

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

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CONEY ISLAND PREP; LESLIE-BERNARD :
JOSEPH; HOUSING WORKS, INC.; CHARLES :
KING; MARK LEVINE; and ALEXANDRA :
GREENBERG, :

Plaintiffs, : No. 1:20-cv-_____

-against- :

UNITED STATES DEPARTMENT OF HEALTH :
AND HUMAN SERVICES; ALEX. M. AZAR II, *in* :
his official capacity as Secretary of Health and :
Human Services; DR. ROBERT KADLEC, *in his* :
official capacity as Assistant Secretary of Health and :
Human Services; CENTERS FOR DISEASE :
CONTROL AND PREVENTION; DR. ROBERT R. :
REDFIELD, *in his official capacity as Director for* :
the Centers for Disease Control and Prevention, :

Defendants. :

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DECLARATION OF MARY T. BASSETT, M.D., M.P.H.
IN SUPPORT OF PLAINTIFFS’ MOTION FOR A PRELIMINARY INJUNCTION

I, Mary T. Bassett, M.D., M.P.H., under penalty of perjury, state as follows:

1. I am the Director of the François-Xavier Bagnoud (FXB) Center for Health and Human Rights and FXB Professor of the Practice of Health and Human Rights in the Department of Social and Behavioral Science at the Harvard T.H. Chan School of Public Health (“Harvard School of Public Health”).

2. From 2014 to the summer of 2018, I was Commissioner of the New York City Department of Health and Mental Hygiene. Prior to my appointment as Commissioner, I was the Department’s Deputy Commissioner for Health Promotion and Disease Prevention from 2002 to

2009. Central to my leadership at the Department was addressing the structural racism at the root of the persistent health disparities between the city's White residents and Black, Latinx, and other communities of color. I have witnessed these disparities firsthand and designed a number of policy interventions to address them.

3. Earlier in my career, I worked for nearly two decades in Africa, including serving 17 years on the medical faculty of the University of Zimbabwe and overseeing the Rockefeller Foundation's Africa AIDS portfolio as Associate Director of Health Equity at the Foundation's Southern Africa office. From 2009 to 2014, I served as Program Director for the Doris Duke Charitable Foundation's African Health Initiative and Child Well-Being Prevention Program.

4. I have won numerous awards during my career, including the prestigious Frank A. Calderone Prize in Public Health, the Kenneth A. Forde Lifetime Achievement Award from Columbia University, the Victoria J. Mastrobuono Award for Women's Health, and the National Organization for Women's Champion of Public Health Award. I am an elected member of the National Academy of Medicine.

5. I am a native of New York City. I received a bachelor's degree in history and science from Harvard College, a master's degree in public health from the University of Washington, and a medical degree from Columbia University's College of Physicians and Surgeons. I served my residency at the Harlem Hospital at the Columbia University Irving Medical Center.

6. I have published many articles in medical journals, including in *The Lancet* and the *New England Journal of Medicine*, and, in my writing and public speaking, I routinely address issues of structural racism and health disparities in the United States.

7. The *Lancet* article, for example, discussed research and interventions seeking to address the public health impact of what we call structural racism—i.e. the ways in which societies foster racial discrimination via mutually reinforcing systems of education, employment, earnings, credit, housing, media, health care and criminal justice. Structural racism’s patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources, including inequities in health resources and disparities in health outcomes. The article argued that addressing structural racism presents a concrete and feasible approach to improving health equity and population health. The article is available at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30569-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30569-X/fulltext).

8. Racial health disparities have worsened COVID-19’s toll in the United States and have complicated the response to the spread of the virus. It has been clear since the beginning of the pandemic that Black, Latinx and other people of color are experiencing higher rates of infection, morbidity and mortality from this pandemic.

9. Since April, I have called for improved collection and reporting of Covid-19 demographic data. For example, I was among a number of public health and medical practitioners who published an article in *HEALTH AFFAIRS*, entitled *The Fierce Urgency Of Now: Closing Glaring Gaps In US Surveillance Data On COVID-19*, on April 14, 2020. A true and correct copy of this article has been attached hereto as Exhibit A.

10. At the time, the COVID-19 data reported by the US Centers for Disease Control and Prevention (“CDC”) was only for total populations—the country as a whole and by state. Private entities like Johns Hopkins University Coronavirus Resource Center (“Johns Hopkins”) were the only place to see reported case counts by county, crediting the contributions of the CDC, newspapers and volunteer groups. Such hodgepodge efforts are incredibly vulnerable to

inconsistencies and gaps in state COVID-19 reporting: for examples, some states have publicly reported only the number of confirmed cases without data on the number of persons tested, or some states have failed to report the number of persons hospitalized.

11. The CDC's detailed intake forms allow local entities to submit social information (including on race), as well as contextual information (including potential circumstances of exposure and clinical presentation). My understanding, however, is that this form is not widely being used or being completed in full. The CDC estimated that this form takes roughly 30 minutes to complete per case, presenting an administrative challenge to potentially overwhelmed health systems with thousands of cases.

12. Few systems have been in place to enable monitoring and interpretation of testing patterns (including who is being tested), likelihood of positive tests (which relates to testing strategy), or mortality (and how we define which deaths are COVID-19 related and which are not). Nor has there been a way to evaluate these data in relation to core sociodemographic variables, such as age, race/ethnicity, sex/gender, and socioeconomic position. This means that health equity is literally off the map, made invisible because data to document inequities are unavailable, even as accounts available in journalism and on social media vividly attest to the risks of those who have not been able to shelter safely at home or afford the economic disruption.

13. The absence of these data directly threatens our ability to take prudent public health action in response to COVID-19. It is not sufficient to know simply whether the virus is or is not present in a particular geographic location. Social data will allow for a better estimation of the likely spread and impact of COVID-19 and the toll of second-order effects on people's economic well-being and safety.

14. From the World Health Organization to US health agencies and academics, public health practitioners now widely recognize the importance of societal determinants in shaping outcomes. We know that social inequalities become embodied as health inequities. Continuing failures to collect and report social data will hamper efforts to respond to a second wave of COVID-19 this fall/winter and to handle future public health emergencies which could arrive at any time.

15. Going forward, the federal government, specifically the Department of Health and Human Services (“HHS”) and the Centers for Disease Control and Prevention (“CDC”), must provide both leadership and sufficient funding to ensure there is a strong coordinated effort to collect the relevant social and clinical data and to make these data available in real time at the national, state, and local levels. While it may be understandable that such federal efforts were flat-footed in the exponential first phase of the epidemic, there is no excuse for the fact that today the federal agencies have still not adequately addressed these problems.

16. As a demonstration of the usefulness of these data, I, along with two colleagues from the Harvard School of Public Health, published a study on the racial and ethnic disparate impact of Covid-19, titled *Variation in racial/ethnic disparities in COVID-19 mortality by age in the United States: A cross-sectional study*. Using recently released data from the National Center for Health Statistics (“NCHS”), we analyzed COVID-19 death rates during the first three months of the pandemic and examined age-specific mortality rates by race and ethnicity. A true and correct copy of the paper reporting the results of this research is attached hereto as Exhibit B.

17. Prior to our study, excess COVID-19 mortality among communities of color had been described only generally, but these disparities had not been studied with respect to *age at death*, in part because national information was not made available by HHS until May, 2020. At

the time of this study, the CDC still did not include breakdowns by race or ethnicity, nor did it include statistics from New York City, a major hotspot in the first wave of COVID-19 in the United States. Newly released data by the National Center for Health Statistics (“NCHS”) made it possible for the first time to analyze age-specific mortality rates and explore the likelihood that groups experiencing higher COVID-19 mortality rates than white Americans—Blacks, Latinx, American Indian/Alaska Natives, and Asian and Pacific Islanders—are also dying at younger ages.

18. Our analysis found that people of color experienced a disproportionately greater likelihood of COVID-19 death at all ages and that higher death rates were even more striking comparing younger people. For example, whereas adjusting for age Black people overall face 3.6 times greater COVID-19 death rates than their White counterparts, and Hispanics overall face 2.8 times greater death rates, the death rates for Black and Hispanic people ages 35-44 are 8.8 to 9 times greater than similarly aged Whites. For Black children age 5-14, the death rates were 13 times greater than White children of the same ages although there are few deaths in this age group and estimates are unstable. We also calculated that Black and Hispanic communities had suffered disproportionate years of potential life lost before the age of 65 years.

19. Our study serves to illustrate the importance of data collection in our pandemic response. The fact that people of color were not only more likely to die overall, but were far more likely to die *at younger ages* was hidden due to a lack of available data. Now that we better understand the risk profiles of different ages in communities of color, we can better design public health interventions to mitigate COVID-19’s harm. The extreme increased risk of dying from COVID-19 for working-aged adults suggested the importance of safe transport and safe workplaces where it is possible to achieve social distancing, perform handwashing and wear

masks. Additionally, enabling frontline workers who live in crowded households or with individuals who have co-morbidities that increase their risk of severe COVID-19 to use alternative accommodation would reduce community spread.

20. Though HHS and the CDC have made public some COVID-19 information on race and ethnicity, their data collection and reporting programs are still falling far short of what is required, and they have not backfilled the gaps of useful information that went unreported during earlier surges in the virus. A recent review showed data on race/ethnicity remains incomplete in many states. Continued underreporting of information on race and ethnicity continues to impede federal, state and local health entities' response to the pandemic, especially in terms of their ability to mitigate the virus' impact on communities of color. Finally, information on occupation and industry for those who have succumbed to COVID-19 remains unavailable at the national level. Lack of access to health care among people who are uninsured or under-insured is a barrier to testing, early diagnosis and care.

21. It is my understanding that the federal government has a duty to design and implement a national biosurveillance network to provide real-time data to the public with respect to the progress of ongoing public health emergencies like the present pandemic. To that end, it is my understanding that the federal government is obligated to include expert and stakeholder input in the design of data collection and reporting standards and to convene a public meeting to discuss in detail the purpose and design of such a biosurveillance effort.

22. The design and implementation of such a system presents an opportunity to close the gaps in data that have hampered the American pandemic response. As a former public health official and a professor of public health practice, I believe that HHS and CDC must, at a

minimum, collect COVID-19 case data stratified by race/ethnicity, sex/gender, age, educational level, at the national, state, county, and Zip Code levels.

23. In order to mitigate the health disparities arising from the pandemic, additional social variables should be recorded including employment status, housing status (e.g., private home, incarcerated, other institution, homeless), health insurance, income level, food insecurity, transportation access, safety at home (for oneself and one's children, given abuse that can happen in a context of remanding people to stay at home), and approximate residential address (for more precise geocoding and linkage to neighborhood social and economic data). These data can help shape numerous public health and policy interventions to mitigate the first and second order impacts of the pandemic—not just to lives but livelihoods and wellbeing.

24. Federal coordination and funding are essential for this work, which necessarily will be carried out by a combination of HHS, the CDC, and state and local health departments. Absent that, the public, and in particular communities of color burdened with disparate adverse outcomes from Covid-19, will continue to suffer unnecessary losses and deaths.

I swear under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct.

Dated: October 25, 2020



MARY T. BASSETT, M.D., M.P.H.