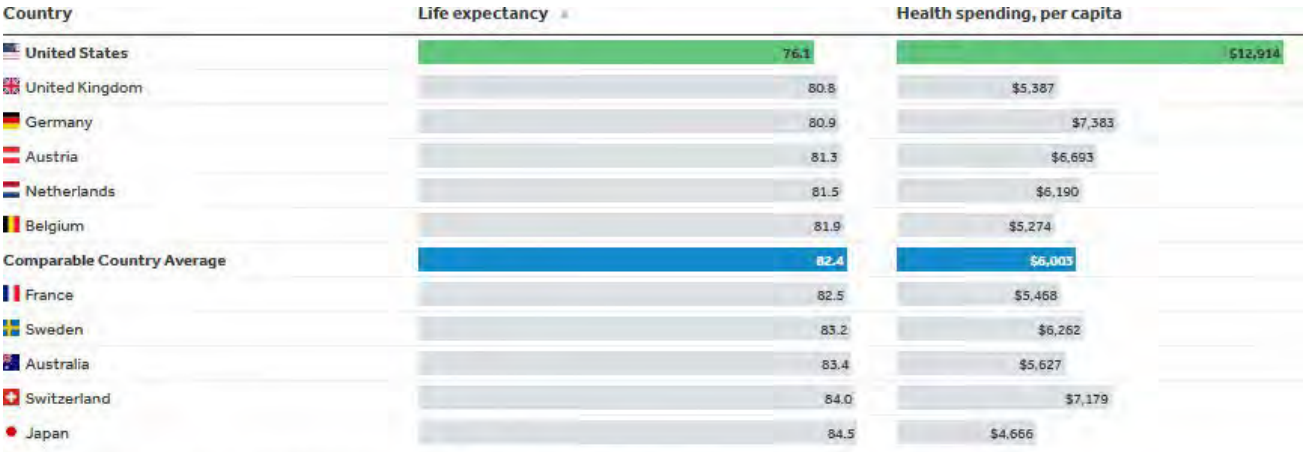
Notes: For 2022, the total death sum for each category is for January 1 - September 30, 2022, except deaths from accidents and suicides are from January - September 2021. Chronic respiratory is chronic lower respiratory disease.

Source: KFF analysis of CDC mortality and KFF COVID-19 tracker data • Get the data • PNG

Peterson-KFF Health System Tracker

People in the U.S. live shorter lives and spend much more on healthcare than people in peer countries

Total deaths in the United States from COVID-19 and other leading causes, 2020-2022



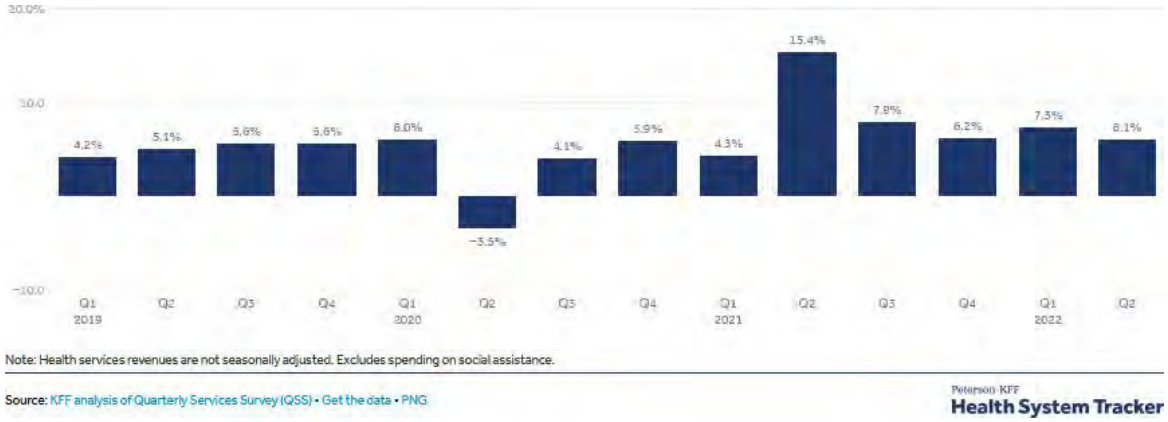
Notes: See Methods section of "How does U.S. life expectancy compare to other countries?"

Source: KFF analysis of CDC, OECD, Japanese Ministry of Health, Labour, and Welfare, Australian Bureau of Statistics, and UK Office for Health Improvement and Disparities data • Get the data • PNG

Peterson-KFF Health System Tracker

In 2022, spending on health services has grown at pre-pandemic rates

In 2022, spending on health services has grown at pre-pandemic rates



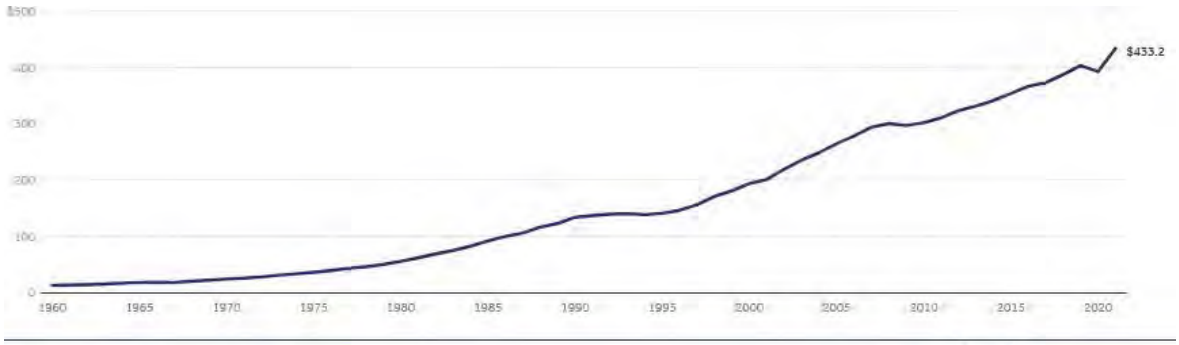
Note: Health services revenues are not seasonally adjusted. Excludes spending on social assistance.

Source: KFF analysis of Quarterly Services Survey (QSS) • Get the data • PNG

Peterson-KFF Health System Tracker

Out-of-pocket spending grew 10.4% between 2020 and 2021

Out-of-pocket spending, U.S. $ Billions, 1960-2021



Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

Peterson-KFF Health System Tracker

23 million people in the U.S. owe a total of at least $195 billion in medical debt

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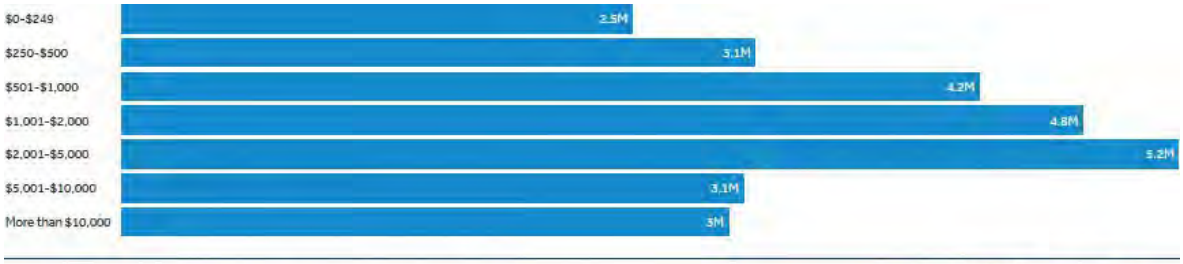

Source: KFF Analysis of U.S. Survey and Income and Program Participation (SIPP) data • PNG

Peterson-KFF Health System Tracker

The Washington Post
Democracy Dies in Darkness

Black communities endured wave of excess deaths in past 2 decades, studies find

The loss of life came at a staggering cost, medically and economically

By Akilah Johnson
May 16, 2023

A woman is treated for COVID-19-related pneumonia in the emergency department at Martin Luther King Jr. Community Hospital.
(Francine Orr / Los Angeles Times)

America's Black communities experienced an excess 1.6 million deaths compared with the White population during the past two decades, a staggering loss that comes at a cost of hundreds of billions of dollars, according to two new studies that build on a generation of research into health disparities and inequity.

In one study, researchers conclude that the gap in health outcomes translated into 80 million years of potential life lost — years of life that could have been preserved if the gap between Black and White mortality rates had been eliminated. The second report determined the price society pays for failing to achieve health equity and allowing Black people to die prematurely: $238 billion in 2018 alone.

“This is our collective challenge as a country because it hurts all of us deeply,” said Marcella Nunez-Smith, associate dean for health equity research at Yale University and co-author of the study on excess deaths and years of life lost. “All of the potential. Which one of those people whose life was cut short was on the way to some scientific discovery that would transform all of our lives or create beautiful art and music? Who among them was going to be a spiritual or religious leader? Not to mention the economic impact.”

The reasons for the excess deaths and resulting economic toll are many, including mass incarceration, but the root is the same, according to the reports published Tuesday in the influential medical journal JAMA: The Unequal Nature of How American society is Structured.

That includes access to quality schools, jobs with a living wage, housing in safe neighborhoods, health insurance and medical care — all of which affect health and well-being. For centuries, Black people were legally deprived of these benefits, and researchers said we have yet to fully ameliorate the effects.

“Just to illustrate the issue, one of the clearest examples of structural racism was in 1935 when the Social Security Act was passed,” said Thomas LaVeist, dean of the Tulane University School of Public Health and Tropical Medicine and the lead author of the study on the economic implications of health disparities. “They intentionally left out domestic workers and farmworkers who were disproportionately Black. That hasn’t been fully unraveled.”

And the shorter life expectancy of Black Americans means they do not derive what they have invested in Social Security. People born in 1960 can start receiving their full Social Security benefits at age 67, but according to the Centers for Disease Control and Prevention, Black men born that year had an average life expectancy of just 61 years.

Not only is that person paying into a system they are not fully benefiting from but society is also losing “because that person isn’t there as part of the economy,” LaVeist said. “We’ve paid for schooling for this person, who gets a job and pays taxes and dies prematurely. The investment in that person is never recovered by society.”

That comes at a significant cost in military readiness, in workforce fitness, in dollars and cents.
Researchers explored the economic burden caused by health inequities when someone dies prematurely or must pay out-of-pocket costs and third-party payments to health-care providers for emergency room visits, ambulance services, or vision and dental care.

They also calculated the economic toll when people can’t work because they or relatives are sick, or when employees show up to work but are less productive because they’re not well.

Expanding their analysis to a broader population, the researchers concluded that the failure to achieve health equity in 2018 cost the nation $1.03 trillion. That price tag includes the burden experienced by American adults older than 25 who do not have a college degree and by Native American, Asian, Black, Latino and Pacific Islander people.

More than two-thirds of the economic burden experienced by communities of color was attributed to premature deaths, with most of those untimely deaths coming from the Black community. Meanwhile, "adults with a 4-year- college degree had zero premature death costs," the report said.

For nearly 40 years, study after study examining disparate health outcomes in the Black community have started by referencing a landmark study on Black and minority health that came to be known as the "Heckler Report," so named because it was written when Margaret Heckler was President Ronald Reagan's health secretary. The two studies released Tuesday are no exception in citing that report, which attributed 60,000 excess deaths a year to health disparities as it became a clarion call to the nation.

"It's not just the '85 report, it's going back to 'The Philadelphia Negro' with W.E.B. Du Bois," which was published 124 years ago and was the first ethnography to outline problems faced by the Black community, said Darrell Hudson, who researches health disparities at Washington University in St. Louis. "The outcome is not new. Our understanding of the mechanisms, policies and practices have evolved."

In the decades since, modern medicine has witnessed major scientific discoveries and technological breakthroughs, but those advances haven't benefited everyone equally. When taken together, researchers say, the reports released Tuesday dispel several myths about how society has — and has not — responded to the alarm sounded more than a generation ago.

"We tend to have this idea as we move through time, we're constantly improving," said Jessica Owens-Young, an assistant professor in the Department of Health Studies at American University, where she researches health equity. But, she said, "we can't always assume that as we continue to innovate that is going to promote and protect people's health."

Nunez-Smith, who was chair of President Biden's Covid-19 Health Equity Task Force, said the report on excess deaths dispenses with the notion that the root causes of racial health disparities reflect "some deterministic factor that race is biological."

Nunez-Smith and the other researchers analyzed death certificates from 1999 through 2020 to reach their conclusions about excess deaths — the observed number of deaths vs. what would be expected if Black and White death rates were the same.

From 1999 to the early 2010s, the report found that the gap in excess deaths narrowed, dropping by about 48 percent for Black men and about 61 percent for Black women compared with their White counterparts. But then progress plateaued, the excess burden of death stubbornly persisting until it ballooned in 2020. Excess mortality during the first year of the coronavirus pandemic, the report said, exceeded that of any previous year of the study.

Infants bore the brunt of excess deaths and years of life lost along with adults older than 50. The death gap between men and women widened sharply, according to the report.

The leading causes of excess death and years of life lost, according to the study, include infant mortality, heart disease and cancer.

“These findings indicate that current efforts to curb or eliminate mortality disparities have been minimally effective, and progress, when made, has been fragile,” the report concluded.

The numbers represent something else, said Harlan Krumholz, a cardiologist at the Yale School of Medicine and co- author of the excess death study: a greater need to recognize “where we’re failing and the magnitude of the problem.”

“Why don’t we accept that this is really racism as cause of death?” Krumholz asked. “What other health problem has created that kind of loss?”

The study shows that, except for ages 1 to 10, Black males experienced the highest rates of excess death and years of life lost, a finding that Derek Griffith, director of Georgetown University’s Center for Men’s Health Equity in the Racial Justice Institute, said reinforces the need to consider the ways “anti-Black racism is gendered and use that as foundation for how we need to intervene.”

Griffith said the report mentions “structural racism, but it’s too blunt of an instrument. Anti-Black racism manifests in stereotypes and tropes. It’s that cultural narrative that shapes why it makes it okay for us to have these patterns.”

Many of those stereotypes are viewed through a gender lens, he said.

Research shows Black boys are often viewed as older, stronger and less innocent than their peers. Black men are seen as criminals, intellectually inferior, “deadbeat dads.” Black women are reduced to racist caricatures of lasciviousness, aggressiveness, the “welfare queen.”

“We don’t tend to think about the structural drivers of racial inequity in a way that is precise enough,” Griffith said. He noted that talking about Black men’s poor health outcomes often “gets uncomfortable. We try to deal with this as a race pattern without dealing with the gender pattern.”

Those differences are evident in how men are socialized to handle stress and their health. Also, researchers said, many government and health programs tend to be geared toward helping single mothers, but those same services aren’t available for men and single fathers.

“Over time, we find that socioeconomic status doesn’t protect in the same way it does for other people, especially for Black men who report more discrimination the more income and education they have,” Hudson, of Washington University, said.

Often, to seek out upward mobility, Black people have to cross boundaries, navigating mostly White spaces to get an education, earn a living, take out a loan, raise a child. That can prove caustic, Hudson said, because if someone is constantly crossing boundaries, they are constantly experiencing stress — or anticipating it. Stress is a physiological reaction, hard-wired. At the first sign of danger, the brain sounds an alarm, setting off a torrent of neurological and hormonal signals that flood the bloodstream. Overexposure to those hormones wears down the body, causing it to become sicker and age quicker, or "weather."

While weathering isn't specific to race, it is believed to take a particular toll on Black people because of the unique, unrelenting stress caused by racism. Research shows Black people have much higher rates of hypertension, obesity, diabetes and strokes than White people do, and they develop those chronic conditions up to 10 years earlier.

"Our bodies are not sophisticated enough to discern that this is not a lion on the savanna but someone who just looked at you funny," said Hudson, who calls it "the cost of upward social mobility."

But there is reason for hope, and it can be found in the period during the coronavirus pandemic when the gap between Black and White death rates began to shrink and even flip. In 2021, White people had the second-biggest drop in life expectancy, losing a full year while Black people lost 0.7 years, according to the CDC.

"And why was that happening?" asked Reed Tuckson, co-founder of the Black Coalition Against Covid. There are two reasons, he said. "One, of course, was the destructive messaging that came from many White political leaders but also the impact of the mobilization of Black faith and community-based organizations and social and fraternal organizations."

Tuckson, an internist and former D.C. public health commissioner, said the herculean efforts by the Black community "to fight for our lives" despite having meager resources show that it is past time for the federal government "to find a way to create sustainable, predictable funding at scale to support the Black community and its institutions."

"We have shown that we can catch up despite running a race with an anvil on our backs," he said.

By Akilah Johnson
Akilah Johnson is a national reporter exploring the effect of racism and social inequality on health for The Washington Post. She joined The Post in 2021 after working at ProPublica, where she won a George Polk award, National Magazine award, and was Pulitzer finalist for examining covid-19's toll on Black Americans. Twitter

JAMA | Original Investigation

Excess Mortality and Years of Potential Life Lost Among the Black Population in the US, 1999-2020

César Caraballo, MD; Daisy S. Massey, BA; Chima D. Ndumele, PhD; Trent Haywood, MD, JD; Shayaan Kaleem; Terris King, BS, MS, ScD; Yuntian Liu, MPH; Yuan Lu, ScD; Marcella Nunez-Smith, MD, MHS; Herman A. Taylor, MD, MPH; Karol E. Watson, MD, PhD; Jeph Herrin, PhD; Clyde W. Yancy, MD, MSc; Jeremy Samuel Faust, MD, MS; Harlan M. Krumholz, MD, SM

IMPORTANCE Amid efforts in the US to promote health equity, there is a need to assess recent progress in reducing excess deaths and years of potential life lost among the Black population compared with the White population.

OBJECTIVE To evaluate trends in excess mortality and years of potential life lost among the Black population compared with the White population.

DESIGN, SETTING, AND PARTICIPANTS Serial cross-sectional study using US national data from the Centers for Disease Control and Prevention from 1999 through 2020. We included data from non-Hispanic White and non-Hispanic Black populations across all age groups.

EXPOSURES Race as documented in the death certificates.

MAIN OUTCOMES AND MEASURES Excess age-adjusted all-cause mortality, cause-specific mortality, age-specific mortality, and years of potential life lost rates (per 100 000 individuals) among the Black population compared with the White population.

RESULTS From 1999 to 2011, the age-adjusted excess mortality rate declined from 404 to 211 excess deaths per 100 000 individuals among Black males (*P* for trend <.001). However, the rate plateaued from 2011 through 2019 (*P* for trend = .98) and increased in 2020 to 395—rates not seen since 2000. Among Black females, the rate declined from 224 excess deaths per 100 000 individuals in 1999 to 87 in 2015 (*P* for trend <.001). There was no significant change between 2016 and 2019 (*P* for trend = .71) and in 2020 rates increased to 192—levels not seen since 2005. The trends in rates of excess years of potential life lost followed a similar pattern. From 1999 to 2020, the disproportionately higher mortality rates in Black males and females resulted in 997 623 and 628 464 excess deaths, respectively, representing a loss of more than 80 million years of life. Heart disease had the highest excess mortality rates, and the excess years of potential life lost rates were largest among infants and middle-aged adults.

CONCLUSIONS AND RELEVANCE Over a recent 22-year period, the Black population in the US experienced more than 1.63 million excess deaths and more than 80 million excess years of life lost when compared with the White population. After a period of progress in reducing disparities, improvements stalled, and differences between the Black population and the White population worsened in 2020.

Supplemental content

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In 1985, the US Department of Health and Human Services (HHS) Secretary Margaret M. Heckler issued the Report of the Secretary's Task Force on Black and Minority Health, also known as the Heckler Report.[1] The landmark report found that the Black population had strikingly higher mortality rates than the White population, resulting in almost 60 000 excess deaths a year relative to the White population. Race offers no intrinsic biological reason for those categorized as Black individuals to have worse outcomes than White individuals, indicating therefore that these disparities are driven by the burden of acquired risk factors, influence of social determinants of health, limitations in access to care, and structural barriers indicative of bias (ie, structural racism).[2-9] Although these static disparities in mortality were and have since been documented, the cumulative magnitude of compounded inequities has not been well articulated. Such metrics, as they relate to racial disparities, can both focus national efforts and communicate progress (or lack thereof).

The Heckler Report focused on excess mortality, as had prior seminal academic reports by Du Bois and others.[10-13] Although comparative death rates are a common way to describe one aspect of health inequity, they do not constitute a summary measure and do not convey the impact of differences in mortality across different age groups. Quantifying excess years of potential life lost provides a complemental and deeper measure of the differential burden of excess mortality as a function of race by giving more weight to deaths at younger ages, thus addressing the impact on the social and economic loss from early deaths.[14,15] Communicating the mortality inequity within a population in terms of excess number of people lost or excess years lost may create the more compelling case for change in the underlying causes of these disparities. However, there is little recent information on the trends in years of potential life lost by race, especially so in Black populations compared with White populations. Because these mortality metrics call attention to the aggregate burden of health inequities, addressing this knowledge gap could motivate national reporting of excess deaths and reporting of years of potential life lost among the Black population.

Accordingly, excess deaths and years of potential life lost as metrics are presented herein to quantify, track, and drive change in the effect of health inequities on lives and years lost, placing in bright relief the health consequences of race in the US. Importantly, these metrics may summarize the inequitable loss of life in a form that can be readily communicated to the general US public as key—though not sole—indicators of the overall societal progress toward health equity. Over the most recent 22-year period for which data are available, the difference in mortality and years of potential life lost rates were calculated between the Black population and the White population in the US. These disparities were also investigated by causes of death and how they varied by age. Besides focusing on the period before the COVID-19 pandemic, this analysis focused on 2020 to provide an early perspective on differences attributable to the pandemic. These metrics can draw attention to the magnitude of the disparities, thereby attracting resources and promoting action to address the unmet need for progress.[16]

This study focuses on differences in non-Hispanic Black and non-Hispanic White populations to understand recent trends in disparities between these 2 specific groups, with the non-Hispanic White population as the reference group. Nevertheless, subsequent studies using data from other racial, ethnic, and socioeconomic groups would be needed to have a complete understanding of mortality inequities in the US.

Key Points

Question How many excess deaths and years of potential life lost for the Black population, compared with the White population, occurred in the United States from 1999 through 2020?

Findings Based on Centers for Disease Control and Prevention data, excess deaths and years of potential life lost persisted throughout the period, with initial progress followed by stagnation of improvement and substantial worsening in 2020. The Black population had 1.63 million excess deaths, representing more than 80 million years of potential life lost over the study period.

Meaning After initial progress, excess mortality and years of potential life lost among the US Black population stagnated and then worsened, indicating a need for new approaches.

Methods

Data Source

We used national US death certificate data from the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC WONDER) for the years 1999 through 2020.[17] For this period, we obtained the annual life expectancy by 5-year age groups from the National Center for Health Statistics life tables.[18] The Yale institutional review boards waived this study from review because it used deidentified population-level data that are publicly available; thus, it was designated as not human-participant research.

Study Population

We included data from the non-Hispanic Black or African American (hereafter Black) population and the non-Hispanic White (hereafter White) population. From CDC WONDER, the annual number of deaths, population size, and age-adjusted mortality rate (per 100 000 individuals) by race (Black, White), sex (female, male), and age were obtained. Also included were the 15 leading causes of death from 1999-2020 among both populations, separately, resulting in a total of 18 unique causes of death (eMethods, eTables 1, 2, and 3 in Supplement 1). For 2020 only, we also included deaths due to COVID-19.

Statistical Analysis

For all analyses, we stratified by sex and reported rates per 100 000 individuals. For each year, all-cause excess

age-adjusted mortality rate was calculated by subtracting the year-specific age-adjusted mortality rate among the White population from that of the Black population. Similarly, the annual age-adjusted mortality rate ratio was estimated by dividing the age-adjusted mortality rate of the Black population by that of the White population.

Separately, to estimate the excess number of deaths, we estimated the annual age-specific mortality rate using 10-year age groups by race and then multiplied the White population age-specific mortality rate by the Black population size for that calendar year. Then, the hypothetical number of deaths among the Black population was divided by the Black population size to arrive at a hypothetical annual Black population mortality rate. We subtracted this hypothetical rate from the observed Black population mortality rate to arrive at the estimated excess age-specific Black population mortality rate, which we multiplied by the observed Black population size to obtain the total annual and 22-year cumulative number of excess deaths among the Black population.[19]

Then, we estimated the rate of annual years of potential life lost (defined as the number of years that a person would have lived had they not died when they did)[20] for each race by multiplying each 5-year age group's crude mortality rate by its respective annual sex- and age-specific life expectancy in years and obtaining the mean rate across all age groups. For both racial groups, year-, age-, and sex-specific White life expectancy was used as the referent metric (eTable 2 in Supplement 1).[18]

To assess the trends over the study period, we graphically assessed the relationship between each metric and study year. Based on this assessment, we used autoregressive integrated moving average models using a 1-year correlation and modeled time as a linear spline with knots that reflected the observed inflection points from 1999 through 2019 (eMethods in Supplement 1) and used a z test to estimate the 2019-2020 change. Separately, annual rates in age-adjusted excess deaths and years of potential life lost rates were calculated and visually evaluated by the leading causes of death (eMethods, eTable 1 in Supplement 1).

To estimate mortality differences by age, we combined all study years and used the average crude mortality rate for each 5-year age group and subtracted the age-specific mortality rate of the White population from that of the Black population. Similarly, to estimate the rate differences by age in years of potential life lost, we estimated the annual mortality rate for each age group, multiplied it by their respective annual sex- and age-specific life expectancy in years, and then estimated the mean rate of years of potential life lost for each age group across the entire study period. Lastly, changes in the relationship between age and the excess mortality rate and the years of potential life lost rate were visually assessed over the study period by analyzing separately data from 5-year periods.

Cause-of-death heatmaps were produced using Python version 3.7.[21-25] All statistical tests performed were 2-sided, with a level of significance of .05, using Stata SE version 17.0 (StataCorp).

Results

Temporal Trends in Racial Differences in Mortality and Years of Potential Life Lost Rates

From 1999 to 2011, the age-adjusted excess mortality rate declined from 404 to 211 excess deaths per 100 000 individuals among Black males (1999-2007, P for trend < .001; 2007-2011, P for trend < .001; **Figure 1**). However, the rate plateaued from 2012 through 2019 (P for trend = .98), with a subsequent single-year increase in 2020 to 395, rates not seen since 2000 (Figure 1). Among Black females, the estimated age-adjusted excess mortality rate declined from 224 excess deaths per 100 000 individuals in 1999 to 87 in 2015 (P for trend <.001; Figure 1). There was no significant change between 2016 and 2019 (P for trend = .71), but in 2020 rates increased to 192—levels not seen since 2005 (Figure 1). Although a similar pattern was observed in the total number of excess deaths, in 2020 the number of excess deaths among both Black males and Black females was higher than in any other year of the entire study period (79 801 and 47 545 excess deaths, respectively; eFigure 1 in Supplement 1). In relative terms, over the study period the age-adjusted mortality rate ranged from 21% to 40% higher among Black males and from 13% to 31% higher among Black females compared with their White counterparts (eFigure 2 in Supplement 1).

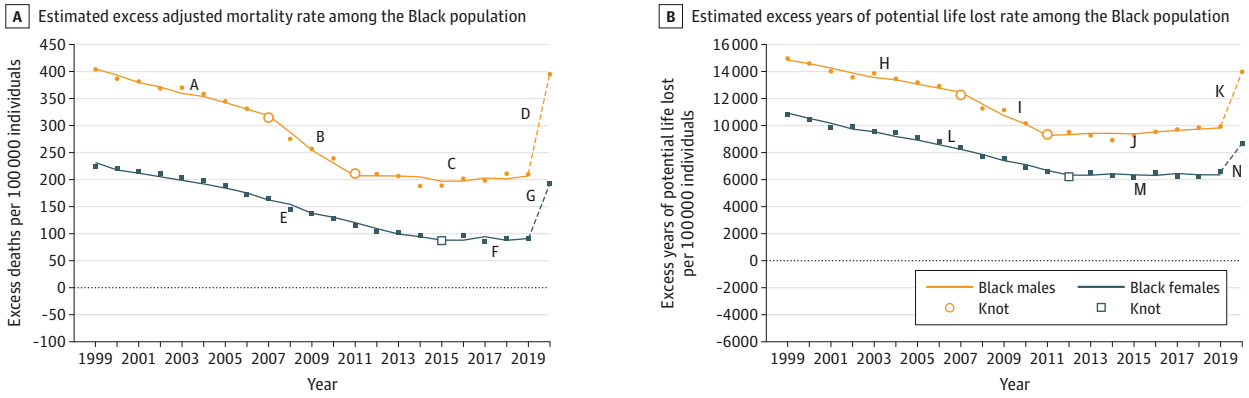
In 1999, the excess years of potential life lost for Black males and Black females were 14 964 and 10 806 per 100 000 people, respectively. There was a continuous decline until 2011 among males (P for trend < .001), and until 2012 among females (P for trend < .001; Figure 1). Then there was a plateau until 2019 for both groups (P for trend = .26 for males and P for trend = .90 for females), after which the rate of excess years of potential life lost increased in 2020 to rates similar to those of 2001 and 2005 among Black males and Black females, respectively (Figure 1). Although there was a reduction in absolute numbers of years of potential life lost from 1999 through 2019, in 2020 the total excess years of potential life lost reached its highest number among Black males (2 898 669 years) and reached numbers similar to those in 1999 among Black females (1 940 604 years; eFigure 3 in Supplement 1). The annual years of potential life lost rate ratio followed a similar pattern over the 22-year period (eFigure 4 in Supplement 1).

The rates of age-adjusted mortality and years of potential life lost are reported separately for the Black population and the White population in eFigure 5 in Supplement 1.

When analyzed by cause of death and year, the highest excess mortality rates among the Black population through the study period were due to heart disease (**Figure 2**). In both sex groups, excess mortality rates for leading causes of death (eg, heart disease, cancer, diabetes) generally decreased over the study period, except for deaths due to assault and cerebrovascular disease in Black males. There were similar patterns in rates of years of potential life lost, with the notable exception of perinatal deaths, which had the highest rates of years of potential life lost through the study period (Figure 2).

In 2020, the highest excess age-adjusted mortality rate among Black males was for deaths due to COVID-19 (80 per

Figure 1. US Black Population Excess Age-Adjusted Mortality and Years of Potential Life Lost Rates, 1999-2020



Excess age-adjusted mortality rate

Period	Segment	Annualized rate of change (95% CI)	*P* value
Males			
1999-2007	A	-11.0 (-15.9 to -6.1)	<.001
2008-2011	B	-28.2 (-34.6 to -21.9)	<.001
2012-2019	C	-0.03 (-2.8 to 2.8)	.98
2020	D	185.3 (177.0 to 193.6)	<.001
Females			
1999-2015	E	-9.0 (-10.1 to -8.0)	<.001
2016-2019	F	0.9 (-3.9 to 5.8)	.71
2020	G	101.9 (96.3 to 107.5)	<.001

Excess years of potential life lost rate

Period	Segment	Annualized rate of change (95% CI)	*P* value
Males			
1999-2007	H	-304.2 (-389.5 to -218.9)	<.001
2008-2011	I	-797.6 (-952.0 to -643.2)	<.001
2012-2019	J	69.7 (-50.9 to 190.4)	.26
2020	K	4050.4 (2755.4 to 5345.5)	<.001
Females			
1999-2012	L	-349.7 (-389.6 to -309.8)	<.001
2013-2019	M	4.8 (-67.9 to 77.5)	.90
2020	N	2102.7 (904.3 to 3301.1)	<.001

To assess trends over time, the relationship between each metric and study year was graphically assessed, and time was modeled as a linear spline with knots that reflected the observed inflection points from 1999 to 2019. For excess mortality rates, these inflection points were from 2007 to 2011 for males and 2015 for females. For excess rates of years of potential life lost, the knots were 2007 and 2011 for males and 2012 for females. Rates that fall above the dotted line indicate rates higher than the White population and those that fall below, rates lower than the White population. Autoregressive integrated moving average models using a 1-year correlation were implemented to account for the serial correlation of annual rates. The 2019-2020 change was estimated using a *z* test.

100 000 individuals), whereas it was only second to heart disease among Black females (47 per 100 000 individuals). Similarly, the excess years of potential life lost due to COVID-19 (per 100 000 individuals) was 2572 among Black males and 1759 among Black females, in both groups ranking third below conditions from the perinatal period and heart disease (eFigure 6 in Supplement 1).

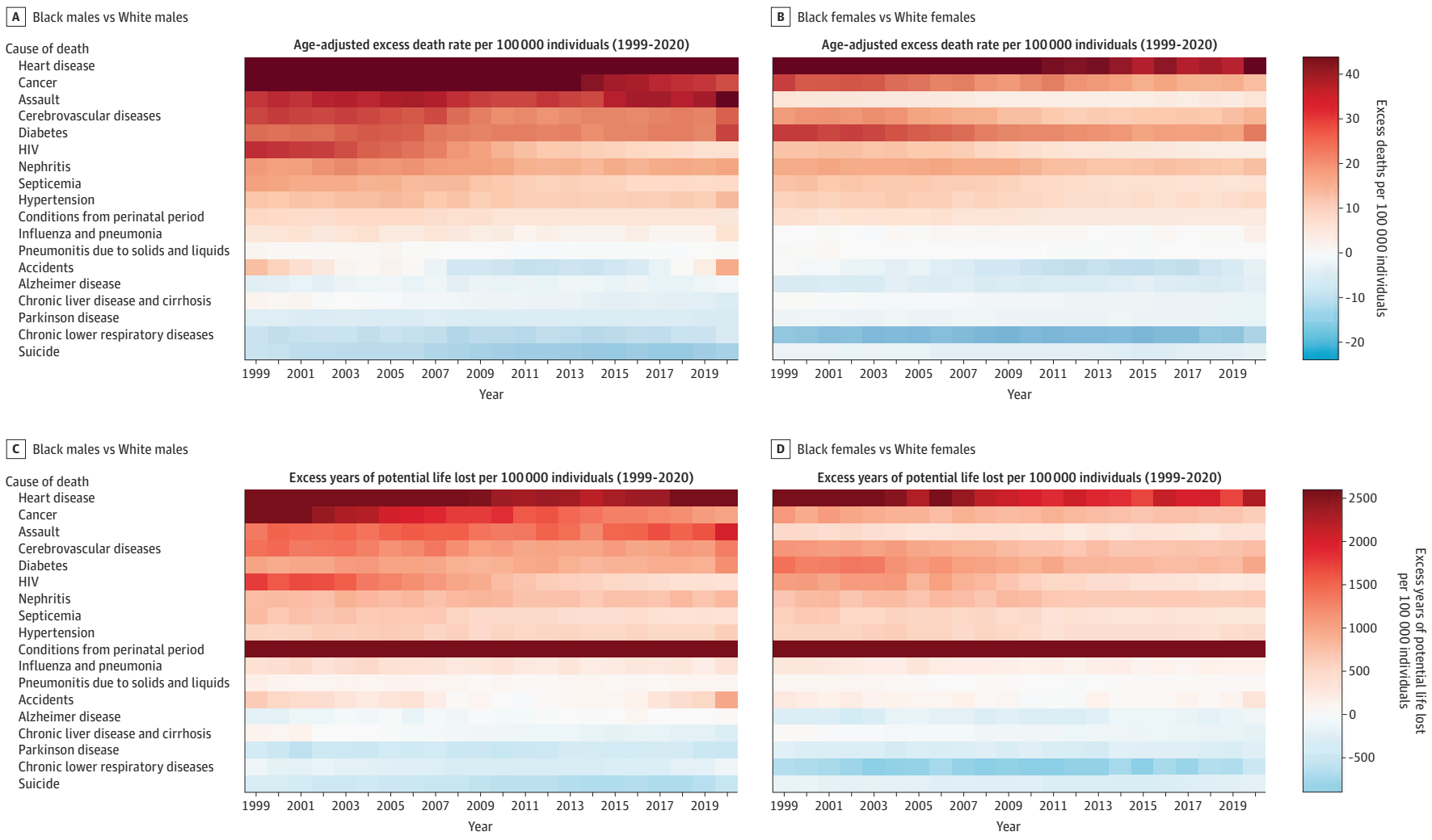
Cumulative 22-Year Excess Mortality and Years of Potential Life Lost Among the Black Population

From 1999 to 2020, the mean age-adjusted mortality rate among White males and females was 930.7 and 667.7, respectively, whereas among Black males and females it was 1214.9 and 816.3, respectively. There was a total of 997 623 estimated excess deaths among Black males and 628 464 excess deaths among Black females over the study period. The distribution of excess deaths by age group is shown in eFigure 7 in Supplement 1. The mean 22-year rate per 100 000 individuals of years of potential life lost among White males and females was 20 365 and 15 428, respectively, whereas among Black males and females it was 31 944 and 23 360, respectively. This represented an estimated total of 47 005 048 and 34 938 070 excess years of potential life lost among Black males and Black females, respectively.

Racial Differences in Rates of Mortality and Years of Potential Life Lost Rate by Age Group

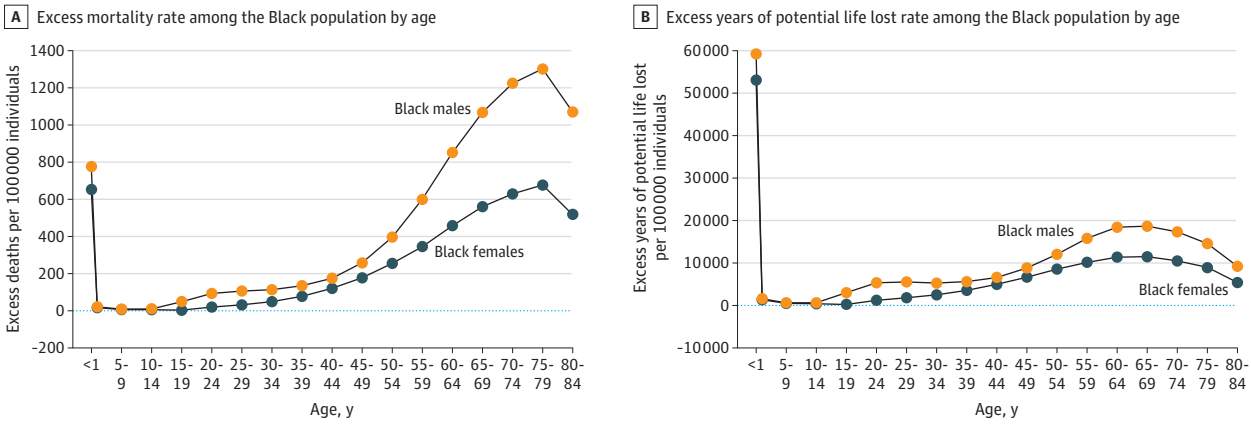
Among those younger than 1 year, excessive deaths per 100 000 individuals among Black males were 776 and among Black females, 654. Such rates narrowed among those aged 1 to 14 years among males, and among those aged 1 through 20 years among females. The maximum excess death rate occurred among those between the ages of 75 and 79 years, reaching 1302 per 100 000 males and 677 per 100 000 females (**Figure 3**; eFigure 8 in Supplement 1). The greatest difference in years of potential life lost rate between the Black population and the White population was among those younger than 1 year (59 232 per 100 000 Black males and 53 061 per 100 000 Black females), decreasing to its minimum among those between the ages of 1 and 14 years. Consistent with the excess mortality pattern, the rate of excess years of potential life lost increased with age among males older than 15 years and among females older than 20 years, increasing up to those aged 65 to 69 years old and decreasing among those older (Figure 3; eFigure 9 in Supplement 1). The strength of the association between age and the rates of excess mortality and years of potential life lost shifted lower from 1999 through 2018, increasing again in 2019-2020, particularly among middle aged and older adults (eFigure 10 in Supplement 1).

Figure 2. US Black Population Excess Age-Adjusted Mortality and Years of Potential Life Lost Rates by Leading Causes of Death, 1999-2020



Excess mortality or the years of potential life lost rates were defined as the difference in each year's mortality rate or years of potential life lost rate between the Black population and the White population. All rates are estimated per 100 000 individuals. Presented herein are the 22-year leading causes of death among both populations (details are in the Methods section). For visualization purposes, causes of death are presented in descending order based on the mean 22-year excess mortality rate among Black males. An excess mortality rate or years of potential life lost rate of 0 is shown in white and represents the absence of a difference. In shades of red are the annual metrics for which the Black population estimates were higher than those of the White population. In shades of blue are the annual metrics for which the White population estimates were higher than those of the Black population.

Figure 3. US Black Population Excess Mortality Rate and Years of Potential Life Lost by Age Group



Excess mortality rates among the US Black population by age group were calculated by subtracting the mortality rate of the White population from that of the Black population. Excess years of potential life lost rates among the US Black population were defined as the difference in years of potential life lost within each age group between the Black population and the White population. An excess mortality or years of potential life lost rate of 0 represents the absence of a difference. Rates were estimated per 100 000 individuals. Rates that fall above the blue dotted line indicate rates higher than the White population and those that fall below, rates lower than the White population.

Discussion

In this study of US mortality data from 1999 through 2020, an estimated 997 623 excess deaths occurred among Black males and 628 464 excess deaths among Black females relative to their White counterparts—accounting for a total of 1.63 million excess deaths. These excess deaths corresponded to a total of 47 million and 35 million excess years of potential life lost among Black males and Black females, respectively. After a period of progress from 1999 to the early 2010s, improvements stalled at least through 2020 when, coincident with the first year of the pandemic, the number of excess deaths increased abruptly and exceeded that of any previous year of the study. Moreover, even at the lowest of excess of deaths and years of potential life lost there were more than 50 000 annual excess deaths and 3 million annual excess years of potential life lost among the Black population compared with the White population. Differences in loss of life were most prominent among infants, with Black-White mortality and years of potential life lost rate ratios greater than 2.3 among those younger than 1 year old. Heart disease in both sexes and cancer in males were the largest drivers of differences in excess deaths. Broadly, these findings indicate that current efforts to curb or eliminate mortality disparities have been minimally effective, and progress, when made, has been fragile.

This study should serve as a call to action—especially for policy makers—as we highlighted and contextualized the substantial toll of structural racism on life in the US. Although the specific causes and drivers of differences in deaths and years of potential life lost are multifactorial and warrant further study, the sheer scale of the difference requires a revisiting of our national approach to combatting disparities. A wealth of prior work, however, points to the contribution of structural racism, unmet social needs, and systemic bias as root causes.[2-5] This study also demonstrated that a brief period of progress stalled and disparities substantially worsened at the onset of and well into the early pandemic. Although this study was not equipped to address the long-term effect of the pandemic on racial disparities, these early trends are consistent with the fear that the pandemic both disproportionately attacked populations experiencing structural inequities and increased existing disparities. The increase in excess mortality among the Black population relative to the White population during the pandemic was so large that it reached levels not seen in the prior 2 decades. In addition to pandemic-specific factors (eg, disproportionately higher infection exposure, financial instability, food insecurity, psychological distress), the pervasive social factors that contributed to such high vulnerability among the Black population include persistently higher barriers to health care, higher prevalence of multimorbidity, and worse average health status.[6,7,26] Overall, these findings demonstrate the potential for progress but indicate the fragility of the gains and herald a need for new approaches to ensure sustainability of advancements.

Prior studies have found persistently large numbers of excess deaths among the Black population but have not explicitly quantified excess years of potential life lost, nor have they measured excess deaths over a recent period. A study found that the disparity in mortality rates between the Black population and the White population remained mostly stable from 1960 to 2000, and another report estimated that 2.7 million excess deaths occurred among the Black population from 1970 to 2004.[27] A separate study found that from 1990 to 2000, the decade leading to the current study period, nearly a million deaths among the Black population would have been averted had their mortality rates been comparable with those of the White population.[19]

We found that excess mortality declined substantially from 1999 through the early 2010s, consistent with other studies of Black and White mortality rates.[28,29] In the current study, there were no substantial increases in all-cause age-adjusted mortality rates for White males and females. These observations could indicate the success of efforts toward reducing disparities. However, the disproportionately higher increases in mortality among White younger adults in the 2000s[30-32] could also marginally contribute to the narrowing of these disparities.

In addition, studies have described disparities in the COVID-19 pandemic toll by comparing the observed mortality rates during this period and the expected mortality rates for specific populations based on recent temporal trends.[33-35] This study places the pandemic toll in context of rates of excess mortality and years of potential life lost as additional metrics of racial disparity that may be useful should another pandemic-type public health calamity occur.

The excess deaths and years of potential life lost were elevated among most of the major causes of death, even though heart disease was the most prominent. This is consistent with a study by Kyalwazi and colleagues[36] who found that, despite a decline in the absolute difference, age-adjusted cardiovascular mortality rates were persistently higher among the Black population than among the White population from 1999 to 2019. It is likely that disparities in rates of hypertension control and other factors associated with heart disease are in part responsible for this excess loss of life.[37,38] Cancer was also an important source of the disparity. Both heart disease and cancer have modifiable risk factors that are importantly affected by social determinants of health. Targeted and renewed efforts aimed at diseases that disproportionately drive differences are necessary to make sure clinical advancements are experienced uniformly across the population.

The sobering disparity noted in this study among infants and during childhood accounted for a markedly elevated number of excess deaths and an even more pronounced disparity in years of potential life lost. This excess mortality occurred in a period of life of highest vulnerability and warrants new dedicated public health initiatives targeting early childhood health. After childhood, the excess deaths and years of potential life lost became evident in early adulthood and generally increased with age. This finding is consistent with a recent report by the National Academies of Sciences, Engineering, and Medicine that found consistently higher mortality rates among Black adults aged 25 through 65 years from 1990 to 2017 compared with other racial and ethnic groups of the same age, despite increasing trends among their White counterparts and regardless of educational attainment or geography.[32,39] These alarming excess deaths in working-aged groups may be the most socially disruptive[15] given the destabilizing effect on productivity and economic gains for Black families, potentially contributing to the perpetuation of generational racial disparities. Among those older than 65 years, these disparity metrics declined, as would be expected because of the persistently lower average lifespan among the Black population.[40,41]

The implications of these findings are important. The Black population in the US, regardless of cause or the burden of risk factors, continue to die at much greater rates than the White population, with dramatic long-run consequences when accounting for the effect of premature mortality. These metrics, especially years of potential life lost, are suitable for public reporting and may inspire strategies directed toward more in-depth root-cause analysis and where qualified by evidence of efficacy, implementation of steps to improve these disparities. As such, an annual publicly reported metric of race-based years of potential life lost may be useful for national accountability. Excess mortality and years of potential life lost by race could serve as a major national (and local) gauge of progress toward achieving health equity. Although achieving equity in these metrics may need persistent multigenerational efforts, it is crucial to advance rapidly in that direction.

Limitations

Our study has limitations. First, there are known inaccuracies in race and ethnicity information reported in death certificates.[42,43] However, there is near complete agreement between self-reported race and the race reported in non-Hispanic Black and non-Hispanic White decedents' death certificates.[44] Second, the cause of death may be uncertain in many cases, especially during the pandemic, but that does not detract from our central findings of a sustained major difference in mortality. Third, the CDC WONDER does not provide rates or population estimates for subsamples of decedents 85 years or older, which prevented evaluation of some disparities in these age groups. Fourth, although there may be differences in mortality rates by country of origin, such data are not publicly available for incorporation in these analyses.

Conclusion

Excess deaths and years of potential life lost among the US Black population persist and by scale warrant national attention. Over a recent 22-year period, the US Black population experienced 1.63 million excess deaths and much greater losses in years of potential life. Although encouraging gains were noted in the early 2000s, the disparities abruptly increased in 2020 and years of potential life lost replicated 1999 benchmarks. The call to action generated more than 100 years ago from Du Bois and echoed nearly 40 years ago by the Heckler Report remains extant today. With millions more lives and life-years at stake, new strategies are needed.

ARTICLE INFORMATION

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Correction: This article was corrected on August 28, 2023, to change the y-axis label on the B panel of Figure 2 to "Excess deaths per 100 000 individuals."

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Original Investigation | Equity, Diversity, and Inclusion

Structural Racism, Mass Incarceration, and Racial and Ethnic Disparities in Severe Maternal Morbidity

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Abstract

IMPORTANCE Racial and ethnic inequities in the criminal-legal system are an important manifestation of structural racism. However, how these inequities may influence the risk of severe maternal morbidity (SMM) and its persistent racial and ethnic disparities remains underinvestigated.

OBJECTIVE To examine the association between county-level inequity in jail incarceration rates comparing Black and White individuals and SMM risk in California.

DESIGN, SETTING, AND PARTICIPANTS This population-based cross-sectional study used statewide data from California on all live hospital births at 20 weeks of gestation or later from January 1, 1997, to December 31, 2018. Data were obtained from hospital discharge and vital statistics records, which were linked with publicly available county-level data. Data analysis was performed from January 2022 to February 2023.

EXPOSURE Jail incarceration inequity was determined from the ratio of jail incarceration rates of Black individuals to those of White individuals and was categorized as tertile 1 (low), tertile 2 (moderate), tertile 3 (high), with mean cutoffs across all years of 0 to 2.99, 3.00 to 5.22, and greater than 5.22, respectively.

MAIN OUTCOME AND MEASURES This study used race- and ethnicity-stratified mixed-effects logistic regression models with birthing people nested within counties and adjusted for individual- and county-level characteristics to estimate the odds of non–blood transfusion SMM (NT SMM) and SMM including blood transfusion–only cases (SMM; as defined by the Centers for Disease Control and Prevention SMM index) associated with tertiles of incarceration inequity.

RESULTS This study included 10 200 692 births (0.4% American Indian or Alaska Native, 13.4% Asian or Pacific Islander, 5.8% Black, 50.8% Hispanic or Latinx, 29.6% White, and 0.1% multiracial or other [individuals who self-identified with ≥2 racial groups and those who self-identified as "other" race or ethnicity]). In fully adjusted models, residing in counties with high jail incarceration inequity (tertile 3) was associated with higher odds of SMM for Black (odds ratio [OR], 1.14; 95% CI, 1.01-1.29 for NT SMM; OR, 1.20, 95% CI, 1.01-1.42 for SMM), Hispanic or Latinx (OR, 1.24; 95% CI, 1.14-1.34 for NT SMM; OR, 1.20; 95% CI, 1.14-1.27 for SMM), and White (OR, 1.02; 95% CI, 0.93-1.12 for NT SMM; OR, 1.09; 95% CI, 1.02-1.17 for SMM) birthing people, compared with residing in counties with low inequity (tertile 1).

CONCLUSIONS AND RELEVANCE The findings of this study highlight the adverse maternal health consequences of structural racism manifesting via the criminal-legal system and underscore the need for community-based alternatives to inequitable punitive practices.

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Key Points

Question Is county-level jail incarceration inequity between Black and White individuals, as a manifestation of structural racism, associated with severe maternal morbidity risk?

Findings In this cross-sectional study of 10 200 692 live hospital births across California between 1997 and 2018, Black and Hispanic or Latinx birthing people residing in counties with high Black-White jail incarceration inequity had increased odds of severe maternal morbidity compared with birthing people residing in low-inequity counties.

Meaning Structural racism operating within the criminal-legal system may drive racial and ethnic inequities in pregnancy-related complications, indicating the need to transform inequitable institutions in order to improve maternal health outcomes in the US.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Introduction

Each year, severe maternal morbidity (SMM) affects more than 50 000 birthing people in the US.[1] Severe maternal morbidity is a set of life-threatening physiologic complications and lifesaving procedures occurring during childbirth and post partum that have serious implications for the survival of a person giving birth.[1] There are persistent racial and ethnic disparities in SMM risk. Black individuals are 2 to 3 times more likely to experience SMM than White individuals.[2-5] Furthermore, the US has the highest rates of maternal mortality among high-resource nations, with Black birthing people facing a 3- to 4-fold higher risk of maternal mortality than White individuals. The US is facing a maternal health crisis,[6-9] and addressing SMM and its racial and ethnic disparities is critical to improving birthing outcomes across the nation.[10,11]

Because prior work on individual-level risk factors for SMM has not been able to explain racial and ethnic disparities, scholars and professional organizations have called for the need to assess structural determinants of health inequities in relation to SMM.[11-14] One such determinant is structural racism—a fundamental cause of racial and ethnic health inequities, defined as a set of historically rooted, intrinsically linked, and mutually reinforcing systems and institutions that work in concert to disenfranchise racially and ethnically marginalized populations.[15-19] Structural racism perpetuates inequitable policies, practices, and discriminatory social norms that directly and indirectly pattern the distribution of health-promoting material resources, socioeconomic opportunities, and psychosocial stressors and assets, which in turn influence disease risk, including poor birthing outcomes.[15,20-22]

The criminal-legal system is one important manifestation of structural racism that continues to disproportionately institutionalize millions of Black and other racially and ethnically marginalized individuals in the US and tear apart countless families and communities.[23,24] Seemingly race-neutral policies and practices that are fueled by racism and classism and inherently rooted in social and political reactions to the civil rights movement, such as the war on drugs, have led to the imprisonment of countless racially and ethnically marginalized individuals and have made the US a world leader in incarceration.[23,25-29] As a result of continued underinvestment in health and social services that promote social, emotional, and financial well-being and racist policing and sentencing practices within racially marginalized communities, there are notable racial inequities in the criminal-legal system.[23,28,30,31] Black individuals have higher incarceration rates than any other racial group.[32] Hence, they and their communities are more likely to bear the collateral social, emotional, financial, mental, and physical consequences of mass incarceration.[33-35]

In addition to the harm it causes to incarcerated people and their families, mass incarceration is known to have ill health effects that permeate communities.[36] Mass incarceration is conceptualized to influence population health inequities through depleted community socioeconomic and psychosocial resources, severed social ties, and heightened stress.[36-38] Consequently, residing in neighborhoods affected by mass incarceration has been shown to increase the risk of various adverse mental and physical health outcomes.[39-46] A small but increasing area of empirical work has also begun to document how living in areas with greater racial inequities in incarceration rates may shape adverse birthing outcomes.[43,47-49] However, how the manifestation of structural racism via the criminal-legal system influences SMM risk remains underinvestigated. To our knowledge, only 2 prior studies have examined this relationship and did not detect any associations,[50,51] highlighting the need for research that further explicates this link.

In this cross-sectional study, we leveraged 21 years of data from California on county-level jail incarceration inequity comparing Black and White individuals as an indicator of structural racism and examined how it may be associated with SMM risk. We hypothesized that individuals residing in counties with high jail incarceration inequity would have increased risk of SMM.

Methods

Study Sample

Study data were obtained from the California Department of Health Care Access and Information and included all live births delivered at 20 weeks of gestation or later within the state from January 1, 1997, to December 31, 2018. We kept the first recorded birth for nonsingleton births to avoid duplicates. Birth hospitalization discharge and vital statistics records were linked with county-level jail incarceration data from the Vera Institute of Justice Incarceration Trends data set,[52,53] the US Census, and American Community Survey (ACS) based on maternal addresses recorded at birth. After removing observations with missing or invalid covariates, the final analytic sample was 10 200 692 births across 57 counties in California (eFigure in Supplement 1). On average, there were 178 960 observations per county throughout the study period (range, 288-2 847 438). This study was approved by the State of California Committee for the Protection of Human Subjects and the institutional review boards of Stanford University and the University of California, Berkeley, which deemed the study exempt from needing to obtain participant informed consent given the nature of the data. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline for cross-sectional studies.

Study Outcome

To determine the occurrence of SMM during birth hospitalization, we used the Centers for Disease Control and Prevention's SMM index designed for use in administrative data sets.[1] This index, which includes a list of 21 life-threatening events and life-saving procedures that occur during childbirth, was constructed using the *International Classification of Diseases, Ninth Revision* (*ICD-9*) and *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (*ICD-10*) diagnosis and procedure codes from birth hospital discharge files. Because blood transfusion may overestimate true SMM prevalence given that transfusion volume is unspecified in the *ICD* codes, we consider SMM excluding cases with blood transfusion as their only indicator (non–blood transfusion SMM [NT SMM]) as well as SMM including cases with blood transfusion as their only indicator (SMM).[54-56]

Exposure

Annual county-level jail incarceration rates for the years 1997 to 2018 were obtained from the Vera Institute of Justice Incarceration Trends data set.[53] This data set compiles incarceration data from the Bureau of Justice Statistics Census of Jails and the Annual Survey of Jails and uses information from National Vital Statistics on county population density (ages 15-64 years) as the denominator to ascertain yearly county-level overall and race- and ethnicity-specific incarceration rates (per 100 000 residents).[52,53] In other words, these rates are determined based on the proportion of residents of a county who are incarcerated in jails. Racial inequity in jail incarceration rates was defined using the ratio of Black to White jail incarceration rates (race and ethnicity of incarcerated individuals were reported by jail officials). This measure is thought to indicate long-term disinvestment and inequity at the area level that is relevant to the health of all birthing people.[43,47,50,57] To quantify risk associated with low, moderate, and high exposure to structural racism, which facilitates an easier interpretation, we categorized counties into tertiles of these annual ratios: low inequity (tertile 1 [reference]), moderate inequity (tertile 2), and high inequity (tertile 3). The mean tertile cutoffs across all study years were as follows: tertile 1, 0 to 2.99; tertile 2, 3.00 to 5.22; and tertile 3, greater than 5.22. Each year of exposure data was then linked with births from the same year.

Covariates

Maternal race and ethnicity was self-reported on birth certificates and included American Indian or Alaska Native, Asian or Pacific Islander, Hispanic or Latinx, multiracial or other (multiracial and those self-identifying as other when asked about their race and ethnicity), non-Hispanic Black (Black), and

non-Hispanic White (White) categories. Multiracial individuals were those who self-identified with at least 2 racial groups. In our models, we controlled for the following individual-level covariates considered to be significant risk factors of SMM: maternal age (<20, 20-34, or ≥35 years), maternal education (high school or less, some college, or college graduate), and insurance (private, public or government, other, unknown, or uninsured).[58] On the basis of prior literature documenting relationships between area-level socioeconomic status, incarceration rates, and adverse birth outcomes, we also included county-level median household income with counties categorized into quartiles in our fully adjusted models.[48] County-level median household income information was determined from the 2000 Decennial Census (for births between 1997 and 2004), the 2010 ACS 5-year estimates (for births between 2005 and 2010), the 2015 ACS 5-year estimates (for births between 2011 and 2015), and the 2019 ACS 5-year estimates (for births between 2016 and 2018) obtained from Social Explorer.[59]

Statistical Analysis

Data analysis was performed from January 2022 to February 2023. In descriptive analyses, we determined the distribution of population characteristics by race and ethnicity and by tertiles of Black-White jail incarceration inequity. We then used race and ethnicity–stratified mixed-effects logistic regression models with random intercepts for counties to estimate odds ratios (ORs) and 95% CIs of NT SMM and SMM associated with county-level jail incarceration inequity comparing Black and White individuals. Our initial models were unadjusted (model 1). Our partially adjusted models included individual-level covariates (maternal age, education, and insurance) (model 2) and the fully adjusted models additionally controlled for county-level socioeconomic status (model 3). In sensitivity analysis, we added year fixed effects to our fully adjusted models to account for potential temporal trends (exogenous factors that change yearly and affect all counties). All hypothesis tests were 2-sided. All analyses were conducted using Stata/IC, version 15.1 (StataCorp LLC).

Results

Our sample of 10 200 692 live births comprised 0.4% American Indian or Alaska Native, 13.4% Asian or Pacific Islander, 5.8% Black, 50.8% Hispanic or Latinx, 29.6% White, and 0.1% multiracial or other individuals. Black birthing people had the highest prevalence of SMM (0.9% NT SMM and 1.8% SMM), and White birthing people had the lowest prevalence (0.5% NT SMM and 1.0% SMM) (**Table 1**). Most birthing people resided in counties with high jail incarceration inequity (tertile 3), which remained the same across racial and ethnic groups (Table 1 and **Table 2**). The prevalence of NT SMM was evenly distributed across tertiles of jail incarceration inequity. However, the prevalence of SMM was slightly higher among birthing people living in low-inequity counties (tertile 1; 1.3%), whereas those living in moderate- and high-inequity counties had a similar prevalence (1.1%).

In models adjusting for individual sociodemographic characteristics, the odds of NT SMM for Black birthing people residing in counties with high Black-White jail incarceration inequity were 28% higher than those residing in low-inequity counties (OR, 1.28; 95% CI, 1.08-1.50) (model 2) (**Table 3**). This association remained consistent when examining SMM including blood transfusion–only cases (OR, 1.27; 95% CI, 1.07-1.49) (model 2) (**Table 4**). Associations were slightly attenuated when adjusting for county-level socioeconomic status (NT SMM: OR, 1.14; 95% CI, 1.01-1.29; SMM; OR, 1.20; 95% CI, 1.01-1.42) (model 3) (Table 3 and Table 4). Increased odds of NT SMM associated with residing in high-inequity counties among Black birthing people remained unchanged in our sensitivity analyses, where we additionally included year fixed effects to account for temporal trends (OR, 1.14; 95% CI, 1.01-1.29) (eTable 1 in Supplement 1). However, sensitivity analysis results were attenuated and no longer statistically significant for SMM (eTable 1 in Supplement 1).

Results were generally similar for Hispanic and Latinx birthing people. After adjustment for individual characteristics and county-level socioeconomic status, the odds of NT SMM were 24% higher and the odds of SMM were 20% higher for those residing in high-inequity counties (NT SMM:

OR, 1.24, 95% CI, 1.14-1.34; SMM: OR, 1.20; 95% CI, 1.14-1.27) (Table 3 and Table 4). In sensitivity analyses, the association observed for NT SMM was moderately attenuated when including year fixed effects (OR, 1.09; 95% CI, 1.01-1.18), whereas the association observed for SMM was no longer significant (eTable 1 in Supplement 1). For Black and Hispanic or Latinx birthing people, associations comparing moderate- vs low-tertile counties were more attenuated across both SMM specifications (Table 3 and Table 4) but did not remain precise when adjusting for temporal trends (eTable 1 in Supplement 1).

Among White birthing people, we observed higher odds of SMM associated with residing in high-tertile counties only when considering SMM including blood transfusion–only cases (NT SMM: OR, 1.02; 95% CI, 0.93-1.12; SMM: OR, 1.09; 95% CI, 1.02-1.17) (model 3) (Table 3 and Table 4). However, this association was not significant when controlling for temporal trends (eTable 1 in Supplement 1). Estimates for American Indian or Alaska Native (NT SMM: OR, 0.97; 95% CI, 0.66-1.43; SMM: OR, 0.88; 95% CI, 0.67-1.15), Asian or Pacific Islander (NT SMM: OR, 0.95; 95% CI, 0.80-1.13; SMM: OR, 1.11; 95% CI, 0.96-1.27), and multiracial or other (NT SMM: OR, 0.96; 95% CI, 0.33-2.79; SMM: OR, 0.87; 95% CI, 0.43-1.75) individuals residing in counties with the highest Black-White jail incarceration inequity were null and imprecise (Table 3 and Table 4). Full regression results are presented in eTables 2 and 3 in Supplement 1.

Table 1. Distribution of Population Characteristics Across Race and Ethnicity, California, 1997-2018

	No. (%)					
	American Indian or Alaska Native	Asian or Pacific Islander	Black	Hispanic or Latinx	White	Multiracial or other[a]
Births	43 254 (0.4)	1 369 170 (13.4)	589 692 (5.8)	5 177 325 (50.8)	3 014 652 (29.6)	6599 (0.1)
Non-blood transfusion severe maternal morbidity						
Yes	264 (0.6)	7678 (0.6)	5157 (0.9)	26 581 (0.5)	14 044 (0.5)	46 (0.7)
No	42 990 (99.4)	1 361 492 (99.4)	584 535 (99.1)	5 150 744 (99.5)	3 000 608 (99.5)	6553 (99.3)
Severe maternal morbidity[b]						
Yes	640 (1.5)	16 891 (1.2)	10 543 (1.8)	61 582 (1.2)	28 806 (1.0)	99 (1.5)
No	42 614 (98.5)	1 352 279 (98.8)	579 149 (98.2)	5 115 743 (98.8)	2 985 846 (99.0)	6500 (98.5)
Black-White jail incarceration inequity						
Tertile 1 (low inequity)	8916 (20.6)	65 911 (4.8)	73 207 (12.4)	685 081 (13.2)	387 932 (12.9)	597 (9.0)
Tertile 2	16 685 (38.6)	347 916 (25.4)	144 079 (24.4)	1 655 716 (32.0)	1 114 087 (37.0)	1432 (21.7)
Tertile 3 (high inequity)	17 653 (40.8)	955 343 (69.8)	372 406 (63.2)	2 836 528 (54.8)	1 512 633 (50.2)	4570 (69.3)
Maternal age, y						
<20	5383 (12.4)	29 900 (2.2)	74 500 (12.6)	618 056 (11.9)	130 249 (4.3)	388 (5.9)
20-34	32 449 (75.0)	973 004 (71.1)	432 315 (73.3)	3 883 014 (75.0)	2 182 370 (72.4)	4867 (73.8)
≥35	5422 (12.5)	366 266 (26.8)	82 877 (14.1)	676 255 (13.1)	702 033 (23.3)	1344 (20.4)
Maternal education						
High school or less	26 245 (60.7)	304 505 (22.2)	306 944 (52.1)	3 767 220 (72.8)	877 714 (29.1)	2676 (40.6)
Some college	12 137 (28.1)	304 578 (22.2)	192 521 (32.6)	987 989 (19.1)	820 119 (27.2)	1908 (28.9)
College graduate	4872 (11.3)	760 087 (55.5)	90 227 (15.3)	422 116 (8.2)	1 316 819 (43.7)	2015 (30.5)
Insurance						
Private	17 257 (39.9)	957 987 (70.0)	244 010 (41.4)	1 661 956 (32.1)	2 261 769 (75.0)	3368 (51.0)
Public or government	24 891 (57.5)	305 621 (22.3)	331 326 (56.2)	3 373 326 (65.2)	695 541 (23.1)	3067 (46.5)
Other, unknown, or uninsured	1106 (2.6)	105 562 (7.7)	14 356 (2.4)	142 043 (2.7)	57 342 (1.9)	164 (2.5)
County median household income						
Quartile 1 (low)	9359 (21.6)	27 168 (2.0)	13 835 (2.3)	317 698 (6.1)	214 731 (7.1)	273 (4.1)
Quartile 2	7223 (16.7)	63 041 (4.6)	37 388 (6.3)	491 999 (9.5)	283 511 (9.4)	388 (5.9)
Quartile 3	19 126 (44.2)	623 562 (45.5)	404 621 (68.6)	3 216 842 (62.1)	1 500 892 (49.8)	4155 (63.0)
Quartile 4 (high)	7546 (17.4)	655 399 (47.9)	133 848 (22.7)	1 150 786 (22.2)	1 015 518 (33.7)	1783 (27.0)

[a] Multiracial or other category includes individuals who self-identified with at least 2 or more racial groups and those who self-identified as other race or ethnicity.

[b] Severe maternal morbidity, including cases with blood transfusion as their only indicator.

Discussion

In this study, we leveraged statewide data from California over 21 years and examined how county jail incarceration inequity between Black and White individuals may be related to SMM risk and its racial and ethnic disparities. Consistent with our hypothesis, we found that for Black and Hispanic or Latinx birthing people, residing in counties with greater jail incarceration inequity was associated with increased risk of NT SMM and SMM compared with residing in low-inequity counties. Associations between county-level jail incarceration inequity and NT SMM were stronger for Black individuals, even when accounting for temporal trends. Our results underscore the multilevel harmful consequences of the criminal-legal system as one key domain of structural racism and highlight the urgent need for structural transformation.

A recent systematic review identified only 6 epidemiologic studies assessing how structural racism indicators shaped maternal morbidity and mortality and found that most studies used either a measure of residential segregation or spatial isolation to operationalize structural racism.[60] Only 1 study examined Black-White incarceration inequity as a measure of structural racism and found no association between this county-level indicator and SMM.[50] Since that review, 1 other study has investigated racial inequity in incarceration within counties of the hospitals where individuals gave

Table 2. Distribution of Population Characteristics Across Tertiles of Black-White Inequity in County Jail Incarceration Rates, California, 1997-2018

	Black-White jail incarceration inequity, No. (%)		
	Tertile 1 (low inequity)	Tertile 2	Tertile 3 (high inequity)
Births	1 221 644 (12.0)	3 279 915 (32.2)	5 699 133 (55.9)
Non-blood transfusion severe maternal morbidity			
Yes	6164 (0.5)	16 551 (0.5)	31 055 (0.5)
No	1 215 480 (99.5)	3 263 364 (99.5)	5 668 078 (99.5)
Severe maternal morbidity[a]			
Yes	15 442 (1.3)	37 587 (1.1)	65 532 (1.1)
No	1 206 202 (98.7)	3 242 328 (98.9)	5 633 601 (98.9)
Maternal race and ethnicity			
American Indian or Alaska Native	8916 (0.7)	16 685 (0.5)	17 653 (0.3)
Asian or Pacific Islander	65 911 (5.4)	347 916 (10.6)	955 343 (16.8)
Black	73 207 (6.0)	144 079 (4.4)	372 406 (6.5)
Hispanic or Latinx	685 081 (56.1)	1 655 716 (50.5)	2 836 528 (49.8)
White	387 932 (31.8)	1 114 087 (34.0)	1 512 633 (26.5)
Multiracial or other[b]	597 (<0.1)	1432 (<0.1)	4570 (0.1)
Maternal age, y			
<20	138 884 (11.4)	290 364 (8.9)	429 228 (7.5)
20-34	930 849 (76.2)	2 461 705 (75.1)	4 115 465 (72.2)
≥35	151 911 (12.4)	527 846 (16.1)	1 154 440 (20.3)
Maternal education			
High school or less	741 723 (60.7)	1 761 240 (53.7)	2 782 341 (48.8)
Some college	304 018 (24.9)	793 697 (24.2)	1 221 537 (21.4)
College graduate	175 903 (14.4)	724 978 (22.1)	1 695 255 (29.7)
Insurance			
Private	516 743 (42.3)	1 633 885 (49.8)	2 995 719 (52.6)
Public or government	675 345 (55.3)	1 562 629 (47.6)	2 495 798 (43.8)
Other, unknown, or uninsured	29 556 (2.4)	83 401 (2.5)	207 616 (3.6)
County median household income			
Quartile 1 (low)	175 615 (14.4)	261 593 (8.0)	145 856 (2.6)
Quartile 2	305 598 (25.0)	400 182 (12.2)	177 770 (3.1)
Quartile 3	685 945 (56.1)	1 481 251 (45.2)	3 602 002 (63.2)
Quartile 4 (high)	54 486 (4.5)	1 136 889 (34.7)	1 773 505 (31.1)

[a] Severe maternal morbidity, including cases with blood transfusion as their only indicator.

[b] Multiracial or other category includes individuals who self-identified with at least 2 or more racial groups and those who self-identified as "other" race or ethnicity.

birth and did not find an association with SMM.[51] To our knowledge, our study is the first to document associations between county-level jail incarceration inequity and increased SMM risk. These results align with prior studies that have found that living in areas with greater Black-White inequity in incarceration rates is associated with small for gestational age births,[47] low birth weight,[48] preterm birth,[43] and infant mortality.[49] Taken together, our findings contribute to the limited but growing body of empirical literature on the links between indicators of structural racism and birthing outcomes more broadly, particularly through the criminal-legal system.

The results of our study are also aligned with theoretical framings that outline pathways by which structural racism operating via the criminal-legal system may shape adverse health outcomes. Inequities in incarceration rates indicate systematic disinvestment in low-income and racially marginalized communities.[25,33] Therefore, such areas may have poor neighborhood physical and social environment attributes that influence health-related behaviors, chronic stress, stress-buffering resources, and access to quality health care, which consequently determine the risk of adverse pregnancy-related outcomes.[13,61-64] Inequities in incarceration rates also correspond to heightened state surveillance within Black and other racially and ethnically marginalized communities.[31,33] Chronic stress arising from fear and worry about arrest and incarceration can be biologically embodied to disrupt a wide range of physiologic systems.[65-68] Heightened surveillance also indicates resources diverted away from essential health and social services and instead toward policing these same communities.[25,28,67] Hence, by stripping marginalized communities of stable social and financial resources essential for healthy pregnancies and childbirth, mass incarceration drives inequities in maternal health.[36,37] These collateral consequences are all in addition to the economic, emotional, social, and health harms that incarcerated individuals and their families sustain, both

Table 3. Associations Between Black-White Inequity in County Jail Incarceration Rates and Non–Blood Transfusion Severe Maternal Morbidity, California, 1997-2018

	Odds ratio (95% CI)		
	Model 1[a]	Model 2[b]	Model 3[c]
American Indian or Alaska Native (n = 43 254)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	0.99 (0.67-1.45)	0.97 (0.66-1.41)	0.90 (0.61-1.32)
Tertile 3 (high inequity)	1.11 (0.76-1.62)	1.06 (0.73-1.54)	0.97 (0.66-1.43)
Asian or Pacific Islander (n = 1 369 170)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	0.99 (0.84-1.18)	0.98 (0.83-1.16)	0.94 (0.79-1.11)
Tertile 3 (high inequity)	1.02 (0.86-1.22)	1.00 (0.85-1.19)	0.95 (0.80-1.13)
Black (n = 589 692)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.20 (1.01-1.42)	1.19 (1.00-1.41)	1.08 (0.95-1.23)
Tertile 3 (high inequity)	1.30 (1.10-1.54)	1.28 (1.08-1.50)	1.14 (1.01-1.29)
Hispanic or Latinx (n = 5 177 325)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.15 (1.07-1.23)	1.14 (1.06-1.23)	1.14 (1.06-1.22)
Tertile 3 (high inequity)	1.26 (1.16-1.36)	1.24 (1.15-1.34)	1.24 (1.14-1.34)
White (n = 3 014 652)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.05 (0.97-1.13)	1.03 (0.95-1.12)	1.03 (0.94-1.12)
Tertile 3 (high inequity)	1.05 (0.97-1.14)	1.03 (0.94-1.12)	1.02 (0.93-1.12)
Multiracial or other (n = 6599)[d]			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.14 (0.34-3.75)	1.2 (0.38-3.78)	1.22 (0.38-3.87)
Tertile 3 (high inequity)	1.00 (0.33-3.00)	1.08 (0.38-3.09)	0.96 (0.33-2.79)

[a] Model 1 was unadjusted.

[b] Model 2 was adjusted for maternal age, education, and insurance.

[c] Model 3 was adjusted for maternal age, education, insurance, and county-level median household income.

[d] Multiracial or other category includes individuals who self-identified with at least 2 or more racial groups and those who self-identified as "other" race or ethnicity.

during imprisonment and after being released, due to exclusion from access to public benefits, employment, and political activity.[24,33]

Our study also provides a unique understanding of the population-level impact of mass incarceration and structural racism, specifically within California. California incarcerates a higher percentage of its population than entire nations, such as the UK, and is home to significant racial inequities.[29] In California, jail incarceration rates are 3 to 4 times higher for Black individuals than White individuals.[69] Data also indicate that although Black individuals comprise only 6% of the state's population, they represent 20% and 28% of the state's jail and prison populations, respectively.[69,70] This finding illustrates that Black individuals are likely to know someone incarcerated in their social networks or community. Estimates indicate that in the US, 44% of Black women have an incarcerated family member compared with 12% of White women.[71] This large difference points to strained emotional, instrumental, and financial resources and increased psychosocial and economic stressors within Black and other racially and ethnically marginalized communities due to a family member, a loved one, a neighbor, or a community member being incarcerated.[72] This, combined with other stressors that disproportionately burden racially and ethnically minoritized individuals, differentially heightens the risk of adverse health outcomes. As such, our study shows that racial inequities in incarceration within California also translate to racial inequities in adverse birthing outcomes. Notably, although jail incarceration inequity was associated with increased risk of SMM for Black, Hispanic or Latinx, and White birthing people, associations were stronger for Black birthing people, particularly when examining NT SMM, even when accounting for county socioeconomic status and temporal trends.

Table 4. Associations Between Black-White Inequity in County Jail Incarceration Rates and Severe Maternal Morbidity (Including Blood Transfusion–Only Cases), California, 1997-2018

Characteristic	Odds ratio (95% CI)		
	Model 1[a]	Model 2[b]	Model 3[c]
American Indian or Alaska Native (n = 43 254)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	0.88 (0.69-1.12)	0.88 (0.69-1.13)	0.86 (0.67-1.09)
Tertile 3 (high inequity)	0.93 (0.72-1.21)	0.93 (0.71-1.21)	0.88 (0.67-1.15)
Asian or Pacific Islander (n = 1 369 170)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.01 (0.89-1.15)	1.00 (0.88-1.14)	1.01 (0.88-1.15)
Tertile 3 (high inequity)	1.12 (0.98-1.28)	1.10 (0.96-1.26)	1.11 (0.96-1.27)
Black (n = 589 692)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.21 (1.04-1.41)	1.21 (1.04-1.41)	1.15 (0.99-1.35)
Tertile 3 (high inequity)	1.27 (1.08-1.50)	1.27 (1.07-1.49)	1.20 (1.01-1.42)
Hispanic or Latinx (n = 5 177 325)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.12 (1.06-1.17)	1.11 (1.06-1.17)	1.11 (1.06-1.16)
Tertile 3 (high inequity)	1.21 (1.15-1.28)	1.20 (1.14-1.27)	1.20 (1.14-1.27)
White (n = 3 014 652)			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	1.07 (1.01-1.14)	1.07 (1.01-1.14)	1.08 (1.01-1.15)
Tertile 3 (high inequity)	1.09 (1.02-1.17)	1.08 (1.02-1.16)	1.09 (1.02-1.17)
Multiracial or other (n = 6599)[d]			
Tertile 1 (low inequity)	1 [Reference]	1 [Reference]	1 [Reference]
Tertile 2	0.83 (0.39-1.79)	0.84 (0.39-1.81)	0.83 (0.38-1.79)
Tertile 3 (high inequity)	0.90 (0.46-1.76)	0.94 (0.48-1.83)	0.87 (0.43-1.75)

[a] Model 1 was unadjusted.

[b] Model 2 was adjusted for maternal age, education, and insurance.

[c] Model 3 was adjusted for maternal age, education, insurance, and county-level median household income.

[d] Multiracial or other category includes individuals who self-identified with at least 2 or more racial groups and those who self-identified as "other" race or ethnicity.

Limitations

This study has several limitations. First, due to a lack of data on incarceration rates at different geographic levels, we assessed exposure at the county level. Counties are large geographic entities and likely contain heterogeneous exposure distribution within smaller subgeographies. This highlights the need for local, state, and federal agencies to make data available at more granular geographic levels for population health research. On the other hand, counties may be more conducive to policy-level interventions that may alleviate inequities due to their governance structure.[73] Second, structural racism is a multidimensional construct that manifests through several social and cultural institutions.[74] However, our study only assesses its impact through the criminal-legal system and does not capture how other domains of structural racism may contribute to the risk of SMM. Hence, future studies should implement multidimensional approaches to better estimate the influence of structural racism on population health outcomes through its multiple domains.[75] Furthermore, this study does not explicitly address policies that shape incarceration rates or racial disparities in sentencing practices, which are also important dimensions of structural racism.[76] Particularly, within the context of California, we did not examine how laws such as Public Safety Realignment, which shifted jurisdiction of certain criminal cases from the state to counties, may be associated with racial and ethnic inequities in jail incarceration rates.[77] Future studies should examine how structural racism influences adverse health outcomes via different policies and practices. Third, although we controlled for a range of individual-level characteristics and county socioeconomic status, we cannot completely rule out the possibility of social selection influencing our results.[78]

Conclusions

Structural racism, entrenched within several social and cultural domains in the US, has far-reaching consequences and drives racial and ethnic health inequities. One such domain is the criminal-legal system, which incarcerates Black and other racially and ethnically marginalized individuals at much higher rates than White individuals. In this study, we found that residing in counties with high jail incarceration inequity between Black and White individuals was associated with increased SMM risk, particularly among Black and Hispanic or Latinx birthing people.

ARTICLE INFORMATION

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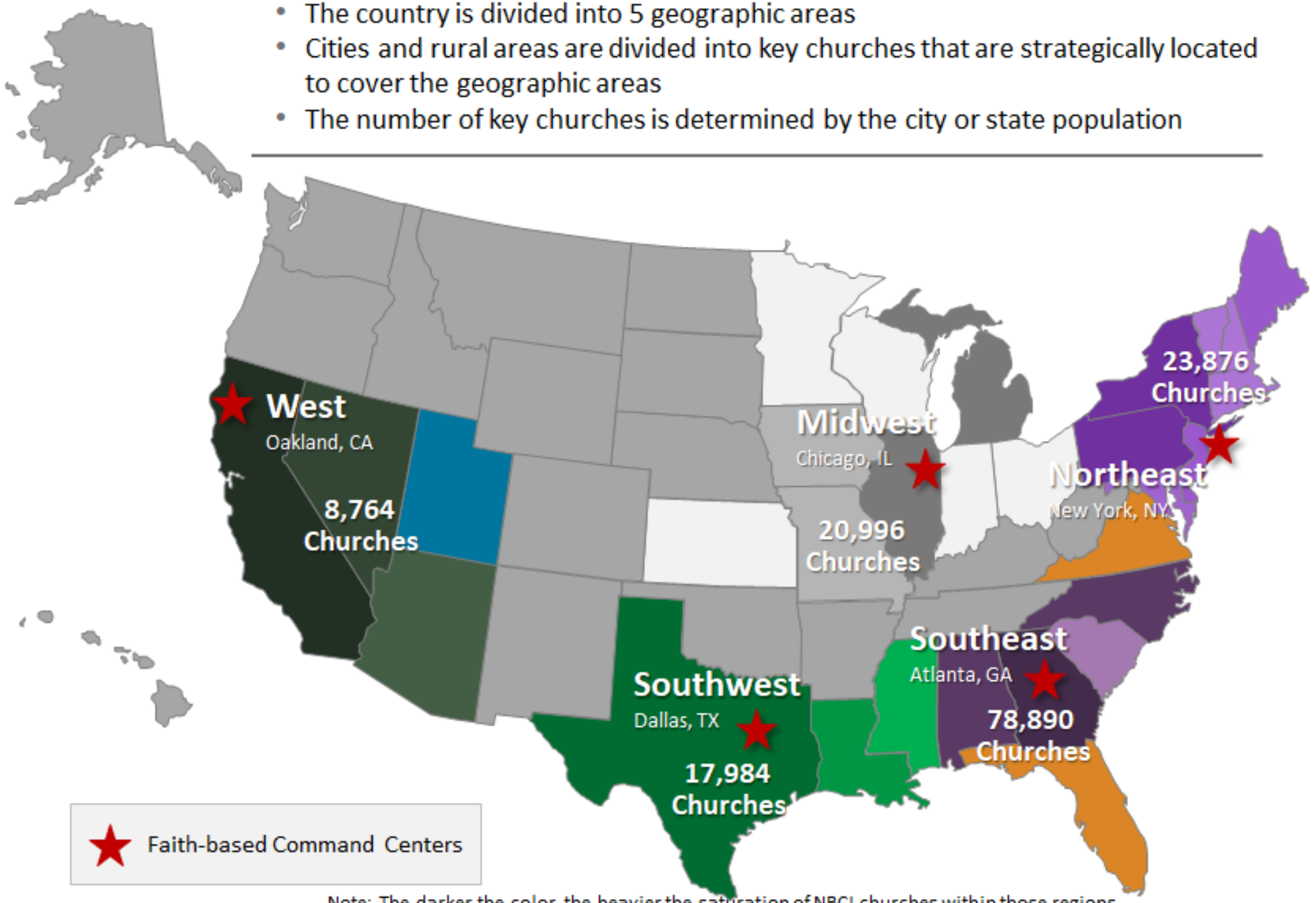
HOW NBCI IS ORGANIZED

- The country is divided into 5 geographic areas
- Cities and rural areas are divided into key churches that are strategically located to cover the geographic areas
- The number of key churches is determined by the city or state population



Note: The darker the color, the heavier the saturation of NBCI churches within those regions

Impacts on NBCI's 27.7 Million Members

Critical disparities questions	Impact on NBCI's 27.7 members
How many people are uninsured?	With pandemic-era coverage protections still in place, particularly the continuous enrollment provision in Medicaid and enhanced subsidies in the Marketplace, the number of uninsured decreased in 2022. In 2022, 25.6 million nonelderly individuals were uninsured, a decrease of 3.3 million from 2019.
The cost factors of the unwinding of Medicaid coverage enrollment level during the pandemic and post pandemics?	With pandemic-era coverage protections still in place, particularly the continuous enrollment provision in Medicaid and enhanced subsidies in the Marketplace, the number of uninsured decreased in 2022. In 2022, 25.6 million nonelderly individuals were uninsured, a decrease of 3.3 million from 2019.
What is the impact of the uninsured in dealing with the issue disparities and cost?	Most uninsured people are in low-income families and have at least one worker in the family. Reflecting the more limited availability of public coverage in some states, nonelderly adults are more likely to be uninsured than children. Despite gains across groups over time, racial and ethnic disparities in coverage persist.
Why are people uninsured?	Despite policy efforts to improve the affordability of coverage, many uninsured people cite the high cost of insurance as the main reason they lack coverage. In 2022, 64% of uninsured nonelderly adults said that they were uninsured because the cost of coverage was too high. Many uninsured people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Additionally, undocumented immigrants are ineligible for federally funded coverage, including Medicaid or Marketplace coverage.
What are saving of dealing with chronic diseases in the early as opposed to late stages?	This could mean saving the government between 1 and 10% of the cost depending on access to care https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10090362/
How does not having coverage affect health care access?	Healthcare coverage increases good access to care by 10,000 percent. It is the critical first step https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/health-care-access
How much money can be saved as a result of increasing the number of insured?	Leading healthcare experts says 3-5 trillion within 10 years
What are the financial implications of being uninsured?	Uninsured people often face unaffordable medical bills when they do seek care. In 2022, uninsured nonelderly adults were nearly twice as likely as those with insurance to say they have difficulty affording health care costs. These costs can quickly translate into medical debt since most people who are uninsured have low or moderate incomes and have little, if any, savings.
What is the cost to the country when these insured lack prescriptions and access to advance therapeutics coverage?	Lives, talent, and the skills this country needs to be competitive.
What is the importance of providing healthcare equal to the black rural population?	There should be no difference in the right to access to care -all of citizens

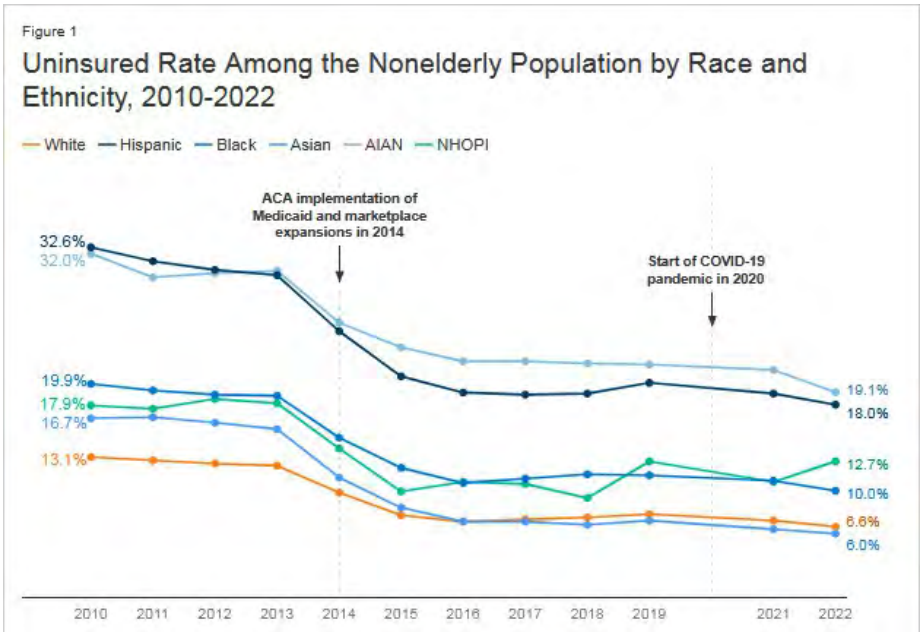
Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Health Insurance and African Americans

Health coverage plays a major role in enabling people to access health care and protecting families from high medical costs. People of color have faced longstanding disparities in health coverage that contribute to disparities in health. This brief examines trends in health coverage by race/ethnicity from 2010 through 2022 and discusses the implications for health disparities. All noted differences between groups and years described in the text are statistically significant at the $p<0.05$ level. It is based on KFF analysis of American Community Survey (ACS) data for the nonelderly population.

The coverage gains between 2019 and 2021 were largely driven by increases in Medicaid coverage, reflecting policies to stabilize and expand access to affordable coverage that were implemented during the COVID-19 pandemic, including a requirement that states keep Medicaid enrollees continuously enrolled during the public health emergency (PHE). These coverage gains helped narrow percentage point differences in uninsured rates between people of color and White people.

Prior to the enactment of the ACA in 2010, people of color were at much higher risk of being uninsured compared to White people, with Hispanic and AIAN people at the highest risk of lacking coverage (Figure 1). The higher uninsured rates among people of color reflected more limited access to affordable health coverage options. Although the majority of individuals have at least one full-time worker in the family across racial and ethnic groups, people of color are more likely to live in low-income families that do not have coverage offered by an employer or to have difficulty affording private coverage when it is available. While Medicaid helped fill some of this gap in private coverage, prior to the ACA, Medicaid eligibility for parents was limited to those with very low incomes (often below 50% of the poverty level), and adults without dependent children—regardless of how poor—were ineligible under federal rules.



Health Coverage by Race and Ethnicity, 2010-2022 | KFF

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Health Care Disparities in the African American Community

Compared to their white counterparts, African Americans are generally at higher risk for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, and HIV/AIDS, according to the Office of Minority Health, part of the Department for Health and Human Services.

While the spotlight right now may be on the disadvantages African Americans face while fighting the novel coronavirus (COVID-19), they are also disadvantaged throughout the health care system when combating other diseases.

Compared to their white counterparts, African Americans are generally at higher risk for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, and HIV/AIDS, according to the Office of Minority Health, part of the Department for Health and Human Services.[1]

One possible contributing factor: The Centers for Disease Control and Prevention (CDC) says African Americans are more likely to die at early ages for all causes,[2] as young African Americans are living with diseases that are typically more common at older ages for other races. For example:

- High blood pressure is common in 12% vs. 10% of Black people vs. Whites aged 18-34 years, respectively. It is common in 33% vs. 22% of those aged 35-49 years, respectively.
- Diabetes is common in 10% of blacks aged 35-49 compared to 6% of whites.
- Stroke is present in 0.7% of blacks aged 18-34 compared to 0.4% of whites the same age. Stroke is common in 2% of African Americans compared to 1% of whites aged 35-49 and 7% vs. 4%, respectively, in those aged 50-64.

The CDC said that social factors compared to others in the U.S., specifically whites, affect African Americans at younger ages: unemployment, living in poverty, not owning a home, cost-prohibitive effects of trying to see an MD, smoking, inactive lifestyle, or obesity.

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Why 7 Deadly Diseases Strike Blacks Most

Health care disparities heighten disease differences between African Americans and white Americans.

Several deadly diseases strike Black Americans harder and more often than they do white Americans.

Yet we're closer to the beginning of the fight than to the end. Some numbers:

- Diabetes is 60% more common in Black Americans than in White Americans. Blacks are up to 2.5 times more likely to suffer a limb amputation and up to 5.6 times more likely to suffer kidney disease than other people with diabetes.
- African Americans are three times more likely to die of asthma than white Americans.
- Deaths from lung scarring -- sarcoidosis -- are 16 times more common among blacks than among whites. The disease recently killed former NFL star Reggie White at age 43.
- Despite lower tobacco exposure, black men are 50% more likely than white men to get lung cancer.
- Strokes kill four times more 35- to 54-year-old Black Americans than white Americans. Black people have nearly twice the first-time stroke risk of whites.
- Blacks develop high blood pressure earlier in life -- and with much higher blood pressure levels -- than whites. Nearly 42% of black men and more than 45% of black women aged 20 and older have high blood pressure.
- Cancer treatment is equally successful for all races. Yet Black men have a 40% higher cancer death rate than white men. African American women have a 20% higher cancer death rate than white women.

Why?

Genes definitely play a role. So does the environment in which people live, socioeconomic status -- and, yes, racism, says Clyde W. Yancy, MD, associate dean of clinical affairs and medical director for heart failure/transplantation at the University of Texas Southwestern Medical Center.

Yancy says that all humans have the same physiology, are vulnerable to the same illnesses, and respond to the same medicines. Naturally, diseases and responses to treatment do vary from person to person. But, he says, there are unique issues that affect Black Americans.

"We must recognize there are some arbitrary issues that are present in the way we practice medicine and dole out health care," Yancy tells WebMD. "It forces us to think very carefully about the very volatile issue of race and what race means. At the end of the day, all of us acknowledge that race is an extremely poor physiological construct. Race is a placeholder for something else.

Like Yancy, LeRoy M. Graham Jr., MD, says the time is ripe for Americans to come to grips with these issues. Graham, a pediatric lung expert, serves on the American Lung Association's board of directors, is associate clinical professor of pediatrics at Morehouse School of Medicine in Atlanta, and serves as staff physician for Children's Healthcare of Atlanta.

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Leading Causes of Death – Non-Hispanic Blacks – United States, 2018

Non-Hispanic Black1, Male, All ages[2]

Rank	Disease	Percent
1)	Heart Disease	24.1%
2)	Cancer	19.7%
3)	Alzheimer's Disease	7.9%
4)	Stroke	5.0%
5)	Homicide	4.5%
6)	Diabetes	4.4%
7)	Chronic Lower Respiratory Disease	3.3%
8)	Kidney Disease	2.7%
9)[3]	Septicemia	1.7%
10)[3]	Hypertension	1.7%

*Data available in Table 1 of the NCHS National Vital Statistics Report Volume 70, Number 4 May 17, 2021
[1] Persons identified as White, Black, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander were of non-Hispanic origin. Persons of Hispanic origin may be of any race. Figures for origin not stated are included in "all races and origins" but not distributed among race and Hispanic origin groups. For more information on race and Hispanic origin classification please see the Technical Notes section of "Deaths: Leading Causes for 2018"pdf icon. [2] Figures include all ages, including age not stated.
[3] The data presented are percentages of deaths. Due to rounding, some percentages appear to be ties but are not.

Non-Hispanic Black[1], Male, by Age Group

	Age Group[3]					
Rank[2]	**1-19 years**	**20-44 years**	**45-64 years**	**65-84 years**	**85+ years**	**All ages**
1)	Homicide 35.1%	Homicide 26.1%	Heart Disease 27.1%	Heart Disease 26.4%	Heart Disease 26.7%	Heart Disease 24.1%
2)	Unintentional Injuries 24.2%	Unintentional Injuries 24.3%	Cancer 20.8%	Cancer 25.6%	Cancer 16.8%	Cancer 19.7%
3)	Chronic Lower Respiratory Disease 8.0%	Heart Disease 12.6%	Unintentional Injuries 9.7%	Stroke 6.0%	Stroke 7.0%	Alzheimer's Disease 7.9%

Age Group[3]						
Rank[2]	**1-19 years**	**20-44 years**	**45-64 years**	**65-84 years**	**85+ years**	**All ages**
4)	Suicide 7.2%	Suicide 6.7%	Diabetes 5.0%	Diabetes 4.9%	Alzheimer's Disease 5.9%	Stroke 5.0%
5)	Cancer 4.7%	Cancer 4.8%	Stroke 4.6%	Chronic Lower Respiratory Disease 4.6%	Chronic Lower Respiratory Disease 4.1%	Homicide 4.5%
6)	Birth Defects 3.5%	Diabetes 2.7%	Kidney Disease 2.5%	Kidney Disease 3.3%	Diabetes 3.6%	Diabetes 4.4%
7)	Heart Disease 3.2%	HIV disease 2.3%	Chronic Liver Disease & Cirrhosis 2.3%	Septicemia 2.1%	Kidney Disease 3.5%	Chronic Lower Respiratory Disease 3.3%
8)	Anemia 0.74%	Stroke 1.6%	Chronic Lower Respiratory Disease 1.9%	Diabetes 2.0%	Influenza & Pneumonia 2.7%	Kidney Disease 2.7%
9)	Diabetes 0.55%	Kidney Disease 0.73%	Hypertension 1.8%	Unintentional Injuries[4] 1.9%	Hypertension 2.4%	Septicemia[4] 1.7%
10)	Stroke 0.48%	Hypertension 0.63%	Homicide 1.1%	Hypertension[4] 1.9%	Septicemia 1.9%	Hypertension[4] 1.7%

[1] Persons identified as White, Black, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander were of non-Hispanic origin. Persons of Hispanic origin may be of any race. For more information on race and Hispanic origin classification please see the Technical Notes section of "Deaths: Leading Causes for 2018".
[2] Based on number of deaths. Tie ranks are listed in order of ICD-10 code.
[3] Figures for origin not stated are included in "all races and origins" but not distributed among race and Hispanic origin groups. [4] Data presented are percentages. Due to rounding, some percentages appear to be ties but are not.

Non-Hispanic Black[1], Female, All ages[2]

Rank	Disease	Percent
1)	Heart Disease	23.0%
2)	Cancer	21.2%
3)	Stroke	6.5%
4)	Diabetes	4.5%
5)	Alzheimer Disease	3.9%

Rank	Disease	Percent
6)	Unintentional Injuries	3.7%
7)	Chronic Lower Respiratory Disease	3.6%
8)	Kidney Disease	3.0%
9)	Septicemia	2.2%
10)	Hypertension	2.0%

*Data available in Table 1 of the NCHS National Vital Statistics Report Volume 70, Number 4 May 17, 2021
[1] Persons identified as White, Black, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander were of non-Hispanic origin. Persons of Hispanic origin may be of any race. Figures for origin not stated are included in "all races and origins" but not distributed among race and Hispanic origin groups. For more information on race and Hispanic origin classification please see the Technical Notes section of "Deaths: Leading Causes for 2018". [2] Figures include all ages, including age not stated.

	Age Group[3]					
Rank[2]	**1-19 years**	**20-44 years**	**45-64 years**	**65-84 years**	**85+ years**	**All ages**
1)	Unintentional Injuries 26.9%	Unintentional Injuries 20.1%	Cancer 29.2%	Cancer 25.0%	Heart Disease 27.3%	Heart Disease 23.0%
2)	Homicide 15.1%	Cancer 16.3%	Heart Disease 21.9%	Heart Disease 23.9%	Cancer 10.5%	Cancer 21.2%
3)	Cancer 8.3%	Heart Disease 15.4%	Unintentional Injuries 5.1%	Stroke 6.9%	Alzheimer Disease 9.9%	Stroke 6.5%
4)	Birth Defects 6.7%	Homicide 8.3%	Diabetes 5.0%	Diabetes 5.3%	Stroke 8.9%	Diabetes 4.5%
5)	Suicide 5.4%	Diabetes 4.4%	Stroke 4.8%	Chronic Lower Respiratory Disease 4.3%	Diabetes 3.4%	Alzheimer's Disease 3.9%
6)	Heart Disease 4.3%	Pregnancy Complications 2.9%	Chronic Lower Respiratory Disease 3.6%	Kidney Disease 3.7%	Chronic Lower Respiratory Disease 3.1%	Unintentional Injuries 3.7%
7)	Chronic Lower Respiratory Disease 3.4%	Stroke 2.8%	Kidney Disease 2.7%	Alzheimer's Disease 2.6%	Kidney Disease 2.9%	Chronic Lower Respiratory Disease 3.6%
8)	*(tie rank)* Anemia and	HIV disease 2.5%	Septicemia 2.4%	Septicemia 2.4%	Hypertension 2.6%	Kidney Disease 3.0%

Rank[2]	Age Group[3] 1-19 years	20-44 years	45-64 years	65-84 years	85+ years	All ages
	Diabetes 0.95%					
9)	_____[4]	Kidney Disease 1.3%	Hypertension 1.2%	Hypertension 2.0%	Influenza & Pneumonia 2.3%	Septicemia 2.2%
10)	*(tie rank)* Perinatal Conditions and Septicemia 0.74%	Septicemia 1.2%	Influenza & Pneumonia 1.1%	Influenza & Pneumonia 1.9%	Septicemia 1.8%	Hypertension 2.0%

[1] Persons identified as White, Black, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander were of non-Hispanic origin. Persons of Hispanic origin may be of any race. For more information on race and Hispanic origin classification please see the Technical Notes section of "Deaths: Leading Causes for 2018".
[2] Based on number of deaths. Tie ranks are listed in order of ICD-10 code. [3] Figures for origin not stated are included in "all races and origins" but not distributed among race and Hispanic origin groups. [4] Data presented are percentages. Due to rounding, some percentages appear to be ties but are not.

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Heart Disease, Heart Failure, Cardiovascular Diseases

Heart Disease and African Americans

What is Heart Disease?
According to the Centers for Disease Control and Prevention (CDC), heart disease is the leading cause of death in the United States. The term "heart disease" refers to several types of heart conditions. In the United States, the most common type of heart disease is coronary artery disease (CAD), which can lead to heart attack. You can reduce your risk for heart disease through lifestyle changes and, in some cases, medicine.

How Does Heart Disease Affect African American Populations?

- In 2019, African Americans were 24 percent less likely to die from heart disease than non-Hispanic whites.
- Although African American adults are 20 percent more likely to have high blood pressure, they are less likely than non-Hispanic whites to have their blood pressure under control.
- African American women are nearly 60 percent more likely to have high blood pressure, as compared to non-Hispanic white women.

Diagnosed Cases of Coronary Heart Disease:

Age-adjusted percentage of coronary heart disease among persons 18 years of age and over, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
5.2	5.6	0.93

Source: CDC 2022. National Center for Health Statistics. Percentage of coronary heart disease for adults aged 18 and over, United States, 2019—2021. National Health Interview Survey. Generated interactively: Jan 04, 2023. https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html

Death Rate:

Age-adjusted heart disease death rates per 100,000 (2019)			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	221.2	284.9	0.78
Women	176.0	235.3	0.75
Total	197.6	259.8	0.76

Source: CDC 2022. National Vital Statistics Report, Vol. 70, No. 8. Table 10. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-08-508.pdf.

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African American People and Cancer

Compared to members of other races, Black and African American people have higher rates of getting and dying from many kinds of cancer.

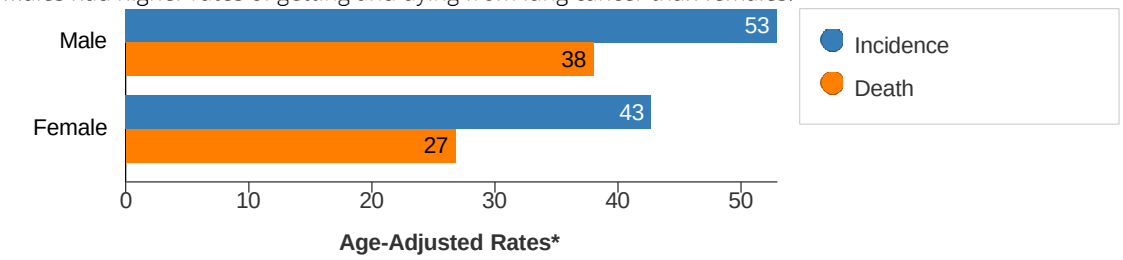
- Black people have the highest death rate for cancer overall.
- Black people have a lower overall 5-year cancer survival rate than White people.
- Black people are more likely than White people to be diagnosed with female breast, lung, and colorectal cancers at a late stage. Cancer is harder to treat after it spreads from the place where it started to other parts of the body.

Many cancers can be prevented. Staying away from tobacco smoke, keeping a healthy weight, drinking little or no alcohol, and getting human papillomavirus (HPV) vaccinations on time can lower the risk of getting cancer. Screening tests can prevent some cancers or find them early, when treatment works best. Some of these risk factors vary by race and ethnicity.

In the United States in 2020—

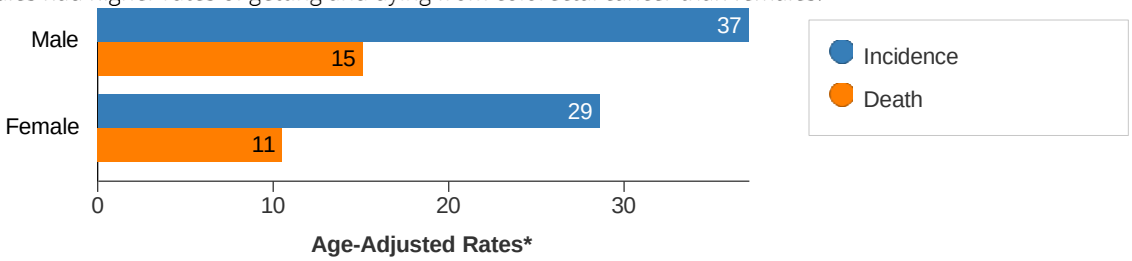
- 197,453 new lung cancers were reported.
- 136,084 people died from lung cancer.

Males had higher rates of getting and dying from lung cancer than females.



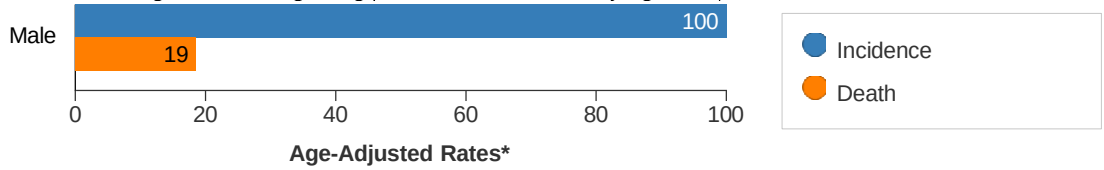
- 126,240 new colorectal cancers were reported.
- 51,869 people died from colorectal cancer.

Males had higher rates of getting and dying from colorectal cancer than females.



- 201,082 new prostate cancers were reported.
- 32,707 males died from prostate cancer.

Males had much higher rates of getting prostate cancer than dying from prostate cancer.



*Age-adjusted rates are per 100,000 standard population.
https://www.cdc.gov/cancer/uscs/about/stat-bites

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Alzheimer's and the African American Community

Among Black Americans ages 70 and older, 21.3% are living with Alzheimer's. Learn what the Alzheimer's Association is doing to address disparities and provide care and support for African Americans living with Alzheimer's or another dementia.

While older Black Americans are twice as likely as older Whites to have Alzheimer's or another dementia, research hasn't yet identified the cause. Higher rates of cardiovascular (heart and blood vessels) disease may play a role. Some studies indicate that after correcting for overall health and socioeconomic status, these differences disappear.

Black Americans and Alzheimer's | Alzheimer's Association

Only 20% of Black Americans say that they have no barriers to excellent health care and support for Alzheimer's or other dementias.

Half of African Americans say that they **have experienced discrimination** while seeking care for a person living with Alzheimer's.

Only 48% of Blacks report being confident they can access culturally competent care.

Only 53% of Blacks **believe that a cure for Alzheimer's will be distributed fairly**, without regard to race, color or ethnicity.

Only 35% of African Americans say that they are concerned about Alzheimer's or dementia

65% of Black Americans say that they **know somebody with Alzheimer's or dementia**

55% of Blacks **think that significant loss of cognitive abilities or memory is a natural part of aging rather than a disease.**

For more information, please see the Association's Alzheimer's Disease Facts and Figures special report on *Race, Ethnicity and Alzheimer's in America* (PDF).

ONLINE FIRST

Racial and Socioeconomic Disparities in Parkinsonism

J. Patrick Hemming, MD; Ann L. Gruber-Baldini, PhD; Karen E. Anderson, MD; Paul S. Fishman, MD, PhD; Stephen G. Reich, MD; William J. Weiner, MD; Lisa M. Shulman, MD

Objective: To assess potential racial and socioeconomic disparities in patients with parkinsonism treated at a tertiary Movement Disorders Center.

Methods: Patients with parkinsonism were evaluated for demographics (age, race, annual income, and educational level), medical comorbidities, medication regimen, disability (Older Americans Resources and Services subcale), presence of Parkinson disease, and disease severity (Unified Parkinson Disease Rating Scale). Disability and disease severity measures were compared by race, income, and educational level using analysis of variance for continuous variables and χ^2 tests for dichotomous variables.

Results: The sample included 1159 patients with parkinsonism (93.4% white, 6.1% African American, 61.2% who earned more than $50 000 annually, 62.7% who completed college, and 79.2% with a diagnosis of Parkinson disease). Cross-sectional analyses by race, income, and educational level showed greater disability and disease severity in African American compared with white patients (African American vs white Older Americans Resources and Services subscale total score, 29.8 vs 25.3, $P=.005$; Unified Parkinson's Disease Rating Scale total score, 53.0 vs 42.8; $P<.001$). African Americans were less likely to be prescribed dopaminergic medications, particularly newer agents (African Americans 20.6% vs whites: 41.1%; $P=.01$). Lower income and lower educational level were independently associated with greater disease severity and disability ($P<.003$).

Conclusion: Racial and socioeconomic disparities exist among patients with parkinsonism being treated at a tertiary Movement Disorders Center. African Americans and those with lower socioeconomic status have greater disease severity and disability than whites. These disparities may be because of problems in diagnosis, access to care, physician referrals, and patient attitudes regarding the appropriate threshold for seeking treatment at a specialized center. Understanding and correction of these disparities may improve outcomes.

Arch Neurol. 2011;68(4):498-503. Published online December 13, 2010. doi:10.1001/archneurol.2010.326

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IDENTIFYING AND ADDRESSING widespread health disparities in the United States is an issue of major significance. Elimination of health disparities is 1 of 2 major themes of Healthy People 2010 (US Department of Health and Human Services).[1] Racial minorities and people with lower socioeconomic status (SES) have inferior health outcomes for many medical conditions, including diabetes mellitus, heart disease, and Alzheimer disease.[2] Minority patients and those with lower SES tend to present later in the course of the disease and are less likely to have regular follow-up from primary care or specialist physicians.[3] The effect of race and SES on patients with parkinsonism is only beginning to be evaluated.

Parkinsonism is characterized by bradykinesia, tremor, and rigidity. As many as one-third of elderly Americans have features of parkinsonism.[4] Its causes are numerous[5] and most are irreversible. The most common cause of parkinsonism is Parkinson disease (PD), a debilitating, chronic, progressive neurodegenerative disorder with an incidence rate that increases with age.[6,7] Since the introduction of levodopa in 1967, numerous additional pharmacologic therapies have been introduced,[8,9] including dopamine receptor agonists, monoamine oxidase inhibitors, and catechol-*O*-methyltransferase inhibitors.[10] Judicious use of these agents alleviates symptoms and delays disability.

It is unclear whether the incidence and prevalence of PD is the same in white and African American populations in the United States. Studies to assess the prevalence of PD in African American populations show varied results.[11,12] A review of 20 studies[13] concluded that differences in prevalence in African Americans com-

Table 1. Patient Characteristics by Race, Income, and Educational Level

Characteristic	No.	Age, y, Mean	CIRS-G Total Score	MMSE Score	PD, %	Years Since Diagnosis[a]	First Visit, %[b]
Race[c]							
White	1024	67.0	5.2	27.6	79.5	5.3	59.8
African American	66	67.1	6.0	27.0	75.8	6.0	59.1
Annual income, $[d]							
<30 000	157	69.7[g]	6.3[g]	26.8[g]	73.2[f]	7.1[f]	58.6
30 000-50 000	166	67.7[g]	5.5[g]	27.1[g]	76.5[f]	5.7[f]	52.4
50 001-70 000	125	64.6[g]	5.2[g]	28.1[g]	79.2[f]	4.0[f]	59.2
>70 000	384	63.7[g]	4.5[g]	28.6[g]	86.2[f]	4.7[f]	56.0
Educational level[e]							
<College	423	68.8[g]	5.6[f]	26.6[g]	74.7[f]	5.8	62.7
≥College	712	65.7[g]	5.0[f]	28.3[g]	82.6[f]	5.0	57.7

Abbreviations: CIRS-G total, the total number of comorbid conditions, as measured by the Cumulative Illness Rating Scale–Geriatrics score, grouped by organ system; PD, Parkinson disease.
[a] Data missing for 192 patients.
[b] The observed visit is the patient's first evaluation at the University of Maryland Movement Disorders Center.
[c] Data missing for 69 patients.
[d] Data missing for 327 patients.
[e] Data missing for 24 patients.
[f] $P < .01$.
[g] $P < .001$.

pared with European populations remain unproven. Some evidence suggests that PD is underdiagnosed in African Americans.[14] The objective of this study is to assess the presence of differences in disease severity and disability in patients with parkinsonism treated at a tertiary Movement Disorders Center based on race, annual income, and educational level.

METHODS

Data were obtained from patients evaluated by movement disorder specialists (P.S.F., S.G.R., W.J.W., and L.M.S.) at the University of Maryland Movement Disorders Center between May 20, 2003, and July 10, 2008. On their initial visit to the clinic, patients were invited to participate in the Quality of Life & Function Study. The study protocol was approved by the University of Maryland Institutional Review Board, and 72.9% of whites and 56.9% of African Americans agreed to participate. Information was obtained from 3 sources: patient-reported measures, documented medical history, and neurologic examination.

Study participants completed a demographics questionnaire for age, time since diagnosis of parkinsonism, and self-identified race, household income, and educational level. Patients completed a modified version of the Older Americans Resource and Services disability subscale (OARS).[15] This subscale assesses the level of difficulty for 14 daily activities, including 7 activities of daily living and 7 instrumental activities of daily living. A more detailed description of the modified OARS is available.[16] If patients were unable to complete the questionnaire, a family member or caregiver completed it. Because parkinsonism may be characterized by fluctuation of symptoms, patients were instructed to provide 2 responses describing their best and worst level of functioning. Data analysis was based on an average of the best and worst ratings on each OARS item for each patient.

Data regarding current medications were obtained from the patient's medical history. The level of medical comorbidity was assessed with the Cumulative Illness Rating Scale–Geriatrics (CIRS-G), with the score based on the number and severity of medical disorders by organ system.[17] Medications were categorized by class, including dopaminergic medications and antipsychotics. Dopaminergics were subcategorized into carbidopa-levodopa only vs newer medications such as carbidopa-levodopa-entacapone or the dopamine receptor agonists. Among all patients with parkinsonism, PD was specifically diagnosed by a movement disorder specialist. The Unified Parkinson's Disease Rating Scale (UPDRS)[18] was used to assess the severity of parkinsonian signs in all patients.

Data were analyzed using SAS 9.1 statistical software (SAS Institute Inc, Cary, North Carolina). Disability and disease severity measures were compared by race, income, and educational level using analysis of variance for continuous variables and χ^2 tests for dichotomous variables. Similar general linear models were used to examine differences among race, income, and educational level groups, unadjusted (analysis of variance) and adjusted for variables found to be different between the groups (analysis of covariance), including age, CIRS-G total score, time since diagnosis, and presence of PD. The Mini-Mental State Examination score was not included in adjusted models (it was associated with educational level) because of concerns that the test itself may be 1 potential cause for the observed outcome differences (on the causal pathway).

RESULTS

A total of 1090 patients with parkinsonism were evaluated between May 20, 2003, and July 10, 2008. Patient characteristics (ie, age, comorbidity, Mini-Mental State Examination score, diagnosis, and years since diagnosis) by race, income, and educational level are presented in **Table 1**. Sixty-six patients with parkinsonism self-identified their race as African American. Lower SES was associated with being older and having greater medical comorbidity, lower cognitive ability, less likelihood of PD, and longer duration of illness. Although differences existed between African Americans and whites in level of medical comorbidity (ie, CIRS-G score), the difference was not significant ($P = .10$).

The OARS and UPDRS scores differed by race, income, and educational level (**Figure**). Most patients (57.4%) com-

pleted self-report forms independently and 40.7% of the total required help. The proportion of patients completing the study questionnaires varied by race but not by educational level or income. For example, for the OARS disability scale, 16.9% of whites and 26.7% of African Americans failed to complete the questionnaire. Variations in completion rates are reported in **Table 2** and **Table 3**. African Americans had greater disability and disease severity (Table 2). The largest differences were seen on the UPDRS (UPDRS motor score: 27.9 vs 35.1, $P<.001$ and UPDRS total score: 42.8 vs 53.0; $P<.001$). Covariate analysis controlling for age, CIRS-G score, time since diagnosis, and diagnosis of PD widened the gaps between African Americans and whites (UPDRS total score: 51.4 vs 40.6, $P=.002$; OARS total score: 29.3 vs 23.3, $P<.001$).

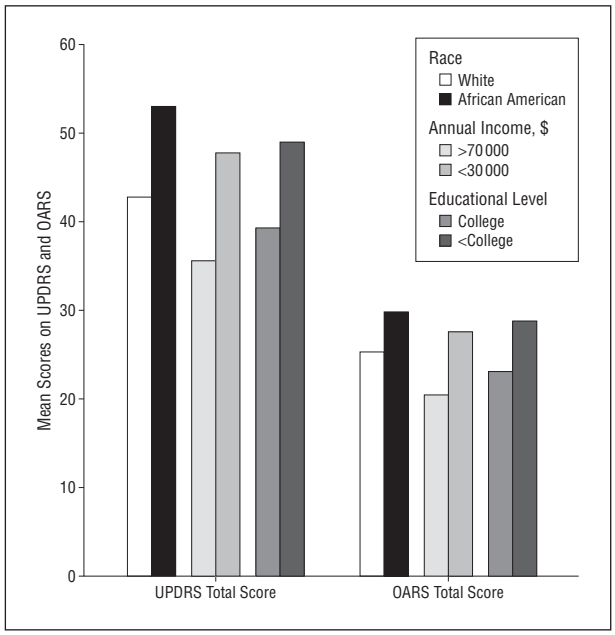


Figure. Disease severity (Unified Parkinson Disease Rating Scale [UPDRS] score) and disability (Older Americans Resources and Services [OARS] subscore) by race, income, and educational level. For overall differences, $P<.001$ for each outcome.

Across all measures of disease severity and disability, significant differences were seen by income and educational level (Table 2). Between high (>$70 000) and low (<$30 000) income groups, the UPDRS total score differed by nearly 15 points (35.6 vs 50.4; $P<.001$) and the total OARS scores were nearly 10 points apart (29.9 vs 20.5; $P<.001$). After controlling for age, CIRS-G score, percentage with PD, and time since diagnosis, significant but less pronounced differences persisted (6.7-point difference in UPDRS, $P<.001$; 5.3-point difference in OARS, $P<.001$). College-educated patients had less disease severity and disability, with scores 10 points lower on the UPDRS total (49.0 vs 39.3; $P<.001$) and 5 points lower on the OARS total (28.8 vs 23.1; $P<.001$). After controlling for covariates, differences diminished but remained significant (7.1-point difference in UPDRS, $P<.001$; 3.6-point difference in OARS, $P<.001$).

Table 3 presents the relationship between race, income, and educational level and disease severity and disability. Within race, trends persisted, but significance disappeared for all the variables except OARS activities of daily living score (African American, 13.8, vs white, 12.2, $P=.046$). This finding may be accounted for by the small number of African American patients. Results remained significant across all variables by income ($P\leq.001$). Differences related to educational level also remained significant (all $P<.01$).

Table 4 presents the comparative use of medications. At the initial visit to the Movement Disorders Center, African Americans were prescribed fewer antiparkinsonian medications (61.9% vs 77.6%; $P=.004$). African Americans were also receiving fewer new dopaminergic agents (catechol-*O*-methyltransferase inhibitors, dopamine agonists, or monoamine oxidase inhibitors, 20.6% vs 41.1%; $P=.001$). The administration of antipsychotic medications was higher in African Americans (12.7% vs 6.1%; $P=.04$).

Table 2. Disability and Disease Severity of Patients Grouped by Race, Income, and Educational Level[a]

Characteristic	No.	OARS Total Score	OARS ADL Score	OARS IADL Score	UPDRS Motor Score	UPDRS Total Score
Race						
White	1024	25.3	12.2	13.3	27.9	42.8
African American	66	29.8[c]	14.3[c]	15.8[b]	35.1[d]	53.0[d]
Annual income, $						
<30 000	157	29.9[d]	14.0[d]	16.2[d]	32.9[d]	50.4[d]
30 000-50 000	166	27.6	13.1	14.7	31.2	47.8
50 001-70 000	125	23.6	11.5	12.3	25.4	39.0
>70 000	384	20.5	10.3	10.5	23.7	35.6
Educational level						
<College	423	28.8[d]	13.6[d]	15.5[d]	31.9[d]	49.0[d]
≥College	712	23.1	11.3	12.0	25.7	39.3

Abbreviations: ADL, activities of daily living; IADL, instrumental activities of daily living; OARS, Older Americans Resource and Services disability subscale; UPDRS, Unified Parkinson Disease Rating Scale.

[a] On the OARS and UPDRS, higher scores indicate greater disability or greater disease severity. The OARS total scale ranges from 14 (no disability) to 70 (completely unable to perform the activities). On the ADL and IADL subscales, the score ranges from 7 (no disability) to 35 (completely unable to perform the activities). The UPDRS rates 35 features of parkinsonism on a scale of 0 (no symptoms) to 4 (severe symptoms). The motor subscale is a set of 14 items representing a total possible score of 108. Total UPDRS score ranges from 0 to 176.

[b] $P<.05$.

[c] $P<.01$.

[d] $P<.001$.

Table 3. Adjusted Means by Race, Income, and Educational Level After Controlling for the Other 2 Variables[a]

Characteristic	No.	OARS Total Score (n=778)	OARS ADL Score (n=773)	OARS IADL Score (n=772)	UPDRS Motor Score (n=778)	UPDRS Total Score (n=778)
Race (controlling for income and educational level)						
White	734	25.4	12.2	13.5	28.5	43.4
African American	44	28.9	13.8	15.3	31.8	48.2
P value for race		.05	.046	.08	.09	.11
Annual income, $ (controlling for race and educational level)						
<30 000	147	30.5	14.4	16.4	33.6	51.3
30 000-50 000	155	28.8	13.6	15.3	32.3	49.4
50 001-70 000	116	26.1	12.6	13.7	28.3	42.8
>70 000	360	23.2	11.5	12.0	26.4	39.5
P value for income		<.001	<.001	<.001	<.001	<.001
Educational level (controlling for race and income)						
<College	266	28.7	13.7	15.2	32.0	48.5
≥College	512	25.6	12.3	13.5	28.2	43.0
P value for educational level		.002	.002	.002	<.001	.001

Abbreviations: ADL, activities of daily living; IADL, instrumental activities of daily living; OARS, Older Americans Resource and Services disability subscale; UPDRS, Unified Parkinson Disease Rating Scale.

[a] Numbers in this table differ from Table 2 because there were only 778 patients with complete data for race, educational level, and income. Number of patients missing any demographic information was 381. Missing data were in the following categories: income (n=327), race (n=69), and educational level (n=24); numbers will not sum to 381 because some characteristics are missing multiple demographic data.

Table 4. Medications by Race, Educational Level, and Income[a]

Characteristic	No.	Antiparkinsonian Medications[b]	New DA[c]	CD/LD[d]	Antid/Anx	Antipsychotics	Dementia[e]
Race							
White	963	77.6[g]	41.1[g]	61.2	22.3	6.1[f]	4.9
African American	63	61.9[g]	20.6[g]	55.6	19.1	12.7[f]	3.2
Annual income, $							
<30 000	150	76.7	30.0[g]	67.3[f]	30.0[g]	12.0[h]	4.7[f]
30 000-50 000	156	77.6	37.2[g]	66.0[f]	28.2[g]	10.3[h]	6.4[f]
50 001-70 000	121	71.9	38.8[g]	53.7[f]	20.7[g]	5.0[h]	1.7[f]
>70 000	360	77.8	47.2[g]	56.7[f]	17.8[g]	1.9[h]	1.9[f]
Educational level							
<College	402	74.4	35.3[f]	60.2	25.6[f]	8.4[f]	5.2
≥College	667	76.9	43.0[f]	60.3	19.3[f]	4.7[f]	4.0

Abbreviations: Antid/Anx, antidepressants/anxiolytics; CD, carbidopa; DA, dopamine agonists; LD, levodopa.

[a] Numbers in this table differ from those in Table 2 because some participants (n = 66) were missing medication coding in the database.

[b] Includes CD/LD, DAs, monoamine oxidase inhibitors, catechol-*O*-methyltransferase inhibitors, anticholinergics, amantadine, and apomorphine.

[c] Includes apomorphine, entacapone, pramipexole, ropinirole, rasagiline, rotigitine, and selegiline.

[d] Includes patients prescribed LD as their sole dopaminergic therapy.

[e] Includes donepezil hydrochloride, rivastigmine, galantamine hydrobromide, and nemantine hydrochloride.

[f] $P<.05$.

[g] $P<.01$.

[h] $P<.001$.

Income was not associated with a difference in the overall use of antiparkinsonian medications; however, 30.0% of patients with incomes less than $30 000 were prescribed newer dopaminergic agents, compared with 47.2% of those making more than $70 000 ($P=.002$). The use of carbidopa-levodopa without newer adjunctive agents was more common in the lower-income population (67.3% in the <$30 000 group and 56.7% in the >$70 000 group, $P=.03$). Lower-income patients were also more likely to be prescribed antidepressants ($P=.004$), antipsychotics ($P=.001$), and antidementia agents ($P=.03$) (Table 4).

Antiparkinsonian medication use was similar across educational levels except for a difference in the use of newer agents (35.3% with less than a college education vs 43.0% with a college education, $P=.002$). Patients with lower educational level were more likely to be prescribed antipsychotics (8.4% with less than a college education vs 4.7% with a college education, $P=.01$).

COMMENT

Evidence of health disparities in PD is growing. Cheng et al[19] examined quality indicators at medical follow-up among veterans with PD and found that non-Hispanic white patients were more likely than minorities to receive care that adhered to certain quality indicators, particularly treatment of depression.

Dahodwala et al[20] abstracted data from the Pennsylvania Medicaid claims bank and reported that African Americans were half as likely to be diagnosed as having PD as whites. After controlling for age, sex, and geography, African Americans were 4 times less likely to receive any treatment for PD.[21] Yacoubian et al[22] found that among the cohort of patients in the Reasons for Geographic and Racial Differences in Stroke study, whites were nearly twice as likely to be prescribed medication for PD.

Our study shows that race and SES influence disease severity and disability related to parkinsonism among patients being treated at an academic Movement Disorders Center. African Americans had greater parkinsonian disease severity and disability than whites, and significant differences in management were also seen based on race and SES. These findings may be explained by delayed diagnosis, referral patterns, access to care, economic factors, or a combination of all these.[23,24]

The demographic makeup of the study sample illustrates important disparities. The University of Maryland Movement Disorders Center is located in Baltimore, where 64% of the population is African American, mean household income is approximately $30 000, and high school dropout rates are high.[25] In contrast, the patient population of the Movement Disorders Center is 93.4% white, 61.2% earn more than $50 000, and 62.7% have completed college. These discrepancies suggest that minorities and those with low SES are less likely to receive specialized care.

The African American and white populations in our study were similar in age, cognitive function, percentage with PD, and years since diagnosis, thereby eliminating these potential confounders. Nonetheless, this study shows greater severity of parkinsonian signs, symptoms, and disability in African Americans. These differences do not persist when income and educational level are controlled, but this may be because of the relatively small number of African Americans.

Parkinson disease severity was higher in African Americans than whites. African Americans scored 10 points higher on the total UPDRS than whites. This is a striking difference that may influence mortality. Wilson et al[26] showed among older Catholic nuns and priests that each higher point on the UPDRS scale was associated with a risk ratio of 1.1 for death within the 7-year study period. Perhaps African Americans or their physicians have a higher threshold for seeking treatment at a specialized center. This threshold may relate to perceptions of parkinsonian symptoms within the African American population. Studies have shown that African Americans and other minorities may perceive common medical conditions as natural processes that do not require medical intervention.[27,28]

Physicians may consciously or unconsciously contribute to health disparities. Race, educational level, and SES may be factors in physician decision-making regarding referral to a specialist for consultation.[29] Bach et al[30] reported that differences also exist between the primary care physicians whom African Americans visit and those whom whites visit. Physicians may be influenced by unconfirmed reports that PD is less common in African American populations. Our study shows that African Americans are less likely to receive antiparkinsonian medications and less likely to receive the newer medications on the market. There was no disparity in the use of antiparkinsonian medications by income or educational level, although lower SES groups were also less likely to receive newer agents. This finding suggests that the racial disparity in PD management is not fully explained by income or educational level. Other factors may include physician decision-making, patient acceptance of medications, and access to care. The increased use of antipsychotics in elderly African American patients seen in our study has been reported previously.[31]

Disparities by income and educational level have been reported in other populations. Lleras-Muney[32] demonstrated that life expectancy was lengthened by as much as 1.7 years for each extra year of schooling. In our study, income and educational level, when controlled for each other and for race, are significantly and independently associated with disease severity.

Differences between total UPDRS scores in high- and low-income patients from the present study reached nearly 15 points. Wilson et al[26] related this magnitude in total UPDRS score to a more than doubling of mortality risk. Although disparities remained after controlling for age and comorbidity, lower-income patients tended to be older and have greater medical comorbidity. This may account partly for the increased use of medications for depression and psychosis.

Several limitations exist in this study. The sample of African Americans is small (n=66) and our ability to detect differences may have been hindered. Not all data were collected from the initial visit at our Movement Disorders Center. This factor is likely to influence medication management and PD severity ratings; however, the proportion of patients receiving initial or follow-up care was similar across groups. The demographics of the center did not permit analysis of racial minorities other than African Americans. Numerous additional factors may confound disparities by SES, limiting conclusions regarding the effects of income and educational level on disability and disease. The generizability of these findings may be limited because our cohort is composed of a select population being referred to a single tertiary center.

The strengths of the study include the size and scope of items contained in the Quality of Life & Function Study database. All patients were examined and diagnosed by neurologists specializing in movement disorders. Future studies should investigate patient attitudes, their beliefs about PD symptoms and therapies, and physician attitudes regarding referral and PD management. This is the first study, to our knowledge, to show health disparities in disease severity and disability in parkinsonism. Studies in different patient populations and geographic locations are necessary to confirm these findings.

Racial and SES disparities are complex phenomena.[33] Parkinsonism reduces quality of life and results in disability and premature mortality. The results of this study suggest we need to better understand the cause of parkinsonism and to find remedies for disparate outcomes among patients with parkinsonian disease who are of different backgrounds and means.

African Americans and Stroke

A stroke, sometimes called a brain attack, happens when blood flow to an area of the brain is blocked or when a blood vessel in the brain bursts. Blood carries oxygen to cells in the body. When brain cells are starved of blood, they die.

Stroke is a medical emergency. It's important to act F.A.S.T. and get treatment as soon as possible (see sidebar). Call 9-1-1 right away if you or someone you are with shows any signs of having a stroke. Some treatments for stroke work only if given within the first 3 hours after symptoms start. A delay in treatment increases the risk of permanent brain damage or death.

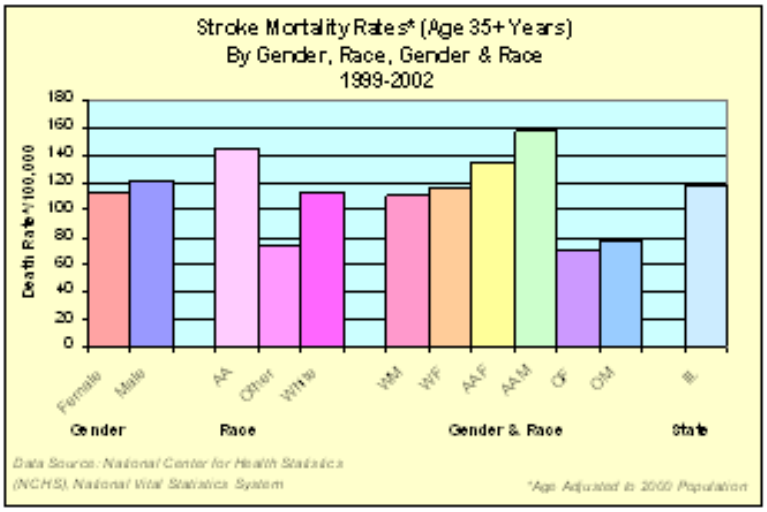
Why are African American women at higher risk for stroke?

Stroke is a leading cause of death among African American women, who are more likely to die from a stroke than non-Hispanic White women or Hispanic women in the United States[3]. African Americans have the highest rate of death due to stroke among all racial and ethnic groups[3].

- Almost 3 in 5 African American women are diagnosed with high blood pressure (greater than or equal to 130/80 mm Hg), which is a much higher proportion than White women (almost 2 in 5).[8]
- African American women are diagnosed with higher rates of obesity (nearly 3 in 5) and diabetes (more than 1 in 8), conditions that increase the risk for stroke, than White women.[9,10]
- U.S. adults, including African Americans, consume more than the recommended amounts of salt or sodium, which raises blood pressure and increases the risk for stroke.
- Smoking greatly increases stroke risk. About 1 in 8 African American women smoke.[9]

Why are African American men at higher risk for stroke?

- More than 1 in 2 African American men have a blood pressure greater than or equal to 130/80 mm Hg or are taking medicine to control their blood pressure.[11]
- Sickle cell disease, a common genetic disorder in African Americans, can lead to a stroke. About 1 in 365 African American babies are born with sickle cell disease.[12]
- About 1 in 5 African American men smoke.[13]
- About 7 in 10 African American men have overweight or obesity.[8]
- U.S. adults, including African Americans, consume more than the recommended amounts of salt or sodium, which raises blood pressure and increases the risk for stroke.



https://www.cdc.gov/stroke/about.htm

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Homicide

According to the Centers for Disease Control (CDC), homicide is the leading manner of death for African American males ages 10-35 and the second leading manner of death for Hispanic males of this same age group. A review of data from 2012 to 2014, regarding fatal gun deaths, reports that guns are the third leading cause of deaths for children under the age of 17.10 Nearly 80% of all homicides are due to firearm related injury.

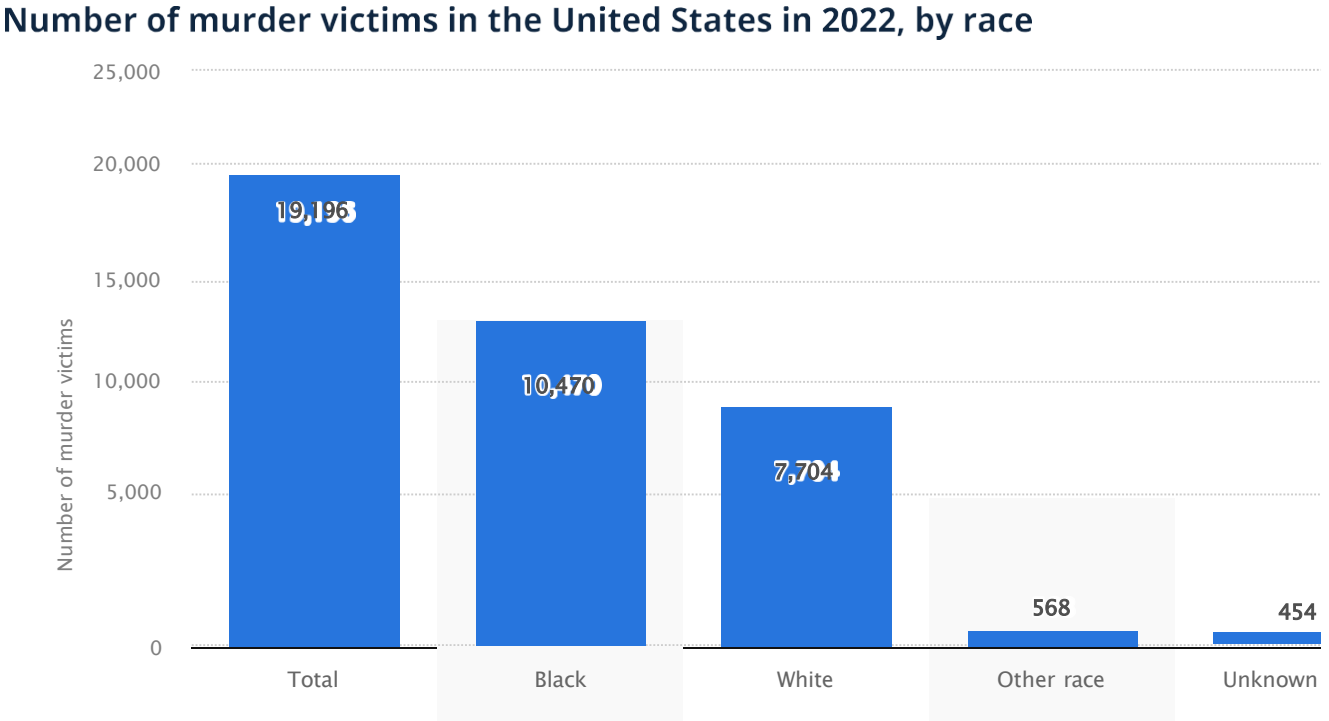
There are approximately 30,000 hospitalizations for gunshot wounds (GSW) each year in the United States. Nearly 6000 African American men die due to gun violence each year. Men are nine times more likely to be hospitalized for GSW when compared to women; and African American men are twice as likely as whites to require life-saving measures.

More-over, African American men make up only six percent of the population but make up greater than 50% of firearm related deaths. Cook et al. reviewed epidemiological data from the National Inpatient Sample (NIS) 2004-2013 and found that the majority of GSW hospitalizations resulted from assaults on young African American males and suicides among older white males.

They also identified that these injuries were associated with elevating health care costs.

In 2022, the FBI reported there were 10,470 Black murder victims in the United States and 7,704 White murder victims. In comparison, there were 454 murder victims of unknown race and 568 victims of another race.

In particular, the issue of police brutality has led to increasing attention following the murder of George Floyd, an African American who was killed by a Minneapolis police officer. Studies show that the rate of fatal police shootings for Black Americans was more than double the rate reported of other races.



https://www.statista.com/statistics/251877/murder-victims-in-the-us-by-race-ethnicity-and-gender/

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Diabetes

According to the Centers for Disease Control and Prevention (CDC), diabetes is a chronic (long-lasting) health condition that affects how your body turns food into energy. Your body breaks down most of the food you eat into sugar (glucose) and releases it into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy.
With diabetes, your body does not make enough insulin or cannot use it as well as it should. When there is not enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, diabetes can cause serious health problems, such as heart disease, vision loss, and kidney disease. There is not a cure yet for diabetes, but losing weight, eating healthy food, and being active can really help. Other things you can do to help your diabetes include taking medication as prescribed; receiving diabetes self-management education and support; and being consistent with your medical appointments.

How Does Diabetes Affect African American Populations?

- In 2019, non-Hispanic blacks were twice as likely as non-Hispanic whites to die from diabetes.
- In 2018, African American adults were 60 percent more likely than non-Hispanic white adults to be diagnosed with diabetes by a physician.
- In 2019, non-Hispanic blacks were 2.5 times likely to be hospitalized with diabetes and associated long-term complications than non-Hispanic whites.
- In 2019, non-Hispanic blacks were 3.2 times more likely to be diagnosed with end stage renal disease as compared to non-Hispanic whites.

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Diagnosed Cases of Diabetes

Age-adjusted percentage of adults aged 18 and over diagnosed with diabetes, 2021		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
12.7	7.0	1.8

Source: CDC 2022. National Diabetes Surveillance System. https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Chronic Lower Respiratory Disease

CLRD actually comprises three major diseases, i.e., chronic bronchitis, emphysema, and asthma, that are all characterized by shortness of breath caused by airway obstruction1. The obstruction is irreversible in chronic bronchitis and emphysema, reversible in asthma. Before 1999, CLRD was called Chronic Obstructive Pulmonary Disease (COPD). While the two classifications are similar, in this document CLRD is used to refer to chronic bronchitis, emphysema, and asthma.

Tobacco smoking is by far the most important risk factor for chronic bronchitis and emphysema, accounting for about 80% of all cases. The American Lung Association states that cigarette smokers are 10 times more likely to die of COPD than nonsmokers (5). Pipe and cigar smokers also have greater COPD morbidity and mortality than nonsmokers; however, their rates are lower than those for cigarette smokers (25). Other environmental exposures, i.e., occupational dusts and chemicals and indoor/outdoor air pollution, contribute to approximately 15% of COPD cases, with 5% due to genetic influences.

While in 1998 COPD ranked ninth as a cause of death among Hispanics and eighth among African-Americans, compared to fourth among whites, this is expected to change as the rates of smoking in these groups increase, according to CDC statistics (58). The strongest predictors of COPD mortality are older age and decreased FEV1. Overall, the median survival rate for patients who have lost two-thirds of their lung function is 10 years (59).

County of Residence	Race %, (Count)			Age Group %, (Count)				Sex %, (Count)	
	Black	White	Other/Unknown	15-54	55-64	65-74	75+	Male	Female
Kent (n =715)	10.8 (77)	88.2 (631)	1.0 (7)	5.2 (37)	9.8 (70)	24.9 (178)	60.1 (430)	46.7 (334)	53.3 (381)
New Castle (n=1874)	13.9 (261)	85.3 (1599)	0.80 (14)	3.9 (74)	10.1 (190)	21.1 (395)	64.8 (1215)	41.0 (766)	59.0 (1108)
Sussex (n=1144)	4.9 (56)	94.0 (1075)	1.1 (13)	2.7 (31)	8.7 (100)	25.7 (294)	62.8 (719)	46.7 (534)	53.3 (610)
Total n = 3733	394	3305	34	142	360	867	2364	1634	2099

Chronic lower respiratory disease mortality (2009-2016) by race, age group, sex and county of residence in Delaware 16,18 (https://www.researchgate.net/figure/Chronic-lower-respiratory-disease-mortality-2009-2016-by-race-age-group-sex-and_tbl1_347644973)

https://dhhr.wv.gov/HSC/publications/A_Z_Index/Documents/CLRD/CLRD_2003.pdf

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Hypertension

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While in 1998 COPD ranked ninth as a cause of death among Hispanics and eighth among African-Americans, compared to fourth among whites, this is expected to change as the rates of smoking in these groups increase, according to CDC statistics (58). The strongest predictors of COPD mortality are older age and decreased FEV1. Overall, the median survival rate for patients who have lost two-thirds of their lung function is 10 years (59).

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https://dhhr.wv.gov/HSC/publications/A_Z_Index/Documents/CLRD/CLRD_2003.pdf

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Nutrition

The incidence of preventable chronic diseases is disproportionally high among African Americans and could be reduced through diet and physical activity interventions. African Americans, in particular, fared the worst of all racial groups with respect to nutrition, with 64.7% at high risk. African Americans also had the highest prevalence of hypertension, hyperlipidemia, and stroke.

While largely preventable, these are known to disproportionately affect African Americans at younger ages,[22]. Nutritional risk among African Americans was disproportionately driven by low levels of fruit, vegetable, and dairy intake, which was consistent with other studies of middle-aged and older African Americans.[23] African Americans frequently reported eating fewer than two meals daily.

African Americans also had the highest frequency of emergency department visits over the course of twelve months. Some evidence[23] shows that malnutrition is associated with emergency department use, and while not casual in nature, studies found African Americans had both the highest frequency of emergency department visits and highest malnutrition risk, thus warranting further exploration.

Obesity is a problem in the African American community and is related to conditions like heart disease, stroke, and cancer. Obesity is common, serious, and costly. The estimated annual medical cost of obesity in the U.S. was $147 billion in 2008.

- African Americans are nearly 1.5 times as likely to have obesity as compared to non-Hispanic Whites.
- From 2011-2014, the prevalence of obesity among African Americans was 48% compared to 35%of non-Hispanic Whites.
- African Americans eat fewer vegetables than other racial/ethnic groups but eat similar amounts of fruit as non-Hispanic Whites.

Table 3. Prevalence of children and adolescents aged 2–19 years with obesity, by demographic characteristics: United States,

Characteristic	Both sexes		Boys		Girls	
	Sample size	Prevalence percentage (95% confidence interval)	Sample size	Prevalence percentage (95% confidence interval)	Sample size	Prevalence percentage (95% confidence interval)
Total	4,749	19.7 (17.9–21.6)	2,410	20.9 (18.9–22.9)	2,339	18.5 (16.3–21.0)
Age group (years):						
2–5	1,141	112.7 (10.8–14.8)	566	13.6 (10.8–16.8)	575	111.8 (9.3–14.8)
6–11	1,765	20.7(17.9–23.7)	894	222.9 (19.5–26.5)	871	318.5 (15.2–22.1)
12–19	1,843	22.2 (19.7–24.8)	950	222.6 (19.7–25.7)	893	21.7 (18.1–25.7)
Race and Hispanic origin:						
Non-Hispanic white	1,471	[4–6]16.6 (13.7–19.8)	743	617.6 (14.8–20.7)	728	[4–6]15.4 (11.2–20.5)
Non-Hispanic black	1,270	[5]24.8 (21.6–28.1)	662	[5,6]18.8 (15.9–22.1)	608	[3,5,6]30.8 (26.0–35.8)
Non-Hispanic Asian	420	[6]9.0 (6.5–12.2)	208	[6]13.1 (8.8–18.4)	212	[*,3,6]5.2 (2.3–9.9)
Hispanic	1,143	26.2 (22.4–30.2)	562	29.3 (23.1–36.0)	581	23.0 (19.6–26.6)

Table 7. Prevalence of adults aged 18 and over with hypertension, by demographic characteristics: United States, 2017–March 2020

Characteristic	Both sexes		Men		Women	
	Sample size	Prevalence percentage (95% confidence interval)	Sample size	Prevalence percentage (95% confidence interval)	Sample size	Prevalence percentage (95% confidence interval)
Total (age adjusted)	7,948	45.1 (42.5–47.6)	3,975	48.7 (44.8–52.6)	3,973	[1]41.2 (38.5–44.0)
Total (crude)	7,948	48.1 (45.4–50.8)	3,975	50.5 (46.9–54.2)	3,973	45.7 (42.8–48.6)
Age group (years):						
18–39	2,608	[2]23.4 (20.5–26.5)	1,280	[2]29.4 (25.0–34.2)	1,328	[1,2]16.9 (13.7–20.6)
40–59	2,534	52.4 (48.7–56.2)	1,231	56.2 (50.4–61.8)	1,303	[1]48.8 (44.3–53.4)
60 and over	2,806	74.1 (71.4–76.7)	1,464	73.1 (68.5–77.3)	1,342	75.0 (72.1–77.7)
Race and Hispanic origin:						
Non-Hispanic white	2,822	[3]43.5 (39.4–47.6)	1,430	[3]46.9 (40.3–53.5)	1,392	[3,5]39.9 (36.0–43.9)
Non-Hispanic black	2,123	[4,5]56.9 (54.1–59.8)	1,037	[4,5]56.0 (51.7–60.2)	1,086	[4,5]57.6 (52.9–62.2)
Non-Hispanic Asian	919	44.6 (41.4–47.9)	451	50.5 (45.8–55.2)	468	[1]38.7 (34.3–43.3)
Hispanic	1,687	42.7 (40.4–45.1)	837	50.2 (45.6–54.8)	850	[1]34.8 (31.2–38.5)

https://www.cdc.gov/pcd/issues/2013/12_0256.htm
https://stacks.cdc.gov/view/cdc/94472/cdc_94472_DS1.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3690829/
https://stacks.cdc.gov/view/cdc/106273

Immunization and the African American Community

What is Immunization?

According to the Centers for Disease Control and Prevention (CDC), immunization is a process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with vaccination or inoculation. Vaccination is the act of introducing a vaccine into the body to produce protection from a specific disease.

What are the Rates of Immunizations among African American Populations?

African American adults are less likely than non-Hispanic white adults to have received a flu vaccine in the past year or to have ever received the pneumonia vaccine.

- In 2018, Non-Hispanic Blacks aged 65 and older were 10 percent less likely to have received the influenza (flu) shot in the past 12 months, as compared to non-Hispanic whites of the same age group.
- African American children aged 19 to 35 months had comparable rates of immunization in 2017.
- African Americans are 10 percent less likely to have received a human papilloma virus (HPV) vaccine as white populations.

Adults (Hepatitis)

Percentage of adults ages 19-49 years, high risk groups, who received 3 doses of the hepatitis B vaccination, 2018		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
35.4	43.6	0.8

Children (Fully Immunized)

Percentage of children aged 19 to 35 months who are fully immunized, 2017 (4:3:1:3)		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black/ Non-Hispanic White Ratio**
66.5	71.5	0.9

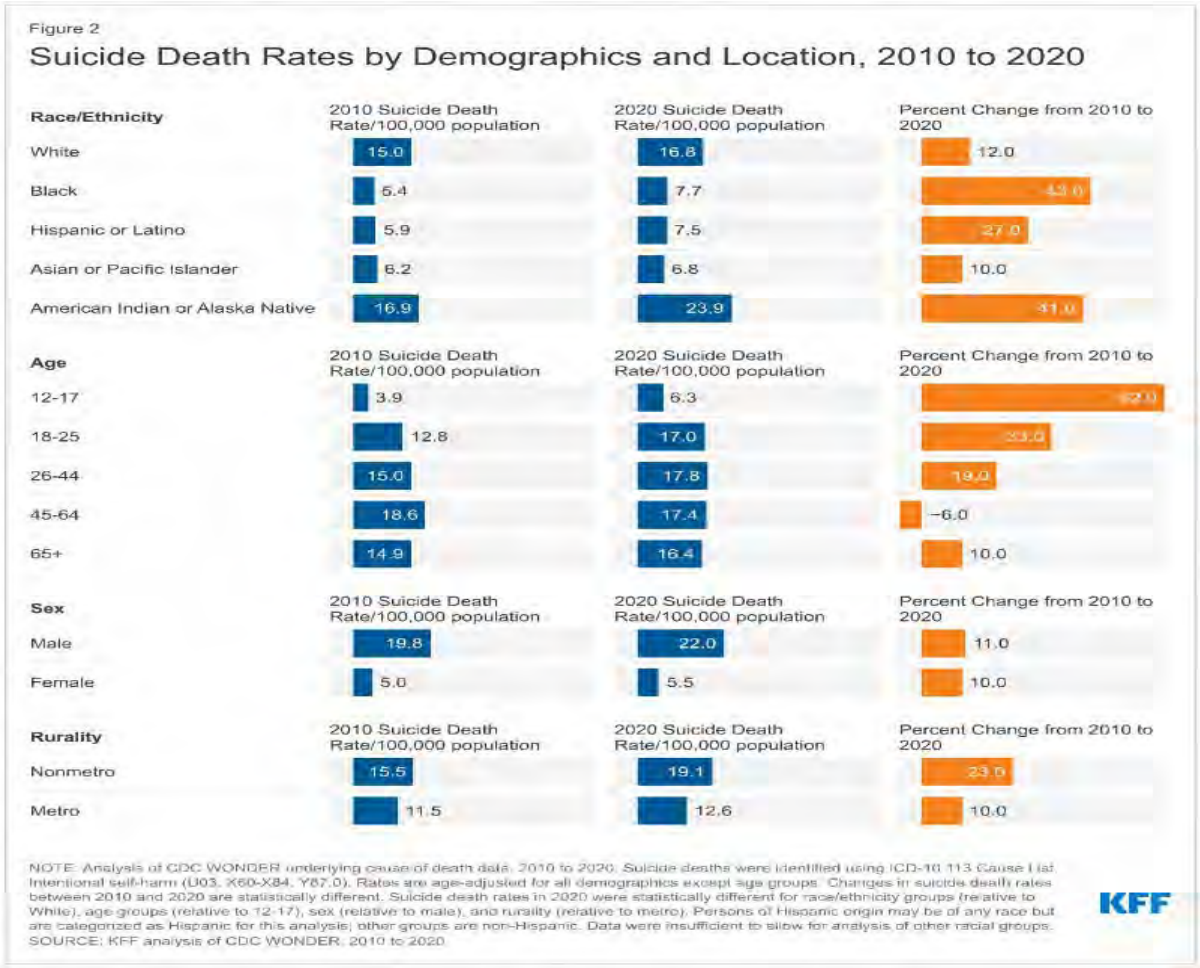
Source: CDC 2022. Vaccination Coverage among Adults in the United States, National Health Interview Survey, 2018. Box 3, Table 2. https://stacks.cdc.gov/view/cdc/105322

Source: CDC 2018. Vaccination Coverage Among Children Aged 19–35 Months — United States, 2017. Supplementary Table 1. https://stacks.cdc.gov/view/cdc/59414

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Mental Health

Findings from the MHA report further show the gapping need of insurance companies to address the mental health services. Insurance companies are not providing funding for these needs in the manner needed by the constituencies served. Again, if the types of mental health services are not provided to address underlining needs, then unfortunately, suicide may become the preferred approach by those who are affected by these conditions.



The Kaiser Family Foundation (2022) from 2010 to 2020, as shown in the extracted map of Figure 2 from the report, shows how suicide death rates increased substantially among people of color, with the highest increase among Black people (43% increase, from 5.4 to 7.7 per 100,000), followed by American Indian or Alaska Native (41% increase, from 16.9 to 23.9 per 100,000), and Hispanic (27% increase, 5.9 to 7.5 per 100,000).

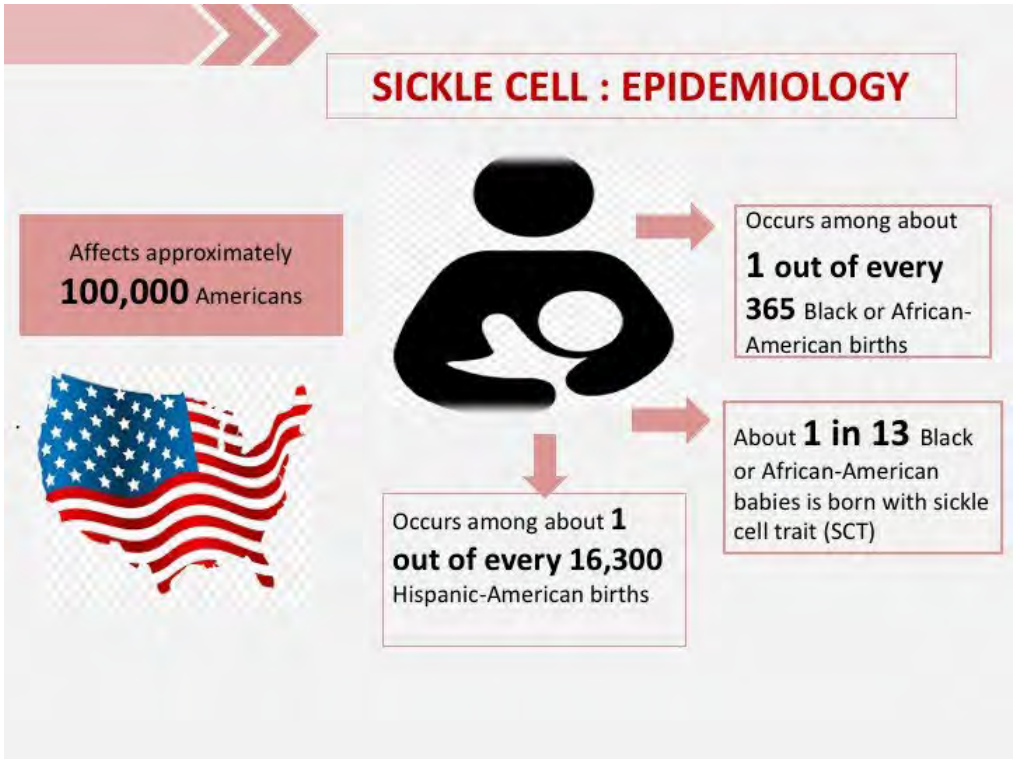
Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Sickle Cell Disease

Sickle Cell Disease (SCD) is a rare blood disorder that affects the hemoglobin involved in delivers oxygen to cells throughout the body. It is inherited in an autosomal recessive trait in which both copies of the genes present in each cell have mutations. The parents of an individual with an autosomal recessive condition comprised of one copy of the mutated gene, and do not show signs and symptoms of the condition. The atypical hemoglobin molecules called hemoglobin S are present among the patients. Sickle cell disease is characterized by the presence of sickle or crescent-shaped, red blood cells in the bloodstream. Sickle Cell Disease occurred due to the mutations in the hemoglobin beta (HBB) gene.

Sickle Cell Disease Epidemiology Insights

- The United States accounts for the highest prevalent cases of Sickle cell disease followed by the EU5 countries (France, Germany, Spain, Italy, and the United States), and Japan
- According to the Centers for Disease Control and Prevention (CDC), Sickle Cell Disease affects approximately 100,000 Americans
- Sickle Cell Disease occurs among about 1 out of every 365 Black or African-American births
- Sickle Cell Disease occurs among about 1 out of every 16,300 Hispanic-American births
- Approximately, 1 in 13 Black or African-American babies is born with sickle cell trait (SCT).
- The mutations in the HBB gene are common in people from African, Mediterranean, Middle Eastern, and Indian ancestry and in people from the Caribbean and parts of Central and South America, but can be found in people of any ethnicity



The Opioid Crisis and the African American Population

Table 1. Number and age-adjusted rates[a] of drug overdose deaths[b] involving selected drugs by race/ethnicity—United States, 2017

	Drug overdose deaths,[b] overall		Drug overdose deaths involving: Any opioid[c]		Natural and semi-synthetic opioids[d]		Synthetic opioids other than methadone[e]		Prescription opioids[f]		Heroin[g]	
Race/Ethnicity	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**
Total	70,237	21.7	47,600	14.9	14,495	4.4	28,466	9.0	17,029	5.2	15,482	4.9
non-Hispanic White	53,516	27.5	37,113	19.4	11,921	5.9	21,956	11.9	13,900	6.9	11,293	6.1
non-Hispanic Black	**8,832**	**20.6**	**5,513**	**12.9**	**1,247**	**2.9**	**3,832**	**9.0**	**1,508**	**3.5**	**2,140**	**4.9**
non-Hispanic Asian/Pacific Islander	756	3.5	348	1.6	117	0.5	189	0.8	130	0.6	119	0.5
non-Hispanic American Indian/Alaska Native	672	25.7	408	15.7	147	5.7	171	6.5	187	7.2	136	5.2
Hispanic	5,988	10.6	3,932	6.8	994	1.8	2,152	3.7	1,211	2.2	1,669	2.9

Source: National Vital Statistics System, Mortality File

[a] Rate per 100,000 population age-adjusted to the 2000 U.S. standard population using the vintage year population of the data year. Rates are suppressed when based on <20 deaths.

[b] Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD–10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined). Because deaths might involve more than one drug, some deaths are included in more than one category. On death certificates, the specificity of drugs involved with deaths varies over time. In 2016, approximately 15% of drug overdose deaths did not include information on the specific type of drug(s) involved.

[c] Drug overdose deaths, as defined using ICD-10 codes, that involve opium (T40.0), heroin (T40.1), natural and semi-synthetic opioids (T40.2), methadone (T40.3), synthetic opioids other than methadone (T40.4) and other and unspecified narcotics (T40.6).

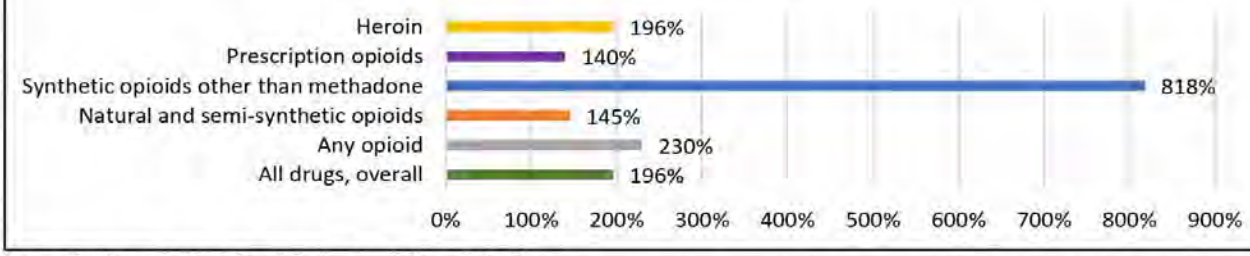
[d] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2).

[e] Drug overdose deaths, as defined, that involve synthetic opioids other than methadone (T40.4).

[f] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2) and methadone (T40.3).

[g] Drug overdose deaths, as defined, that involve heroin (T40.1).

Figure 1. Percent Increase from 2014 to 2017 in overdose death rates by drug among the non-Hispanic Black population in the United States,
data from CDC National Vital Statistics System



See notes from Table 1 for details about drug definitions

Overdose deaths and 43 percent of the total drug overdose deaths for non-Hispanic Blacks in 2017.[13] Synthetic opioids are especially affecting the overdose death rates among older non-Hispanic Blacks.[16] From 2015-2017, non-Hispanic Blacks aged 45-54 and 55-64 had synthetic opioid-related overdose death rates double in large urban areas.[16]

Percent increase in overdose death rates by drug among the non-Hispanic Black population. From 2014-2017, among the non-Hispanic Black population drug overdose death rates involving all types of opioids increased, with the sharpest rise from synthetic opioids (Figure 1).[13,17] Death rates involving synthetic opioids increased by 818 percent, and was the highest for non-Hispanic Blacks compared to all other race/ethnicities (data not shown).[13,17]

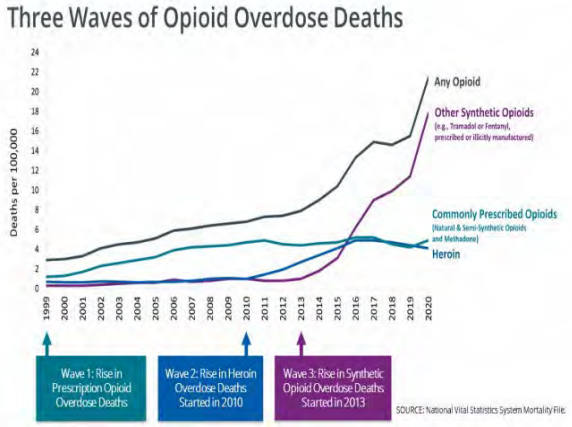
Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and the Opioid and Fentanyl Crisis

In 2020, overdose death rates (number of drug overdose deaths per 100,000 people) increased 44 percent for Black* people and 39 percent for American Indian and Alaska Native (AI/AN) people compared with 2019, according to a new CDC Vital Signs report with drug overdose data from 25 states and the District of Columbia. Overdose death rates in other groups, specifically White people, for whom the increase was 22 percent, are also at historic highs. Against the backdrop of the COVID-19 pandemic, disruption in access to prevention, treatment, harm reduction, and recovery support services has likely contributed to this growth in overdose deaths. Recent increases in deaths were largely driven by illicitly manufactured fentanyl and fentanyl analogs (IMFs). Among the key findings for drug overdose deaths:

- In 2020, the overdose death rate among Black males 65 years and older was nearly seven times that of White males 65 years and older.
- Black people 15–24 years old experienced the largest rate increase (86 percent) compared with changes seen in other age/race groups during 2019–2020.
- Overdose death rates for AI/AN women 25–44 years of age were nearly two times that of White women 25–44 years of age.

Additionally the report analyzed drug overdose death rates by treatment access and income inequality, which continue to show concerning trends and widening disparities between different population groups. A history of substance use was common, but a history of receiving substance use treatment was not. Only about 1 in every 10 AI/AN and Hispanic people had reportedly received substance use treatment; evidence of treatment was even lower for Black people (1 in every 12). In counties with more income inequality, there were greater disparities in overdose deaths, particularly among Black people, where the rate was more than two times as high in areas with more income inequality versus those with less income inequality.



The opioid crisis has impacted the broader American public and the Centers for Disease Control and Prevention (2022) has particularly identified the opioid crisis as occurring within three different waves. Figure 1, as extracted from the Centers for Disease Control and Prevention (2022), has identified those waves as any opioid, other synthetic opioids, and commonly prescribed opioids. What the Center for Disease Control and Prevention (2022) indicates in their report, "Three Waves of Opioid Overdose Deaths," is that the "number of drug overdose deaths increased by nearly 30% from 2019 to 2020 and has quintupled since 1999 and that nearly 75% of the 91,799 drug overdose deaths in 2020 involved an opioid." The Centers for Disease Control and Prevention (2022) further reports that from 2019 to 2020, "there were significant changes in opioid-involved death rates: 1) Opioid-involved death rates increased by 38%; 2) Prescription opioid-involved death rates increased by 17%; 3) Heroin-involved death rates decreased by 7%; and 4) Synthetic opioid-involved death rates (excluding methadone) increased by 56%." Such findings show the steady increase of opioid deaths for the American public.

https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html

African Americans and Alcohol

Binge drinking among African Americans (23%) is slightly less common than in Hispanics (24.6%) and Caucasians (25.7%). The rate of heavy drinking among African Americans (4.3%) is much less than the general population (6.1%) and Caucasians (7.2%).Sep 14, 2022

African Americans are reported to drink less than their Caucasian counterparts. However, alcohol impacts the African American community differently and can have extremely damaging and long-lasting effects.

African Americans And Alcohol Abuse

Alcohol is the most widely-used drug in America and impacts different demographics differently, not excluding African-Americans. A 2010 Johns Hopkins study concluded 20.4% of African Americans between the ages of 12 and 20 consumed alcohol in a 30-day period. As a result, alcohol consumption has been responsible for "contributing to 3 leading causes of death" in African American communities recently.

African Americans have been victims of alcohol-related illnesses, although alcohol consumption is lower compared to Caucasian-Americans. Historically, African Americans have consumed lower amounts of alcohol, partially due to "religious beliefs and social disapproval." This, however, makes many African Americans more likely to be intoxicated under lower amounts of alcohol.

African Americans, Minority Stress, And Alcoholism

Varying factors contribute to alcoholism in African-Americans, such as minority stress and anxiety or depression. Similar to the LGBTQ community, African Americans endure unique social stigmas and violence due to racial discrimination. Social pressure to conform to behavioral expectations based on societal ideals, as well as projected prejudice is often a chronic source of stress and ill health. In response to higher levels of minority stress, coupled with the stress of daily life, some can develop anxiety or psychosis. Others can self-medicate by drinking alcohol and gradually increase their alcohol intake.

African Americans and Tobacco Use

Although African Americans smoke at lower or similar rates compared with other racial and ethnic groups, they are disproportionately affected by tobacco use in several ways. For example, African Americans have higher death rates from tobacco-related causes and are more likely to be exposed to secondhand smoke.

The tobacco industry has targeted African Americans and strategically marketed its products to appeal to the community for decades, including placing more advertising in predominantly black neighborhoods and in publications that are popular with black audiences.

The most striking example is menthol cigarettes, which are easier to smoke and harder to quit. Today, nearly 90% of all African American smokers use menthol cigarettes, and more than 39,000 African Americans die from tobacco-related cancers each year. Experts believe that racial differences in smoking habits, socioeconomic factors and the metabolism of tobacco carcinogens may all play a role.

Youth

- According to the 2019 National Youth Tobacco Survey, the current cigarette smoking rate was 4% among African American high school students compared with 5.8% of all high schoolers.
- The current cigarette smoking rate among African American middle schoolers was 1.8%compared with 2.3% of all middle schoolers.

Young Adults and Adults

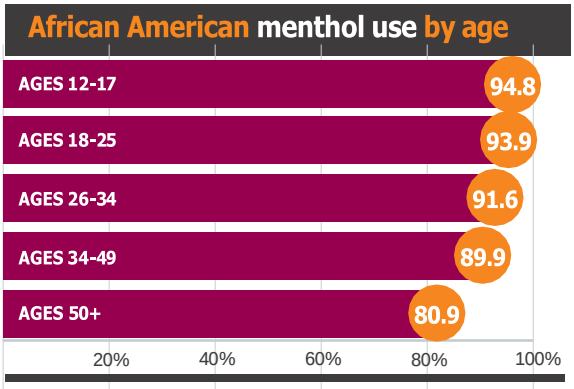
- According to the 2018 National Health Interview Survey (NHIS), among adults ages 18 and above, 14.6% of African Americans are current smokers, compared with 15% of whites and 9.8% of Hispanics.

MENTHOL CIGARETTES

Menthol is a chemical compound extracted from peppermint or corn mint plants, or created synthetically. It reduces the harshness of cigarette smoke due to its characteristic cooling effects on the mouth and throat. It also suppresses the coughing reflex, which makes inhaling smoke from cigarettes more tolerable.

For more information, see the Truth Initiative® fact sheet on menthol tobacco products.

- Nearly 9 in 10 (88.5%) African American smokers ages 12 and older use menthol cigarettes.
- African American youth who smoke menthol cigarettes have greater nicotine dependence and a greater desire to smoke than nonusers, and therefore have a harder time quitting.



HEALTH EFFECTS

- Smoking is a major cause of heart disease, cancer and stroke, which are the three leading causes of deaths for African Americans in the U.S.
- African Americans have the highest rates of tobacco-related cancer of all racial and ethnic groups, and are more likely to die because of the disease.
- More than 72,000 African Americans are diagnosed with a tobacco-related cancer each year.

Rev Anthony Evans Urges the Biden Administration to Leave the Menthol Cigarette Ban in Place

Menthol is Killing the Black Community

Rev Anthony Evans

WASHINGTON, DC, UNITED STATES, November 21, 2023 /EINPresswire.com/ -- The Right Most Rev. Anthony Evans, President of the National Black Church Initiative (NBCI), a coalition of 150,000 African American and Latino churches which constitute 27.7 million churchgoers, is sending the Biden Administration a clear message to leave the Menthol Ban in place as there will be unforeseen consequences in 2024. It is no secret that the Biden Administration is now struggling with Black voters in an unprecedented way. For the first in a long time, NBCI members are losing faith in President Biden and if they succumb to the political pressure of the perceived power of Al Sharpton and Black farmers it will be difficult for NBCI to get our 27.7 million to the polls in 2024.

History has shown voting against the Black church is not morally wise.

Menthol is but one of NBCI health concerns. We have compiled and disseminated a comprehensive list of black health priorities in the "NBCI Black Health Concerns" booklet. www.naltblackchurch.com/pdf/health-booklet.pdf

According to the Center for Disease Control (CDC), fewer people now smoke cigarettes than in recent decades(1, 2), but the proportion of people who smoke and use menthol cigarettes has increased, particularly among population groups that experience tobacco-related disparities(3, 4).

The tobacco industry aggressively targets its marketing to certain populations, including young people, women, and racial and ethnic minority groups, particularly Black people(5, 6, 7, 8). These

groups are more likely to smoke menthol cigarettes compared to other population groups.

Youth and Young Adults

Nearly all people who smoke cigarettes begin in adolescence or young adulthood(9, 10). Studies show that youth and young adults are more likely to try a menthol cigarette as their first cigarette, rather than a non-menthol cigarette(11, 12, 13). Those who first start with a menthol cigarette are more likely to continue smoking(11, 12).

In 2023, 40.4% of middle school and high school students who currently smoked cigarettes reported using menthol cigarettes(14). In 2020, 53% of young adults (18-25 years old) who currently smoked cigarettes reported using menthol cigarettes(14). That same year, fewer than 42% of adults over 35 years old who currently smoked cigarettes reported using menthol cigarettes(3).

In 2023, nearly 9 in 10 (86.9%) youth (grades 6-12) who reported using tobacco products used flavored varieties(14). In addition to menthol-flavored cigarettes, other menthol-flavored tobacco products are popular among youth.

> NBCI members are losing faith in President Biden and if they succumb to the political pressure of Al Sharpton and Black farmers it will be difficult for NBCI to get our members to the polls in 2024" *Rev. Anthony Evans, President of the National Black Church Initiative*

Among middle and high school students:

- 23.9% of those who used flavored nicotine pouches used menthol pouches.
- 17.4% of those who used flavored smokeless tobacco used menthol smokeless tobacco.
- 21.4% of those who used flavored e-cigarettes used menthol e-cigarettes.
- 16.5% of those who used flavored cigars used menthol cigars(14).

In 2018-2019, among adults 18-34 years old:

- 93.1% of those who used flavored smokeless tobacco used mint/menthol smokeless tobacco.
- 45.1% of those who used flavored hookah used mint/menthol hookah.
- 35.7% of those who used flavored e-cigarettes used mint/menthol e-cigarettes.
- 20.8% of those who used flavored cigars used mint/menthol cigars.
- 11.1% of those who used flavored blunts (the hollowed-out tobacco leaf wrapper of a cigar filled with marijuana) used mint/menthol blunts(15).

It is estimated that 40% of excess deaths due to menthol cigarette smoking in the U.S. between 1980 - 2018 we e those of African Americans, despite African Americans making up only about 12% of the U.S. population(17).

Non-Hispanic Black or African American people who smoke cigarettes, regardless of age, are more likely to smoke menthol cigarettes than people of other races or ethnicities who smoke cigarettes(16). It is estimated that between 1980 – 2018, 1.5 million African Americans began smoking menthol cigarettes and 157,000 African Americans died prematurely because of menthol cigarettes(17).

· In 2018, 51.4% of non-Hispanic Black and 50.6% of Hispanic high school and middle school students who smoked used menthol cigarettes, compared to 42.8% of non-Hispanic White youth(18).

· In 2018-2019, approximately 70% of Black or African American adults 18-34 years old who currently smoked cigarettes used menthol cigarettes, compared to 39% of White adults in that same age group(15).

· A survey of people ages 12 years and older who used a menthol cigarette, menthol cigar, or menthol cigarillo as their first tobacco product between 2014 and 2018 found that 24.7% of those surveyed were non-Hispanic Black people and 29.3% were Hispanic people. These were significantly higher proportions as compared to the U.S. population. The study authors noted that census data at the time showed that 12.6% of the U.S. population were Black or African American people and 16.3% were Hispanic people(19). That same census year, 14.6% of the U.S. population were non-Hispanic Black people(20).

· A survey conducted between 2013 and 2015 showed that among non-Hispanic Black adults who smoke, approximately 93% used menthol cigarettes when they first tried smoking. Among non-Hispanic White adults who smoke, 44% used menthol cigarettes when they first tried smoking(13).

· In 2020, approximately 81% of non-Hispanic Black adults who currently smoked cigarettes used menthol cigarettes, compared to 34% of non-Hispanic White adults(3).

People who smoke menthol cigarettes make more attempts to quit smoking than those who smoke non-menthol cigarettes(21). However, the proportion of people who tried and succeeded in quitting non-menthol cigarettes is greater than the proportion of people who have tried and succeeded in quitting menthol cigarettes(21). This could be due to a number of factors, including the way in which menthol enhances the effects of nicotine in the brain(22). African American people who smoke menthol cigarettes may be even less successful in quitting than other population groups.(6) Black or African American people can face barriers when trying to find and use proven quit smoking treatments. Also, the conditions in which non-Hispanic Black people live, learn, work and play may make it harder to quit(2).

Click the following links to all mentioned statistics. See CDC articles: Menthol Smoking and Related Health Disparities and Menthol Tobacco Products are a Public Health Problem

ABOUT NBCI
The National Black Church Initiative (NBCI) is a coalition of 150,000 African American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment. The mission of NBCI is to provide critical wellness information to all its members, congregants, churches, and the public. NBCI utilizing faith and sound health science and partners with major organizations and officials reduce racial disparities in the variety of areas cited above. NBCI's programs are governed by credible statistical analysis, science-based strategies and techniques, and methods that work and offer faith-based, out-of-the-box, and cutting-edge solutions to stubborn economic and social issues.

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Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Infant Mortality and African Americans

According to the Centers for Disease Control and Prevention (CDC), infant mortality is the death of an infant before his or her first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving us key information about maternal and infant health, the infant mortality rate is an important marker of the overall health of a society.

How Does Infant Mortality Affect African American Populations?

- Non-Hispanic blacks/African Americans have 2.4 times the infant mortality rate as non-Hispanic whites.
- Non-Hispanic black/African American infants are almost four times as likely to die from complications related to low birthweight as compared to non-Hispanic white infants.
- Non-Hispanic black/African American infants had 2.9 times the sudden infant death syndrome mortality rate as non-Hispanic whites, in 2020.
- In 2020, non-Hispanic black/African American mothers were twice as likely to receive late or no prenatal care as compared to non-Hispanic white mothers.

Infant Mortality Rate

Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Black / Non-Hispanic White Ratio
10.4	4.4	2.4

Source: CDC 2022. Infant Mortality Statistics from the 2020 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports. Table 2.
https://stacks.cdc.gov/view/cdc/120700

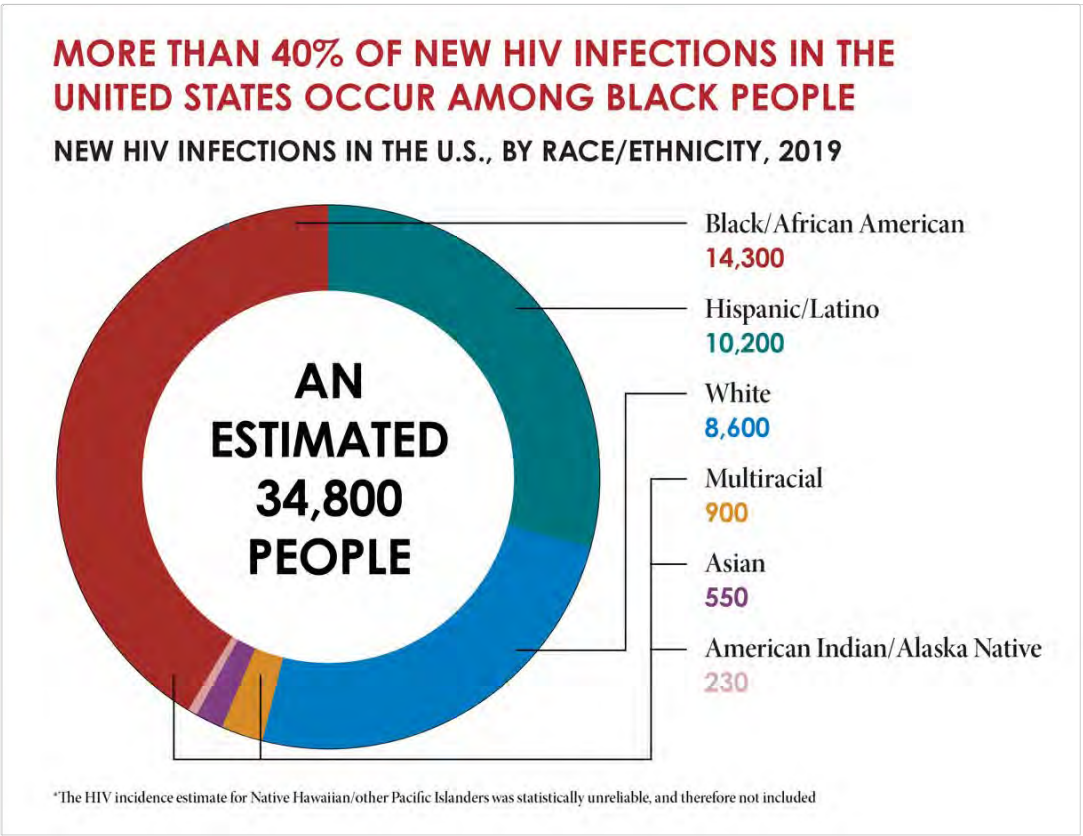
Leading Causes of Infant Mortality

Infant deaths and mortality rates for the top 5 leading causes of death for African Americans, 2020 (Rates per 100,000 live births)					
Cause of Death (By rank)	**# Non-Hispanic Black Deaths**	**Non-Hispanic Black Death Rate**	**# Non-Hispanic White Deaths**	**Non-Hispanic White Death Rate**	**Non-Hispanic Black / Non-Hispanic White Ratio**
(1) Low birthweight	1,136	214.4	1,040	56.4	3.8
(2) Congenital malformations	705	133.1	1, 976	107.2	1.2

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

HIV and Black/African American People in the U.S.

Racism, systemic inequities, social and economic marginalization, residential segregation, and other longstanding barriers are key drivers of the disproportionate impact of HIV among Black or African American (hereafter referred to as Black) communities in the U.S.



The donut graph shows the estimated 34,800 people with new HIV infections in the U.S., by race and ethnicity, in 2019

A growing body of research shows that centuries of racism and discrimination in this country have had a profound negative impact on communities of color. The impact is pervasive and deeply embedded in society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to housing, quality education, wealth, employment, and a range of other social and economic benefits.

These conditions—often referred to as social determinants of health—are key drivers of health inequities, causing people within some populations to experience greater risk for poor health outcomes. With selective prevention and treatment tools at our disposal, the nation has a decades-in-the-making opportunity to end the domestic HIV epidemic and eliminate disparities in HIV prevention and care.

CDC is working with partners on many fronts—including the federal Ending the HIV Epidemic in the U.S. (EHE) initiative—to deliver and scale up key, science-based HIV treatment and prevention strategies in innovative ways that reach populations equitably.

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Venereal Diseases and African Americans/ Sexually Transmitted Diseases (STD)

HIV

In 2018, African Americans/Blacks accounted for 42% of the 37,968 new HIV diagnoses in the United States and dependent areas. Of the 37,968 new HIV diagnoses in the US and dependent areas in 2018:

- 42% were among adult and adolescent African Americans/Blacks
- 31% were among African American/Black men
- 11% were among African American/Black women

In 2018, in the United States, the death rate for African Americans/Blacks was higher (16.3 per 100,000) compared with any other racial/ethnic group (2.5 Whites). A recent study showed that African Americans/Blacks diagnosed with HIV are less likely than other groups to be linked to care, retained in care, receive antiretroviral treatment, and achieve adequate viral suppression.

Sexually Transmitted Diseases (STD)

Chlamydia

In 2018, the overall rate of reported chlamydia cases among Blacks in the United States was 1,192.5 cases per 100,000 population. Rates of reported cases of chlamydia were highest for Blacks aged 15–19 and 20–24 years in 2018.

Gonorrhea

In 2018, the overall rate of reported gonorrhea cases among Blacks in the United States was 7.7 times the rate among Whites. As in previous years, the disparity in gonorrhea rates for Blacks in 2018 was larger in the Midwest and Northeast than in the South and West.

Primary, Secondary and Congenital Syphilis

In 2018, 34.7% of reported P&S syphilis cases with known race/Hispanic ethnicity information occurred among Blacks. From 2014 to 2018, the rate of reported congenital syphilis increased 126.7% among Blacks (38.2 to 86.6 cases per 100,000 live births).This disparity was similar for Black females and males. Similar disparities were seen in all regions of the United States.

Disease	Cases					Percent Change	
	2018	2019	2020	2021	2022	5 Year	1 Year
Chlamydia	1,758,668	1,808,703	1,579,885	1,644,416	1,649,716	-6.2	0.3
Gonorrhea	583,405	616,392	677,769	710,151	648,056	11.1	-8.7
Syphilis (All Stages)	113,739	127,943	131,797	173,858	203,500	78.9	17.0
Congenital Syphilis	1,325	1,882	2,162	2,875	3,755	183.4	30.6
Total Reported STIs	2,457,137	2,554,920	2,391,613	2,531,300	2,505,027	1.9	-1.0

African Americans/Blacks | Health Disparities | CDC

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Race, Ethnicity &Kidney Disease

33% of American adults are at risk for kidney disease. Yes, one in three people.
If you are Black or African American, Hispanic or Latino, Asian American, Pacific Islander, American Indian, or Alaska Native, or Native Hawaiian or Other Pacific Islander heritage you may be at an increased risk for kidney disease.

Black or African Americans are more than 3 times as likely and Hispanics or Latinos are 1.3 times more likely to have kidney failure compared to White Americans. Minority populations have much higher rates of high blood pressure, diabetes, obesity and heart disease, all of which increase the risk for kidney disease. Access to health care may also play a role. The key is to find kidney disease as early as possible and understand its risk factors before the trouble starts. Regular testing for everyone is important and is especially important for people at risk.

What is kidney disease?

Healthy kidneys have many important jobs. They remove waste products and extra water from your body, help make red blood cells, help keep your bones healthy and help control blood pressure. When you have kidney disease, kidney damage keeps the kidneys from doing these important jobs the way they should. Kidney damage may be due to a physical injury or a disease like diabetes, high blood pressure, or other health problems. If you have kidney disease, you may need to take medicines, limit salt and certain foods in your diet, get regular exercise, and more.

Finding and treating your kidney disease early can help slow or even stop kidney disease from getting worse. But if your kidney disease gets worse, it can lead to kidney failure. If your kidneys fail, you will need dialysis or a kidney transplant to stay alive.

Yes, anyone can get kidney disease at any age. However, some people are more likely than others to get it.

These are the 5 main risk factors of kidney disease:

- Diabetes (you or your family)
- High blood pressure (you or your family)
- Heart disease (you or your family)
- Family history of kidney failure, diabetes, or high blood pressure
- Obesity

Other important risk factors for kidney disease:

- Black or African American, Hispanic or Latino, Asian American, American Indian, or Alaska Native, or Native Hawaiian or Other Pacific Islander heritage
- Age 60 or older
- Low birth weight
- Prolonged use of NSAIDs, a type of painkillers, such as ibuprofen and naproxen
- Lupus, other autoimmune disorders
- Chronic urinary tract infections
- Kidney stones

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

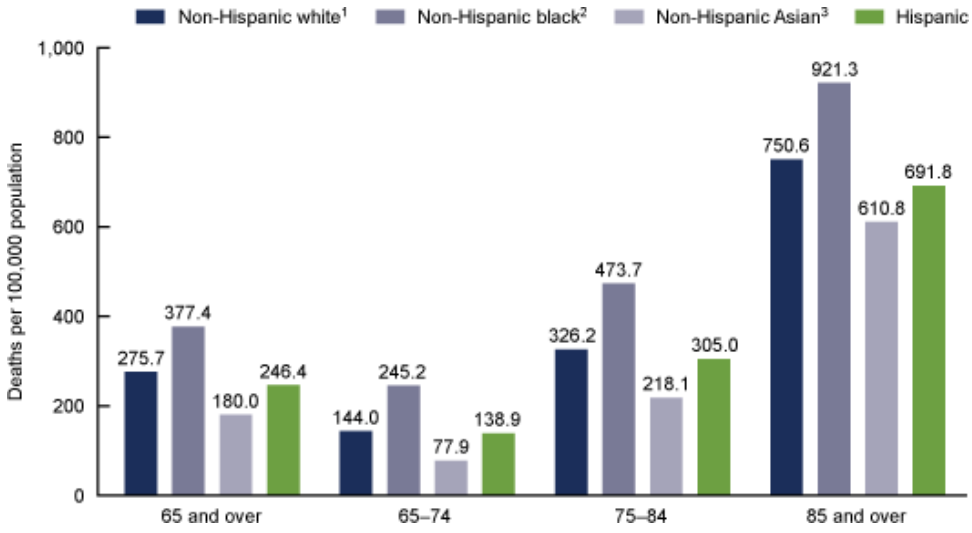
African Americans and Sepsis-related Mortality (Septicemia)

Sepsis is the body's extreme response to an infection and, if not identified and treated quickly, may lead to serious medical consequences and death (1). Sepsis can occur at any age, but infants, people with chronic conditions, people with weakened immune systems, and older adults are at high risk (1). In 2019, there were 201,092 deaths in the United States involving sepsis, with three-fourths of those deaths occurring among persons aged 65 and over (2).

Sepsis-related death rates among adults aged 65 and over were higher among non-Hispanic black adults than among other race and Hispanic-origin groups.

- Among adults aged 65 and over, sepsis-related death rates were highest among non-Hispanic black adults (377.4 per 100,000), followed by non-Hispanic white (275.7), Hispanic (246.4), and non-Hispanic Asian (180.0) adults (Figure 3).
- Sepsis-related death rates were also highest among non-Hispanic black adults compared with other race and Hispanic-origin groups for those aged 65–74 (245.2), 75–84 (473.7), and 85 and over (921.3).
- Sepsis-related death rates increased with age among all race and Hispanic-origin groups.

Sepsis-related death rates for adults aged 65 and over, by age group and race and Hispanic origin: United States, 2019



[1]Significantly lower than non-Hispanic black adults and significantly higher than non-Hispanic Asian and Hispanic adults ($p < 0.05$). [2]Significantly higher than non-Hispanic Asian and Hispanic adults ($p < 0.05$). [3]Significantly lower than Hispanic adults ($p < 0.05$).

NOTES: Significant linear trend by age group for all race and Hispanic-origin groups ($p < 0.05$). Estimates are based on single-race data. Sepsis-related deaths are those with sepsis or septicemia, *International Classification of Diseases* codes A40–A41, reported anywhere on the death certificate. For mortality statistics, sepsis and septicemia are synonymous and used interchangeably for classification purposes. Access data table for Figure 3pdf icon.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

https://www.cdc.gov/nchs/products/databriefs/db422.htm#section_3

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

African Americans and Clinical Research

African Americans have been underrepresented in clinical trials. A historical review documented past medical experimentation and other practices on blacks that were often brutal and unethical. These experiences may have served to fortify the legacy of African-American mistrust in the medical system and culminated in the infamous Tuskegee Syphilis Study. Four major barriers to participation in clinical trials were identified: lack of awareness about trials, economic factors, communication issues, and mistrust.

Historically, African Americans, other minorities, and women have been underrepresented in clinical trials.[6-9] For African Americans, this trend parallels other health-care trends that indicate a general lack of access to care and use of preventive and palliative medical diagnostic and treatment services.[1, 3, 10, 11] As clinical trials play a dominant role in the development of safe and effective treatments to reduce the societal burden of disease, participation by minorities and women is crucial to assure sufficient scientific information to assess the safety and efficacy of new treatments.

All study participants were African-American. The mean age was 59.3 years, and most participants were women (68.4%), married (47.4%), lived with their spouse or some other family member (68.5%), and had at least a high school education (58%). Furthermore, there was a relative high frequency of hypertension (57.9%), diabetes mellitus (31.6%), heart disease (10.5%), and stroke (21.1%). Most had a primary care physician (68.4%); the mean number of visits to the doctor in the past 12 months was 4.2.

TABLE 1. PATIENT CHARACTERISTICS

Characteristic No. (%)*

Demographics	
Age	(mean years±SD) 59.3+9.2
Women	13 (68.4)
African Americans	19 (100)

Marital Status	
Married	9 (47.4)
Widowed	5 (26.3)
Separated/divorced	2 (10.5)
Never married	3 (15.8)

Living Arrangement	
Alone	2 (10.5)
With husband/wife only	4 (21.1)
With husband/wife and other	3 (15.8)
Family, no husband/wife 6	(31.5)
Other	4(21.1)

Years of Formal Education	
Grade school	5 (26.3)
Some high school	3 (15.8)
Graduated high school	6 (31.5)
Some college	4 (21.1)
Graduated college	0 (0)
Postgraduate	1 (5.3)

Annual Income	
$0 to $5999	5 (26.3)
$6000 to $19,999	8 (42.0)
$20,000 to $29,999	3 (15.8)
$30,000 to $39,999	1 (5.3)
$40,000 to $49,999	1 (5.3)
¢'$50,000 1	(5.3)

*N=19.

† Respondents were asked to choose one category only.

Few were familiar with terms used to refer to clinical trials. Furthermore, few had ever participated in a clinical trial (5.4%), had ever been asked to participate (15.8%), or knew of family or friends who had ever participated (10.5%). Sixty-eight percent responded that they might participate if asked to, with the rationale being to save lives, benefit themselves or others, and obtain free health care and medication. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2608128/pdf/jnma00387-0030.pdf

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Black Women and Childbirth: A National Crisis

A maternal death is defined by the World Health Organization as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (1). Maternal mortality rates, which are the number of maternal deaths per 100,000 live births, are shown in this report by age group and race and Hispanic origin.

Black women are three times more likely to die from a pregnancy-related cause than White women. Multiple factors contribute to these disparities, such as variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias. Social determinants of health prevent many people from racial and ethnic minority groups from having fair opportunities for economic, physical, and emotional health.

In 2021, the maternal mortality rate for non-Hispanic Black (subsequently, Black) women was 69.9 deaths per 100,000 live births, 2.6 times the rate for non-Hispanic White (subsequently, White) women (26.6). Rates for Black women were significantly higher than rates for White and Hispanic women. The increases from 2020 to 2021 for all race and Hispanic-origin groups were significant.

Race and Hispanic origin and age	2019			2020			2021		
	Number of live births	Number of deaths	Maternal mortality rate[1]	Number of live births	Number of deaths	Maternal mortality rate[1]	Number of live births	Number of deaths	Maternal mortality rate[1]
Total[2]	3,747,540	754	20.1	3,613,647	861	23.8	3,664,292	1,205	32.9
Non-Hispanic Black[3]	548,075	241	44.0	529,811	293	55.3	517,889	362	69.9
Non-Hispanic White[3]	1,915,912	343	17.9	1,843,432	352	19.1	1,887,656	503	26.6
Hispanic	886,467	112	12.6	866,713	158	18.2	885,916	248	28.0

* Rate does not meet National Center for Health Statistics standards of reliability.
[1]Maternal mortality rates are deaths per 100,000 live births.
[2]Includes deaths for race and Hispanic-origin groups not shown separately, including women of multiple races and origin not stated.
[3]Race groups are single race.

NOTES: Maternal causes are those assigned to code numbers A34, O00–O95, and O98–O99 of the *International Classification of Diseases, 10th Revision*. Maternal deaths occur while pregnant or within 42 days of being pregnant.
https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm

Hepatitis and African Americans

According to the Centers for Disease Control and Prevention (CDC), hepatitis means inflammation of the liver. The liver is a vital organ that processes nutrients, filters the blood, and fights infections. When the liver is inflamed or damaged, its function can be affected. Heavy alcohol use, toxins, some medications, and certain medical conditions can cause hepatitis. However, hepatitis is often caused by a virus. In the United States, the most common types of viral hepatitis are hepatitis A, hepatitis B, and hepatitis C.

How Does Hepatitis Affect African American Populations?

Hepatitis B infection has dropped significantly since 1991 but remains an area of concern for the African American population.

- In 2020, non-Hispanic blacks were 1.4 times as likely to die from viral hepatitis, as compared to non-Hispanic whites.
- In 2020, non-Hispanic blacks were almost twice as likely to die from hepatitis C as compared to the white population.
- While having comparable case rates for hepatitis B in 2020, non-Hispanic blacks were 2.5 times more likely to die from hepatitis B than non-Hispanic whites.

Death Rates

Death Rates for Viral Hepatitis, 2019 (all types)			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Male	2.0	1.3	1.5
Female	0.8	0.6	1.3
Total	1.4	1.0	1.4

Source: CDC 2022. Deaths: Final Data for 2019. National vital statistics reports; vol. 70, no. 8. Table 10. https://stacks.cdc.gov/view/cdc/106058

Hepatitis A, Acute (Cases per 100,000 population), 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
1.6	3.9	0.4

Source: CDC 2022. Viral Hepatitis Surveillance Report – United States, 2020. Table 1.2 https://www.cdc.gov/hepatitis/statistics/2020surveillance/index.htm. Published September 2022. Accessed 12/8/2022.

NBCI Lends Support for President Biden's $11.3 Billion Plan Over the Next 5 Years to Help Eliminate Hepatitis C

African Americans Continue to Die from Hepatitis C Needlessly


Rev Anthony Evans

WASHINGTON, DC, UNITED STATES, September 5, 2023 /EINPresswire.com/ -- Honorable Rep. Kay Granger
Chairwoman
US of House of Representative
Appropriations Committee
H-307 The U S Capitol
Washington, DC 20515

Honorable Sen. Patty Murray
Chairwoman
US Senate
Appropriations Committee
154 Russell Senate Office building
Washington, DC 20510

Dear Honorable Rep. Kay Granger and Honorable Sen. Patty Murray,

The National Black Church Initiative is pleased to extend 100% support of President Biden's proposed spending of $11.3 billion dollars over the next five years to help eliminate hepatitis C. We recognize there is a cure for hepatitis C, but this investment will save our nation billions of dollars in the long run. And so, this proposed spending by President Biden, is a national imperative, critically important in drastically curtailing both the mortality and morbidity of African Americans and hepatitis C and other related illnesses.

We strongly urge a bipartisan approach to work with President Biden to help make this legislation into reality for all Americans, especially for African Americans. This is one disease that we can all conquer now and narrow the health disparities a little.

African Americans are twice as likely to be infected with the hepatitis C virus (HCV) compared to the general U.S. population, according to the CDC. While African Americans represent only 12 percent of the U.S. population, they make up roughly 22 percent of the estimated 3.2 million persons with chronic HCV infection. Moreover, chronic liver disease, often hepatitis C-related, is a leading cause of death among African Americans ages 45-64.


Rep. Kay Granger

Despite the seriousness of this health problem in the African-American community, too few African Americans know about the disease or get tested for it. “Early detection of chronic viral hepatitis infection can save lives,” observes Dr. Ronald Valdiserri, MD, MPH, Deputy Assistant Secretary for Health, Infectious Diseases and Director, Office of HIV/AIDS and Infectious Disease Policy at the U.S. Department of Health and Human Services. “Many people can get care and treatment that can limit disease progression, prevent liver cancer deaths, and help break the cycle of unknowingly transmitting the virus to others.”

> “Eliminating Hepatitis C is our number one concern because we strongly believe we as a nation can solve this problem and move on to large challenges like cancer”
>
> *Rev. Anthony Evans*

The National Black Church Initiative (NBCI) and its 27.7 million members represent every congressional district in the country and are active voters, NBCI, a coalition of 150,000 African American and Latino churches, works to eradicate racial disparities in healthcare, technology, education, housing, and the environment. NBCI's mission is to provide critical wellness information to all of its members, congregants, churches and the public. NBCI’s methodology utilizes faith and sound health science solutions to address stubborn economic and social issues.

NBCI's programs are governed by credible statistical analysis, science-based strategies and techniques, and methods that work. NBCI seeks to engage with major organizations and officials whose main mission is to reduce racial disparities in the variety of areas cited above.

To that end, NBCI has partnered with agencies across the government to implement the Action Plan for the Prevention, Care and Treatment of Viral Hepatitis. The plan’s goals include increasing the proportion of Americans who are aware of their viral hepatitis infection and reducing the number of new cases of Hepatitis C infection. To achieve these goals, the plan prioritizes education efforts to address viral hepatitis-related disparities and thereby reduce the disproportionate burden of Hepatitis C and increase awareness of this silent killer in the African-American community.

Here are the facts:

• Hepatitis C is a liver disease caused by a virus.

• Hepatitis C is usually spread when blood from a person infected with the Hepatitis C virus enters the body of someone who is not infected. This can happen from sharing equipment for injecting drugs, receiving blood transfusions or organ transplants before 1992, getting a needlestick injury in health care settings, and even being born to a mother who has Hepatitis C. And some people don't know how they got infected. Hepatitis C can spread through sexual intercourse, but it's rare.

• Anyone can get Hepatitis C, but Africa Americans – as well as people born between 1945-1965, sometimes called "baby boomers" – bear a disproportionate burden of disease.

• Most people living with Hepatitis C do not know they are infected.

Rep Patty Murray

• The Hepatitis C Virus (HCV) can cause chronic hepatitis, in which the infection is prolonged, sometimes lifelong. Chronic hepatitis can lead to cirrhosis, liver failure, and liver cancer. In fact, viral hepatitis is the leading cause of liver cancer and the most common reason for liver transplantation.

• People living with HCV infection often have no symptoms until significant damage has bee done.

• The e is no vaccine to prevent Hepatitis C infection.

• Getting a blood test is the only way to know if you have been exposed to Hepatitis C.

• New and improved treatments exist for Hepatitis C.

Thus, eliminating Hepatitis C is our number one concern because we strongly believe we as a nation can solve this problem and move on to large challenges like cancer. We intend to use all the strength in our toolbox to get this legislation.

We are looking forward to working with you and your colleagues on this winnable issue, a national imperative.

Sincerely,
Rev. Anthony Evans
NBCI President

Anthony Evans
National Black Church Initiative

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Visit us on social media:
Facebook
Twitter
Instagram
YouTube

Level of Spending requested for FY year (2025-2026): $2,025 Trillion

Homelessness, Housing and Racial Disparities

Most minority groups, especially African Americans and Indigenous people, experience homelessness at higher rates than Whites, largely due to long-standing historical and structural racism.

The most striking disparity can be found among African Americans, who represent 13 percent of the general population but account for 37 percent of people experiencing homelessness and more than 50 percent of homeless families with children. This imbalance has not improved over time.

What Are the Causes?
From slavery to segregation, African Americans have been systemically denied rights and socioeconomic opportunities. Other minority groups, including Indigenous and Latinx people, share similar histories. The disproportionality in homelessness is a by-product of systemic inequity: the lingering effects of racism continue to perpetuate disparities in critical areas that impact rates of homelessness.

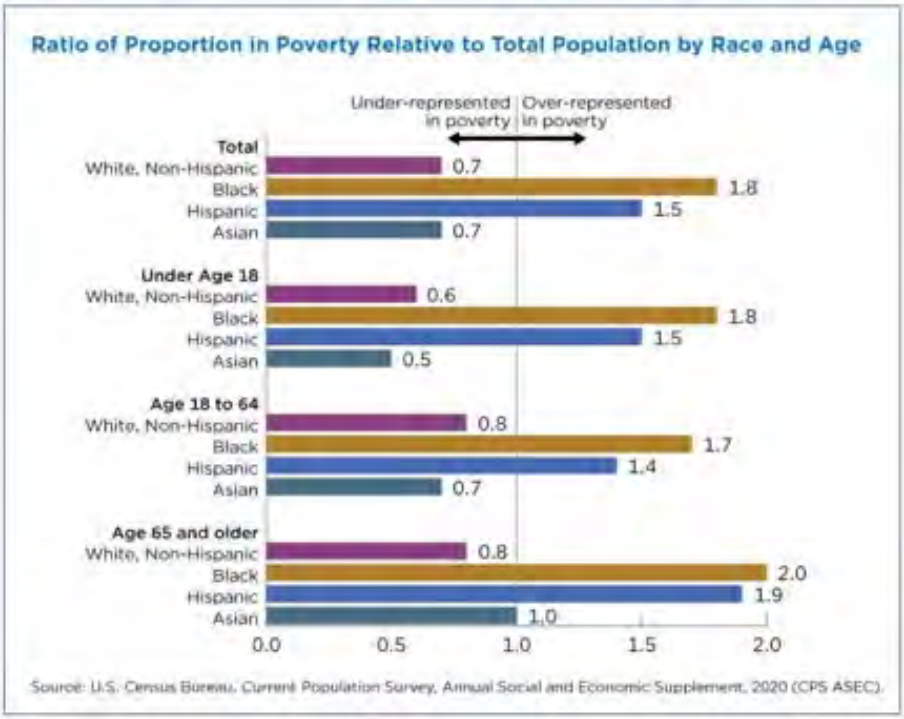
Poverty
Poverty, and particularly deep poverty, is a strong predictor of homelessness. Black and Latinx groups are overrepresented in poverty relative to their representation in the overall population, and are most likely to live in deep poverty, with rates of 10.8% and 7.6% percent, respectively.

Segregation/Rental Housing Discrimination
Redlining - systemic housing discrimination supported by the federal government decades ago - is a root cause of the current wealth gap between White households and households of color. Redlining discouraged economic investment, such as mortgage and business loans, in Black and Brown neighborhoods.

The effects are still with us today: African Americans still live disproportionately in concentrated poverty0 or in neighborhoods where they are regularly exposed to environmental toxins, and have limited access to quality care, services, nutritious food and economic opportunities. People that become homeless are likely to have lived in these types of neighborhoods.

For most minority groups, the transition to neighborhoods with less crime, no environmental hazards, and close proximity to services, are often met with challenges. A study by the U.S Department of Housing and Urban Development (HUD)[3] on racial discrimination found that people of color were often shown fewer rental units and denied more leases in comparison to White people. White people, on the other hand, were frequently offered lower rents. Deposits and other move-in costs were also quoted as “negotiable,” making it easier for White people to secure units.

Incarceration
The racial disparity in incarceration rates has continuously worsened. The rate for African Americans has tripled between 1968 and 2016 and is more than six times the rate of White incarceration.I11 These racial disparities are no accident. Black and Brown people are at far greater risk of being targeted, profiled and arrested for minor offenses, especially in high poverty areas.



The implications of overcriminalization are far-reaching: A criminal history can keep people from successfully passing background checks to secure both housing and employment. People exiting jails and prisons often face significant problems in accessing safe and affordable housing and their rate of homelessness is high.

Access to Quality Health Care

People of color are far more likely'. to lack health insurance than White people, especially'. in states without Medicaid expansion. Even with expansion, overall about 30 million people are uninsured, with about half of them being people of color.

The lack of health insurance for people with chronic medical conditions and/ or untreated serious mental illness can place them at risk of becoming homeless or being precariously housed. For example, people with mental health disabilities are vastly overrepresented in the population of people who experience homelessness. Of the more than 653,000 people in America who experienced homelessness on a given night in 2023, nearly 1 in 5 had a behavioral health issue. While the rate of serious mental illness may not vary by race, studies show African Americans have more difficulty accessing treatment.

The Homelessness System's Response

Any effort to end homelessness in the United States must address the range of issues that have resulted from racial inequity. This includes assuring affordable, stable housing for all. Systems, 12rograms, and individuals that serve people experiencing homelessness should monitor their outcomes in order to eliminate disparities in the way that they provide services.

Asthma and African Americans

According to the Centers for Disease Control and Prevention (CDC), asthma is a disease that affects your lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medicine and avoiding the triggers that can cause an attack. You must also remove the triggers in your environment that can make your asthma worse.

How Does Asthma Affect African American Populations?

- From 2018-2020, 4.0 million non-Hispanic blacks (adults and children) reported that they currently have asthma.
- Non-Hispanic African Americans were 30 percent more likely to have asthma than non-Hispanic whites, in 2019.
- In 2020, non-Hispanic blacks were almost three times more likely to die from asthma related causes than the non-Hispanic white population.
- In 2020, non-Hispanic black children had a death rate 7.6 times that of non-Hispanic white children.
- Non-Hispanic black children were 4.5 times more likely to be admitted to the hospital for asthma, as compared to non-Hispanic white children, in 2019.
- While all the causes of asthma remain unclear, children exposed to secondhand tobacco smoke exposure are at increased risk for acute lower respiratory tract infections, such as bronchitis. Children living below or near the poverty level are more likely to have high levels of blood cotinine, a breakdown product of nicotine, than children living in higher income families.[1]

Diagnosed

Current asthma prevalence percentage, adults ages 18 and over, 2019			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	8.6	5.8	1.5
Women	11.9	10.2	1.2
Both Sexes	10.4	8.0	1.3

Death Rate

Deaths per 1,000,000, adults 18 years and over with asthma as the underlying cause, National Vital Statistics System, 2020		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
34.9	13.0	2.7

Source: CDC 2022. National Health Interview Survey Data 2019. Table 4-1. https://www.cdc.gov/asthma/nhis/2019/table4-1.htm

Source: CDC 2022. Division of Vital Statistics CDC WONDER. https://wonder.cdc.gov/ucd-icd10.html

Conclusion

There has been so much written about health disparities. NBCI leaves the last word to Dr. Satcher and his approach and vision.

Given the public health approach to the elimination of disparities in health and the evidence of successful programs that have implemented this approach, clearly this model can be effective in reducing disparities. However, applying this approach on a nationwide scale will require robust support for public health and prevention. Less than 3% of our country's massive health budget goes toward population-based prevention, and more than 90% is spent on treating diseases and their complications—many of which are easily preventable. It is now critical that more of these programs be made available to all populations affected by disparities in health. We urge our colleagues in public health to advocate for this approach with public officials, policymakers, grant-making organizations, and their constituent communities. To eliminate health disparities, we need leaders who care enough, know enough, will do enough, and are persistent.

African Americans have been and continue to be the victims of multiple assaults on their humanity by the health care system. Many experts believe that with the proper investment as outlined in this report at the level of $2,025,000,000,000 can avoid and eliminate African Americans dying from these causes

Areas of Mortality and Morbidity in African Americans

- Racism
- Access to care
- Medical Mistakes*
- Quality of Care
- Mental Health
- Medical Misdiagnosis
- Exercise and Nutrition
- Alcohol and Tobacco
- Heart Disease
- Drugs and Violence
- Diabetes and all of its complications
- Hospital Germs and bacteria*
- Toxins of Drugs

Forty-five percent of African American deaths are preventable if this country has the will to change with legislation, strategic planning, funding, and leadership from organizations like the National Black Church Initiative

Medical Mistakes

The researchers, from Johns Hopkins and the Risk Management Foundation of the Harvard Medical Institutions, looked at 15 diseases and concluded that 371,000 Americans died and 424,000 were permanently disabled as a result of misdiagnoses.

About 75% of the serious harm happens in connection with vascular events, infections, and cancers. In all, 15 diseases account for nearly 51% of the serious harms.

Five conditions — stroke, sepsis, pneumonia, venous thromboembolism, and lung cancer — cause nearly 39% of total serious harm.

Across diseases, the overall average error rate was estimated at 11%, but the rate ranges widely — from 1.5% for heart attack to 62% for spinal abscess. Stroke was the top cause of serious harm from misdiagnosis, found in 17.5% of cases.

Hospital Germs and bacteria

How many deaths are caused by HAIs?

The numbers are staggering – 1.7 million patients will acquire at least one of these infections, and 99,000 will die annually. [iii] This is the equivalent of a 275-person passenger jet crashing to the ground every day.

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June 17, 2024

More Revenue Is Required to Meet the Nation's Commitments, Needs, and Challenges

By Richard Kogan, Joel Friedman, Sharon Parrott, and Sarah Calame

Executive Summary

To support sound budget policies, the level of federal revenue — measured as a percent of the nation's economy, or gross domestic product (GDP) — needs to increase over previous and currently projected levels. Our nation's budget policies reflect our approach to two fundamental questions: what and whom will our country invest in and support, and how will we pay for those investments? Our current approach is one of low investment and support for people and communities relative to other wealthy nations, coupled with even lower revenue. This has led not only to a fiscal deficit, with federal debt growing more quickly than GDP, but also an investment deficit.

To meet our commitments to seniors, make high-value investments that will improve well-being and broaden prosperity, and improve our fiscal outlook, we must raise more revenue. Simply put, we cannot meet 21st-century needs with past levels of revenue. As a first step, policymakers should use the scheduled expiration of most provisions of the 2017 tax law in 2025 as an opportunity to bolster the revenue base, not erode it by failing to pay for any tax cuts that are extended and potentially adding still more tax cuts for corporations and high-income households on top.[1]

Specifically, higher revenue is needed to address three challenges:

- **Meeting long-standing retirement and health care commitments to seniors**. Budget needs are growing simply because the increasing number of baby boomers in retirement increases the costs of Social Security and Medicare. Costs for these two programs are growing faster than the economy and are projected to continue doing so.

  The demographics underlying this upward budgetary pressure have been understood for decades — the results are no surprise. Indeed, cost growth for Social Security and Medicare has been slower than the Congressional Budget Office (CBO) predicted in 2010. Federal costs *outside* of these two programs are projected to grow more slowly than the economy, but this will not completely offset the demographic shift propelling the growth of Social Security and

[1] Jacob Bogage, "Republicans pitch tax cuts for corporations, the wealthy in 2025," *Washington Post,* June 9, 2024, https://www.washingtonpost.com/business/2024/06/09/biden-trump-taxes-election/.

Medicare. (See Figure 1.) To finance our commitments to current and future seniors, we will need to raise more revenue.

- **Making high-value investments that improve well-being and broaden opportunity**. Underinvesting in people, communities, and the building blocks of the U.S. economy increases poverty and hardship, worsens racial and ethnic inequities, shortchanges opportunity, and restrains economic growth.

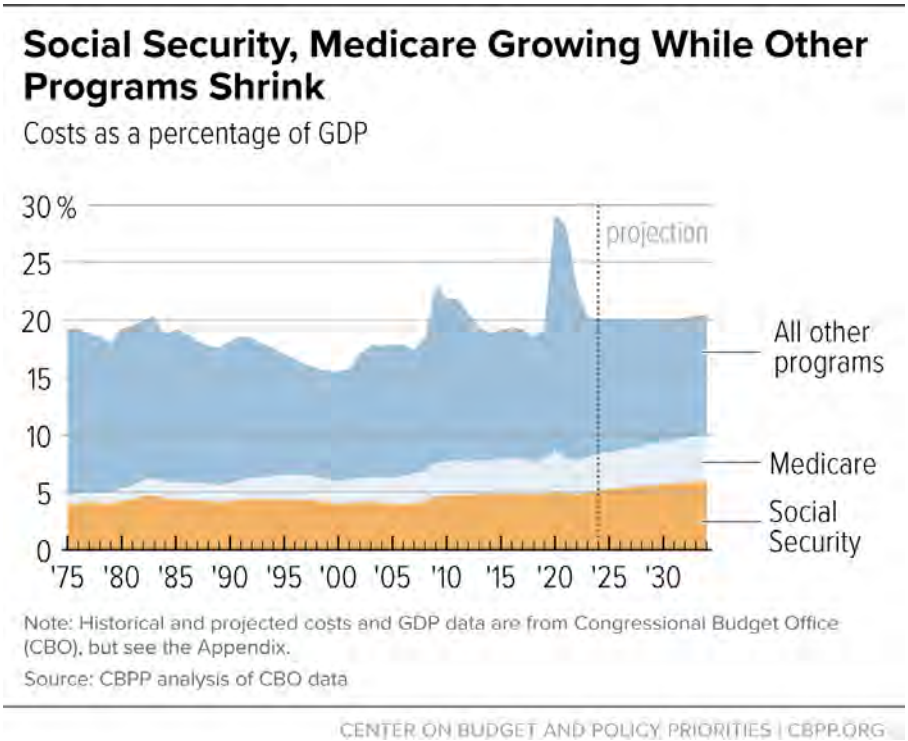
  For example, child poverty is higher in the U.S. than in other similarly wealthy countries due to our weaker support for families with children. Temporary policies enacted during the COVID-19 pandemic produced a historic decline in child poverty and narrowed differences in poverty rates by race and ethnicity, but those gains disappeared when the measures expired. Investing in children has long-term payoffs for the entire country, and that means our under-investment is harming the nation's potential.

  Investments in this and other areas — including investments to bring down the high cost of housing and child care for families, address climate change, expand access to higher education, improve our infrastructure, and support research and technological advances — all could yield significant short- and long-term benefits to people, communities, and the economy as a whole. But they will require more revenue.

- **Managing the future risks associated with higher debt**. Policymakers should consider the risks associated with a federal debt that's growing faster than the economy and is projected to continue doing so. While there is no consensus among economists as to what level of debt relative to the size of the economy (known as the debt ratio) will cause significant economic harm, higher debt ratios increase risks to the economy.

  At the same time, policymakers must weigh the uncertainty of those risks against the more certain, damaging consequences of underinvestment in public services and the economy, which include higher poverty, reduced health and well-being, and limited opportunity. They can best manage these risks by raising sufficient revenue both to finance investments today and to improve our long-term fiscal outlook.

FIGURE 1



Arguments Against New Revenue Don't Hold Up

Some critics argue that increasing revenue slows economic growth. But research doesn't support the conclusion that countries with higher levels of revenue have experienced lower economic growth over time. Studies have produced conflicting findings, likely because many factors affect growth — including the type of tax, economic conditions, monetary policy, the time frame examined, and importantly, what the funds are used for. Revenue is used for a range of spending and investment that itself can both improve well-being and bolster growth.

Some critics also argue that the nation's long-term fiscal challenges are caused by overspending and thus should be addressed by cutting programs rather than raising revenue. This argument ignores the very substantial costs in deficits and debt caused by the Bush and Trump tax cuts. Absent those tax policies, deficits and debt would be much lower. And in any case, those critics have been unable or unwilling to show how the budget can be cut to achieve their fiscal goals. Budget proposals claiming to embrace that approach have combined some specific, extreme, and damaging program cuts with large additional cuts that are generally *unspecified*.[2]

The most recent House Republican budget resolution, for instance, called for $9.3 trillion in program cuts over ten years, but almost half of the cuts were unspecified. The specified cuts, which

[2] Sharon Parrott, "House Republican Budget Reflects Disturbing Vision for the Country," CBPP, September 19, 2023, https://www.cbpp.org/press/statements/house-republican-budget-reflects-disturbing-vision-for-the-country. Also see Richard Kogan and Joel Friedman, "Five Things to Look for in the House Republican Budget Plan," CBPP, September 18, 2023, https://www.cbpp.org/research/federal-budget/five-things-to-look-for-in-the-house-republican-budget-resolution.

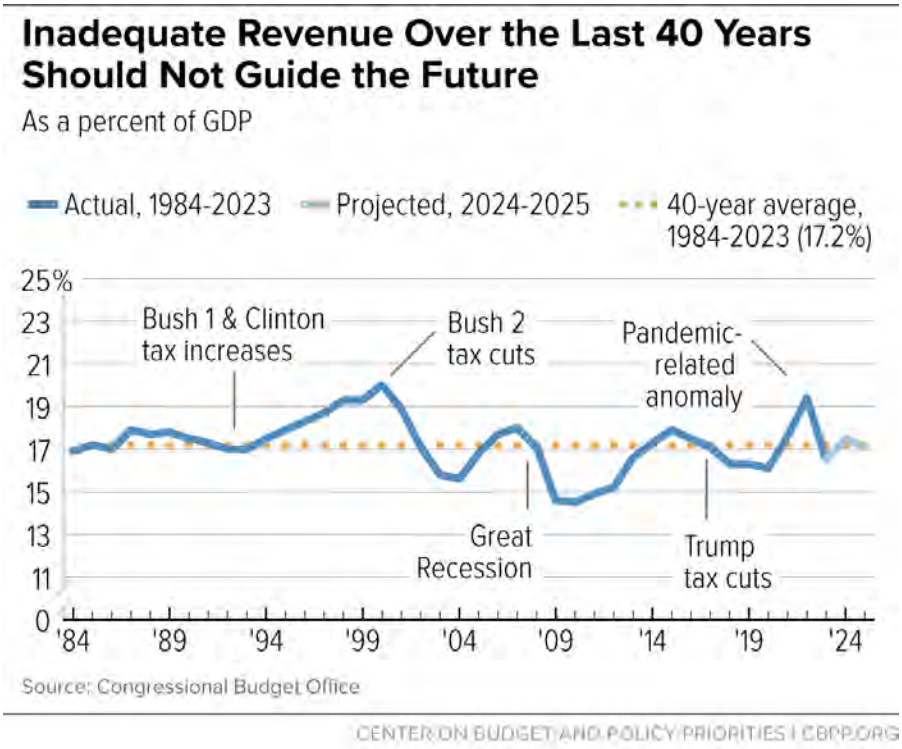
targeted health care and programs that help people with low incomes afford the basics, would drive up poverty and hardship and the number of people without health coverage. The unspecified cuts would require, among other cuts, massive disinvestment from the part of the budget that funds a broad range of public services, such as national parks, child care, education, scientific and medical research, and veterans' health care. While some reasonable savings can be achieved in certain areas, such as by ending inefficient subsidies, they are far less than these extreme proposals call for, and far less than the amounts required to address the needs discussed in this report.

Similarly, some argue that revenue today (relative to the economy) should not be allowed to exceed historical levels, as if they represent an inevitable or natural constraint on revenue. But a backward-looking benchmark is of little use in guiding policies designed to meet current and future needs and a country with far different demographics than decades ago.

In 2024, CBO estimates that revenue will be 17.5 percent of GDP — roughly equivalent to the average over the past 40 years and close to the level in 1984. (See Figure 2.) But the country today is very different. For example, 40 years ago members of the baby boom generation (those born between 1946 and 1964) were in or still approaching their "prime working years;" today they are in the "prime retirement years," with all but the very youngest now eligible for Social Security. And over the next 40 years, this aging trend will continue. By 2064, the share of the population over age 65 is projected to reach 22.7 percent, or nearly double the 11.6 percent share in 1984. Similarly, the dangers and challenges of climate change are more dramatic and urgent than they were 40 years ago, demanding more action today and in the future. And in 1984 we did far less than we do today to reduce child poverty, invest in child care, or ensure that people without health coverage through their jobs have access to health coverage.

In short, 21st century revenue needs are much different from those in the 1980s.

FIGURE 2



It is notable that policymakers did not let revenue levels from the first half of the 20th century dictate those of the second half. Federal revenue averaged only about 4 percent of GDP from the beginning of the last century to the beginning of World War II. But during the second half of the century, when our defense needs were notably greater and key social insurance costs (such as Social Security and public support for health insurance for seniors) emerged or began to grow, federal revenue averaged more than 17 percent of GDP. It should also be noted that economic growth was faster in the second half. The past should not bind the present or future.

Moreover, revenue levels from the past four decades were insufficient even then; the debt ratio more than doubled over that period, even before the pandemic. Despite some progress in recent decades, we invest notably less than other wealthy countries in children, families, and workers — including less in child care, paid leave, and financial help to families — and we have significantly more people without health coverage.[3] Counting all levels of government, the U.S. collects only about two-thirds as much revenue as other wealthy countries such as those in the European Union, relative to the size of the economy. Addressing our underinvestment in children, workers, and access

[3] This comparison of economic security investments is based on an analysis of 2019 OECD data on gross public social spending, excluding health, at all levels of government in a country. This OECD category of spending covers old age pensions, disability benefits, families and children, unemployment benefits, and housing, among other supports, but excludes most social benefits provided through the tax code (for instance, for the U.S., it includes only the refundable portion of the Earned Income Tax Credit). See "Social Expenditure Database (SOCX)," OECD, https://www.oecd.org/social/expenditure.htm. Some 90 percent of the U.S. population had health insurance coverage, compared with an average of 99 percent among European Union countries in the OECD in 2019. See "Population Coverage for a Core Set of Services, 2019 (or nearest year)," OECD, November 9, 2021, https://doi.org/10.1787/dcae7ac1-en.

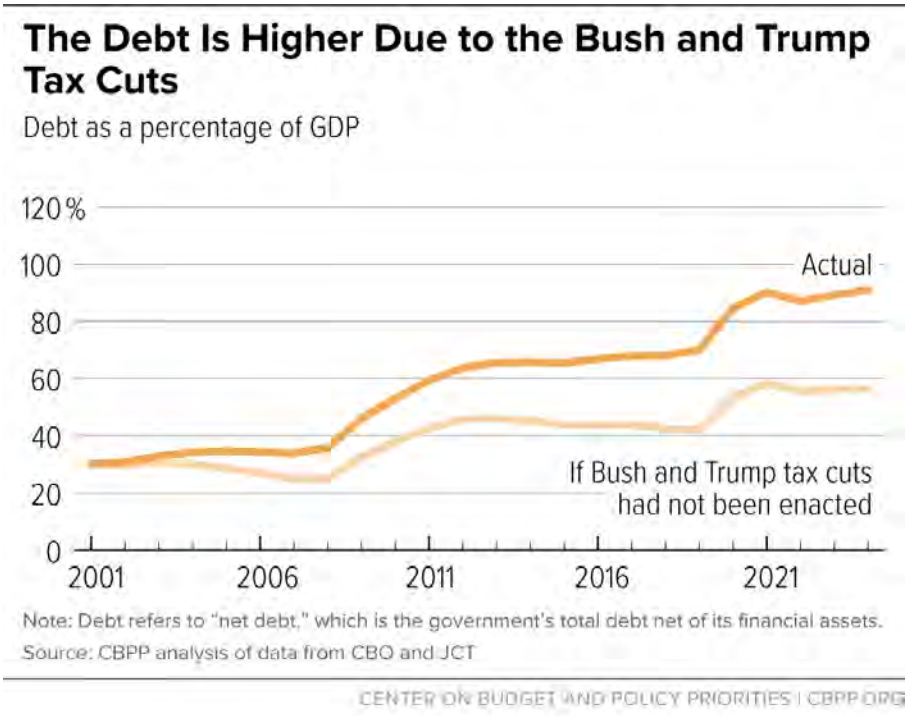
to health care, as well as other challenges such as climate change and aging infrastructure (the result, in part, of underinvestment over past decades), will require making greater investments in the future than in the past.

Tax Cuts Have Weakened Revenues; Focus Should Be on Raising Revenues

Despite rising costs due to the aging of the baby boom generation and our investment deficit, policymakers have enacted tax cuts in the past two decades that have eroded the revenue base. This has undermined investments and driven up deficits and debt, increasing future economic risks.

Tax cuts enacted during the Bush and Trump administrations have substantially increased the nation's deficits and debt. We estimate that if the Bush tax cuts and their extensions and the 2017 Trump tax cuts had not been enacted, the deficit would be less than half its current size, and the debt ratio would be considerably lower as well: 56 percent of GDP in 2024, compared to the actual 91 percent.[4] (See Figure 3.)

FIGURE 3



[4] The Bush tax cuts and their extensions included revenue losses caused by limiting the amount that the Alternative Minimum Tax (AMT) would recapture from better-off tax filers. Because the AMT was not indexed for inflation in 2000, just before enactment of the Bush tax cuts, the AMT would have recaptured growing amounts of revenue as the years passed. As a result, legislation to limit the reach of the AMT became increasingly costly as the years passed, relative to 2000 AMT law. Those very costly effects were part of the Bush tax cuts and its extensions and so were part of all scores of that legislation by the Congressional Budget Office and Joint Committee on Taxation. In our analysis, however, we attribute smaller revenue losses to the AMT provisions of those tax cuts, measuring those revenue losses relative to a hypothetical AMT that had been indexed for inflation (rather than the actual, unindexed AMT), so our estimates of the costs of the Bush tax cuts are more conservative.

The individual and estate tax provisions of the 2017 tax cuts are scheduled to expire in December 2025. Extending these tax cuts without offsets would cost about $4 trillion over ten years. Allowing many of these provisions to expire, and completely offsetting any extensions with other revenue increases, is an essential first step toward rebuilding the revenue base.[5]

Even with this step, revenue in the next decade would remain below the levels of the late 1990s as a percent of the economy and below the levels of nearly all of our peer countries. Most importantly, revenue would still be well short of what is needed to accommodate the costs of an aging population and to manage our long-term fiscal challenges, let alone address our investment deficit. Additional revenue-raising efforts will therefore be needed.

These revenue increases should be progressive, which is particularly appropriate given that the nation's income in recent decades has grown increasingly unequal. Typical middle-income families with children had almost 50 percent more income after taxes in 2019 than such families had in 1984, after adjusting for inflation. But among the top 1 percent of households, their already disproportionate incomes grew three times as fast over that period: almost 150 percent. Indeed, by 2019, the top 1 percent had annual incomes averaging $1.7 million, almost 20 times that of typical middle-income families with children.[6] Revenue-raising efforts should therefore focus on those who have gained the most over the last four decades, while new investments should focus on solving national problems and expanding opportunity.

The United States is a significantly wealthier nation than it was in 1984 and can afford to devote a greater share of its resources to addressing these challenges. It is among the world's richest countries on a per-person basis;[7] per-person income is twice the level it was four decades ago, after adjusting for inflation, and per-person wealth has grown even more, rising 270 percent.[8] Moreover, CBO projects that over the next 30 years, inflation-adjusted per-person income will rise by another 46 percent.[9] Growing income and wealth means that even if revenue rises somewhat faster than GDP

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[5] Chuck Marr, Samantha Jacoby, and George Fenton, "The 2017 Trump Tax Law Was Skewed to the Rich, Expensive, and Failed to Deliver on Its Promises," CBPP, updated June 13, 2024, https://www.cbpp.org/research/federal-tax/the-2017-trump-tax-law-was-skewed-to-the-rich-expensive-and-failed-to-deliver.

[6] CBPP analysis of CBO's distribution of household income for households with children, at Congressional Budget Office, "The Distribution of Household Income in 2020," November 14, 2023, https://www.cbo.gov/publication/59509. We use CBO's data through 2019 (2020, the latest year with available data, is distorted by COVID effects). Amounts are after taxes, exclude medical benefits, include other means-tested government transfers, and are adjusted for inflation to 2019 dollars. Incomes are ranked by post-tax, post-transfer incomes.

[7] U.S. GDP per person is an estimated $80,000 in 2023, according to the International Monetary Fund, which uses Purchasing Power Parity as the basis for its calculations. This compares favorably with that of virtually every other country. The exceptions are a few tax havens (e.g., Luxembourg, Ireland, Switzerland, San Marino) and a few oil-rich nations (e.g., Qatar and the Emirates). See International Monetary Fund, "Report for Selected Countries and Subjects," June 4, 2024, https://www.imf.org/en/Publications/WEO/weo-database/2023/October/weo-report.

[8] The income figures compare 2024 estimates with 1984 figures, using data from CBO. Wealth data are as of December 31, 2023, from Table b.1 of the Federal Reserve's quarterly "Financial Accounts of the United States." We adjust the Fed's nominal wealth data for population growth and inflation. See Board of Governors of the Federal Reserve System, Financial Accounts Guide - Display Table, https://www.federalreserve.gov/releases/z1/default.htm.

[9] Congressional Budget Office, "The Long-Term Budget Outlook Under Alternative Scenarios for the Economy and the Budget," May 21, 2024, https://www.cbo.gov/publication/60169. See CBO's backup tables for the data underlying its charts.

over time, the after-tax levels of inflation-adjusted income and wealth will also continue to grow. And the investments supported by that revenue will themselves improve well-being.

In short, we can afford to raise revenue and invest in people, communities, and the economy to strengthen the country and create a more broadly shared prosperity.

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Maintaining Retirement and Health Care Commitments to Seniors

Social Security provides retirement, disability, and survivor benefits, and its costs are heavily dependent on the number of seniors; Medicare provides health care to retirees and some people with disabilities. These commitments to seniors have been in place for generations and are essential to their well-being.

The costs of these programs relative to the economy were always slated to grow after 2005 as the baby boom generation began to retire. (See Figure 4.) In addition to the effect of demographics, the cost of medical care — in both the public and private sectors — generally rises faster than the economy as new medical technology and prescription drugs are developed. These advances result in better health care and improved quality and length of life but are more costly.[10] And while it has long been understood that the costs of Social Security and Medicare would rise as the baby boom generation aged, the current cost of each program is lower than was projected in 2010; most importantly, health care cost growth has moderated relative to prior estimates.

CBO projects that, from 2024 through 2034, the combined costs of Social Security and Medicare will grow from 8.3 to 10.1 percent of GDP.[11]

For Social Security, the projected cost growth is fundamentally demographic, traceable to more beneficiaries rather than more generous benefits. The average Social Security retired worker benefit is about $1,910 a month in 2024, or $22,900 a year — hardly an excessive amount, and most beneficiaries rely on Social Security for at least half of their income. Moreover, future retirees face lower benefits than current retirees, relative to their past earnings.[12]

The aging of the population will also raise Medicare costs, for three reasons. More people will turn 65 and become eligible for Medicare; the share of the population that is very old (and hence in greater need of costly care) is projected to increase even more rapidly than the elderly population as a whole; and, as noted, the cost of medical care generally rises faster than the economy (even with the slowdown in cost growth over the last decade or so). Over the next ten years, the portion of the population that is 85 or over — a group with the highest health care costs — will grow from 1.9 percent to 2.8 percent, and it will continue to grow in succeeding decades.[13]

(Medicaid, which serves those with limited incomes, is also important to seniors' well-being, and some factors noted above will raise its costs as well. For example, Medicaid provides assistance with Medicare premiums and cost sharing for seniors with low incomes and also covers long-term care, while Medicare does not.)

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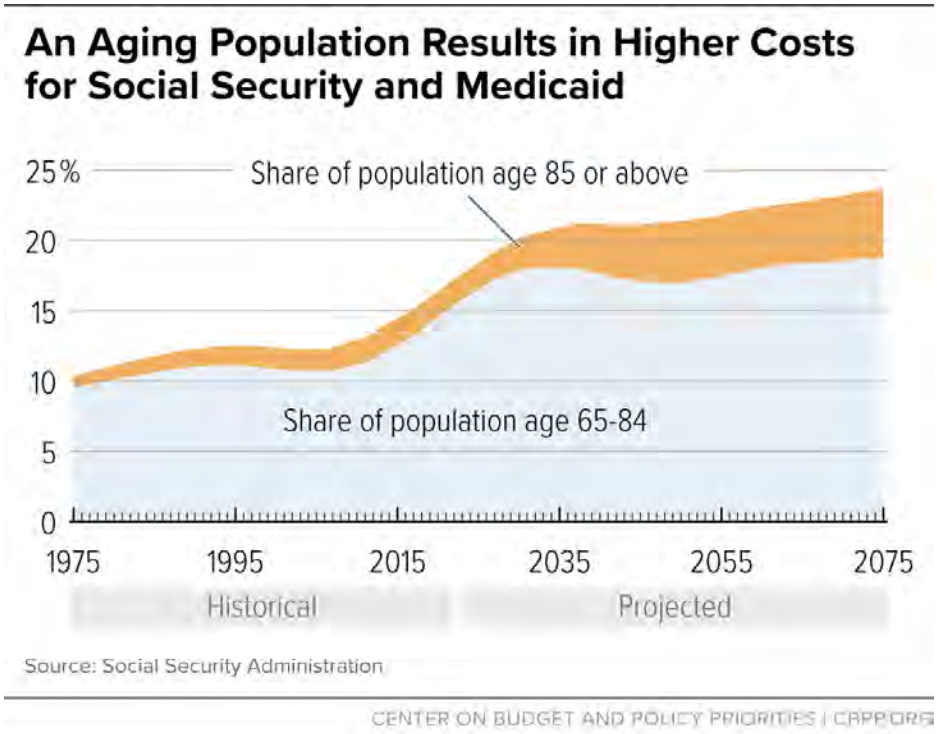
[10] The cost growth of Medicare is not due to significant design flaws; per-person *private-sector* health care costs have grown faster than the equivalent Medicare costs.

[11] These estimates exclude administrative costs, which are appropriated annually.

[12] Paul N. Van de Water and Kathleen Romig, "Social Security Benefits Are Modest," CBPP, December 7, 2023, https://www.cbpp.org/research/social-security/social-security-benefits-are-modest. For 2024 benefit amounts, see Social Security Administration, Benefits Paid by Type of Beneficiary, https://www.ssa.gov/OACT/ProgData/icp.html.

[13] Projections are from the 2024 report of the Social Security Trustees and show the share of the population age 85 or older growing to 5.0 percent by 2075. See Social Security Program Data, https://www.ssa.gov/OACT/HistEst/Population/2024/Population2024.html.

FIGURE 4



As with Social Security, the benefits provided by these health programs are not overly generous. Medicare's benefits are in some respects less comprehensive than a typical employer-sponsored health plan. Medicare households spend on average about $6,600 a year on out-of-pocket health care costs, which is about 15 percent of their budgets — over twice the average for non-Medicare households.[14]

Some savings in health care costs can be achieved without reducing eligibility or benefits, such as by using the government's negotiating power to reduce prescription drug costs beyond the early steps taken in the 2022 Inflation Reduction Act. We can also cut down on overly generous payments to Medicare Advantage plans.

Even if health care cost growth moderates, there is no doubt that demographic changes in the U.S. population will increase the costs of Social Security and Medicare — and that more revenue will be needed to meet our commitments to seniors.

Making High-Value Investments

The United States underinvests in people, communities, and the building blocks of the economy in ways that shortchange opportunity, exacerbate inequality, widen racial and ethnic inequities, and limit the nation's potential. A key reason to raise revenue is to address this investment deficit.

[14] Nancy Ochieng, Juliette Cubanski, and Anthony Damico, "Medicare Households Spend More on Health Care Than Other Households," KFF, March 14, 2024, https://www.kff.org/medicare/issue-brief/medicare-households-spend-more-on-health-care-than-other-households/.

The nation can well afford to make high-value investments that broaden opportunity and promote more widely shared prosperity. Yet federal spending outside of Social Security and Medicare has *declined* as a percent of GDP over the last 40 years and is projected to keep falling.[15] This part of the budget encompasses everything from the armed forces and veterans' benefits to education, infrastructure, agriculture, environmental protection, science and medical research, and economic security programs. It is the part of the budget where the nation can invest in its future.

Areas in need of additional investment include:

Children. Some 1 in 8 children in the U.S. live in families with incomes below the U.S. poverty line,[16] and there are glaring differences in poverty rates by race and ethnicity. Child poverty in the U.S. is higher than in most similarly wealthy nations as measured by conventional international standards, driven by our relatively weak public supports for families with children.[17] Making policy choices that keep child poverty high shortchanges children's futures and the country as a whole.

Research shows that investing in children in families with low incomes has enormous payoffs in longer-term educational, health, and employment outcomes. (See Figure 5.) In a 2019 report by the National Academy of Sciences, for example, stronger income assistance for children with low incomes — through policies such as the Child Tax Credit and food assistance through SNAP — was linked with healthier birthweights, better childhood nutrition, higher school enrollment, higher reading and math test scores, higher high school graduation rates, less use of drugs and alcohol, and higher rates of college entry.[18]

Other wealthy nations have broad-based child allowances akin to the expanded Child Tax Credit created by the 2021 American Rescue Plan. They also invest in child care and education, both to make care affordable for families and to improve developmental outcomes for children.

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[15] Spending outside Social Security and Medicare has shrunk from 12.9 percent of GDP in 1984 to 11.8 percent in 2024 and is projected to be 10.3 percent by 2034.

[16] The figure is 12.4 percent, using the supplemental poverty measure, with data for 2022, the most recent available. See U.S. Census Bureau, Poverty in the United States: 2022, Table B-2, https://www.census.gov/library/publications/2023/demo/p60-280.html.

[17] Before the pandemic, 20 percent of U.S. children lived in families with incomes below half the national median, the poverty measure most commonly used for international comparisons. This is a much higher share than in any of the world's 18 other similarly wealthy nations, where between 3 and 15 percent of children are poor. See Arloc Sherman *et al.*, "Widespread Economic Insecurity Pre-Pandemic Shows Need for Strong Recovery Package," CBPP, July 14, 2021, https://www.cbpp.org/research/poverty-and-inequality/widespread-economic-insecurity-pre-pandemic-shows-need-for-strong. U.S. child poverty rates would stand out less among peer nations if poverty were defined as one-half of U.S. median income rather than half of each nation's own median income. That is because average and median incomes in the U.S. are particularly high. Its relatively high overall income also means that the U.S. has relatively high capacity to further reduce child poverty, should it choose to do so. For a recent analysis of child poverty rates across countries using multiple measures, see Zachary Parolin and Stefano Filauro, "The United States' Record-Low Child Poverty Rate in International and Historical Perspective: A Research Note," *Demography,* Vol. 60, Issue 6, December 2023, https://doi.org/10.1215/00703370-11064017. Note that their analysis also includes some nations that are less comparable to the U.S. in terms of income levels.

[18] National Academies of Sciences, Engineering, and Medicine, *A Roadmap to Reducing Child Poverty,* National Academies Press, 2019, https://www.nap.edu/read/25246.

We know how to reduce poverty and hardship and improve families' economic security. During the pandemic, we saw that the Child Tax Credit expansion — which, critically, made the full credit available to children in families with low earnings or who lacked earnings in a year — reduced child poverty to historically low levels. Unfortunately, this progress was reversed when the expansion ended.[19] We also saw that investing in child care could expand access to care and help child care providers raise very low wage levels and stay in business.[20]

Workers and their families. Child care is not the only challenge facing workers. All too often, workers who lose a job due to a layoff or the need to care for a family member face deep financial hardship for themselves and their families.

The United States is alone among wealthy countries in lacking a national paid leave program, relying instead on a patchwork of federal, state, and local policies. The vast majority of employers do not voluntarily offer paid family and medical leave.[21]

FIGURE 5

The benefits of paid leave are well established. Paid medical and caregiving leave lets workers care for themselves and loved ones when ill or injured and reduces financial insecurity and stress during those times. Paid leave also benefits businesses by improving worker retention and productivity and boosting labor force participation.[22]

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[19] Sharon Parrott, "Record Rise in Poverty Highlights Importance of Child Tax Credit; Health Coverage Marks a High Point Before Pandemic Safeguards Ended," CBPP, September 12, 2023, https://www.cbpp.org/press/statements/record-rise-in-poverty-highlights-importance-of-child-tax-credit-health-coverage; Danilo Trisi, "Expiration of Pandemic Relief Led to Record Increases in Poverty and Child Poverty in 2022," CBPP, June 10, 2024, https://www.cbpp.org/research/poverty-and-inequality/expiration-of-pandemic-relief-led-to-record-increases-in-poverty.

[20] Testimony of Sharon Parrott, "Robust COVID Relief Achieved Historic Gains Against Poverty and Hardship, Bolstered Economy," Before the House Committee on the Budget, June 14, 2022, https://www.cbpp.org/research/poverty-and-inequality/robust-covid-relief-achieved-historic-gains-against-poverty-and-0.

[21] Kathleen Romig and Kathleen Bryant, "A National Paid Leave Program Would Help Workers, Families," CBPP, April 27, 2021, https://www.cbpp.org/research/economy/a-national-paid-leave-program-would-help-workers-families.

[22] *Ibid.*

The U.S. lacks not only a comprehensive paid leave program but also an adequate unemployment insurance (UI) system. The current UI system, a federal-state partnership, fails to provide any help to most unemployed workers, often provides benefits that are too low to ensure households can make ends meet when a worker does qualify, and, in some states, fails to provide enough weeks of help to allow workers to find new employment that best matches their skills. For example, the share of unemployed workers receiving any UI benefits has fallen in recent decades from roughly 50 percent to under 30 percent in 2023.

During the pandemic, the U.S. expanded eligibility and increased benefit levels, providing critical financial protection to workers who lost their jobs. While there were implementation issues and crime rings that targeted inadequate systems, expanded jobless benefits kept millions of households afloat. But those expansions ended, and workers who lose their jobs today once again face a severely inadequate UI system.[23]

Housing and food security. Millions of households face unaffordable rent burdens, and homelessness is rising.[24] More than 80 percent of renter households earning less than $30,000 per year pay over 30 percent of their income for housing, which leaves less available for food, medicine, clothing, school supplies, or other necessities.[25] As unmet needs pile up, families often find themselves one setback — a cut in their work hours or an unexpected bill — away from eviction or homelessness.

The housing crisis stems partly from inadequate supply of housing in some communities, but many people do not have enough income to afford housing even in areas where supply is sufficient. Rental assistance is the most effective way to help people bridge the gap between what they can afford and the cost of housing, but it reaches just 1 in 4 households needing assistance due to inadequate funding.[26] (See Figure 6.) The nation must also invest in retaining the current stock of affordable housing and adding to it.

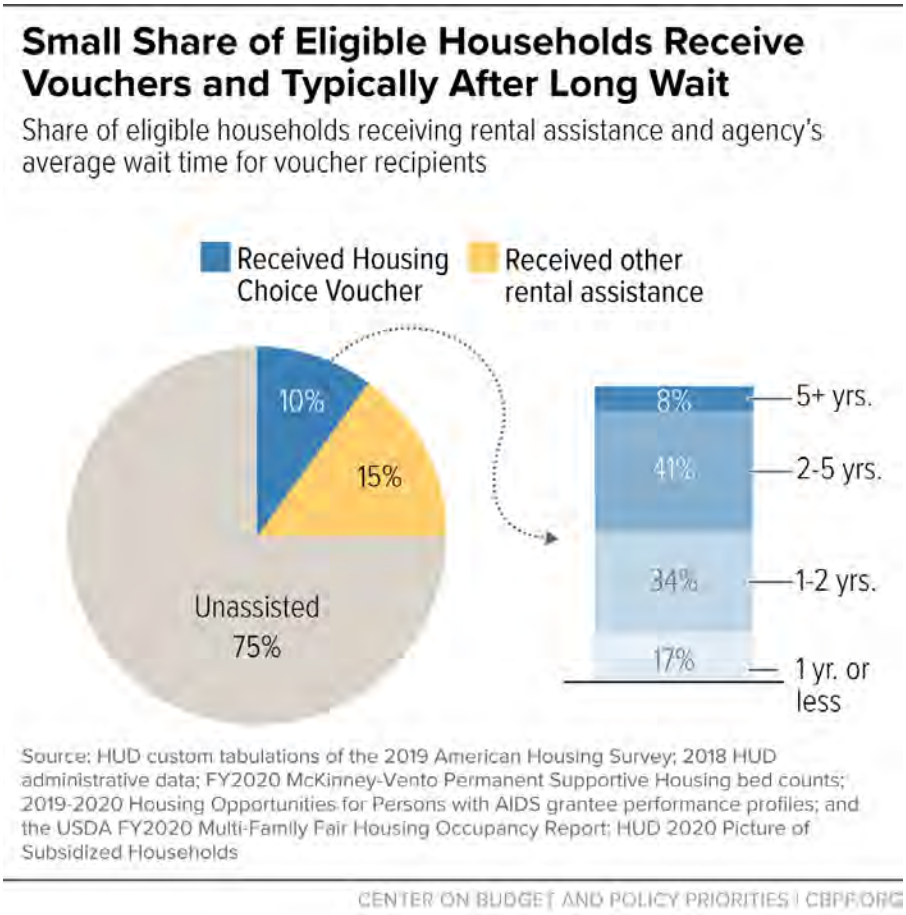
[23] Nick Gwyn and Jenna Gerry, "Unemployment Insurance System Unprepared for Another Recession," CBPP, April 18, 2023, https://www.cbpp.org/research/economy/unemployment-insurance-system-unprepared-for-another-recession.

[24] See Testimony of Peggy Bailey, "Examining Proposals to Address Housing Affordability, Availability, and Other Community Needs," Before the Senate Banking, Housing, and Urban Affairs Committee, March 12, 2024, https://www.cbpp.org/research/housing/examining-proposals-to-address-housing-affordability-availability-and-other.

[25] Joint Center for Housing Studies of Harvard University, "America's Rental Housing 2024," January 25, 2024 https://www.jchs.harvard.edu/sites/default/files/reports/files/Harvard_JCHS_Americas_Rental_Housing_2024.pdf.

[26] CBPP, "Families With Children and Non-Elderly Adults Without Children Have the Greatest Unmet Need for Rental Assistance," https://www.cbpp.org/research/housing/three-out-of-four-low-income-at-risk-renters-do-not-receive-federal-rental-assistance.

FIGURE 6

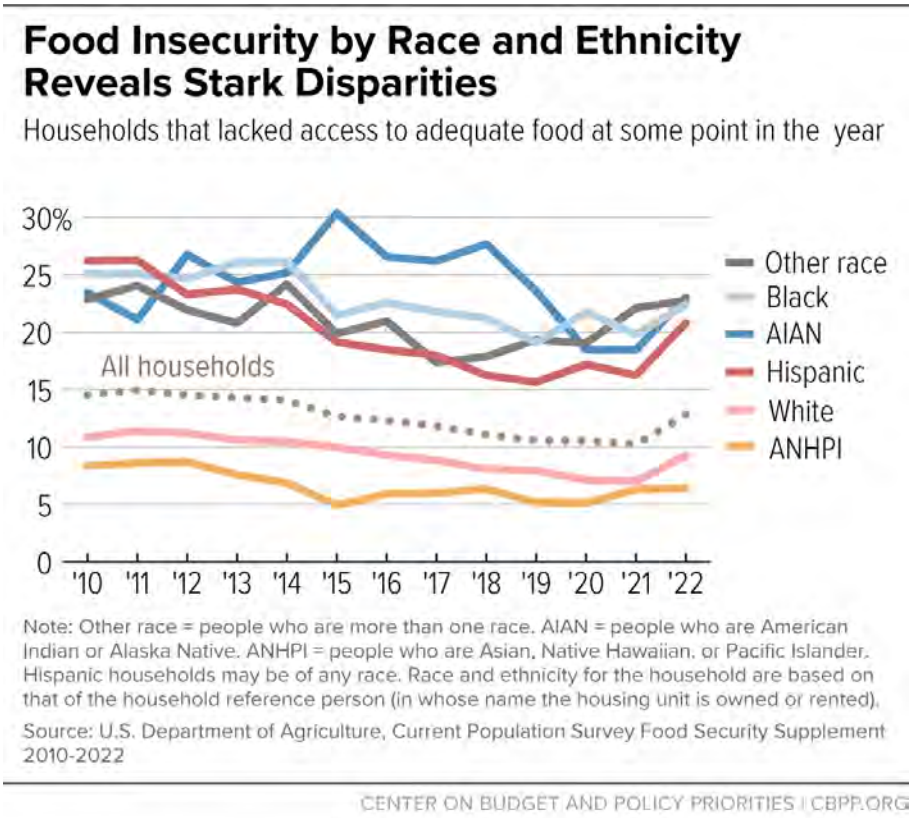


Food insecurity is another hardship far too prevalent in our wealthy nation — faced by 44 million people in 2022.[27] Rates of food insecurity are substantially higher among households identifying as American Indian or Alaska Native, Black, Hispanic, or multiracial, as well as households with children. (See Figure 7.) These inequities reflect the impact of systemic racism and discrimination in areas such as housing, health care, education, and employment, which make it more difficult for those affected to afford food.[28]

[27] Matthew P. Rabbitt *et al.*, "Household Food Security in the United States in 2022," USDA Economic Research Service, October 2023, https://www.ers.usda.gov/publications/pub-details/?pubid=107702.

[28] Lauren Hall, "Food Insecurity Increased in 2022, With Severe Impact on Households With Children and Ongoing Racial Inequities," CBPP, October 26, 2023, https://www.cbpp.org/blog/food-insecurity-increased-in-2022-with-severe-impact-on-households-with-children-and-ongoing.

FIGURE 7



Health care. Because of the Affordable Care Act (ACA), the nation has made enormous progress in reducing the number of uninsured people as well as the differences in uninsured rates among racial and ethnic groups. But 26 million individuals remain uninsured and uninsured rates vary widely among racial and ethnic groups, indicating persistent inequities.[29] And even for people with coverage, challenges with affording and accessing care remain.[30]

Additionally, more than 1.6 million people are in the Medicaid coverage gap, meaning their incomes are too low to be eligible for premium tax credits in the health insurance marketplaces, but they are ineligible for Medicaid because they live in the ten states that haven't adopted the ACA's Medicaid expansion.[31]

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[29] Breanna Sharer and Gideon Lukens, "Health Coverage Rates Vary Widely Across — and Within — Racial and Ethnic Groups," CBPP, May 9, 2024, https://www.cbpp.org/research/health/health-coverage-rates-vary-widely-across-and-within-racial-and-ethnic-groups.

[30] People with little financial margin to cover unexpected health costs face challenges affording deductibles and other out-of-pocket charges under marketplace plans and other private health insurance coverage. CBPP, "Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges," findings of the Marketplace Affordability Project, April 10, 2024, https://www.cbpp.org/research/health/building-on-the-affordable-care-act-strategies-to-address-marketplace-enrollees.

[31] Jennifer Sullivan, Allison Orris, and Gideon Lukens, "Entering Their Second Decade, Affordable Care Act Coverage Expansions Have Helped Millions, Provide the Basis for Further Progress," CBPP, updated March 25, 2024, https://www.cbpp.org/research/health/entering-their-second-decade-affordable-care-act-coverage-expansions-have-helped.

Policymakers can expand health coverage and care and improve affordability by closing the Medicaid coverage gap, reducing immigration-related barriers to coverage, and making recent improvements to marketplace premium tax credits permanent.

Post-secondary education. Accessible, high-quality post-secondary education is a crucial contributor to a strong economy and thriving communities. However, since the Great Recession of 2007-09, rising education costs have made it less accessible. The burden is especially great for families of color, who pay a greater share of their income for college due to long-standing employment and wage discrimination.

Increasing aid for college boosts both attendance and completion, numerous studies indicate.[32] Pell Grants — the nation's largest source of need-based grant aid, assisting more than 6 million students — are well targeted to students with high financial need, but they fall far short of the cost of attending college, and the gap has grown over the last four decades. In the 2023-24 school year, the maximum grant covered just 31 percent of the cost of attending a state university, including tuition, fees, and room and board.[33]

Low-income seniors and people with disabilities. The Supplemental Security Income (SSI) program for low-income elderly and disabled people is woefully inadequate, excluding many people in need entirely and leaving many recipients without enough resources to meet basic needs. Its maximum benefit is only three-fourths of the poverty line, and 4 in 10 SSI recipients have incomes below the poverty line even with their SSI benefits. SSI's income and asset limits have not been updated for decades and allow recipients to keep only a meager amount of their earnings, other benefits, and savings. SSI also excludes most immigrants (until they become U.S. citizens) and residents of U.S. Territories, most of whom are people of color.[34]

Furthermore, many seniors, people with disabilities, and their families struggle to afford and access needed long-term services and supports, including home- and community-based care. Additional investments, for example in Medicaid, are necessary to ensure both that there is an adequate workforce to provide services, given growing demand, and that these supports and services are in reach for recipients.

Other areas. In addition to the areas noted above, the nation has investment deficits in other areas that matter for the economy and people's well-being — ensuring access to clean water, addressing the threat of climate change, repairing and modernizing infrastructure, and increasing scientific and medical research, to cite just a few examples. Investments in areas such as these are also investments in the future that will, if designed well and funded adequately, make future generations better off. Conversely, failure to make these investments will leave future generations worse off.

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[32] Arloc Sherman *et al.,* "Recovery Proposals Adopt Proven Approaches to Reducing Poverty, Increasing Social Mobility," CBPP, August 5, 2021, https://www.cbpp.org/research/poverty-and-inequality/recovery-proposals-adopt-proven-approaches-to-reducing-poverty.

[33] College Board, "Trends in College Pricing and Student Aid 2023," https://research.collegeboard.org/media/pdf/Trends%20Report%202023%20Updated.pdf.

[34] Kathleen Romig and Sam Washington, "Policymakers Should Expand and Simplify Supplemental Security Income," CBPP, updated May 4, 2022, https://www.cbpp.org/research/social-security/policymakers-should-expand-and-simplify-supplemental-security-income.

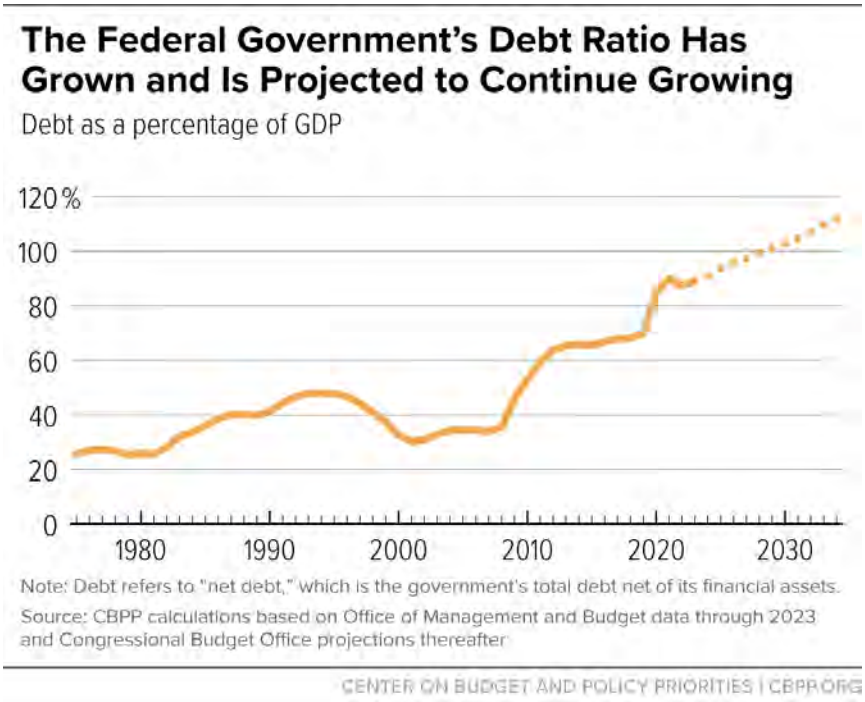
Managing Risks Associated With a Higher Debt Ratio

Continued growth in the federal debt ratio poses potential future risks to the economy and fiscal policy. Some are more political in nature, such as the risk that policymakers will adopt misguided policies or fail to make high-value investments in light of a rising debt ratio. Managing those risks by limiting the growth in the debt ratio is another key reason to raise revenue.

When the federal government collects less revenue than it spends, it takes on debt,[35] which the government must then pay to service. Those interest-related costs are the annual budgetary cost of taking on debt. On our current trajectory, both the nation's debt and the cost of servicing it are projected to rise relative to the size of the economy.

The debt as a percent of the economy is approaching historically high levels (see Figure 8) and is projected to reach 112 percent by 2034, according to CBPP estimates.[36] (For a discussion of the debt ratio, see the box, "What Causes the Debt Ratio to Rise?")

FIGURE 8

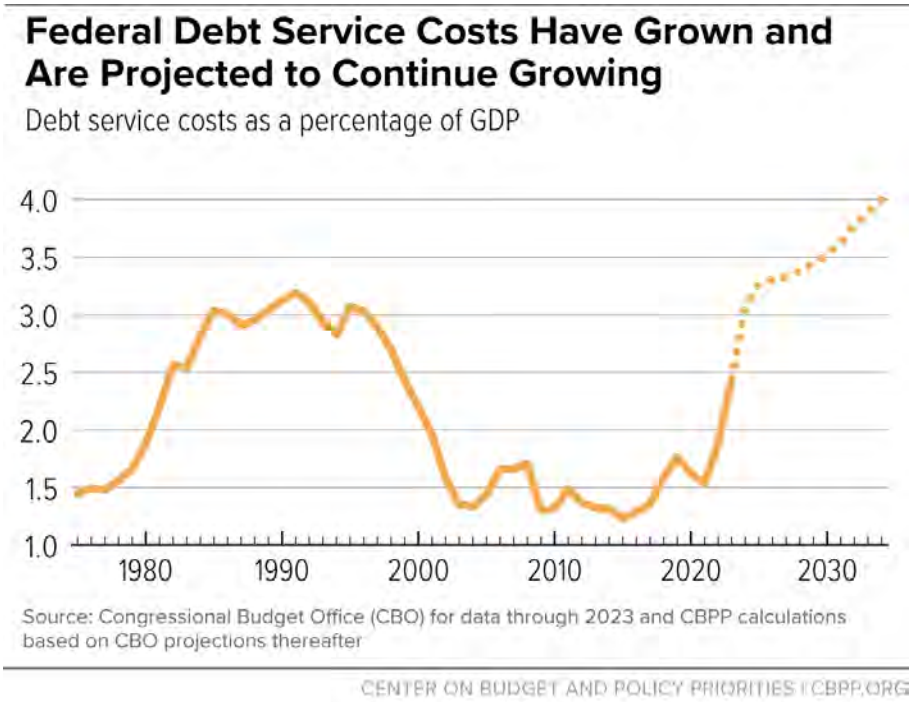


Interest costs as a percent of the economy are higher than they have been since the 1990s and are expected to keep growing. (See Figure 9.)

[35] In this paper, "debt" refers to "net debt," which is the government's total debt net of its financial assets, such as cash, gold, Treasury securities held by U.S. government agencies, and the value of student loans held by the government. Net debt is a better measure of the federal government's financial position at any point in time than gross debt or debt held by the public because it includes all the financial assets and liabilities of the government. And because it does, it is the only measure of debt that equals the sum of annual deficits (and surpluses) while excluding financial transactions to the extent they do not affect deficits.

[36] See the Appendix for a discussion of the ten-year budget projections in this report. Like the CBO estimates, the CBPP estimates assume the expiring 2017 tax cuts expire on schedule.

FIGURE 9



There is considerable uncertainty in these projections; over the next decade and even more over longer periods, the levels of revenue, program costs, interest costs, deficits, and debt could be higher or lower than projected. For instance, long-term budget projections made in 2010 showed a considerably *higher* debt ratio in 2050 than is projected today, even with additional costs stemming from unexpected events such as the pandemic, because projections now reflect much slower health care cost growth and lower interest rates than were assumed in 2010.

Standard economic theory suggests that, all else being equal, a high and rising debt ratio will, over time, put upward pressure on interest rates and reduce private investment, slowing overall growth in income and wealth to some extent. The magnitude of that effect is highly uncertain, with most analysts predicting a small effect. And of course, not all else is equal, so the effect can be hard to distinguish from other economic and demographic changes. Indeed, over the last 45 years, the debt ratio has grown, but real Treasury interest rates have generally trended *down*, and GDP growth has trended down only slightly. All this suggests that the macroeconomic effects of a rising debt ratio are likely small.

CBO's most recent long-term projections show modest effects, with the average real (i.e., inflation-adjusted) income per person increasing by 46 percent over the next three decades if the growing debt ratio slows economic growth as CBO assumes, but by 56 percent if the growing debt ratio does not slow economic growth.[37] Under either scenario, per capita income is projected to grow substantially. (Reducing deficits simply by cutting investments would not necessarily improve the well-being of typical families if those cuts were in high-value investments that support income growth and broaden prosperity.)

[37] Congressional Budget Office, "The Long-Term Budget Outlook Under Alternative Scenarios for the Economy and the Budget." See CBO's backup tables for the data underlying its charts.

Some are concerned that a high and rising debt ratio could, at some point, help trigger a sudden crisis where investors lose confidence in the U.S. government's ability to meet its debt service obligations, causing interest rates to spike.[38] But CBO views the risk of this kind of crisis to be low in the near term, and concludes that gauging the likelihood of such an event in the future with any confidence is nearly impossible. As CBO states:

> CBO cannot reliably quantify the probability of a fiscal crisis. In the agency's assessment, no tipping point can be identified at which the debt-to-GDP ratio would become so high that it would make a crisis likely or imminent, nor is there a fixed point at which interest costs would become so high in relation to GDP that they were unsustainable.[39]

Some policymakers have used the increase in debt as an excuse to push for deep and harmful budget cuts, even though economists do not agree on the levels of debt or debt service that pose a significant risk to the economy and a fiscal crisis is not imminent. But whereas the effects of higher debt levels are uncertain, the effects of such spending cuts would be both clear and damaging. They include higher poverty and the attendant long-term impacts on children and the economy, more people without access to health coverage, and less investment in public infrastructure and medical research (which would also hurt economic growth). Also, in a future recession or disaster, debt concerns could dissuade policymakers from responding with robust measures to bolster the economy and mitigate harm; this failure could prolong the downturn and slow the recovery — and, ironically, harm long-term economic growth.

A different example of such counter-productive behavior is that a rising debt ratio encourages some in Congress to demand policy concessions in return for raising the debt limit, an irresponsible strategy that risks defaulting on the nation's obligations. For example, the debt limit imbroglio in the spring of 2023 led Fitch Ratings to downgrade the reliability of Treasury securities, citing "the erosion of governance."[40]

The most responsible approach to fiscal policy would be to recognize both the future risks associated with higher levels of debt and the consequences of failing to address current underinvestment, which is hurting both near-term and long-term well-being. President Biden's 2025 budget, for example, calls for raising substantial revenue and using it for a combination of

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[38] Ernie Tedeschi, "Political Risks to the U.S. Safe Harbor Premium," Budget Lab at Yale, May 2024, https://budgetlab.yale.edu/sites/default/files/2024-05/The%20Budget%20Lab%20Safe%20Harbor%20Analysis%202024_0.pdf.

[39] Congressional Budget Office, "The Long-Term Budget Outlook: 2024 to 2054," March 2024, https://www.cbo.gov/publication/59711.

[40] On August 1, 2023, Fitch Ratings downgraded U.S. long-term Treasury securities from their long-standing AAA rating. Among a number of reasons, Fitch cited "the erosion of governance" and wrote, "The repeated debt-limit political standoffs and last-minute resolutions have eroded confidence in fiscal management." See Fitch Ratings, "Fitch Downgrades the United States' Long-Term Ratings to 'AA+' from 'AAA'; Outlook Stable," August 1, 2023, https://www.fitchratings.com/research/sovereigns/fitch-downgrades-united-states-long-term-ratings-to-aa-from-aaa-outlook-stable-01-08-2023.

investments and deficit reduction.[41] This is a prudent approach, which weighs the uncertain consequences of a rising debt ratio against the more certain consequences of underinvesting or, worse, disinvesting in people, communities, and the economy.

What Causes the Debt Ratio to Rise?

The dollar level of the debt grows from one year to the next whenever the government runs a deficit. Whether this causes the debt ratio to rise depends on two factors.

The first factor is the size of the primary deficit, or the mismatch between revenue and program costs. ("Program costs" are all expenditures other than the interest costs of net debt.) The second factor is the difference between the GDP growth rate and the Treasury interest rate. If the two rates are equal — if, for example, GDP is growing at a nominal 3.5 percent per year and the interest rate on Treasury securities is also 3.5 percent — then the debt ratio will be stable as long as the primary deficit is zero.

Fortunately, in most years throughout U.S. history, the GDP growth rate has been a bit *higher* than the Treasury interest rate, and CBO projects that it will be half a percentage point higher over the coming decade. As a result, even if the budget runs a small primary deficit, the debt ratio will not rise because the faster GDP growth will cancel the effect of the small primary deficit.[a] But the existing and projected primary deficits are large enough that the leeway afforded by a faster GDP growth rate is insufficient to stop the debt ratio from rising.

Importantly, primary deficits are projected to hold steady over the coming decade at about 2.4 percent of GDP. Primary deficits of this size produce a rising debt ratio. Put differently, the debt ratio is rising not because spending on programs is "rising too fast" or "revenue is rising too slowly," but because the mismatch between them is too big.

Primary deficits were also large in the past. This means that past levels of revenue are not only insufficient to cover *future* needs, they were also insufficient to cover *past* needs.

Finally, it is necessary to view the trends in debt and deficits over long periods rather than a single business cycle. When the economy is weak, and especially during recessions, policymakers can significantly shorten both the duration and depth of the downturn — as well as the hardship caused — by allowing deficits and debt to rise automatically and by providing additional temporary stimulus. This approach also results in higher economic growth over time than if policymakers failed to respond aggressively to periodic recessions.

a See Richard Kogan *et al.*, "Difference Between Economic Growth Rates and Treasury Interest Rates Significantly Affects Long-Term Budget Outlook," CBPP, February 27, 2015, https://www.cbpp.org/sites/default/files/atoms/files/2-27-15bud.pdf.

Arguments Against Higher Revenues Are Flawed

Opponents of raising more revenue typically make three related arguments: that higher revenues are bad for economic growth, that overspending is the cause of rising debt and thus cutting

[41] Sharon Parrott, "President's Budget Lays Out Sound Architecture for Key Policy Decisions That Will Shape the Nation's Future," CBPP, March 11, 2024, https://www.cbpp.org/press/statements/presidents-budget-lays-out-sound-architecture-for-key-policy-decisions-that-will.

programs is the only logical solution, and that revenue as a share of the economy should hew closely to the average level over the past several decades. None of these is a sound prescription for fiscal policy.

The Effect of Higher Revenue on Economic Growth

The weight of the empirical evidence does not support claims that raising revenue harms economic growth. Studies addressing this topic have generally found contradictory or inconclusive results. An analysis by tax economist Jon Bakija that reviewed a range of cross-country data and major economic studies concluded:

> [T]here is no convincing evidence that the countries choosing larger government [and the taxes that go with it] suffered any significant loss of GDP per person as a result. Healthy skepticism is in order regarding claims that growth of government, at least within the range we've seen in countries comparable to the United States, is bad for the economy in the long run.[42]

Another recent study, by four University of Michigan economists, concluded that analyses comparing taxes and growth across countries "do not credibly support" claims that tax rate changes have a strong effect on economic growth over time.[43] And a study by Brookings Institution economists found no consistent link between the amount of revenue a state collects (or its top marginal income tax rate) and the state's economic growth, either over time or in comparison to other states.[44]

There remains uncertainty about how taxes impact economic activity, in part because the impact can depend on context. A previous CBPP analysis of more than two dozen economic studies concluded that "the effect of tax increases on growth depends on many different factors, such as the type of tax, the country, the state of the economy, monetary policy, the time frame studied, and what the revenue is used for."[45] How the revenue is used can be critical in assessing the effects of tax policy, the analysis explained. It noted studies that found tax increases used to finance deficit reduction and education are associated with increased economic growth.

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[42] Jon Bakija, "Would Bigger Government Hurt the Economy?" chapter 3 of *How Big Should Our Government Be?* University of California Press, 2016, https://muse.jhu.edu/book/45735/.

[43] Laura Kawano, Johns S. Olson, Joel Slemrod, and Meng Hsuan Hsieh, "A Transparent Look at How Taxes Affect Growth: Evidence from Cross-Country Panel Data," November 2023, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4669075.

[44] William Gale, Aaron Krupkin, and Kim Reuben, "The relationship between taxes and growth at the state level: New evidence," Brookings Institution, April 29, 2015, https://www.brookings.edu/articles/the-relationship-between-taxes-and-growth-at-the-state-level-new-evidence/. See also William Gale and Andrew A. Samwick, "Effects of Income Tax Changes on Economic Growth," Economic Studies at Brookings, September 2014, https://www.brookings.edu/wp-content/uploads/2016/06/09_effects_income_tax_changes_economic_growth_gale_samwick.pdf.

[45] Chye-Ching Huang and Nathaniel Frentz, "What Really Is the Evidence on Taxes and Growth?" CBPP, February 18, 2014, https://www.cbpp.org/research/what-really-is-the-evidence-on-taxes-and-growth.

It is also important to understand that the effect on economic growth is only one dimension of an appropriate cost-benefit analysis of a tax policy.[46] The benefits of past economic growth have not been shared equitably, and focusing on the overall growth rate masks these differences.[47] Improvements in well-being and opportunity — such as income growth among people with incomes in the bottom half or three-quarters of the income distribution, longer and healthier lives, safer communities, and a healthier environment — may not always show up in aggregate economic statistics. And some policies may provide large benefits to those who have shared less in the economic growth of recent decades and may improve overall well-being even if they don't grow the overall economy.

Perhaps for all these reasons, one recent review of the data concluded that "the main effects of tax changes are to increase or decrease inequality and government revenue" rather than to affect economic growth.[48]

The Mismatch Between Revenue and Program Spending

Some opponents of raising revenue claim that because total spending (that is, program costs plus interest costs) is rising faster than revenue as a percent of GDP, this means spending is the source of our long-term fiscal challenges. This argument confuses cause and effect. Excluding interest costs, spending and revenue as a percent of GDP are projected to rise at much the same rate over the coming decade. Total spending as traditionally measured is projected to rise faster than revenue almost exclusively because of rising interest costs. Those rising interest costs are the result of the rising debt ratio, not its cause.[49]

And the projected increase in interest costs as a percent of GDP is itself mostly the product of tax cuts, because tax cuts enacted over the last 25 years are the major cause of the gap or mismatch between the level of revenue and the level of program costs. Rising interest costs associated with tax cuts should be thought of not as "higher spending" but as the additional fiscal cost of enacting those tax cuts.

The underlying cause of the rising debt ratio is that revenue is not sufficient to cover program costs, which exclude interest. In other words, the gap or mismatch between revenue and program spending is too large. These non-interest deficits can be addressed by raising projected revenue, cutting projected program costs, or some combination of both. Fundamentally, these are policy choices. And they have enormous implications for whether we close the investment deficit, who gets invested in, and who gets left behind.

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[46] The inadequacy of GDP as a measure of national well-being is the theme of *Mismeasuring Our Lives: Why GDP Doesn't Add Up,* by Amartya Sen, Jean Paul Fitoussi, and Joseph Stiglitz, New Press, 2010, https://wcfia.harvard.edu/publications/mismeasuring-our-lives-why-gdp-doesnt-add.

[47] Austen Clemens, "GDP 2.0: Measuring who prospers when the U.S. economy grows," Washington Center for Equitable Growth, July 11, 2023, https://equitablegrowth.org/gdp-2-0-measuring-who-prospers-when-the-u-s-economy-grows/. The analysis points out that growth has increasingly been tilted toward the rich, making aggregate GDP growth a misleading statistic for guiding public policy.

[48] Corey Husak, "The relationship between taxation and U.S. economic growth," Washington Center for Equitable Growth, June 30, 2021, https://equitablegrowth.org/the-relationship-between-taxation-and-u-s-economic-growth/.

[49] See box, "What Causes the Debt Ratio to Rise?" The box explains the basic relationship between non-interest (or "primary") deficits, interest rates, and the rate of economic growth.

Moreover, those who claim that spending is the problem have been unable or unwilling to show how the budget can be cut to achieve their fiscal goals. Republicans have championed relying solely on program cuts to address our nation's fiscal challenges; they have resisted raising revenue since the 1990 bipartisan budget agreement, which the first President Bush signed into law and which included bipartisan revenue increases. But their spending-cut-only budget plans have increasingly eschewed details of exactly which programs should be cut — and the cuts they do detail would be unworkable, highly undesirable, and highly unpopular.

The most recent House Republican budget resolution, for instance, called for $9.3 trillion of program cuts over ten years, but almost half were not specified in any way.[50] The cuts that were specified would result in millions losing health coverage and a sharp increase in poverty and hardship. The unspecified cuts would require, among other cuts, massive disinvestment from the part of the budget that funds a broad range of public services, such as national parks, child care, education, scientific and medical research, and veterans' health care.[51] Proponents of such plans often claim when asked about a particular popular program area that it could be spared, but this would only deepen the cuts elsewhere.

Some conservative groups have provided more details in their budget plans, and those plans would be extremely unpopular for good reason, as they too would result in millions losing health care, massive increases in poverty and hardship, and deep disinvestment.

Some proponents of large spending cuts say they would shield Social Security, Medicare, defense, and veterans' programs from reductions, but these programs account for about two-thirds of all program spending. To stabilize the debt ratio at its current level (a less extreme target than the budget balancing that conservatives often espouse) would require cutting the remaining third of the budget, which includes programs such as Medicaid, the Earned Income Tax Credit, and law enforcement, by 33 percent.[52] (See box, "Exempting Large Spending Programs Would Mean Massive Cuts Elsewhere.") Even larger cuts would be needed if such a budget plan included new tax cuts or tried to reach balance.

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[50] U.S. House of Representatives, Concurrent Resolution on the Budget for Fiscal Year 2025, ordered reported by the House Budget Committee on a party-line vote on March 7, 2024, https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=116938. These figures are relative to the baseline explained in this paper's Appendix.

[51] Sharon Parrott, X, March 7, 2024, https://x.com/ParrottCBPP/status/1765754151705690264.

[52] The ten-year baseline described in the Appendix has net debt rising from 91 percent of GDP in 2024 to 112 percent of GDP in 2034. To limit the 2034 debt ratio to 91 percent of GDP would require raising revenue, cutting program costs, or some combination of both. If all the deficit reduction were achieved by cutting programs — if tax law were left untouched — then budget programs would need to be cut 11 percent over the decade. But if Congress chose to leave Social Security, Medicare, defense, and veterans' programs untouched, the needed cuts in all *other* programs would rise to 33 percent. And if the goal were a deficit of zero by 2034, rather than a 2034 debt ratio equal to the current debt ratio, the needed program cuts would rise to 52 percent.

Exempting Large Spending Programs Would Mean Massive Cuts Elsewhere

If programs were cut by enough to limit the debt ratio to its current level, with no contribution from higher revenue, then protecting Social Security, Medicare, defense, and veterans' programs from cuts would subject all other programs to cuts of 33 percent.

The programs at risk from such cuts include:

- Mandatory programs such as Medicaid, ACA marketplace coverage, SNAP, SSI, the refundable portions of the Earned Income Tax Credit and the Child Tax Credit, unemployment benefits, child nutrition, civil service retirement, and farm price supports.
- Discretionary programs including medical and scientific research (such as by the National Cancer Institute) and support for health clinics; aid to public schools, pre-K, Head Start, and child care; assisted housing; highways and mass transit; natural resources such as parks, forests, rivers, and aid to states for clean drinking water and clean air; relief from natural disasters; law enforcement; the Treasury and State Departments; and the administrative expenses of the mandatory programs, including Social Security, Medicare, and veterans' compensation.

Past Revenue Levels Are a Poor Guide to Future Policy

Federal revenue averaged 17.2 percent of GDP over the past 40 years. Some point to this historical average as the key metric for setting future revenue levels. There are numerous problems with this argument.

First, the historical average for revenue is entirely backward looking. It offers little guidance for appropriate policy to address ongoing and future demographic changes and to meet current and future policy needs.

Second, those historical revenue levels supported budgets that failed to fund key investments, which is why the nation's current list of unmet needs is lengthy. The historical average also reflects the effects of the Bush and Trump tax cuts, which have suppressed revenue and led the debt ratio to rise substantially even as the budget under-invested in critical areas. Partly for this reason, the debt ratio more than doubled over the past four decades, even before the pandemic.

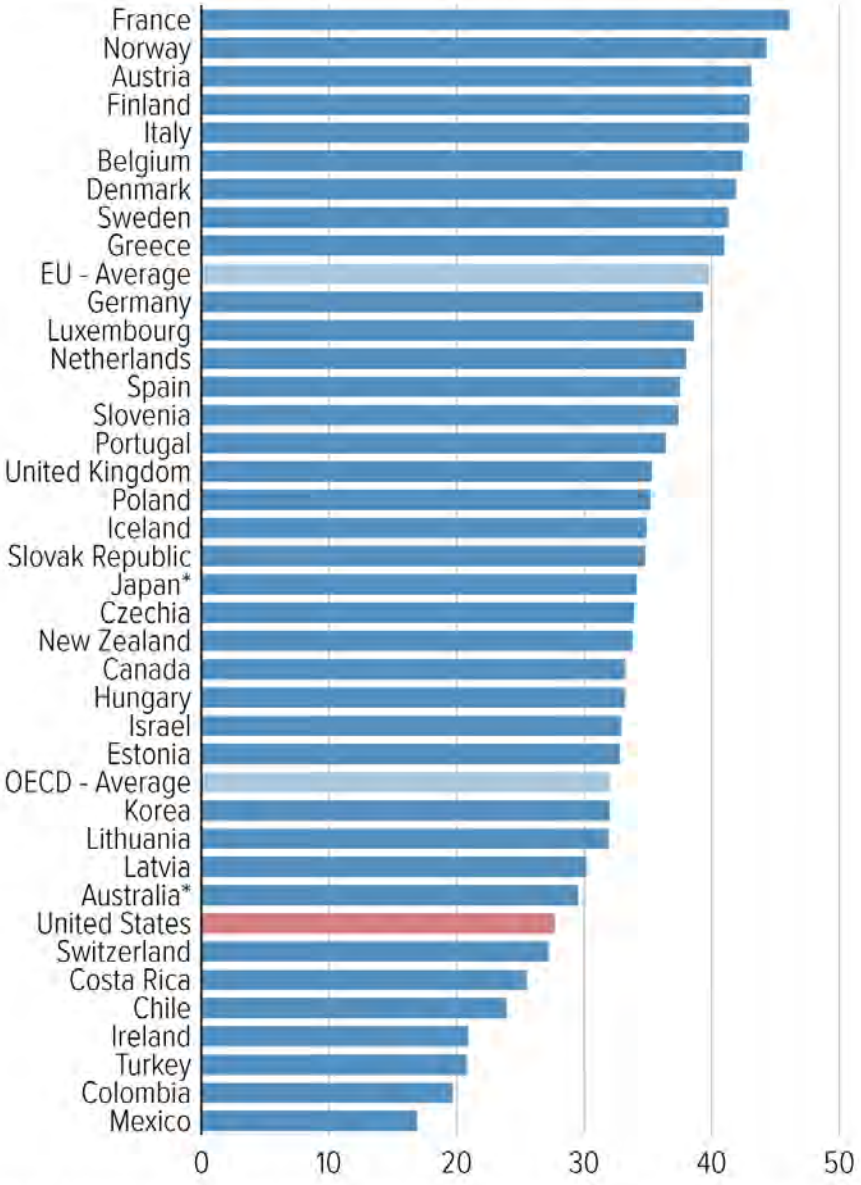
Third, it's clear that the United States can sustain a higher level of revenue in the future than it has on average over the last 40 years. Indeed, revenue was significantly higher in the late 1990s. The U.S. collects less in total government tax revenue (considering all levels of government) than nearly any other wealthy country: 27.7 percent of GDP, compared with 32.0 percent for all OECD countries and a 39.8 percent average for those that are part of the European Union.[53] Total government receipts in the United States are not only well below other wealthy, industrialized countries; they're also lower than in many countries that are far less wealthy than the United States. (See Figure 10.)

[53] These figures, from the Organization for Economic Cooperation and Development (OECD), include tax collections by all levels of government; in the United States, that means federal, state, and local governments. They exclude charges for public services and other items that the OECD classifies as non-tax receipts. The data are from https://www.oecd.org/tax/revenue-statistics-2522770x.htm.

FIGURE 10

Government Tax Revenue Is Smaller in the United States Than in Nearly All OECD Countries

Federal, state, and local tax revenues as a percent of GDP, 2022



Note: Asterisk indicates 2021 data because 2022 data are unavailable; OECD average excludes these countries. Government tax revenues include all levels of government.

CBPP calculation of the EU average includes only the countries listed above that are in the EU. Both EU and OECD averages are weighted by GDP.

Source: Organisation for Economic Cooperation and Development (OECD) Revenue Statistics.

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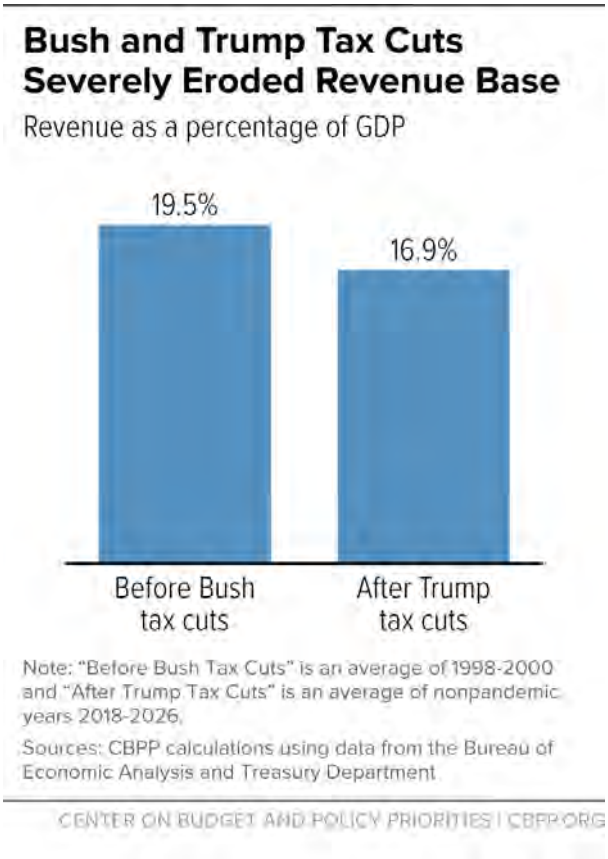
The 2025 Tax Debate Provides an Opportunity for a Course Correction

Current revenue levels are suppressed because of the major tax cuts enacted during the George W. Bush Administration (most of which were made permanent on a bipartisan basis during the Obama Administration) and further tax cuts enacted during the Trump Administration. Absent these tax cuts, revenue would be close to 20 percent of GDP rather than roughly 17 percent. (See Figure 11.)

The individual and estate tax provisions of the 2017 Trump tax cuts are scheduled to expire in December 2025. CBO's February 2024 projections assume that they will expire on schedule, and that revenue will rise to 17.9 percent of GDP by 2034. Extending these tax cuts, which disproportionately benefit high-income households, would cost $3.9 trillion over ten years (2026-2035), further raising the debt ratio.[54] (The $3.9 trillion figure does not include associated debt service costs.)

FIGURE 11



While an important first step, simply allowing the 2017 tax cuts to end on schedule or paying for any extension will be insufficient. We will need to raise more revenue to secure the resources required to address our investment deficit, meet our commitments to seniors, and reduce future risks associate with a higher debt ratio. Policymakers should use the tax legislation expected in 2025 to raise revenues *beyond* those needed to offset any tax cuts that are extended. Given the nation's wide inequality in income and wealth, revenue raisers should focus on high-income and high-wealth households and profitable corporations, all of whom gain tremendously from public investments that create the conditions for economic growth.[55]

In short, we need more revenue, the nation can afford it, and it should come from those who can most easily afford it. We should use the added revenue to manage the risks of a rising debt ratio, to

[54] CBPP estimates based on CBO estimates. See Congressional Budget Office, "Budgetary Outcomes Under Alternative Assumptions About Spending and Revenues," May 8, 2024, https://www.cbo.gov/publication/60114. We use the ten-year period 2026-2035 because extending the Trump tax cuts would reduce tax liability starting in 2026. And in 2025, when Congress will debate how to handle the scheduled expirations, it will be looking at the 2026-2035 ten-year budget window.

[55] Testimony of Chye-Ching Huang, "Funding Our Nation's Priorities: Reforming the Tax Code's Advantageous Treatment of the Wealthy," Tax Law Center, Before the House Ways and Means Subcommittee on Select Revenue Measures, May 12, 2021, https://www.congress.gov/117/meeting/house/112604/witnesses/HHRG-117-WM05-Wstate-HuangC-20210512.pdf.

meet our long-standing commitments to seniors, and, vitally, to invest in the many national needs that have been shortchanged, holding back people and the country as a whole.

Appendix:

Difference Between CBPP and CBO Ten-Year Budget Projections

CBO's February 2024 ten-year baseline shows net debt rising from 89 percent of GDP at the end of 2023 to 109 percent by the end of 2034. Its projections assume that the expiring 2017 tax provisions will expire on schedule. We have modified CBO's budget projections modestly, leading to a debt ratio that rises a bit more, reaching 112 percent by 2034, while still assuming that the expiring tax provisions either expire or any extensions are paid for.

Because 2024 appropriations were not enacted at the time CBO made its projections, CBO chose to assume that appropriations in 2024 and 2025 would adhere to the statutory caps on defense and non-defense discretionary (NDD) funding established in the Fiscal Responsibility Act of 2023 (FRA)[56] or to the continuing resolution in effect in February, whichever was lower. In addition, CBO did not take into account the spending adjustments that were negotiated alongside the FRA that allowed for additional non-defense funding under the caps.[57] As a result, CBO's baseline was below the enacted levels of both defense and non-defense funding in 2024. For the same reason, it was also below the intended levels in 2025, and CBO projected those low levels to grow only with inflation over the reminder of the decade.

Since CBO released its February baseline, Congress has enacted 2024 appropriations that conform to the 2024 defense and NDD caps and the negotiated adjustments. We modify CBO's February baseline in three ways.

- We assume Congress will also adhere to the FRA caps that apply to 2025, including the negotiated adjustments for 2025 that are analogous to those implemented in 2024. This raises the level of defense and NDD funding in all ten years of the projection, although both will still decline as a percent of GDP every year from 2023 on.
- One of the adjustments rescinded a portion of the mandatory funding for the Internal Revenue Service that was enacted in the Inflation Reduction Act. We reflect that rescission and also the consequent loss of revenue; CBO estimates that IRS funding cuts lose more revenue than the amount of the spending reduction and so increase the deficit.[58]
- We modify CBO's projected funding to respond to natural disasters such as hurricanes, tornadoes, floods, and earthquakes. Such funding is outside the FRA's caps, so CBO's baseline follows the standard rule of assuming that it grows with inflation from year to year,

[56] The Fiscal Responsibility Act suspended the statutory debt limit until January 2025 and imposed separate dollar limits on defense and non-defense discretionary funding for 2024 and 2025.

[57] For an initial discussion of the FRA caps and adjustments, see David Reich, "Debt Ceiling Deal Squeezes Non-Defense Appropriations, Even with Agreed-Upon Adjustments," CBPP, June 21, 2023, https://www.cbpp.org/research/federal-budget/debt-ceiling-deal-squeezes-non-defense-appropriations-even-with-agreed-upon. With respect to the adjustments, see Bobby Kogan and Jean Ross, "The Schumer-Johnson Budget Deal, Explained," Center for American Progress, February 6, 2024, https://www.americanprogress.org/article/the-schumer-johnson-budget-deal-explained/.

[58] For a discussion of the merits of adequate IRS funding, see Chuck Marr *et al.,* "Rebuilding IRS Would Reduce Tax Gap, Help Replenish Depleted Revenue Base," CBPP, December 16, 2022, https://www.cbpp.org/research/federal-tax/rebuilding-irs-would-reduce-tax-gap-help-replenish-depleted-revenue-base.

starting from the amount provided so far in 2024. Experience teaches us that in most years, disaster needs are below average, as they are so far in 2024. But in a minority of years, disaster funding is far above the average, as when a major destructive hurricane cuts a swath across heavily populated areas.[59] For this reason, over the course of a decade the historical average — the statistically likely level — is frequently greater than a simple projection of what occurred in the most recent year. We therefore modify CBO's baseline to assume a slightly higher level of disaster funding, consistent with the statistically likely level, over the coming decade, 2025-2034.

Together, these three modifications directly increase deficits and therefore accumulated net debt; the higher net debt, in turn, leads to increased interest costs through 2034.

In total, our baseline differs from CBO's over the 2024-2034 period by including $937 billion more expenditures for discretionary programs (for defense, non-defense, and disaster relief), $40 billion less mandatory expenditures, $118 billion less revenue, and $174 billion more interest costs.

[59] We have gathered data on federal funding enacted in response to, or in anticipation of, natural disasters. Chief among them is the Disaster Relief Fund of the Federal Emergency Management Agency, but other agencies and programs may receive substantial funding when especially damaging disasters hit. From 1989 through 2008, we have relied primarily on data gathered by J. David Cummins, Michael Suher, and George H. Zanjani, in "Federal Financial Exposure to Natural Catastrophe Risk," December 7, 2007, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1071065. Our figures show that over the period 1989-2023, such funding has averaged 0.15 percent of GDP. In 25 of those 35 years, the funding level was lower, but it was far higher in 2005 and 2006, 2013, and 2018, stemming from hurricanes Katrina, Sandy, Harvey, Irma, and Maria. Our estimates are conservative in that we project the average level since 1989 but there is also an upward trend, which we have not built into our projections.

VIEWPOINT

Partnering With the Faith-Based Community to Address Disparities in COVID-19 Vaccination Rates and Outcomes Among US Black and Latino Populations

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Viewpoint pages 595, 597, 599, 601, 603, 605, and 607

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The latest data from the Centers for Disease Control and Prevention (CDC) document that Black and Latino individuals in the US are 3 times more likely than White individuals to be hospitalized for COVID-19 and twice as likely to die from the disease.[1] Of the US population of approximately 330 million individuals, more than 100 million are Black or Latino individuals, who comprise 32%.[2] Nevertheless, Black and Latino individuals account for only 25% of the 184 million people in the US who have received at least 1 dose of the COVID-19 vaccine, whereas White individuals account for 59% of those who have received the vaccine.[3] Similarly, Black and Latino individuals comprise only 24% of the 159 million persons in the US who are fully vaccinated against COVID-19, whereas White individuals account for 60% of those fully vaccinated.[3]

The proportion of White individuals who have received a COVID-19 vaccine (47%) is about 1.4 times higher than the proportion of Black individuals (34%) and 1.2 times the proportion of Latino individuals (39%) who have received a COVID-19 vaccine.[4] A consistent pattern continues with communities of these racial and ethnic minority groups having substantially lower vaccination rates in relation to their share of the population and their overrepresentation among COVID-19 infections and deaths. In California, Latino individuals have received only 29% of COVID-19 vaccinations, although they account for 63% of those with COVID-19, 48% of deaths related to COVID-19, and 40% of the state's total population.[4] In the District of Columbia, Black individuals have received 43% of vaccinations, but comprise 56% of those with COVID-19, 71% of deaths related to COVID-19, and 46% of the total population.[4]

> [L]everaging a network of 150 000 churches to advance the public's health could prove to be a potent national model for eliminating Black and Latino racial and ethnic disparities in health and health care across the US.

Several factors appear to be driving these concerning and unacceptable disparities in COVID-19 vaccination. Decades of published research has documented that Black and Latino individuals have substantially worse access to primary care and specialty care and are much more likely to lack health insurance than White individuals. As the medical literature and recent events, such as the George Floyd killing, have underscored, systemic racism continues to be a major challenge for the US health care system and for US society. In addition, Black and Latino individuals have understandably low levels of trust in the federal government and medical care due to egregious past events involving ethically unacceptable studies and programs such as the US Public Health Service and CDC 40-year Tuskegee Study of Black men with untreated syphilis, unethical development of the HeLa cell line from Henrietta Lacks without her permission, and decades of forced sterilization of Latina women in Puerto Rico and California. It is not surprising, therefore, that myth-based concerns exist among these communities that deter their willingness to receive COVID-19 vaccination, such as beliefs that these vaccines contain microchips to track Black individuals or that the vaccine registration process will be used to deport Latino individuals.

How is it possible to overcome the triple burdens of impaired access to care, systemic racism, and distrust of the federal government and health care systems to eliminate COVID-19 vaccine disparities among Black and Latino communities? A promising and powerful strategy is to partner with the faith-based community, a highly trusted resource and frequent central gathering place for communities that are composed of racial and ethnic minority populations. The National Black Church Initiative (NBCI) is a coalition of 150 000 Black and Latino churches aiming to eradicate racial and ethnic disparities in health care, technology, education, housing, and the environment.[5] The mission of the NBCI is to provide critical wellness information to all members, congregants, churches, and the public.

In 2021, NBCI announced a 5-year plan that offers the CDC its 150 000 Black and Latino churches across the US as vaccination centers. The plan will include a national advisory committee of 9 prominent Black and Latino physicians who have evaluated the effectiveness of each COVID-19 vaccine; will leverage approximately 1000 Black and Latino US medical professionals to administer vaccines; and will mobilize several million volunteers to raise awareness among and communicate to underserved communities, provide transportation to vaccination centers, and ensure that communities of racial and ethnic minority populations obtain their second vaccinations (when indicated). The NBCI plan has been designed to seamlessly integrate with the efforts of local and state governments and health

departments and build communities and networks of cooperation and trust.

To date, NBCI has engaged 2.5 million volunteers and held more than 157 vaccination events. In addition, NBCI will soon distribute a half million copies of *VACCNEWS*, a newspaper-style single sheet in simple language (at an eighth-grade literacy level) that describes COVID-19, COVID-19 vaccines, and the importance of getting vaccinated. The information will be distributed in NBCI's 150 000 churches, focusing on low-income Black and Latino communities throughout the country. *VACCNEWS* additionally will be posted on social media and disseminated nationally as a supplement to 274 Black newspapers and regional dailies targeting Black and Latino communities.

The NBCI plan also will provide assistance and navigation for Black and Latino individuals to ensure that they obtain patient-centered medical homes for primary care, enhance access to care by collaborating with clinics and hospitals in both urban and rural areas, launch African American National Health Week during the last week of July every year, aim to increase childhood and adult vaccination rates for all diseases by 60% over the next 10 years, and create special emphasis programs for patients with diabetes, obesity, or cancer. In addition, NBCI's approximately 2.5 million nationwide volunteers will ensure that Black and Latino individuals receive culturally appropriate guidance and education in language they can understand and trust. It will also ensure that vaccine administration at churches is an optimal fit with their beliefs, lifestyles, communities, and cultural values.

The NBCI's national advisory committee of 5 Black and 4 Latino physicians (the NBCI COVID-19 Data and Information Committee) is doing more than just evaluating and reporting on vaccine effectiveness and safety. NBCI national advisory committee members will publicize the plan via Black and Latino radio stations, write articles targeting Black and Latino newspapers and magazines, leverage social media to eliminate vaccine myths and correct misinformation, directly address the concerns of Black and Latino populations, and mobilize neighborhood influencers, civic groups, and local public health officials to advocate for vaccination.

Additionally, the NBCI plan will involve sending critical response teams to zip code–based locations with the highest proportions of impoverished residents, those living in public housing, or both. Critical response teams will consist of a local team leader, Latino and Black health professionals, a community representative, 5 to 10 outreach workers/volunteers, and mental health specialists. Critical response teams will develop and disseminate culturally and linguistically diverse multimedia outreach programs about COVID-19 vaccinations; promote use of best practices for disease prevention, detection, and treatment; and identify future COVID-19 health care priorities for Black and Latino communities.

NBCI estimates indicate that the total cost of implementing this plan is $100 million, equivalent to less than $1 per person to ensure that all 100 million Black and Latino individuals in the US are fully immunized against COVID-19. Although the NBCI plan is ambitious, it would be money well spent. If successful, the NBCI initiative could help ensure progress in the following ways: dispel COVID-19 vaccine myths, reduce vaccine hesitancy by having culturally relevant information delivered by trusted health care professionals and volunteers of racial and ethnic minority groups, administer COVID-19 vaccines equitably to those at greatest risk and with the least access, eliminate COVID-19 hospitalization and mortality disparities for Black and Latino individuals, and empower communities of racial and ethnic minority populations to help themselves. Indeed, the NBCI plan of leveraging a network of 150 000 churches to advance the public's health could prove to be a potent national model for eliminating Black and Latino racial and ethnic disparities in health and health care across the US.

ARTICLE INFORMATION

Conflict of Interest Disclosures: None reported.

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"Bringing people together to serve humanity"

ATTN: Dr. Rochelle P. Walensky
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

Dear Dr. Rochelle P. Walensky:

My name is Reverend Anthony Evans and I serve as the President of the National Black Church Initiative (NBCI), one of our nation's largest faith-based organization comprised of 150,000 Black and Latino churches with 27.7 million members.

NBCI is pleased that you have assumed the leadership helm of the Center for Disease Control (CDC) and commend you on shepherding comprehensive efforts through the COVID pandemic. While initial responses to COVID resulted in CDC apologies to domestic and global communities, NBCI recognizes the enormity and complexity of the role assumed and perceived the CDC as operating in good faith and with the interest of the people served.

To that end, the nature of this correspondence is two-fold: 1) To provide background information about the NBCI programmatic endeavors unique to COVID and steps taken against misinformation campaigns; and 2) To request data about African American, Latino and related ethnic communities unique to COVID to inform the delivery of messaging of our VACCNEWS, an information sheet on COVID-19 vaccinations that also dispels vaccine myths, and for purposes of other NBCI dissemination efforts.

The nature of the correspondence is situated within the broader interest of NBCI as fostering a meaningful and strategic partnership with the CDC. Through funded and informational data support, such level of engagement furthers efforts of both CDC and NBCI to ensure the dissemination of quality and accurate COVID information to constituencies served.

BACKGROUND INFORMATION AND PROGRAMMATIC ENDEAVORS

The mission of NBCI is to eradicate racial disparities in healthcare, technology, education, housing, and the environment. We provide critical wellness information to all of our members and the public, and partner with all other organizations and officials with similar goals. NBCI offers faith-based, out-of-the-box, cutting-edge solutions to stubborn economic and social issues based on statistical analyses, science-based strategies, and methods that work. NBCI is comprised of an advisory committee of African American and Latinx medical professionals to guide and ensure that the information we

distribute is scientifically accurate. The composition of the advisory committee along with our strategic partnerships has established internal and external credibility toward ensuring appropriate development and implementation of programmatic endeavors.

- **NBCI AND THE IMPLEMENTATION OF TARGETED COVID INITIATIVES**

What We Have Done as NBCI with Current Collaborative Partners: Since the start of the COVID pandemic, NBCI has engaged in diverse efforts to address the holistic needs of our 27.7 million members. Our programmatic initiatives have generated critical efforts toward educating African Americans and Latinos about COVID. Here is the link highlighting one approach NBCI has addressed COVID: https://www.naltblackchurch.com/healthcovid-19.html. Such user-friendly site offers concise responses to pertinent questions. Following are other videos to highlight efforts pursued by NBCI to address COVID:

1. COVID Success Story with Shannon
   https://www.youtube.com/watch?v=5MNxH4Kh4C8&list=PL3TJQ8W0kdiDMASF7gNRV7NCEdQTDxNrG&index=4

2. Promotion of Vaccine with the Mayor of Charlotte, North Carolina
   https://www.youtube.com/watch?v=oL9_qwaJl-w&list=PL3TJQ8W0kdiBtOn5rMI7CB39hJUWbwqlQ

3. Black Churches Work to Boost Baltimore Vaccination Rates
   https://www.wypr.org/wypr-news/2021-09-06/black-churches-work-to-boost-baltimore-vaccination-rates

4. Baltimore Vaccination Campaign
   https://www.youtube.com/watch?v=3PzBYIZCOrg&t=34s

5. NBCI's Publication of VACCNEWS
   https://www.naltblackchurch.com/health/pdf/vacc-news0612221.pdf

6. NBCI Launched Children's' Vaccination Program in Savannah, Georgia
   https://www.facebook.com/NBCIonline/videos/970551947158686/

***What We Will Do with CDC as a New Collaborative Partnership*:** NBCI has been on the forefront of the fight against COVID-19 since December 2019. To that end, we will leverage work with our 150,000 African American and Latino Churches and 27.7 million partners to engage with CDC to further current programming of COVID safety measures and related innovative and emerging programming endeavors. Black and Latino churches are powerful forces within our communities and we will be good allies with the CDC given the capacity of our internal constituencies served.

- **NBCI SPEAKS OUT AGAINST COVID MISINFORMATION**

What We Have Done as NBCI with Current Collaborative Partners: African Americans are still dying at very high rates from COVID given the level of pre-existing medical conditions existing among this group. Consequently, anything that discourages them from getting vaccinated is not helpful and does not advance the need for achieving overall health and wellness within our community. To that end, NBCI is sorely disappointed in the Nation of Islam and their documented spread of misinformation in the Black community regarding the effectiveness and safety of COVID-19 vaccinations. While many of our NBCI members love and respect the work of the Nation of Islam and its focus on socioeconomic programs in our community, we strongly believe the COVID misinformation about COVID, the vaccines, the vaccines' effectiveness, and whether or not the vaccines harm African American people is completely and fundamentally wrong. The conscientious nature of this ill-willed and ill-intent phenomenon is unnecessary and a blatant attempt to confuse our people within our own community. Additionally, NBCI recognizes the Nation of Islam as a religious organization and thereby is neither scientifically competently nor medically qualified to make such unwarranted claims. Our 150,000 African American churches including 37 major Black Protestant denominations have stood in agreement with the National Medical Association as well as the National Black Nurses Association regarding the safety and effectiveness of the COVID vaccine.

What We Will Do with CDC as a New Collaborative Partner: NBCI, along with our NBCI Scientific Team, remains willing to engage with the CDC regarding the spread of COVID misinformation and the seriousness of this matter. NBCI remains committed toward eliminating any misconceptions about COVID, the vaccine, the effectiveness, and adverse implications associated with COVID misinformation for African Americans. Thus, given our platform of churches and the congregants served, we would continue to work with the CDC in developing targeted communication plans for addressing the concerns of similarly-situated organizations that spread COVID misinformation.

REQUESTED DATA AND FUNDING SUPPORT

- **NATIONAL DATA**: As you are acutely aware, within our society, we are encountering a catastrophic wholesale failure of the entire healthcare system from municipal, state, and federal levels. In some ways, trying to determine who and where we can retrieve accurate and current data becomes challenging. Reversing the racism and discriminatory practices from the American healthcare and integrating cultural competency for all groups into it are important goals that will reduce the health disparity gaps between White communities and communities of color.

  To that end, we are asking the CDC to provide us with COVID-19 data involving African Americans and Latinos and their mortality and morbidity from the across the country to address and/or clear up any misconceptions therein. We would be interested in having the data disaggregated by race, gender, and age.

  Following are the requested data:

- The number of COVID deaths to date in the USA broken down by age, gender, race, and location;
- The number of COVID deaths to date in each state broken down by age, gender, race, and location;
- The number of these deaths to date that were in African American, Latin American, and Asian communities;
- The pre-existing medical conditions of those who died;
- The marital status of those who died;
- The educational levels of those who died; and
- The results of contact tracing within each community, state, and the nation as a whole that show the pattern of spread.

- **DATA PUBLICATION AND FUNDING SUPPORT**: As we prepare to publish our second edition of VACCNEWS, an information sheet on COVID that also dispels vaccine myths, the data will be helpful toward ensuring that NBCI is able to create effective vaccination and lifestyle change programs. Such data will contribute to the overall efforts of NBCI to actually reduce the incidence of COVID as well to deliver and disseminate appropriate information to rural and urban communities that might be underserved among our NBCI constituencies.

  It is important to note that a half million copies of the first edition of VACCNEWS were distributed in African American and Latinx communities. The distribution of VACCNEWS was a huge success and we could have distributed a million more. Unfortunately, we applied for funding from the CDC and CDC Foundation and was denied the requested funding. The funds to support this dissemination effort came from a small grant from a healthcare agency.

  While we were denied initial funding, NBCI is still interested in receiving the aforementioned data request to be used in the publication of our second edition VACCNEWS. We would also be interested in seeking your approval or support of the second edition VACCNEWS on social media prior to the publication. NBCI is aware of review processes that might have to occur for this type of approval, support, or some type of endorsement. Nonetheless we welcome the opportunity to engage in this type of dialogue.

  Additionally, it is important to note that one of the biggest issues facing NBCI related to COVID, the vaccine, and therapies is the misinformation campaigns that occurring from organizations whom we share similar values. As indicated in the above section, we have spoken out against religious organizations like The National of Islam for disseminating misinformation about COVID vaccinations. Having funding to support the publication of VACCNEWS would serve as important resource to ensure accurate and current COVID information is disseminated to our 150,000 African American and Latino churches with its 27.7 million members.

- **DATA CLARIFICATION AND INFORMATION DISSEMINATION:** Through data searches conducted by our researchers, NBCI recently found preliminary

information that African American and Latino women of childbearing age are refusing to get COVID-19 vaccinations. The reports suggest these women believe that COVID vaccines will cause infertility. When we checked the CDC website and other health-related websites to see if there was any data on this phenomenon, we could not find any substantiating data. More specifically, an article published by Mariel Padilla in the Journal of General Internal Medicine by Harvard GenderSci Lab, found that Black women are dying of coronavirus at three times the rate of both White and Asian men in Georgia and Michigan. Black men had far higher mortality rates than any other race or gender group. When we checked the CDC website and other health-related websites to see if there was any data on this phenomenon, again, we could not find any substantiating data. The aforementioned examples regarding data [or misapplied data] impacting the NBCI constituencies could be clarified through informational communication and dissemination within a NBCI-CBC partnership. Such partnership would be a viable source for all of the constituencies involved.

- **ETHNIC GROUP COMPARISON**: Although we have plenty of anecdotal evidence about COVID mortality and morbidity of worldwide people of African, Asian, European, and related ethnic groups, NBCI would be interested in having data unique to broader ethnic groups. Following is the request for data to conduct ethnic group comparisons:

    - What is the percentage of people of African, Latin, European, Asian, and related ethnic groups who contracted COVID-19 worldwide?

    If the CDC does not collect and/or maintain this type of data, does the World Health Organization maintain this type of data? If CDC does not maintain this type of data, NBCI would seek to engage with the CDC collaboratively in legislative efforts to require more detailed records and/or demographical information regarding the collected data. NBCI certainly recognizes how onerous a task that is and understand the need for such records and/or information will be needed, not just for COVID-19, but for any pandemics or health emergency situations in the future.

Being able to engage in a meaningful and strategic partnership between the NBCI and CDC would serve impactfully for all of our millions of constituencies involved domestically and globally. Accessing critical data from the CDC for publication, clarification, and/or related dissemination purposes are important toward keeping our constituencies informed as well as the need for funding toward ensuring sustainability of this COVID-focused effort. I would welcome the opportunity to speak with you to engage further in dialogue around the possibilities of this NBCI-CDC collaborative opportunity.

Thank you for your time and consideration of this important proposed collaborative.

Sincerely,
Reverend Anthony Evans, *President*
The National Black Church Initiative

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

December 12. 2022

The Right Most Rev. Anthony Evans
President
ational Black Church Initiative
Washington, DC 20035

Dear Reverend Evans:

Thank you for our letter to Centers for Disease Control and Prevention (CDC) Director Rochelle P. Walensky, MD, MPH, regarding coronavirus disease 2019 (COVID-19) data. I am responding on behalf of Dr. Walensky.

Data-driven, evidence-based approaches, including sharing data on COVID-19 outcomes among African American, Latino, and other racial and ethnic minority populations, is central to CDC's COVID-19 Health Equity Response Strategy.[1] COVID-19 mortality and related data are collected through multiple data sources and systems, as well as special studies, and shared on the CDC's website through data tools, reports, and in peer-reviewed publications. As these data and tools are regularly updated, some recent data on COVID-19 mortality and related outcomes and disparities are provided below.

A new CDC report[2] provides a comprehensive look into recent and overall trends in COVID-19–related mortality among adults in the United States. The data show that the risk of severe illness and death has significantly decreased for most people; however, thousands of people continue to die each week. The people most at risk of COVID-19–related death continue to be older adults, people with underlying medical conditions, people with disabilities, and people who are not up to date with COVID-19 vaccinations. In a recent study, CDC found that racial and ethnic disparities persisted in outpatient COVID-19 treatment through July 2022. More specifically, the study found that during April–July 2022, the percentage of COVID-19 patients aged 20 years and older treated with Paxlovid was 36% and 50% lower among Black and Hispanic patients than among White and non-Hispanic patients, respectively.[3] These disparities existed among all age groups and patients with immunocompromise.

CDC has also examined excess mortality, including an analysis of 2020 data, "Disparities in Excess Mortality Associated with COVID-19,"[4] which found that excess mortality incidence rates were higher for people aged 65 years or older, with notable racial and ethnic disparities

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across all age groups. In 2020, among Black and Hispanic people aged 65 years or older, more than 1,000 excess deaths per 100,000 person-years occurred compared with the number of deaths expected to occur.[4] Another study "COVID-19–Associated Hospitalizations Among Adults During SARS-CoV-2 Delta and Omicron Variant Predominance, by Race/Ethnicity and Vaccination Status — COVID-NET, 14 States, July 2021–January 2022"[5] showed that during the period of Omicron predominance, hospitalization rates increased most sharply among Black adults in the United States relative to all other racial and ethnic groups examined and reached the highest rate observed among all racial and ethnic groups since the beginning of the pandemic.

CDC's COVID Data Tracker provides a range of publicly available data on COVID-19 vaccinations, cases, and deaths and how they differ by age, race and ethnicity, sex, and other demographic characteristics.[6] Data includes COVID-19 weekly cases per 100,000 population by age group and race and ethnicity,[7] which is important to track changes in trends over time. CDC provides data on several aspects of COVID-19 deaths, including race and ethnicity, education, state and county location, and other contributing causes of death, via the National Center for Health Statistics' ational Vital Statistics System (NVSS). Data from NVSS indicate that between 2020 and 2022 so far, 148,972 COVID-19 deaths have been recorded among the non-Hispanic Black population; 165,645 deaths recorded among the Hispanic population; and 33,090 deaths among the non-Hispanic Asian population. COVID-19 mortality data from VSS are available publicly from CDC's Jational Center for Health Statistics COVID-19 mortality data website,[8] including a site focused on health disparities[9] in COVID-19 mortality, and through CDC WO DER,[10] which allows users to tabulate their own data.

In addition, CDC shares data on the "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity,"[11] which is updated monthly. Data updated through September 2022 show that compared to White, non-Hispanic persons, Black, non-Hispanic persons are 1.1 times more likely to be infected, 2.3 times more likely to be hospitalized, and 1.7 times more likely to have died from COVID-19. These data are age-adjusted, which is important because risk of infection, hospitalization, and death is different by age, and age distribution differs by racial and ethnic group.

Further, CDC collects information on long COVID from the Household Pulse Survey,[12] conducted by CDC's ational Center for Health Statistics in partnership with the U.S. Census Bureau. From the most recent survey, among adults who had COVID-19, the percent currently reporting long COVID was highest for Hispanics (16.2%), followed by non-Hispanic Whites (15.4%), non-Hispanic others (14.5%), non-Hispanic Blacks (12.2%), and lowest among non-Hispanic Asians (6.1%).

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[7] https://covid.cdc.gov/covid-data-tracker/#demographicsovertime

[8] https://www.cdc.gov/nchs/nvss/covid-19.htm

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[11] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html#footnote02

[12] https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm

As you noted, non-Hispanic Black and Hispanic persons experience higher COVID-19–associated morbidity and mortality, yet COVID-19 vaccination coverage is lower in these groups. A previous CDC study among 9.6 million people in the eight integrated healthcare organizations from six states included in CDC's Vaccine Safety Datalink found that COVID-19 vaccination coverage continued to increase for all racial and ethnic groups, especially among people with medical conditions that place them at higher risk for severe COVID-19.[13] However, racial and ethnic minority groups, including Black and Hispanic persons, continue to have lower vaccination coverage, and these gaps may have even widened over time. CDC agrees that efforts to address vaccine misinformation, barriers to access, and insufficient vaccine confidence, coupled with strategies to prioritize equity, could help increase coverage and reduce COVID-19 incidence, especially among populations disproportionately affected by the pandemic.

CDC appreciates the efforts that the ational Black Church Initiative (NBCI) has taken to disseminate accurate information regarding COVID-19. Most misinformation and disinformation that has circulated about COVID-19 vaccines has focused on vaccine development, safety, and effectiveness, as well as COVID-19 denialism.[14]

A community of trusted messengers is integral in addressing this misinformation and disinformation. Faith and community leaders, like those involved in BCI, are uniquely positioned as trusted messengers to engage with the members of their communities to both hear concerns that have arisen surrounding vaccination and address those concerns. Faith-based and community-based organizations foster community and provide healthcare every day during a time rife with feelings of confusion and isolation. CDC strongly values partnerships that help inform, implement, and assess activities focused on vaccine awareness, access, availability, and confidence in their communities. BCI's continuing efforts to address misinformation and disinformation within the African American, Latino, and related ethnic communities are appreciated.

The best way to apply for CDC funding is through Grants.gov.[15] Two programs that may be of interest for NBCI to apply to during future funding opportunities are the Racial and Ethnic Approaches to Community Health (REACH) program and the Partnering for Vaccine Equity (P4VE) program.

- The REACH program is at the forefront of CDC's efforts to reduce health disparities and achieve health equity. Since 1999, REACH has worked to reduce health disparities among specific racial and ethnic groups in communities with the highest risk or rates of chronic disease.[16] It is especially important for patients with chronic health conditions to be up to date on recommended vaccinations as they are at increased risk for complications from certain vaccine-preventable diseases.[17]

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[13] Pingali C, Meghani M, Razzaghi H, et al. COVID-19 Vaccination Coverage Among Insured Persons Aged ≥16 Years, by Race/Ethnicity and Other Selected Characteristics — Eight Integrated Health Care Organizations, United States, December 14, 2020–May 15, 2021. MMWR Morb Mortal Wkly Rep 2021;70:985–990. DOI: http://dx.doi.org/10.15585/mmwr.mm7028a1

[14] https://www.cdc.gov/vaccines/covid-19/health-departments/addressing-vaccine-misinformation.html

[15] https://www.grants.gov/

[16] https://www.cdc.gov/chronicdisease/resources/publications/factsheets/reach.htm

[17] https://www.cdc.gov/vaccines/hcp/adults/for-patients/health-conditions.html

- The P4VE program was launched in 2020 and focuses on increasing equity in adult immunization. Through the P4VE program and broader adult immunization efforts, CDC aims to improve equity in adult immunization across disproportionately affected populations, including racial and ethnic minority groups, through partnerships that drive community-level action.[18] As part of this effort, the Vaccine Resource Hub offers resources to help increase adult vaccination in the community.[19] Funding for the P4VE program is made possible through a sub-award from the CDC Foundation.

Thank you again for your letter. CDC continues to improve our messaging on vaccine effectiveness and safety, and feedback is welcome.

Sincerely,

Brendan R. Jackson

Brendan R. Jackson, MD, MPH
Incident Manager
COVID-19 Emergency Response
CDC

[18] https://www.cdc.gov/vaccines/health-equity/index.html
[19] https://vaccineresourcehub.org/

The Miami Times

Black churches launch effort to tackle heart health

Coconut Grove hosts national pilot program

Samantha Morell Miami Times Staff Writer
Nov 14, 2023

Rev. Anthony Evans, president of the National Black Church Initiative, speaks at a press conference at St. James Baptist Church in Coconut Grove Nov. 10, 2023.

(Samantha Morell for The Miami Times)

The National Black Church Initiative launched its “Heart First” program last week to educate members of the Black faith community on the risks of heart failure, and ways to prevent or manage it.

The pilot program was announced at a press conference Nov. 10, 2023, at St. James Baptist Church in Coconut Grove, which will participate in the initiative. Rev. Anthony Evans, president of the National Black Church Initiative (NBCI), visited the locale from headquarters in Washington, D.C., to share the news.

“We’re going to bring critical, science-based education here in South Florida to African American churches and Latino churches, in dealing with the issues surrounding heart failure,” Evans said.

Phase one of Heart First will connect at least five churches in Coconut Grove with leading Black cardiologists who will lead miniature health sermons for each congregation. Churchgoers will then have an opportunity to connect with their assigned cardiologist after service for follow-up discussions.

The National Black Church Initiative is launching its Heart First pilot program in Black churches across Coconut Grove. (Samantha Morell for The Miami Times)

The National Black Church Initiative is launching its Heart First pilot program in Black churches across Coconut Grove. (Samantha Morell for The Miami Times)

The cardiologists are expected to connect with and introduce the subject of heart failure to the participating congregations before the year is up. Beginning in 2024, the NBCI will also facilitate a one-year course on heart failure risks, prevention and management, created by trained physicians and available either online or in person.

The program is funded in part by biopharmaceutical company Cytokinetics.

The NBCI is a coalition of 150,000 Black and Latino churches nationwide that constitute about 27.7 million churchgoers across the country. Its mission is to provide critical wellness information to its members and reduce racial disparities in areas such as technology, education, housing, the environment and health care.

Research shows that Black people are more likely to develop heart failure and at a younger age than their white peers. In 2018, Black Americans were 30% more likely to die from heart disease than white Americans. This is in part because Black adults are also more likely to be affected by those factors which cause heart disease, such as diabetes, obesity and high blood pressure.

Evans says the goal of the program is to reduce heart disease in participating churches by 15% to 20% over the next five years. It also aims to understand the root cause underlying heart failure's prevalence in the Black community.

The pilot program in Coconut Grove, which will be duplicated in Charlotte, N.C., is just the beginning. A press release issued before last Friday's conference said that baseline data will be collected to create a more effective and comprehensive prevention program.

The NBCI is also working with city of Miami Commissioner Sabina Covo's office to purchase defibrillators for the participating churches, for which the city's fire department is expected to provide training.

The program and its one-year course will eventually be available nationwide, as well as to church neighbors who are not part of the faith-based community.

During the Nov. 10 press conference, several clergy members stepped up to share individual stories of how their churches and communities have been affected by heart failure.

Apostle Dr. John H. Chambers said that his daughter's stepfather had died from heart failure just two days prior to the conference.

"The bible says to guard your heart because that's where the issues of life flow from," said Chambers. "The heart is like the engine of a car, and it's time for the Church to keep moving."

smorell@miamitimesonline.com

Samantha Morell

Miami Times Writer

Addressing Immunization Disparities in Underserved Communities

A Partnership Between CME Outfitters (CMEO) and the National Black Church Initiative (NBCI)

NBCI Immunization Survey Results

NBCI Immunization Survey Results

NBCI distributed a 5-question survey to members across the United States related to adult vaccination

12,457
Surveys Distributed

⇩

4,341
Returned Surveys

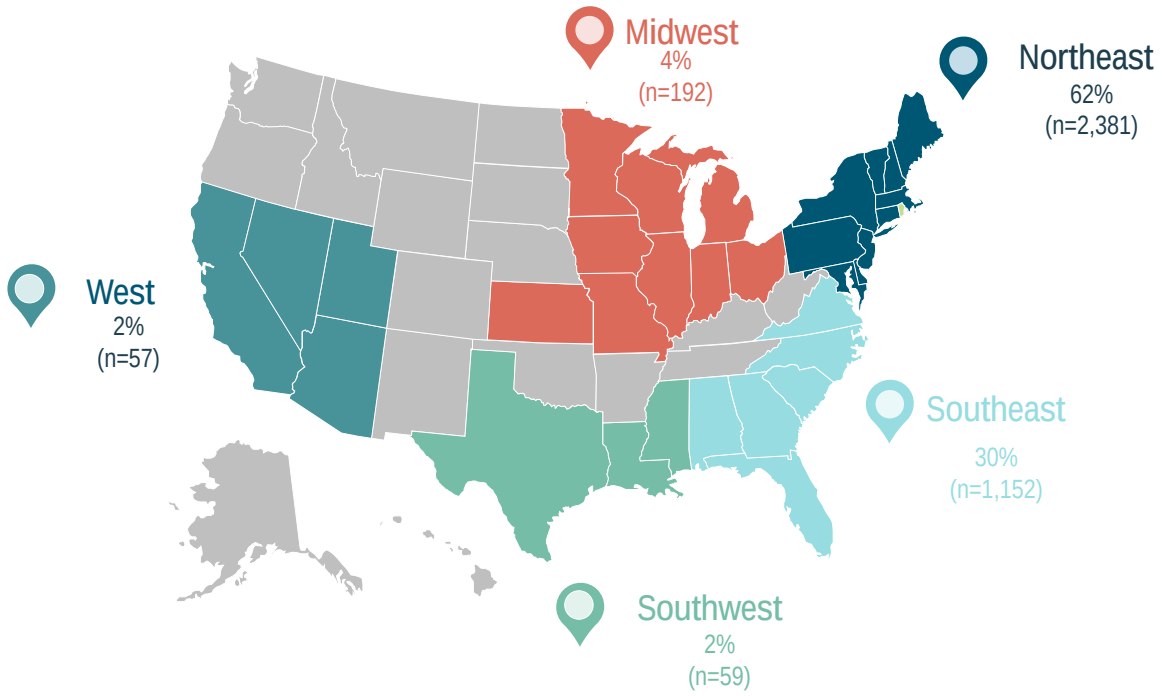
⇩

3,841
Completed Surveys

⇩

Overall Response Rate:
31%

NBCI US Regions with Number & Percent Responses to Survey



https://www.naltblackchurch.com/about/index.html

NBCI Survey – Vaccination Status (N=3,841)

NBCI Survey Question: Do you know if you are up to date on all of your immunizations vaccine (shots)?

2.3% of respondents responded, “What are you talking about?”

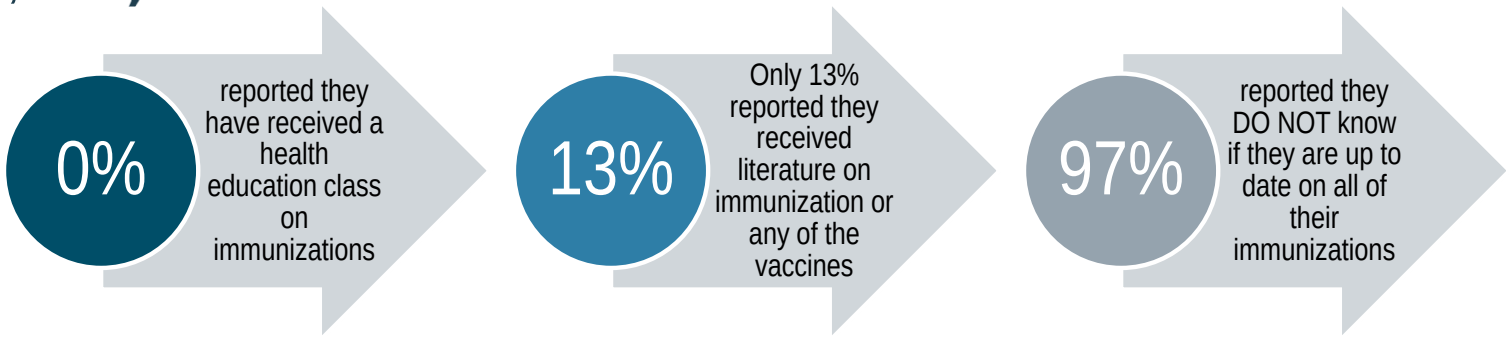
1.7%

of the 3,800+ NCBI survey respondents only 65 (1.7%) reported they **knew** if they were **up to date** on all of their **immunizations**

This data starkly reinforces government reports that Black individuals are 10% less likely to receive influenza vaccines than their White counterparts and are significantly less likely to be up to date on vaccines for tetanus, hepatitis A and B, and shingles, in addition to vaccines for COVID-19 and pneumococcal disease.[1,2]

1. African American Wellness Project. https://aawellnessproject.org/immunizations-and-black-america/. Updated 2023. 2. U.S. Department of Health and Human Services, Office of Minority Health. https://minorityhealth.hhs.gov/immunizations-and-african-americans. Updated 2023.

NBCI - Access to Education Regarding Immunizations (N=3,841)



Lack of education on immunizations will result in lack of knowledge in vaccine status.

- In a study of 1,488 women, 95% trust their medical doctor to provide information regarding HPV and HPV vaccine. However, Black women were significantly more likely to trust information obtained from the following compared to White women:[1]
  - Family members
  - Television
  - Religious organizations
  - Government health agencies

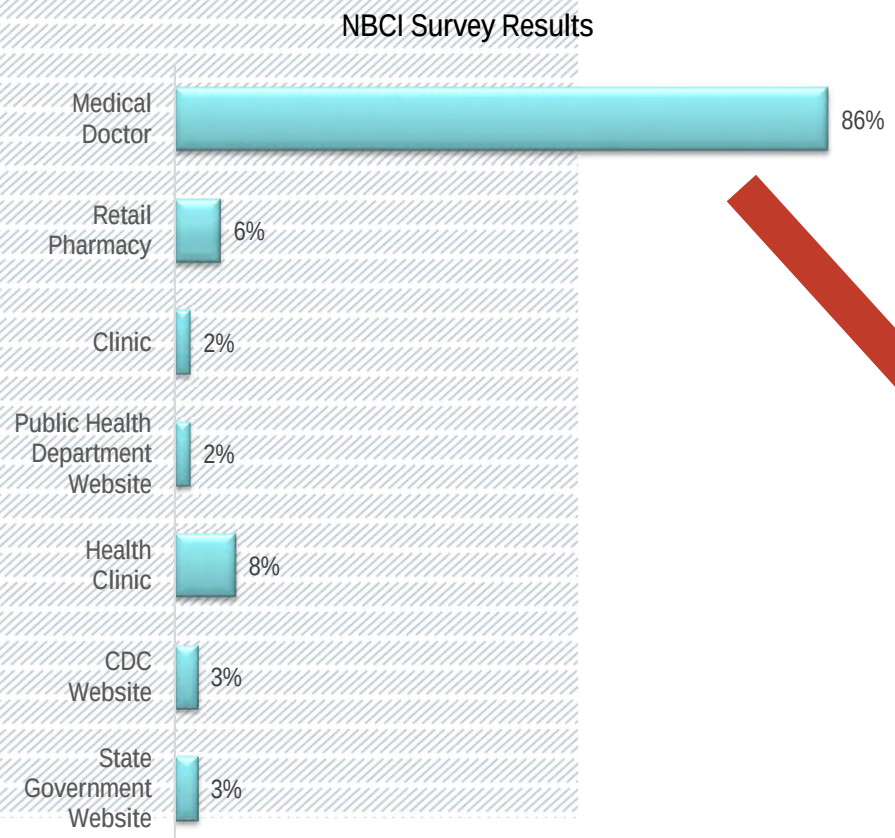
- In general, Black patients preferred the following sources of information for health information:[2]
  - Newspapers/magazines
  - Radio
  - Internet
  - Television
  - Government
  - Charitable organizations
  - Religious organizations

Education may be provided in non-traditional locations, such as religious organizations or through a community health worker

 | [1]*AIMS Public Health.* 2021;8(2):352-368, [2] Quantitative Research. *Am J Health Promot.* 2021;35;84-92.

Access to Immunizations Needed (N=3,841)

NBCI Survey Question: Do you know where you will go to get the list of the vaccines you need?



NBCI Survey Question: Do you have a doctor?

97% Responded "No"

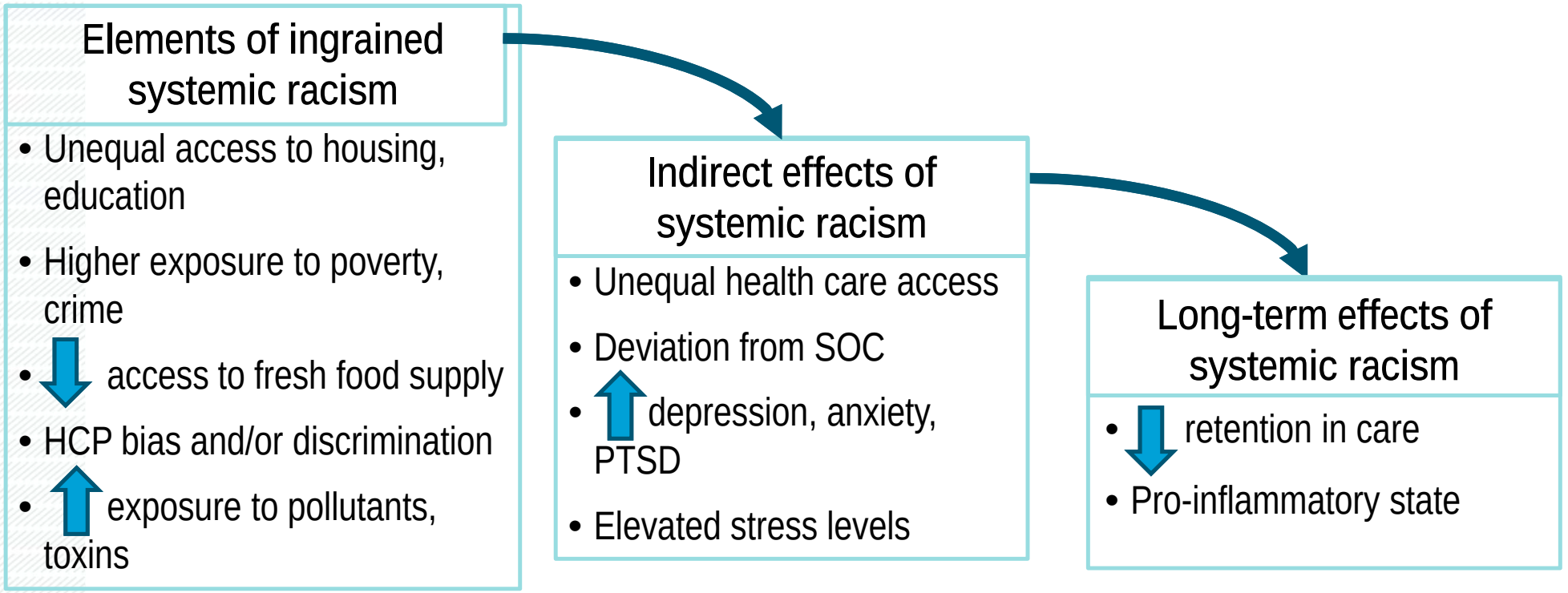
Based on recent Kaiser Family Foundation (KFF) data, 13% of U.S. Black adults do not have a personal doctor/health care provider.

The results reveal an interesting gap in that community members understand that HCPs, particularly physicians, are significant resources related to vaccination; however, 97% of the respondents do not have a regular medical doctor. The data far exceeds the KFF data that represents national populations.

 | Kaiser Family Foundation. State Health Facts. https://www.kff.org/other/state-indicator. Accessed May 10, 2024.

Gap Analysis

Health Disparities: How We Got Here[1-5]

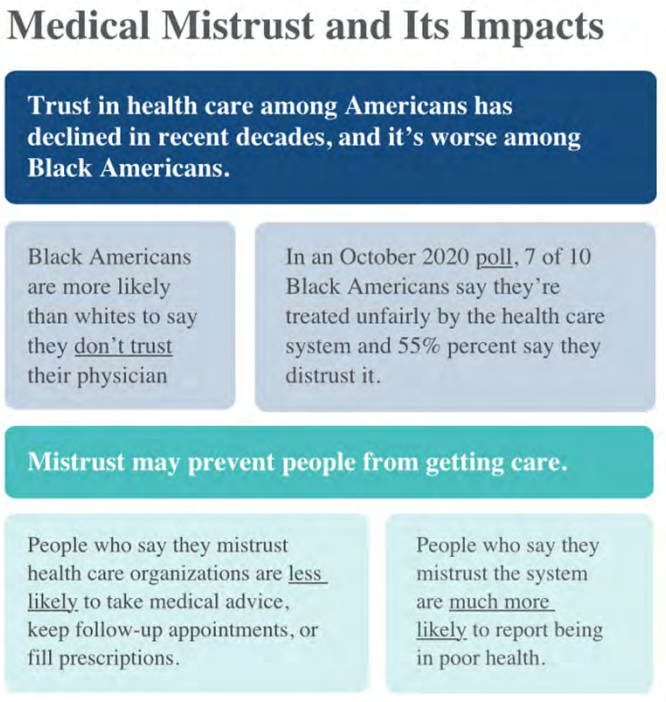


HCP = health care professional; PTSD = post-traumatic stress disorder; SOC = standard of care

1. Hasan B, et al. *Clin Rheumatol*. 2022;31:1–13. 2. CME Outfitters, LLC. 2021. Equity and Health Care Disparities: The Role of Leaders in Addressing the Crisis. 3. CME Outfitters, LLC. 2021. Addressing Racial Disparities in Orthopedic Care. 4. CME Outfitters, LLC. 2021. Achieving Equity in the Management of Chronic Pain: Treating the Whole Patient. 5. CME Outfitters, LLC. 2021. Parameters of Pain Care: Mitigating Racial Disparities in Patients with Chronic Pain.

Reasons for Disparities in Vaccination Coverage

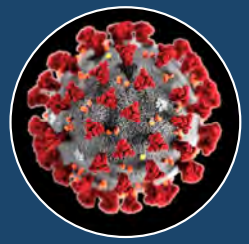
- Structural racism: aspects of the healthcare structure that lead to disparities
  - Access
  - Insurance status
  - Not having a primary care doctor
  - Delaying care due to cost
  - Provider bias
  - Historical mistreatment leads to medical mistrust
  - Language and cultural barriers
- Vaccine hesitancy: reluctance to get vaccination due to perceptions of:
  - Safety concerns/side effects
  - Trust of medical providers
  - Low health literacy



Artiga S, et al. Kaiser Family Foundation (KFF) Website. 2020. https://www.kff.org/policy-watch/racial-disparities-flu-vaccination-implications-covid-19-vaccination-efforts/. Accessed September 16, 2022. Brewer LI, et al. *BMC Public Health.* 2021;21(1):1166. Fairless E, et al. *J Racial Ethn Health Disparities.* 2019;6(6):124401249. The Commonwealth Fund. https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans. Published January 14, 2021. Accessed May 28, 2024.

Inequitable Factors in Specific Vaccines

COVID-19



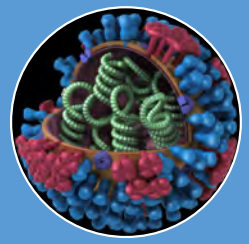
-AAMR Latino 77% ↑ vs. White

-AAMR Black 67% ↑ vs. White

-Highest AAMR = Indigenous Americans

-↑ Death in POC

Influenza

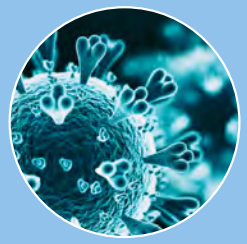


-Highest group vaccinated only 51%

-POC less than half vaccinated

-Low pre-pandemic and now bigger gap with COVID and Monkeypox

HIV

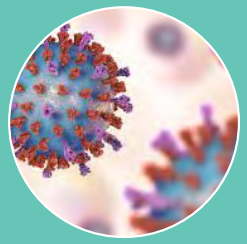


-14% still undiagnosed

-42% new infections in African Americans

-Need to normalize sexual health in conversation

RSV



-↑ Hosp. admits in populations with poverty and crowding

-↑ Rate of hosp. in children; parents miss work

-More common than "common cold"

Vaccine Hesitancy

-3x ↑ in vaccine hesitancy among Black population

-↓ trust among men

-↓ trust in rural communities

-Role of social media in vaccine hesitance

Other Concerns

-Screening

-Monkeypox

-Polio & measles

-Perpetuated myths

AAMR = age-adjusted mortality rate, POC = people of color, RSV = respiratory syncytial virus

Centers for Disease Control and Prevention (CDC). CDC Website. 2022. https://www.cdc.gov/flu/fluvaxview/dashboard/vaccination-dashboard.html#:~:text=Flu%20Vaccination%20Coverage&text=9.5%20percentage%20points%20lower%20this,season%20compared%20with%20March%202020. Accessed September 16, 2022. Gawthrop, E. American Public Media (APM) Research Lab Website. 2019. https://www.apmresearchlab.org/covid/deaths-by-race. Accessed September 29, 2022. Haukoos J, et al. *J AM Coll Emerg Physicians Open.* 2020;1(4):484-486. Holmen JE, et al. *BMC Infect Dis.* 2021;21(1):293. McElfish PA, et al. *J Prim Care Community Health.* 2021;12:21501327211040746.

What Can We Do to Bridge These Gaps?

Community-based Educational Design through Partnerships and Leveraged Resources

Proposed Strategic Blueprint – Vaccination Pilot Program

Initiative Goals

1. Educate patients and community members to reduce disparities and improve health literacy on adult vaccination
2. Improve vaccination rates for underserved adults in 10 communities

The proposed initiative from CME Outfitters and NBCI will utilize the community survey and national data to address individual local community needs.

- Lack of health literacy on importance of adult vaccination in Black and Hispanic communities
- Lack of regular connection to a community provider to monitor vaccination schedule and provide patient education
- Impact of social drivers and stigma of vaccination in underserved communities
- Lack of transcreated resources for non-English speaking communities

Vaccination Pilot Program

- Identify 10 communities in NBCI network based on survey for initiative
- Execute strategic blueprint
- Survey HCPs and community members for self-report feedback on initiative and improvement in initiative goals

Scalable and Sustainable

- Vaccination program expansion to additional communities with tailored resources based on those community needs
- Apply pilot program design to other therapeutic areas of need in underserved communities

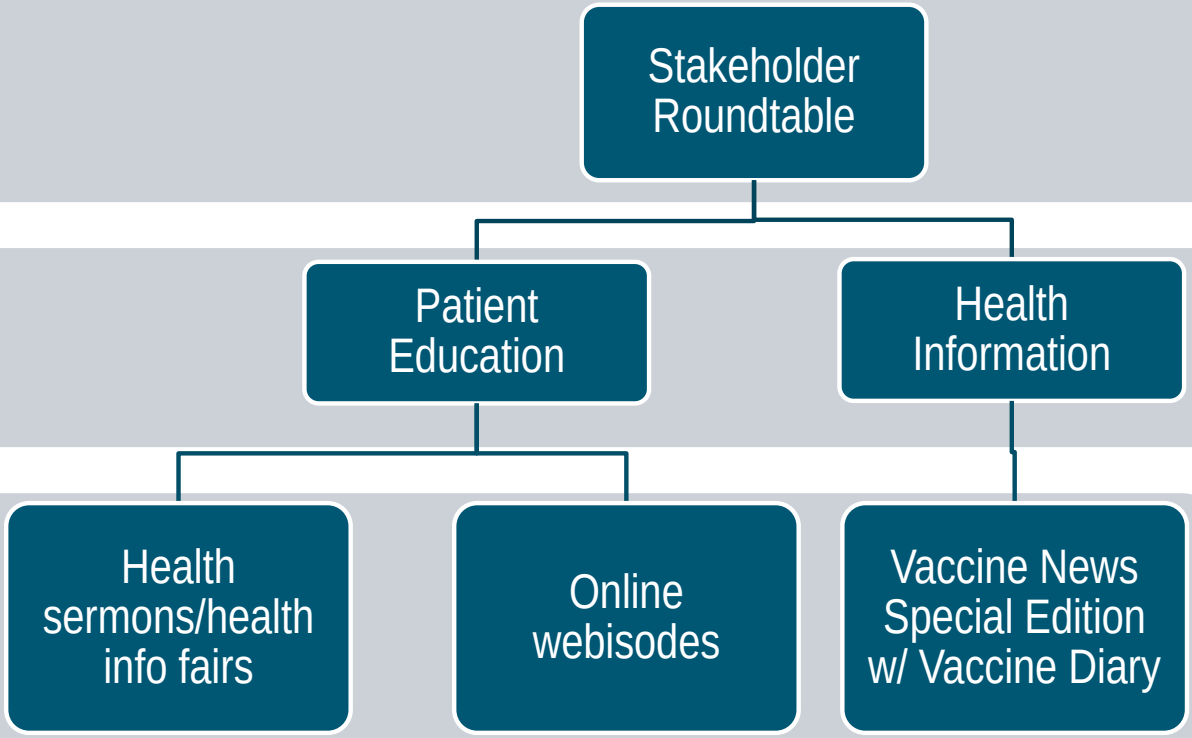
Proposed Strategic Blueprint – Pilot Program

CME OUTFITTERS

CMEO and NBCI will bring together key stakeholders including expert HCPs in vaccination disparities, community HCPs, church volunteers/representatives, pharmacists, and advocates/community members for a **1.5-day meeting** to review and address local gaps and confirm strategies to connect communities with health services and education.

From the roundtable, CMEO and NBCI will partner to **identify 10 communities** for a pilot initiative that combines strategies including HCP-led education, online education, and printed information to meet community members where they are in health literacy and connecting them to local services to improve vaccination rates.

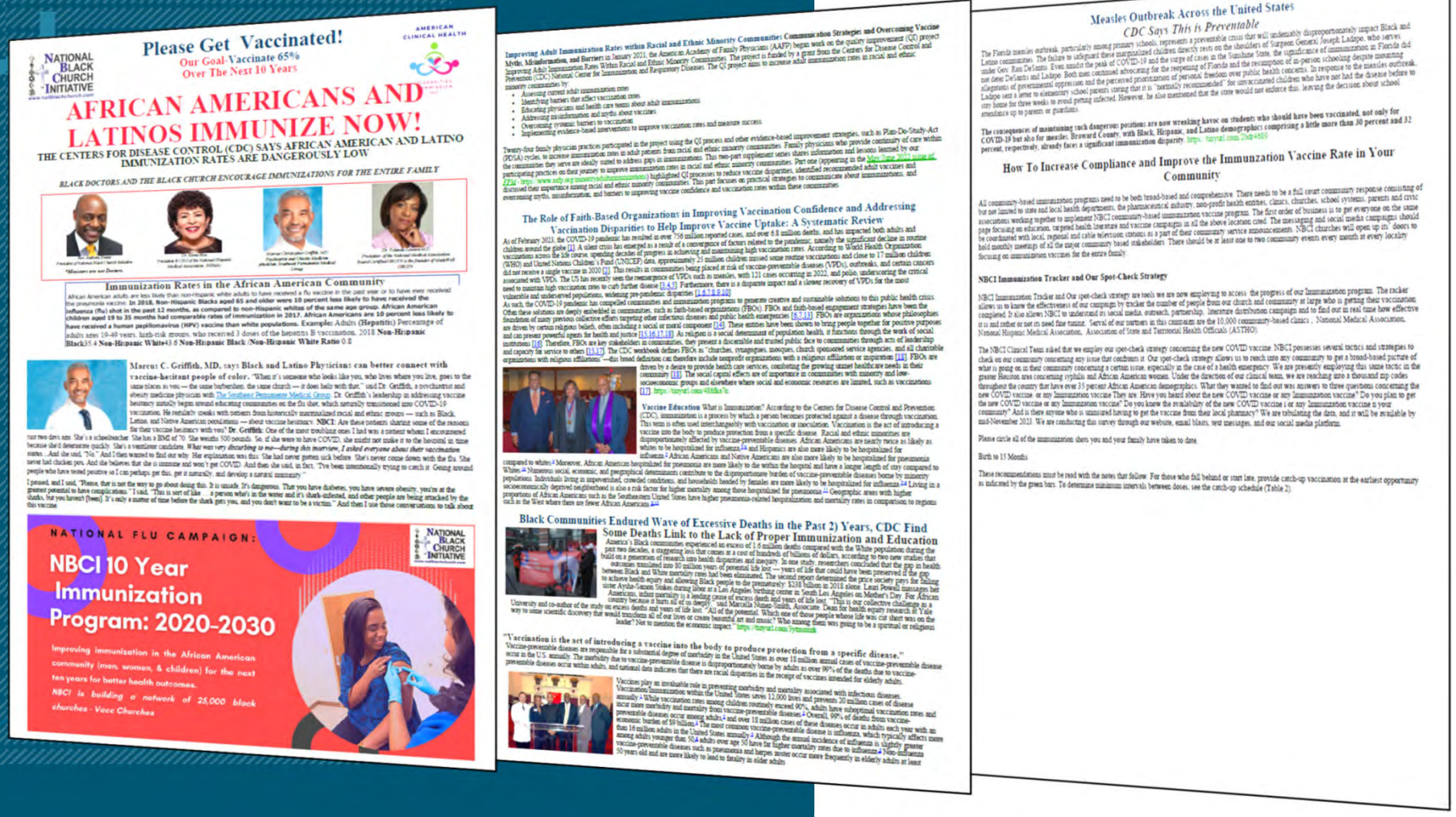
CMEO and NBCI will hold either **health sermons led by an expert HCP or health fairs with vaccination information/services** in the 10 communities. **Online, short webisodes** will be developed as additional resources related to specific vaccines. The established NBCI Vaccine News **will feature a special printed edition** handed out in the community at church services, shelters, local pharmacies, senior living facilities, correctional facilities, and community health centers. The edition will include a QR code/link to more information online and a **vaccination diary** for members to complete as they receive their vaccines



Proposed Strategic Blueprint – Vaccination Pilot Program

Stakeholder Roundtable	Individualizes the needs/gaps of the 10 identified local communities to develop tailored resources with HCP, community leader, and community member feedback
Health Sermons	Presents evidence-based patient education on the important of vaccination, the appropriate schedule, and solutions to social drivers to communities where they are from trusted HCP congregant members
Health Information Fairs	Addresses access to culturally sensitive information from local advocates and community HCPs in a safe environment to ask questions about science, access, and schedules
Online Modules	Reinforces and reminds community members there is a trusted place to find vetted, evidence-based information on vaccination to build confidence in discussions with providers
Vaccine News Special Edition	Provides community members with reminders of health information events, access to online hub, quick guide to adult vaccination schedule, and copy of vaccination diary. Addresses gap in underserved community members that may not have a regular provider or access to vaccination records in one place, by empowering them to manage their records as they access care

NBCI Vaccine News



Please Get Vaccinated!

Our Goal-Vaccinate 65%
Over The Next 10 Years

AFRICAN AMERICANS AND LATINOS IMMUNIZE NOW!

THE CENTERS FOR DISEASE CONTROL (CDC) SAYS AFRICAN AMERICAN AND LATINO IMMUNIZATION RATES ARE DANGEROUSLY LOW

BLACK DOCTORS AND THE BLACK CHURCH ENCOURAGE IMMUNIZATIONS FOR THE ENTIRE FAMILY

Immunization Rates in the African American Community

Marcus C. Griffith, MD, says Black and Latino Physicians can better connect with vaccine-hesitant people of color.

NATIONAL FLU CAMPAIGN:

NBCI 10 Year Immunization Program: 2020-2030

Improving immunization in the African American community (men, women, & children) for the next ten years for better health outcomes.

NBCI is building a network of 25,000 black churches - Vaxx Churches

Improving Adult Immunization Rates within Racial and Ethnic Minority Communities Communication Strategies and Overcoming Vaccine Myths, Misinformation, and Barriers

The Role of Faith-Based Organizations in Improving Vaccination Confidence and Addressing Vaccination Disparities to Help Improve Vaccine Uptake: A Systematic Review

Black Communities Endured Wave of Excessive Deaths in the Past 2) Years, CDC Find Some Deaths Link to the Lack of Proper Immunization and Education

Measles Outbreak Across the United States

CDC Says This is Preventable

How To Increase Compliance and Improve the Immunization Vaccine Rate in Your Community

NBCI Immunization Tracker and Our Spot-Check Strategy

Newsletter developed by NBCI for distribution among members for improved vaccine knowledge.

NATIONAL CLINICAL TRIAL STRATEGIC PLAN (NCTSP)

Who is The National Black Church Initiative and The American Clinical Health Disparities Commission?

WHO WE ARE:
The National Black Church Initiative (NBCI)

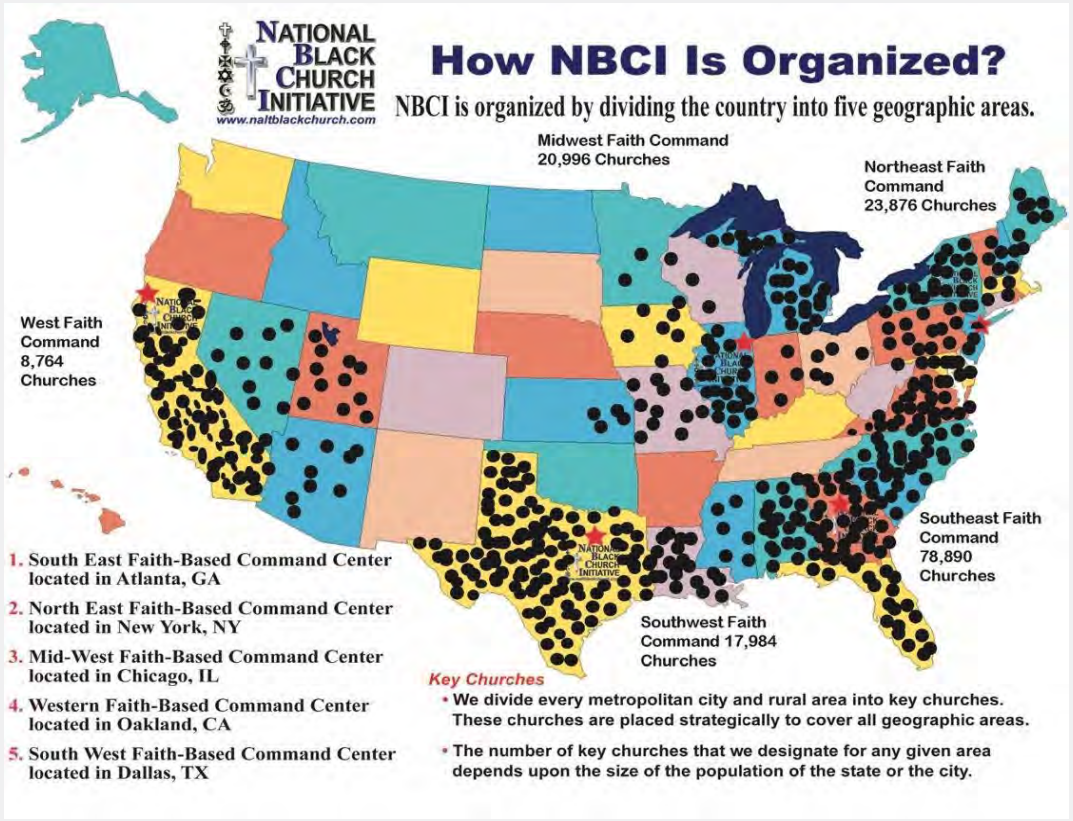
- The National Black Church Initiative (NBCI) is a coalition of **150,000 African American and Latino churches** constituting **27.7 members** working to eradicate racial disparities in healthcare, technology, education, housing, and all its members, congregants, churches and the public.
- The mission of NBCI is to provide critical wellness information to all its members, congregants, churches and the public. NBCI's methodology utilizes faith and sound health science and critical wellness information to science and partners with major organizations and officials reduce racial disparities in the variety of areas cited above.

WHO WE ARE:
The National Black Church Initiative (NBCI)

- NBCI's programs are governed by credible statistical analysis, science-based strategies and techniques, and methods that work and offer faith-based, out-of-the-box and cutting-edge solutions to stubborn economic and social issues. **https://www.naltblackchurch.com**

NBCI Demographic Reach

Below is the map of NBCI constituencies throughout the various regions of the country:



WHAT WE DO:
MISSION FORWARD

- NBCI and American Clinical Health Disparities Commission (ACHDC) are ushering in a new era of broadened engagement of African American and Latino communities in clinical trials.
- ACHDC is a coalition African American and Latino clinicians and African American church leaders.
- Particularly given the unethical and illegal behaviors involved with the Tuskegee Experiment and the intentional absence or lack of critical information for the involved subjects by governmental officials, NBCI engages in a comprehensive approach to utilize important lessons learned from historic medical abuses for generating robust interest in substantially improving clinical trial participation.

Why NBCI:
Infrastructural Capacity for Implementing Programs

- **NBCI** has a Clinical team of 42 African American physicians to bring to bear.
- **NBCI** is the largest faith-based preventative health initiative in the country.
- **NBCI** has successfully been conducting clinical health prevention programming over the past 30 years.
- **NBCI** created and completed a successful clinical lecture tour of Black and Latino researchers talking the importance of clinical trials.

What is the Issue?

Diversity Plans to Improve Enrollment of Participants From Underrepresented Racial and Ethnic Populations in Clinical Trials

- The FDA are currently writing rules that require diversity in all clinical trials moving forward.
- African Americans morbidity and mortality continue to move an unprecedented rate over the past two decades.
- African American and Latino clinicians attribute this to the lack of participation in clinical trials to answer the question, “Why?”

What is NBCI's and ACHDC's Solution

- Over the past ten years NBCI has built an infrastructure to support the goals and objectives under the National Clinical Trial Strategic Plan

The American Clinical Health Disparities Commission (ACHDC)

- NBCI has created the infrastructure for the first time in the history of this country to deliver in a systematic way critical clinical trial education to its' 27.7 million members and the Latino community.
- This will be the largest health educational effort ever by a 150,000-member faith-based coalition.
- We have teamed up with African American and Latino clinicians and have constructed a clinical trial curriculum that will be delivered to millions of church goers.
- We will do this under a forthcoming organization called The **American Clinical Health Disparities Commission (ACHDC)**

NBCI and the ACHDC Website

- NBCI has created the first of its' kind – a comprehensive website that will walk African Americans and Latinos through the basic education of the benefits and risks of clinical trials. blackchurchclinicaltrials.com
  - There is a comprehensive workbook and an ability to ask questions to clinicians who look like them about the risks and benefits of clinical trials and their overall value to their own health and the health of their people.
- blackchurchclinicaltrials.com was created by African American and Latino clinicians and clergy and has been analyzed through comprehensive focus groups consisting of both African Americans and Latinos
  - Presently it's being evaluated by 25,000 low-income African Americans and Latinos to evaluate their knowledge base on clinical trials

What is the Ask?

WHAT IS THE ASK?

- NBCI is seeking a $5 million grant over the next 4 years to support and implement its' National Clinical Trial Strategic Plan (NCTSP)

https://blackchurchclinicaltrials.com

- NCTSP is the most serious, substantive, systematic and science-based attempt by African-American physicians and ministers to persuade the black community of the risks and benefits of participating in clinical trials.

WHAT IS THE ASK?

- Many experts agree that by combining faith and science with the largest pool of prospective and educated members and dealing forthrightly with the historical mistrust of science and government this approach has more than an 80% chance of succeeding.

https://blackchurchclinicaltrials.com/faith-health.php

What is the Ask?

A fully funded ask will permit the following activities to take place.

- Hiring of an outreach staff
- Marketing of the website blackchurchclinicaltrials.com
- The development of a comprehensive social media plan
- The activation of a “Train the Trainers” program
- The implementation of cultural competency clinical education for clinicians
- The continuation of the Clinical Trial Mobile Pavilion targeting 15 cities
- The implementation of the Clinical Trial Day Long Program
- The video production of “How to Successfully Communicate with African American and Latino Patients”

How We Plan to Achieve Our Educational Goals

- Conduct 500 to 1,500 education sessions using the Trainer of Trainers methodology to facilitate preparation of the NBCI members.
- Engagement with 50,000 to 105,000 NBCI members to educate and encourage annually the need to complete the online clinical trials course.


What Has Been Accomplished in This Area To Date
SECURITY

Current Activities:
Laying the Ground-Work

- NBCI is currently testing its new NCTSP Clinical Trials website with 25,000 low-income members of its churches.
- NBCI is briefing:
  - BIO partners
  - National Medical Association
  - National Hispanic Medical Association
- NBCI is currently engaging in the process to establish a meetings with:
  - FDA
  - NIH
  - American Heart Association
  - American Lung Association
  - American Diabetes Association
  - large health insurers

PROGRAM DESCRIPTION

Program Goal

- To offer comprehensive efforts to enhance the overall health and well-being of African American and Latinos.

Program Objectives

- To conduct a needs assessment of 25,000 low–income African Americans and Latinos to determine their health and wellness and their willingness to participate in clinical trials.
- To implement educational modules of clinical trials to 100,000 to 150,000 African Americans and Latinos to promote health and wellness.

The Success of the NBCI Clinical Program and Demonstrated Capacity

What We Have Done as NBCI with Current Collaborative Partners…

Since the start of the COVID pandemic, NBCI has engaged in diverse efforts to address the holistic needs of our 27.7 million members.

- ✓Our programmatic initiatives have generated critical efforts toward educating African Americans and Latinos about COVID.
  - oHere is the link highlighting one approach NBCI has addressed COVID: https://www.naltblackchurch.com/healthcovid-19.html.
- ✓Other videos have been done to show our concerted efforts.
- ✓https://www.youtube.com/watch?v=gMiQh5JXw7k&t=275s

Proposed Budget Allocation

• Personnel	22%
• Education and Outreach	22%
• Overhead	17%
• Social Media	7%
• Public Policy/Seminars	6%
• Technology Compliance/Maintenance	6%
• Clinical Consultants	5%
• Marketing/Publication(Clin-news)	5%
• Liability Insurance	5%
• Legal/Accountant	3%
• Other	2%

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From 1989 through 2008, we have relied primarily on data gathered by J. David Cummins, Michael Suher, and George H. Zanjani, in "Federal Financial Exposure to Natural Catastrophe Risk," December 7, 2007, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1071065. Our figures show that over the period 1989-2023, such funding has averaged 0.15 percent of GDP. In 25 of those 35 years, the funding level was lower, but it was far higher in 2005 and 2006, 2013, and 2018, stemming from hurricanes Katrina, Sandy, Harvey, Irma, and Maria.
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