

**Written Testimony of the United Hospital Fund  
Submitted to the Senate and Assembly Joint Legislative Hearing on  
Exploring Solutions to the Disproportionate Impact of COVID-19  
on Minority Communities**

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United Hospital Fund (UHF) is an independent nonprofit organization dedicated to building a more effective health care system for every New Yorker, with a special focus on the needs of the most vulnerable. Since 1879, UHF has helped solve vexing problems in the health care system and collaborated on addressing critical health issues facing New Yorkers, especially in times of crisis. We analyze public policy, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care.

We thank the collective legislative committees, task forces, and caucuses for the opportunity to submit testimony on the importance of robust, community-based primary and preventive care in alleviating the disparities in health outcomes in minority communities—disparities made even more apparent by the disproportionate impact of COVID-19.

**Primary Care and Disparities in New York**

We have all seen the troubling and unacceptable disparities between communities around COVID-19 outcomes. But this should not have come as a surprise, because these same communities experience disparate health outcomes across almost all conditions. Our focus today is to bring some insight to the health care delivery system context that drives these disparities, while also acknowledging that changes in the health care system alone are only part of the long-term solution.

Almost forty years ago, Dr. Julian Hart observed that the availability of good medical care tends to vary inversely with the need for it in the population served—or what is known as the inverse care law—particularly in market-based systems.<sup>i</sup> It is unfortunate that this principle holds true for primary care here in New York: our supply of primary care physicians in minority and lower-income communities with the greatest health needs and poorest health outcomes is consistently below statewide averages.<sup>ii</sup> For instance, in the Community District covering Mott Haven and Melrose in the Bronx, where primary care is in short supply,<sup>iii</sup> adults are more than three times as likely as all city residents to have an avoidable hospitalization—that is, one that could have been prevented with strong outpatient management. They also have an elevated rate of premature death in the district, with an astounding 302 people dying before age 65 per every 100,000 residents—well above the citywide rate of 169.5.<sup>iv</sup> Similar disparities can be found in neighborhoods across the five boroughs and in communities around the state.<sup>v</sup>

These aren't just observations. Research consistently shows that access to quality primary care can have substantial positive effects on health outcomes.<sup>vi</sup> Federal, New York State, and New

York City governments have recognized the importance of primary care access and quality in their respective “prevention agendas”.<sup>vii</sup> UHF has worked to encourage the adoption of a comprehensive medical home model, especially in the small practices that often provide culturally appropriate care in underserved communities.<sup>viii</sup> Progress, however, has been slow. This is likely due in large part to the intersectionality of health care access and other social barriers noted in the federal Healthy People 2020 agenda:

*“Primary care providers offer a usual source of care, early detection and treatment of disease, chronic disease management, and preventive care. Patients with a usual source of care are more likely to receive recommended preventive services such as flu shots, blood pressure screenings, and cancer screenings. However, disparities in access to primary health care exist, and many people face barriers that decrease access to services and increase the risk of poor health outcomes. Some of these obstacles include lack of health insurance, language-related barriers, disabilities, inability to take time off work to attend appointments, geographic and transportation-related barriers, and a shortage of primary care providers. These barriers may intersect to further reduce access to primary care.”<sup>ix</sup>*

As New York emerges from the initial COVID response and enters the recovery and rebuilding phases of the crisis, it will be all too easy to focus on the hospitals that were on the front lines of the response. While that may well be necessary, it alone is insufficient to address the underlying health and economic disparities that led to the disproportionate impact of the disease on minority communities. To have any chance of reducing a disproportionate impact during the next crisis, the federal, state, and local governments must focus on the everyday needs of minority New Yorkers; these include, but are by no means limited to, their access to and utilization of high-quality primary care. We also acknowledge that to ensure health equity beyond the health care system, investments are needed in economic development, housing, jobs, education, and the other social determinants of health.

### **Toward a Vision for Equity Through Enhanced Primary Care In New York**

The National Academies of Sciences, Engineering, and Medicine defines primary care in these terms:

*“the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”<sup>x</sup>*

In an ideal world, this definition would apply to every New Yorker regardless of geography, race/ethnicity, or any other demographic factor.

There are many elements to the definition, each of them requiring focus as we consider how a robust primary care system can improve health and reduce disparities in minority communities. The word “integrated” alone carries many sometimes conflicting definitions in health care circles. Integrated primary care means at minimum the capacity to meet a large majority of

patient health care needs by coordinating basic well-care, sick-care, chronic condition management, and behavioral health care from the primary care office. In larger practices, these services may all be available in one location. In smaller practices, the quarterbacking office may have to work with many different receivers, managing referrals and multiple medications and treatments ordered by different providers. Despite substantial investments and improvements over the past decade, many practices in minority communities still lack the basic technology and collaboration tools to effectively integrate and quarterback care. Improved support for primary care integration in minority communities will foster the sustained and trusted relationships necessary between patients and their primary care practitioners.

The definition of accessibility may change substantially as a result of COVID. Primary care practices were forced to quickly shift to telemedicine as offices closed and individuals heeded stay-at-home guidance. Anecdotal evidence suggests that small and under-resourced practices in minority communities may be having the most difficulty making this transition. Not to mention that their patients may face technological barriers to telemedicine services. As telemedicine takes a prominent position as part of the long-term access conversation, providers and patients in minority communities will need support to ensure the new access points are universally available and do not instead further reinforce historic barriers to access.

Culturally competent primary care that accounts for family and community context is key to improving health outcomes in minority communities. This means there is no one-size-fits-all approach to what the primary care system should look like in any community. Across New York, there are strong examples of high-quality primary care in minority communities provided by small independent practices, federally qualified health centers, and hospital-based outpatient departments and clinics. Any mix of these providers could fully meet the needs of minority communities, but there must be enough providers to do so. Those providers must understand and speak the languages of the communities they serve (both literally and figuratively), and they must be collectively accountable for broader population health improvement goals. The current health care financing system has failed to generate this type of broader accountability. Community-based population health improvement efforts can only do so much if the health care financing system does not reinforce population health goals.

### **Supporting the Vision**

Achieving this vision will require a broad reconsideration of how the health care system is organized and financed. Health insurance coverage remains a key determinant of access to care, and as people lose jobs and employer-sponsored coverage, we must strive to connect them to existing free or low-cost options available to New Yorkers. To reduce health outcome disparities, it is highly likely that more money will need to be invested in primary care, particularly in underserved communities. Such investments should be connected to accountability around community health improvement. This does not necessarily mean increasing overall health care spending, but at a minimum it does require a conversation about rebalancing current spending toward primary care to achieve better long-term outcomes and reduce future acute care costs.

As we enter the COVID-19 recovery phase, we need to collectively look beyond the needs of hospitals and focus on the primary and preventive care that is necessary to improve health and keep people out of hospitals. Federal funding has long supported primary care in under-resourced communities, and more will be needed to further enhance access to high-quality primary care in these communities. We must also collectively redouble our efforts to coordinate health care system improvements with efforts to address the many social conditions that affect health. Improving primary care for New Yorkers in minority communities will only help so much if we don't also focus on the education, income, housing, food, and transportation needs in these communities.

We appreciate the opportunity to provide testimony on this important issue. We look forward to engaging in ongoing conversations and collaborations with the legislature, stakeholders, and community members on how to improve the health of minority communities disproportionately affected by COVID-19.

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<sup>i</sup> Hart JT: The inverse care law. *Lancet*. 1971, 1: 405-412.

<sup>ii</sup> County Health Rankings comparison of Bronx and Queens to New York State, [https://www.countyhealthrankings.org/app/new-york/2020/compare/snapshot?counties=36\\_005%2B36\\_081](https://www.countyhealthrankings.org/app/new-york/2020/compare/snapshot?counties=36_005%2B36_081)

<sup>iii</sup> UHF analysis of New York City Neighborhood Health Atlas, <https://www1.nyc.gov/site/doh/health/neighborhood-health/nyc-neighborhood-health-atlas.page>. The primary care physician rate in the two Neighborhood Tabulation Areas covering most of Bronx Community District 1 is 150.6 per 100,000 residents compared to the citywide rate of 332 per 100,000 residents.

<sup>iv</sup> New York City Department of Health and Mental Hygiene, Community Health Profiles 2018, Bronx Community District 1, Mott Haven and Melrose, <https://www1.nyc.gov/assets/doh/downloads/pdf/data/2018chp-bx1.pdf>

<sup>v</sup> New York City Department of Health and Mental Hygiene Community Health Profiles 2018, <https://www1.nyc.gov/site/doh/data/data-publications/profiles.page>; and New York State 2017 Health Equity Reports, [https://www.health.ny.gov/statistics/community/minority/mcd\\_reports.htm](https://www.health.ny.gov/statistics/community/minority/mcd_reports.htm).

<sup>vi</sup> Shi L. The impact of primary care: a focused review. *Scientifica* (Cairo). 2012;2012:22; and Starfield B, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83:457-502.

<sup>vii</sup> Healthy People 2020, <https://www.healthypeople.gov/>; Prevention Agenda 2019-2024: New York State's Health Improvement Plan, [https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/); and Take Care New York 2020, <https://www1.nyc.gov/site/doh/about/about-doh/take-care-new-york-2020.page>.

<sup>viii</sup> A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City, <https://uhfnyc.org/publications/publication/a-strategy-for-expanding-and-improving-the-impact-of-the-medical-home-across-new-york-city/>; and NYC PHIP Small Practice Project, <https://uhfnyc.org/publications/publication/nyc-hip-small-practice-project/>.

<sup>ix</sup> Healthy People 2020, Access to Primary Care, <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary#2>.

<sup>x</sup> Institute of Medicine (US) Committee on the Future of Primary Care; Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, editors. Primary care: America's health in a new era. Washington (DC): National Academies Press (US): 1996.