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PHO Grand Rounds: Recognizing and Combatting Hate and Racism as a Public Health Issue

Dr. Aletha Maybank

September 29, 2020

Disclosures

- None of the presenters at this session have received financial support or in-kind support from a commercial sponsor.
- None of the presenters have potential conflicts of interest to declare.

Learning Objectives

By the end of this session, participants will be able to:

- Recognize hate and racism as a public health issue and ways to identify it as such
- Describe how the public health community can address the issue
- Explore potential methods and approaches to take action on combating hate and racism

Racism is a Public Health Crisis

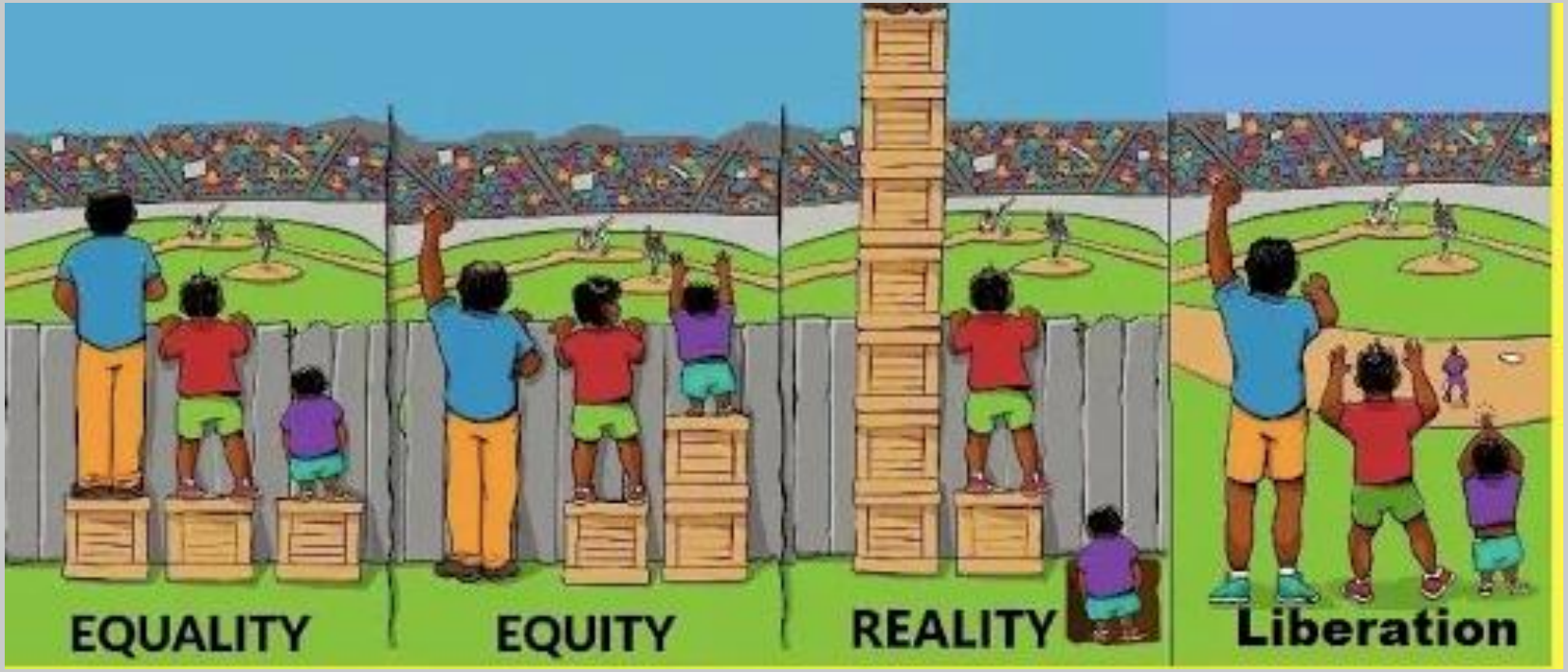
Public Health Ontario
September 29, 2020

Aletha Maybank, MD, MPH
Chief Health Equity Officer, GVP
American Medical Association

Honoring Indigenous People

@the15WhiteCoats

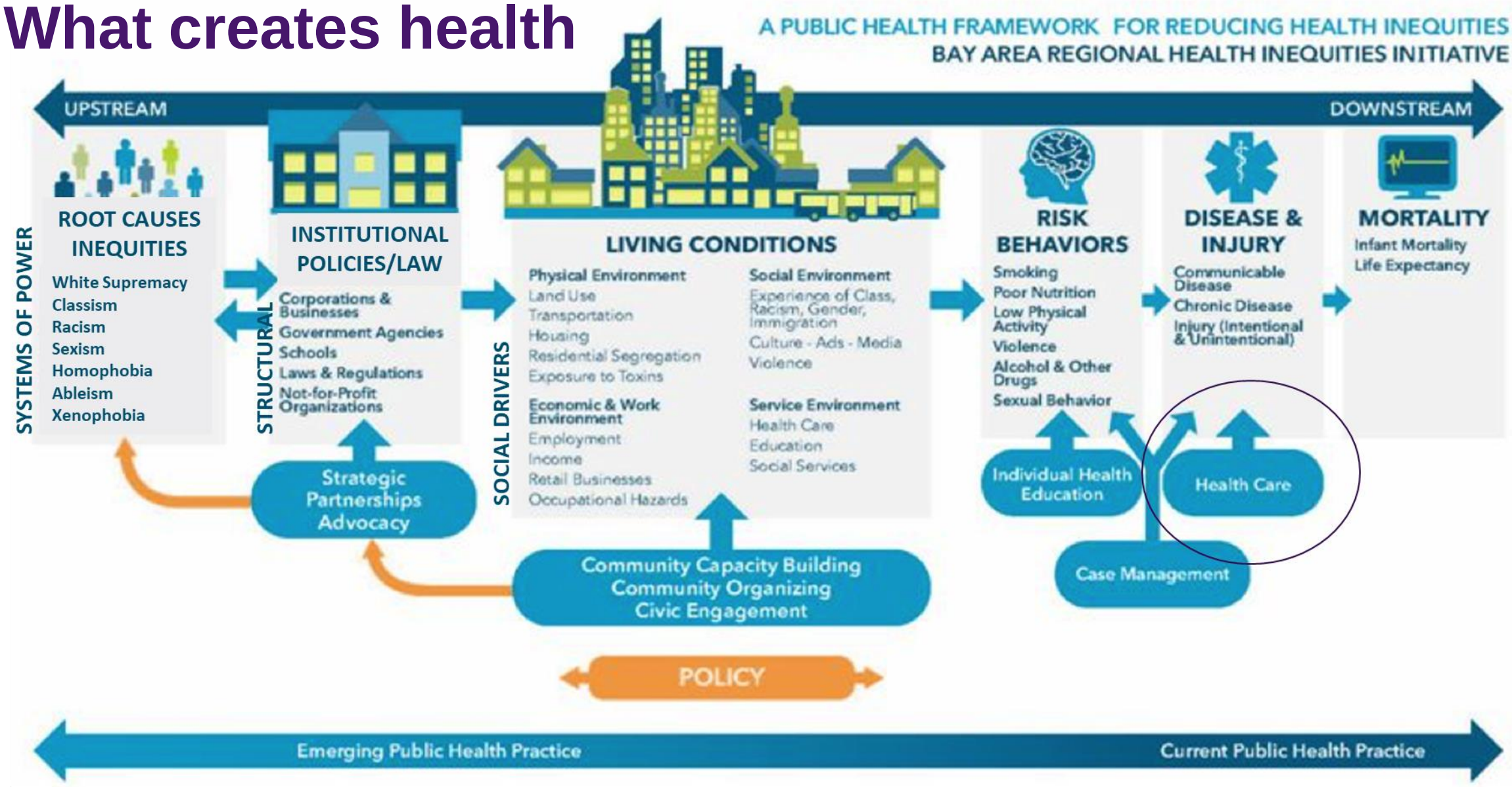
permission received to use photo



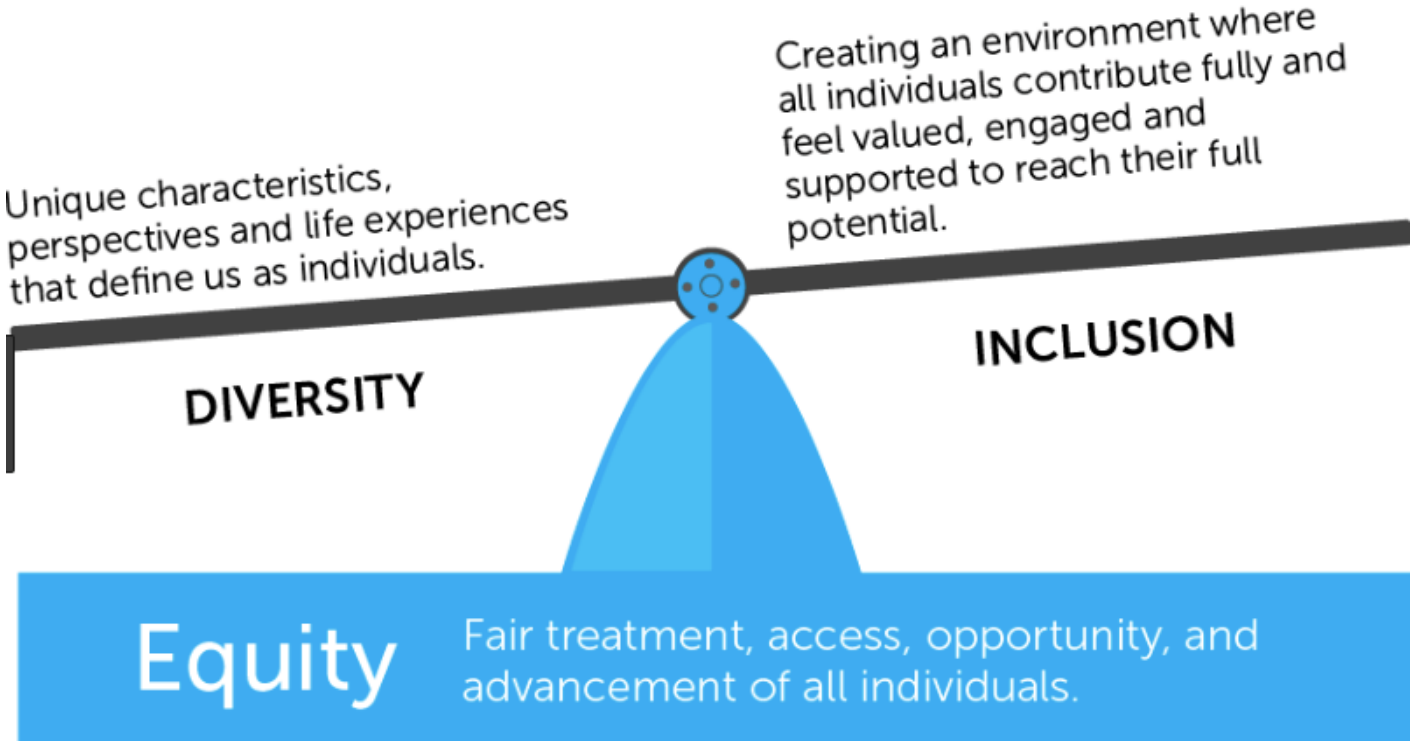
Health equity means…

Having the conditions, resources, opportunities, and power to achieve optimal health.

What creates health



Adapted from the Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.



"First, we should demand inclusion and **power** in school and programs of public health—if for no other reason than our basic civil rights…. Let us stop the "cultural competence" and "diversity and inclusion" jargon.
This is racism."

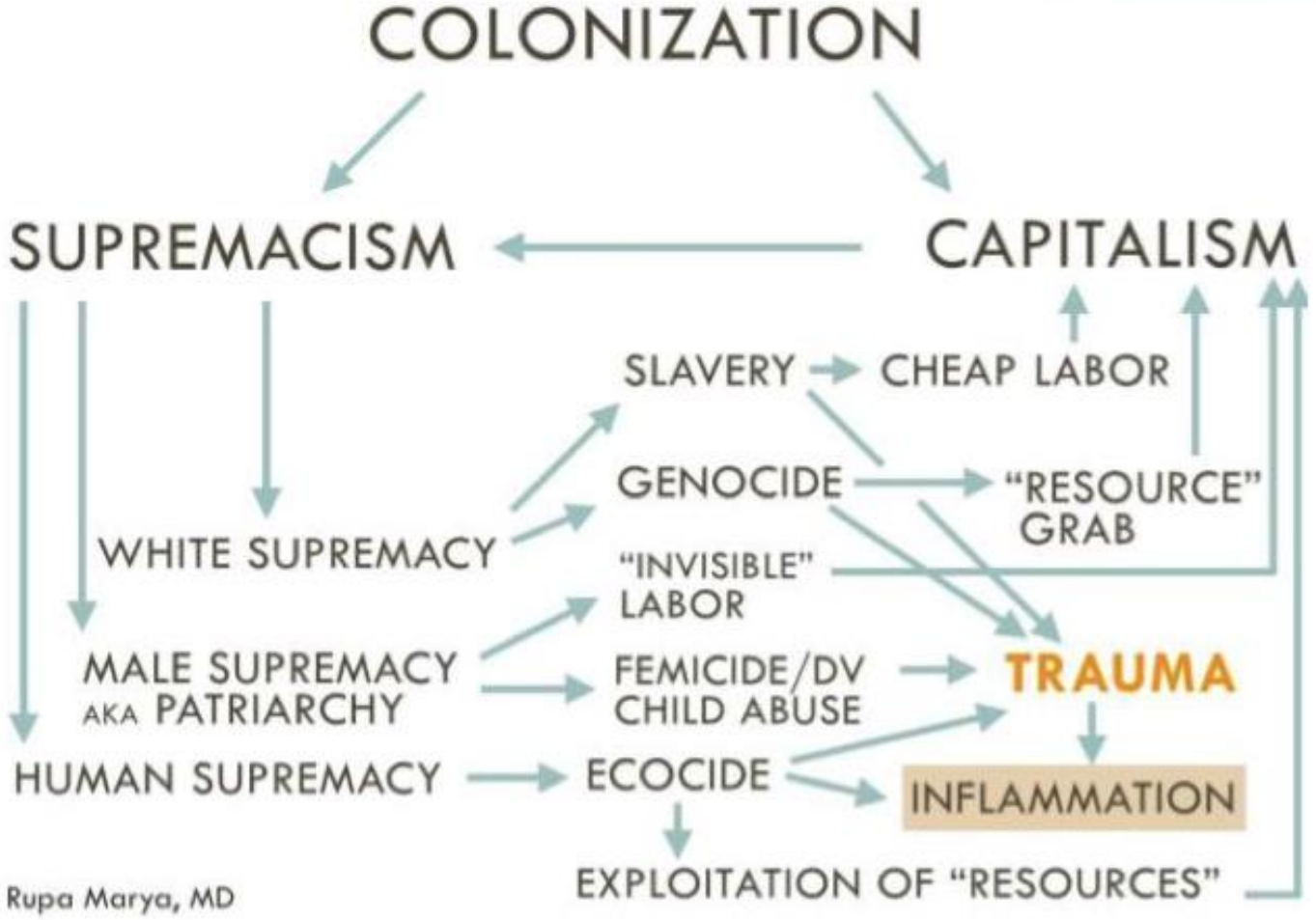
Jesus Ramirez-Valles,
Health Equity Institute, San Francisco State University
Public Health Has an Equity Problem: A Latinx Voice
9.11.2020

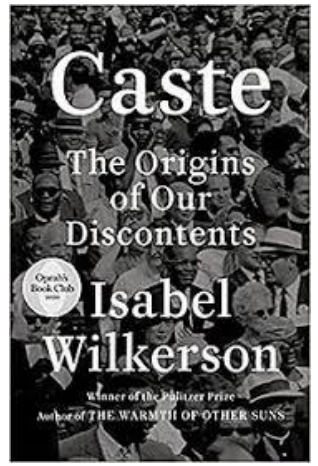
What produces health inequities?

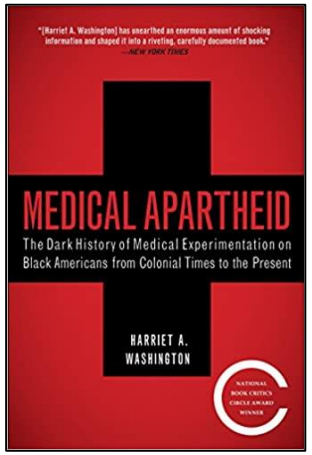
Terms	Common Definition	Populations targeted
Structural determinants / SDH inequities	***"The causes of the causes"*** The climate, the socioeconomic-political context (e.g. societal norms and macroeconomic, social, and health policies) and the structural mechanisms that shape social hierarchy and gradients (e.g. power, class, racism, sexism, exclusion).	Cities, states, nations, or the world, typically defined by political jurisdictions, cultural boundaries, or economic relationships.
Social determinants of health (SDH)	***"The causes of poor health"*** Underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age. • Systems that offer health, social services to a community are themselves a SDH. • As intermediary determinants, SDH shape individual material and psychosocial circumstances as well as biologic and behavioral factors.	Defined communities or regions, typically defined by geography.
Social needs / health-related social needs (HSRNs)	***"The effects of the causes"*** Individual material resources and psychosocial circumstances required for long-term physical and mental health & wellbeing. • Material resources: physical living and working conditions, factors such as housing, food, water, air, sanitation. • Psychosocial circumstances: stressors such as negative life events, stressful living circumstances, (lack of) social support.	Specific individuals or defined populations, typically defined by attribution.

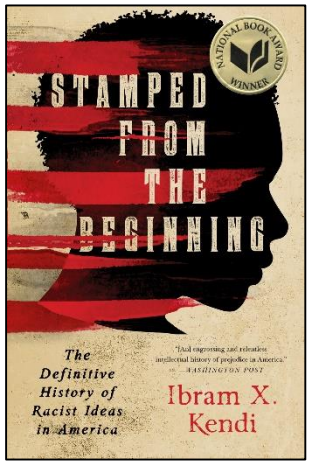
Source: HealthBegins 2020. 1. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on social determinants of health. Final Report. Geneva. World Health Organization (CHE); 2008.

"To understand the root causes of the pathologies we see today, which impact all of us but affect Brown, Black and Poor people more intensely, we have to examine the foundations of this society which began with COLONIZATION.... Colonization was the way the extractive economic system of Capitalism came to this land, supported by systems of supremacy and domination which are a necessary part to keep wealth and power accumulated in the hands of the colonizers and ultimately their financiers." — Dr. Rupa Marya

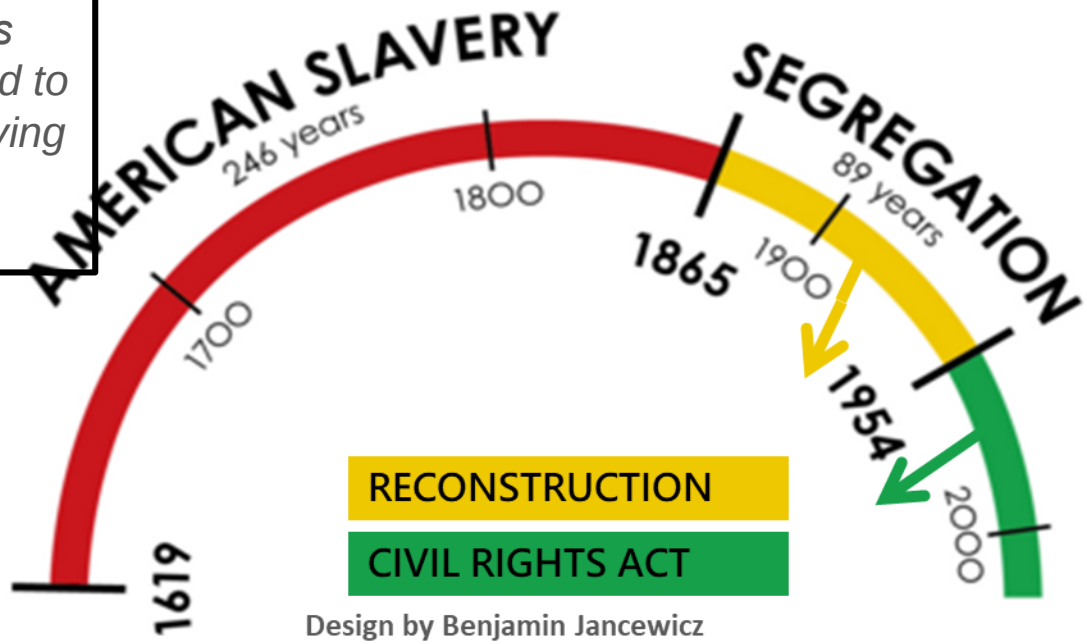








"Racism is, perhaps, America's earliest tradition. Its practice pre-dates the founding of the nation, as settler colonialism and Indigenous genocide powered the land theft that established the United States. And enslaved humans were the capital that generated this stolen land's economy. In spite of centuries of legal advancements that endeavored to excise racism from the roots of this republic, racism remains a bloodying force, structuring every facet of US life." – Boyd, Lindo, Weeks, McLemore



Racism is a System of power and oppression that **structures opportunities** and **assigns value based on race**, unfairly disadvantaging people of color (racial oppression), while unfairly advantaging Whites (racial privilege & supremacy)

Internalized-Interpersonal-Institutional-Structural

America: Equity and Equality in Health 3

Structural racism and health inequities in the USA: evidence and interventions

Zinzi D Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett

Despite growing interest in understanding how social factors drive poor health outcomes, many academics, policy makers, scientists, elected officials, journalists, and others responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities. In this conceptual report, the third in a Series on equity and equality in health in the USA, we use a contemporary and historical perspective to discuss research and interventions that grapple with the implications of what is known as structural racism on population hea… discrimination… media, health c… and distributio… approach towa…

Lancet 2017; 389: 1453–63

See Editorial page 1369

See Comment pages 1376 and 1378

This is the third in a Series of

Introduction

Racial and … inequities, are … have been a … founding of co… abound over e… report, we offe… medical literature or taught to students of health sciences, by focusing on structural racism (panel 1)[9–11] as a key determinant of population health.[9,10,12,13] To explore this determinant of health and health equity, we examine a range of disciplines and sectors, including but not limited to medicine, public health, housing, and human health professionals.[9,10,12,13] In this report, we examine what constitutes structural racism, explore evidence of how it harms health, and provide examples of interventions that can reduce its impact. Our central argument is that a focus on structural racism is essential to advance health equity and improve population health.

Correspondence to:
Dr Mary T Bassett,
42-09 28th Street, Long Island City, NY 11101, USA
mbassett@health.nyc.gov

See Online for infographic
www.thelancet.com/

"…the ways in which historical and contemporary racial inequities in outcomes are perpetuated by social, economic, and political systems, including mutually reinforcing systems of health care, education, housing, employment, the media, and criminal justice. It results in systemic variation in opportunity according to race."

Panel 2: Pathways between racism and health[9,12,13,16–18]

Economic injustice and social deprivation[8,9,12,32–35]
Examples include residential, educational, and occupational segregation of marginalised, racialised groups to low-quality neighbourhoods, schools, and jobs (both historical de jure discrimination and contemporary de facto discrimination), reduced salary for the same work, and reduced rates of promotion despite similar performance evaluations

Environmental and occupational health inequities[9,36–38]
Examples include strategic placement of bus garages and toxic waste sites in or close to neighbourhoods where marginalised, racialised groups predominantly reside, selective government failure to prevent lead leaching into drinking water (as in Flint, MI, in 2015–16), and disproportionate exposure of workers of colour to occupational hazards

Psychosocial trauma[9,15,16,18]
Examples include interpersonal racial discrimination, micro-aggressions (small, often unintentional racial slights and insults, such as a judge asking a black defence attorney "Can you wait outside until your attorney gets here?"), and exposure to racist media coverage, including social media

Targeted marketing of health-harming substances[9,30,39]
Examples include legal substances such as cigarettes and sugar-sweetened beverages, and illegal substances such as heroin and illicit opioids

Inadequate health care[9,17,40–45]
Examples include inadequate access to health insurance and health-care facilities, and substandard medical treatment due to implicit or explicit racial bias or discrimination

State-sanctioned violence and alienation from property and traditional lands[9,21,30,46–48]
Examples include police violence, forced so-called urban renewal (the use of eminent domain to force the relocation of urban communities of colour), and the genocide and forced removal of Native Americans

Political exclusion[49,50]
Examples include voter restrictions (eg, for former felons and through identification requirements)

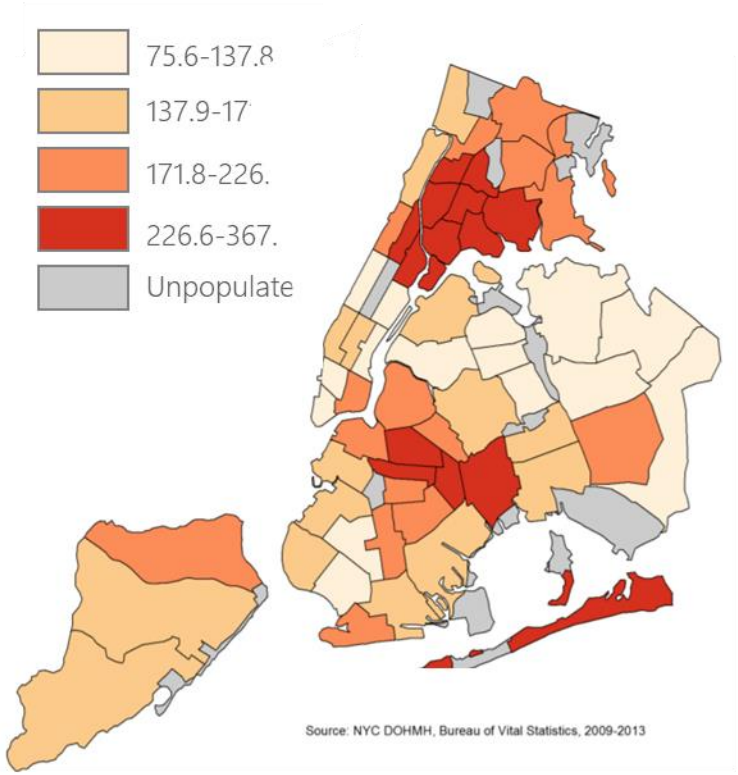
Maladaptive coping behaviours[9,16,18]
Examples include increased tobacco and alcohol consumption on the part of marginalised, racialised groups

Stereotype threats[15–18]
Examples include stigma of inferiority, leading to physiological arousal, and an impaired patient-provider relationship

NYC - Across Neighborhoods

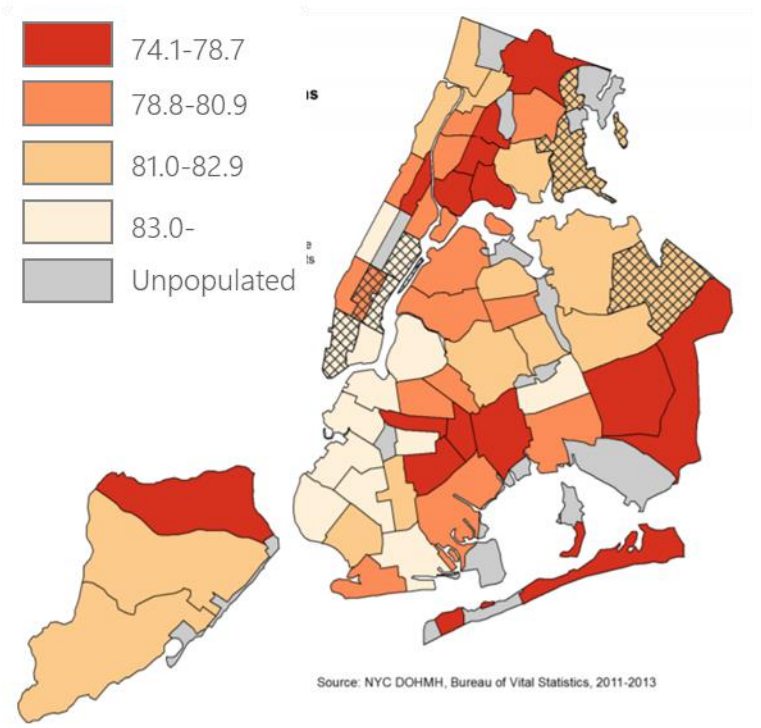
PEOPLE ARE DYING TOO EARLY

Premature Mortality (death before age 65) Rate per 100,00 population



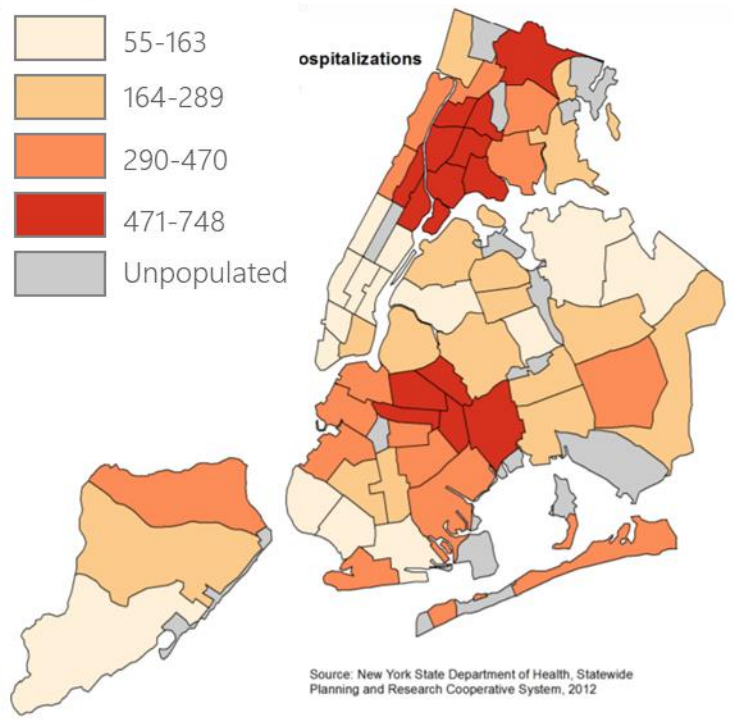
Life Expectancy

Years



Avoidable Adult Diabetes Hospitalizations

Rate per 100,00 adults



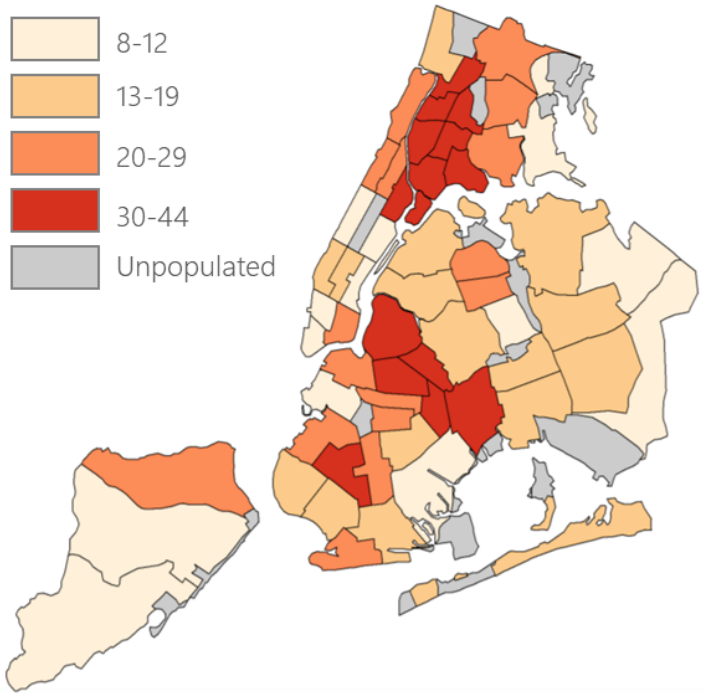
Source: NYC Dept. Health: Community Health Profiles — 2015 Atlas

Across Neighborhoods

DIFFERENCES IN SOCIAL CONDITIONS

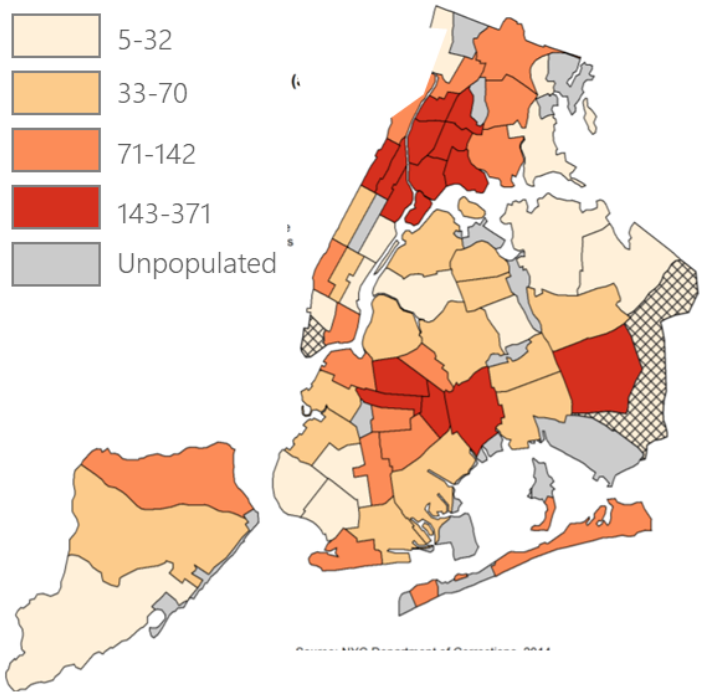
Poverty

Percent below federal poverty level



Jail Incarceration

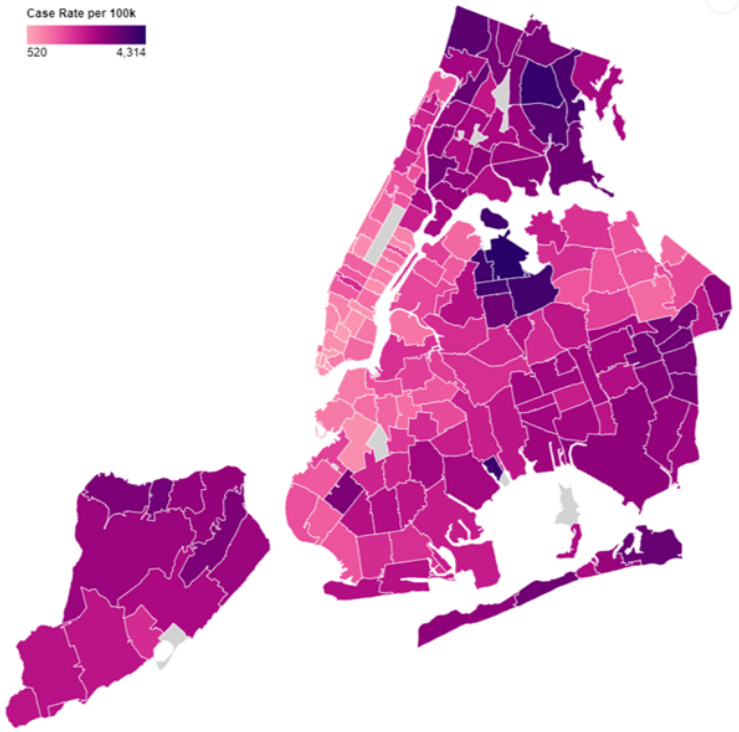
Rate per 100,00 adults (ages 16+)



Source: NYC Dept. Health: Community Health Profiles — 2015 Atlas

COVID Case Rate

Rate per 100,00 adults (ages 16+)



Source: https://www1.nyc.gov/site/doh/covid/covid-19-data.page

Policy Dictates Where People Lives

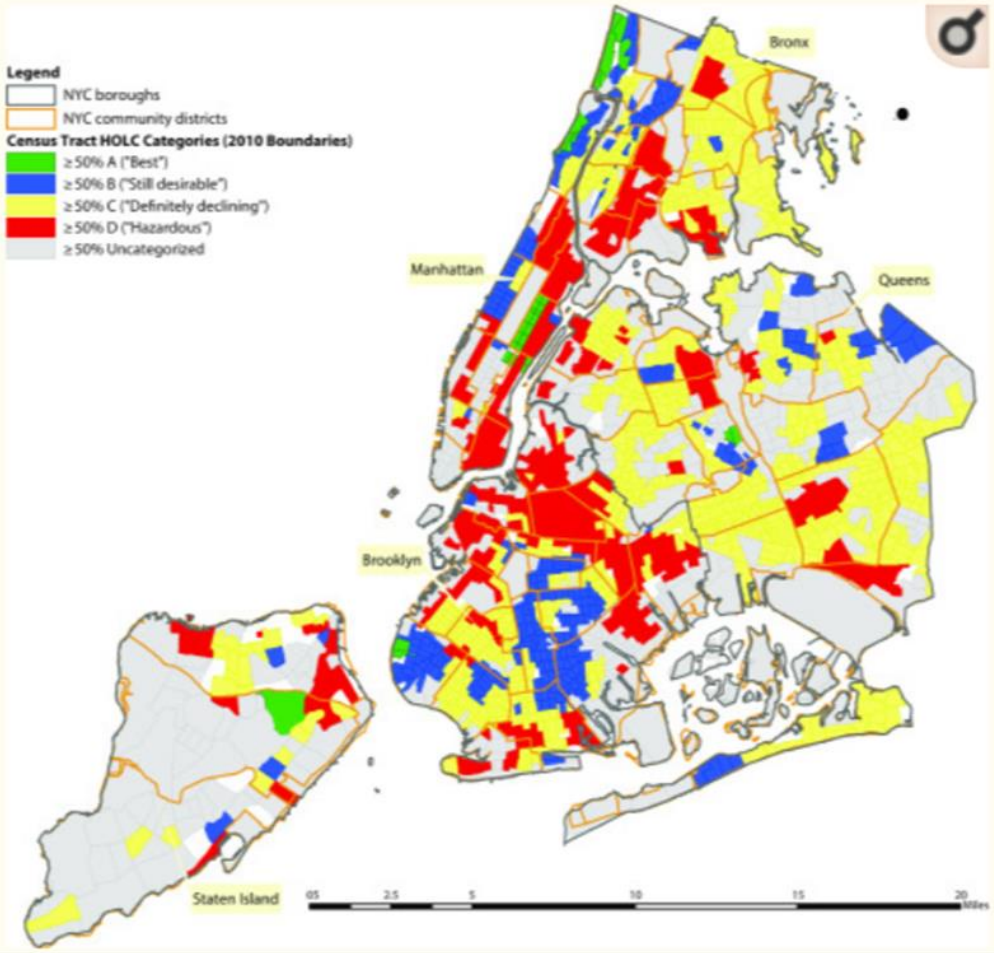
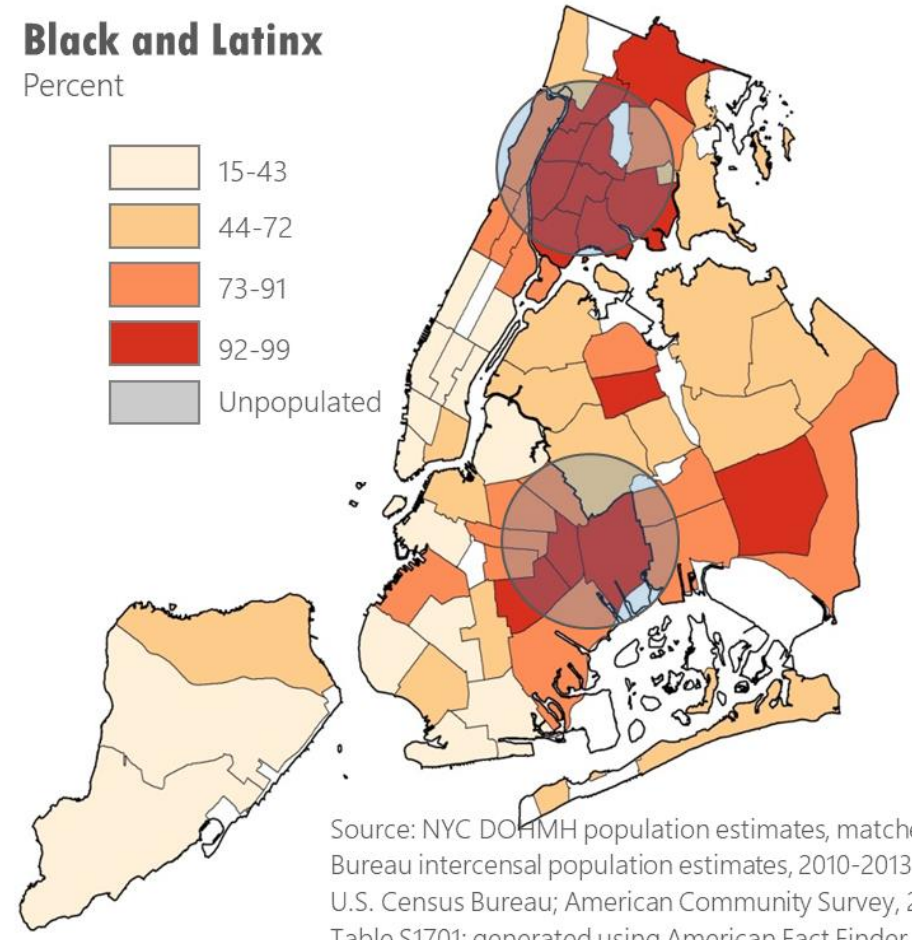


FIGURE **Redlining practices and policies**

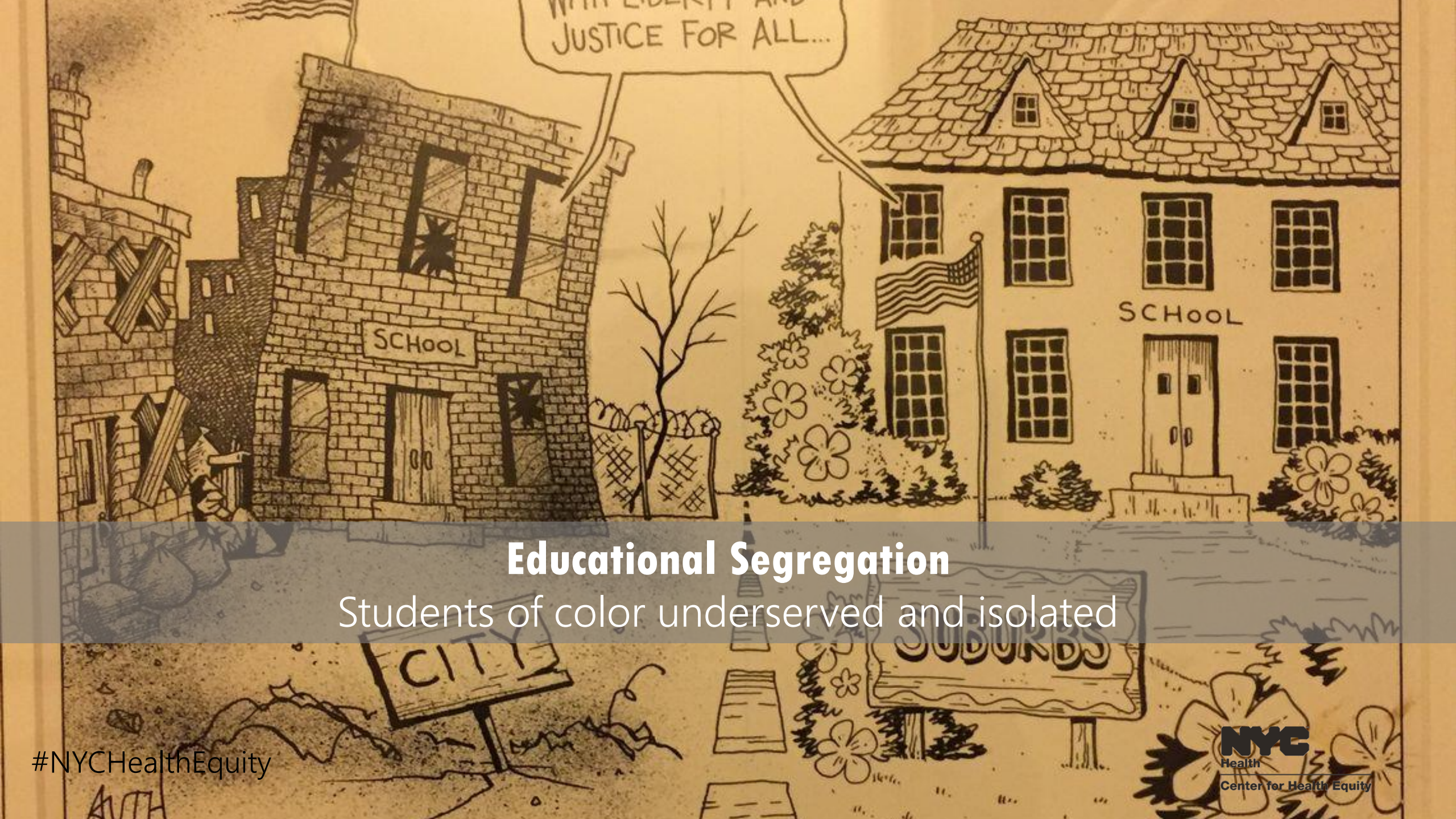
Census Tracts (n = 2166) by 1938 Home Owners' Loan Corporation (HOLC) Grade: New York City

Forced segregation and the deprivation of resources

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7287548/



Source: NYC DOHMH population estimates, matched from US Census Bureau intercensal population estimates, 2010-2013, updated June 2014 U.S. Census Bureau; American Community Survey, 2013 3-year Estimates, Table S1701; generated using American Fact Finder (http://factfinder2.census.gov/)



Educational Segregation

Students of color underserved and isolated

#NYCHealthEquity

NYC Health
Center for Health Equity

Forced Segregation and Integration of Health Care

Impacts on the workforce and health outcomes still present

Slum Clearance and Displacement

Forced segregation and the deprivation of resources

* Queensbridge Houses, Long Island City, Queens NY

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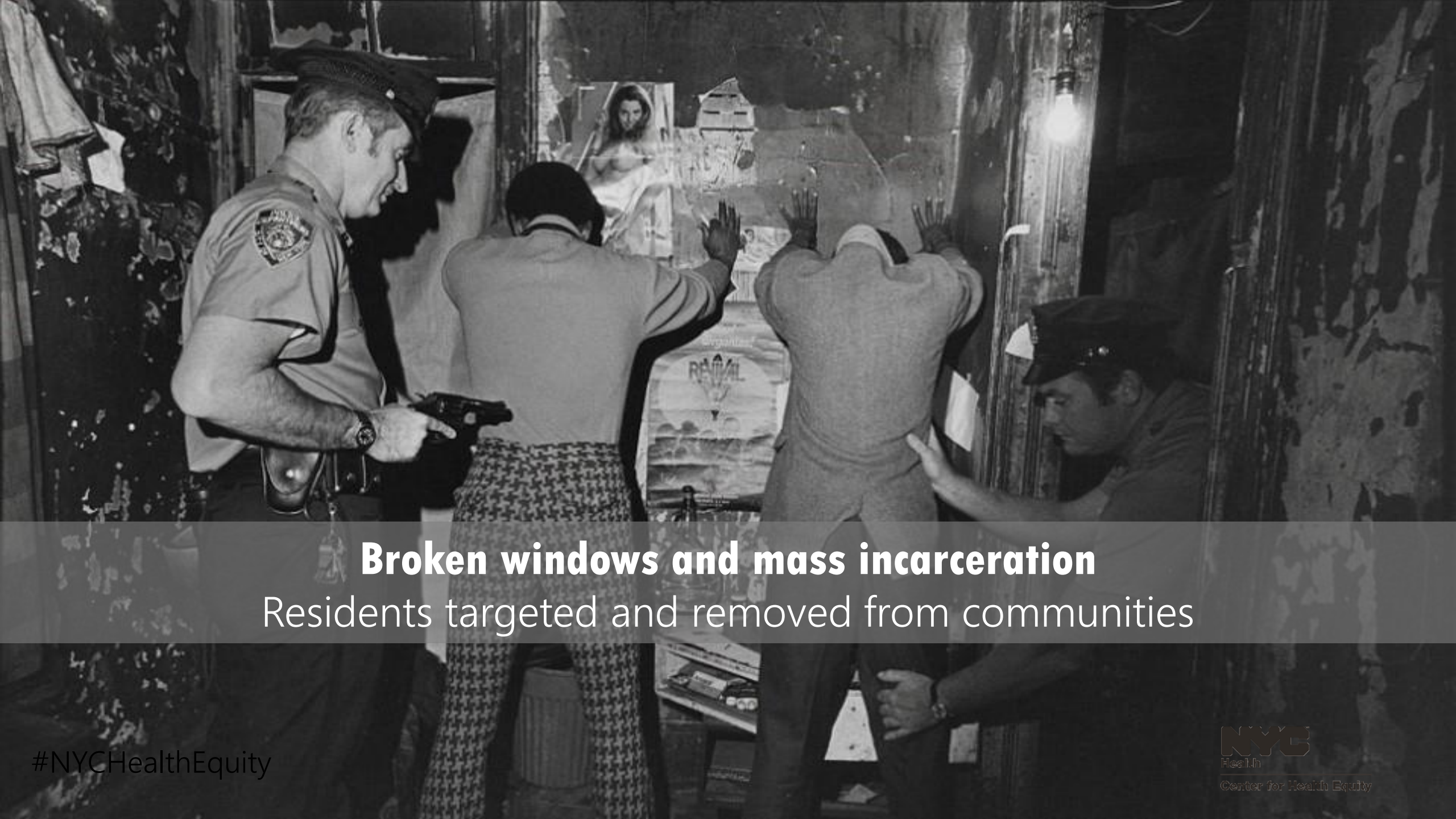

Broken windows and mass incarceration

Residents targeted and removed from communities

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Criminalization of Immigrants

Residents targeted and removed from communities

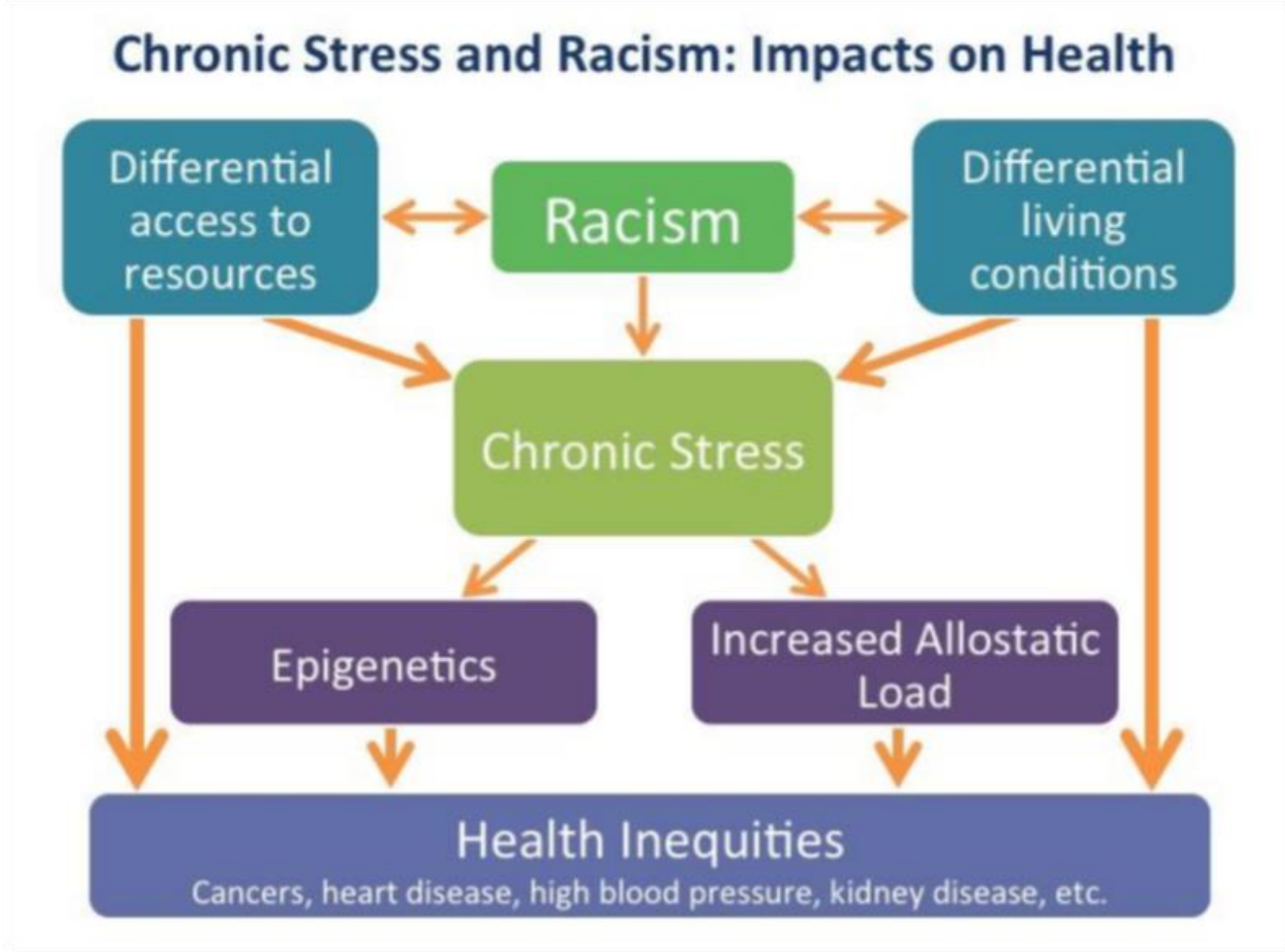
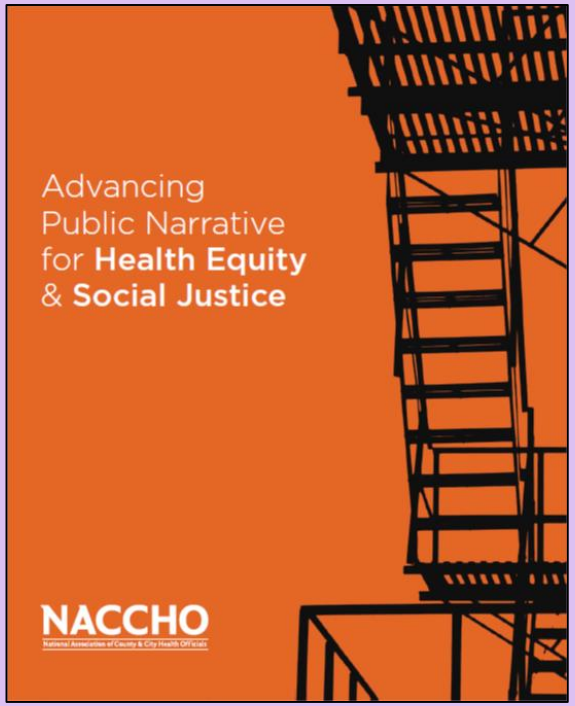


Image Source: California Department of Public Health

Kevin McKinney, MD
Member since 1989

Centering Equity in Public Health



Dominant narratives, embedded in our institutions and culture, represent voices reinforcing social relations that generate social, political, and economic inequality and racial injustice marginalizing or silencing the voices of social groups with limited power. These narratives shape consciousness, meaning, and explanations of events.

Narrative

Their effect is to **obscure power (and responsibility)**, divide populations with common concerns, enforce compliance, and ensure that opposing visions of society's future do not become reality.

Narrative shapes beliefs and actions …dominant narratives (myths) undermine health equity

- Racial and class inequities are “unfortunate, but not necessarily unjust”
- Self-determining individuals make right or wrong “lifestyle” choices (Rendering political, structural, and social determinants of health inequities invisible)
- Cultures of oppressed and marginalized racial and ethnic groups are responsible for and blamed their own poorer health outcomes (“Othering”)
- Pick ourselves by our bootstraps (meritocracy)
- American exceptionalism
- “If you gain, I lose” (zero-sum game)
- Hierarchy of human value based on skin color (White supremacy)

Power and privilege

“In my class and place, I did not recognize myself as a racist because I was taught to see racism only in individual acts of meanness by members of my group, never in invisible systems conferring unsought racial dominance on my group from birth.”

"For me, white privilege has turned out to be an elusive and fugitive subject. The pressure to avoid it is great, for in facing it I must give up the myth of meritocracy. If these things are true, this is not such a free country; one's life is not what one makes it; many doors open for certain people through no virtues of their own."

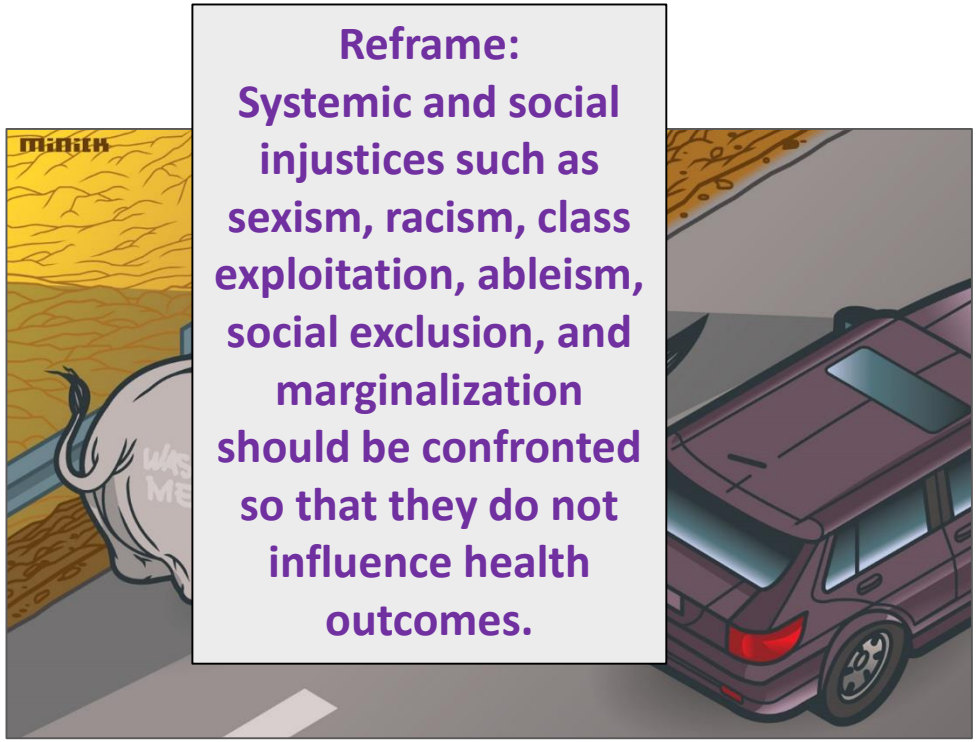
Peggy McIntosh, 1988
White Privilege:
Unpacking the Invisible Knapsack

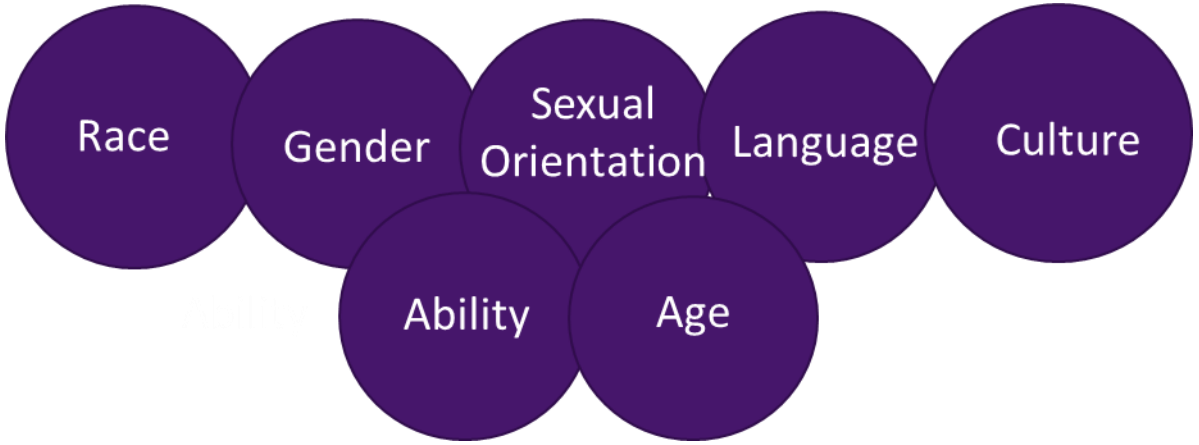
Bias and blindspots

“All of us, despite the best of all possible intentions, are affected by unconscious processes. It affects what we see, how we react, how we feel, how we behave. If we’re not aware of it and taking measures to counter it, it affects quality of care.”

- Michelle van Ryn, Ph.D.

Director of Mayo’s Research Program on Equity and Inclusion in Health Care





THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.

Source (2020): https://phnci.org/national-frameworks/10-ephs

Taskforce

Public Health Accreditation Board (PHAB) & The Public Health National Innovation Center (PHNCI)

Funded by the DeBeaumont Foundation

American Medical Association
American Public Health Assoc.
Centers for Disease Control & Prevention
HHS
Trust for America's Health
Robert Wood Johnson Foundation
WK Kellogg Foundation
ASTHO
NACCHO
Big Cities Health Coalition
Bloomberg American Health Initiative
Michigan & Philadelphia Depts of Health
Assoc of Public Health Nurses
Time's Up Healthcare

Anti-Racism Work at the Institutional Level - Emerging Practice

Siobhan Wescott, MD
Member since 2013

Center for Health Equity

Vision: A nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, and everyone has the power to achieve optimal health; and all physicians are equipped with the consciousness, tools, and resources to confront and dismantle injustices as well as embed and advance equity within and across all aspects of the healthcare system.

Mission: Strengthen, amplify, and sustain the AMA's work to eliminate health inequities – improving health outcomes and closing disparities gaps – which are rooted in historical and contemporary oppressive systems of power and structural injustices, such as racism, exclusion, and discrimination.

- **Embed equity** in practice, process, action, innovation and organizational performance and outcomes
- **Build alliances and share power** via meaningful engagement
- **Ensure equitable** opportunities and conditions in **innovation** for marginalized and minoritized people and communities
- **Push upstream** to address all determinants of health
- **Create pathways** for truth, **reconciliation**, racial healing, and transformation

No set of commitments to anti-racism can begin without an honest assessment of an institution's own history and present practices.

- In the early years following the Civil War, the AMA declined to embrace a policy of nondiscrimination and excluded an integrated local medical society through selective enforcement of membership standards;

- From the 1870s through the late 1960s, the AMA failed to take action against AMA affiliated state and local medical associations that openly practiced racial exclusion in their memberships—practices that functionally excluded most Black physicians from membership in the AMA, in turn excluded Black physicians from receiving hospital privileges;

- In the early decades of the 20th century, the AMA listed Black physicians as "colored" in its national physician directory and was slow to remove the designation in response to protests from the National Medical Association (NMA);

- The Flexner Report of 1910, commissioned by the AMA's Council of Medical Education along with other Foundation partners, contributed to the closure of five of the seven Black Medical Schools and all three women medical schools.

- The AMA was silent in debates over the Civil Rights Act of 1964 and put off repeated NMA requests to support efforts to amend the Hill-Burton Act's "separate but equal" provision, which allowed construction of segregated hospital facilities with federal funds.

AMA's Apology

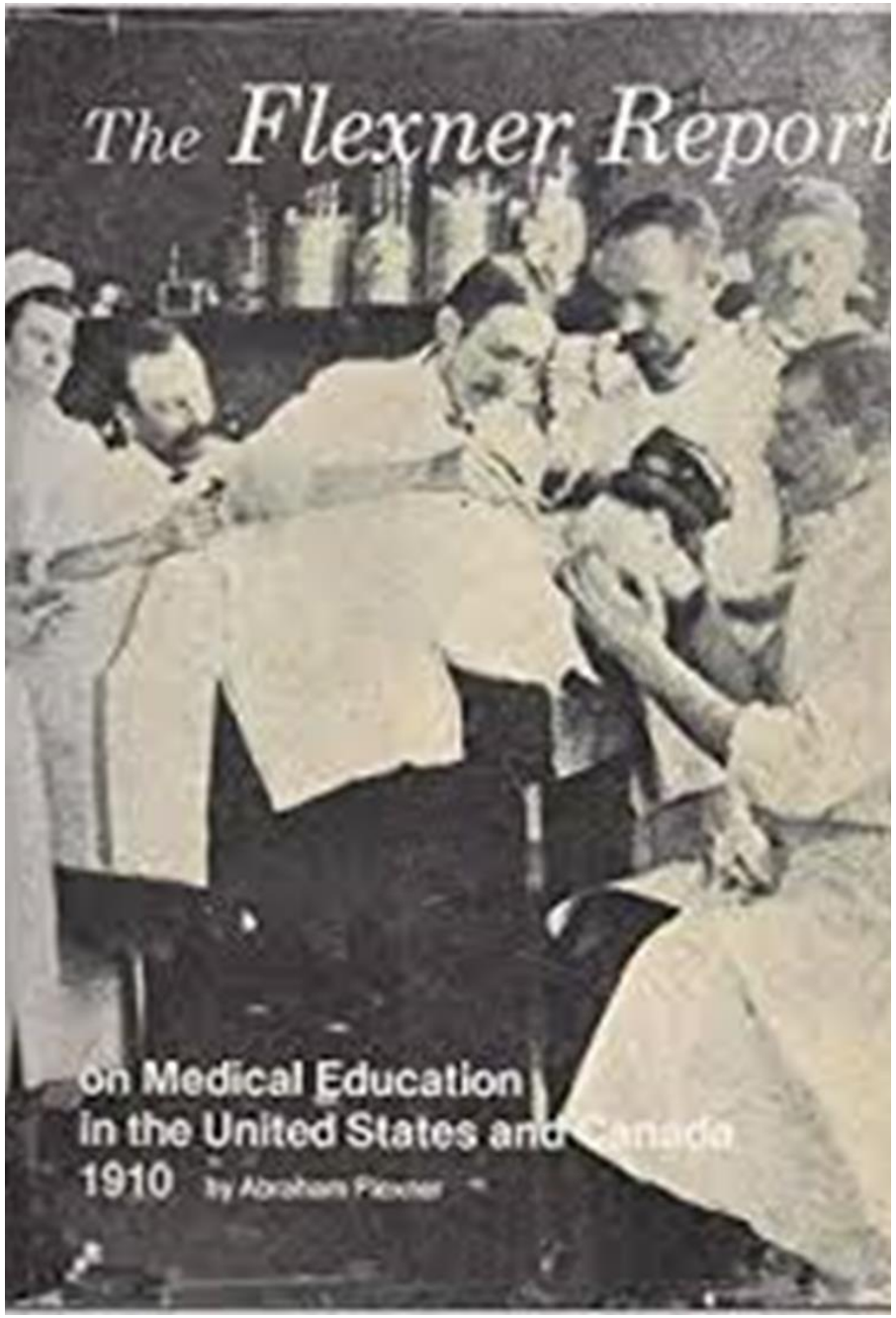
"….on behalf of the American Medical Association, I unequivocally apologize for our past behavior. We pledge to do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients.

So yes, this history is still being written.

It noted that, "The [AMA's] expression of regret is the culmination of rigorous introspection. … There are those who say that apologies can't change the past, and they have a point. The hope is that they will change the future." We recognize that our apology is a modest first step toward healing and reconciliation. Just as Churchill said in 1942 after the "Battle of Egypt,"

This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."

Ronald M. Davis, MD, AMA Immediate Past President @ National Medical Association (NMA) Annual Meeting, Atlanta, Georgia, July 30, 2008



JAMA Network | Open

Original Investigation | Medical Education

Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools

Kendall M. Campbell, MD; Irma Corral, PhD, MPH; Jhojana L. Infante Linares, MS; Dmitry Tumin, PhD

Abstract

IMPORTANCE There continue to be low numbers of underrepresented minorities, including African Americans, in academic medicine. Historically Black medical colleges and universities are major sources of training for medical school graduates who are African American or who belong to other underrepresented minority groups. Several historically Black medical schools were closed during the period surrounding the 1910 Flexner report. The implications of these school closures with regard to the number of African American medical school graduates have not been fully examined.

Key Points

Question What are the pro
estimates of the number of
American students who wo
graduated from historically
medical schools that were
the period surrounding the
of the 1910 Flexner report?

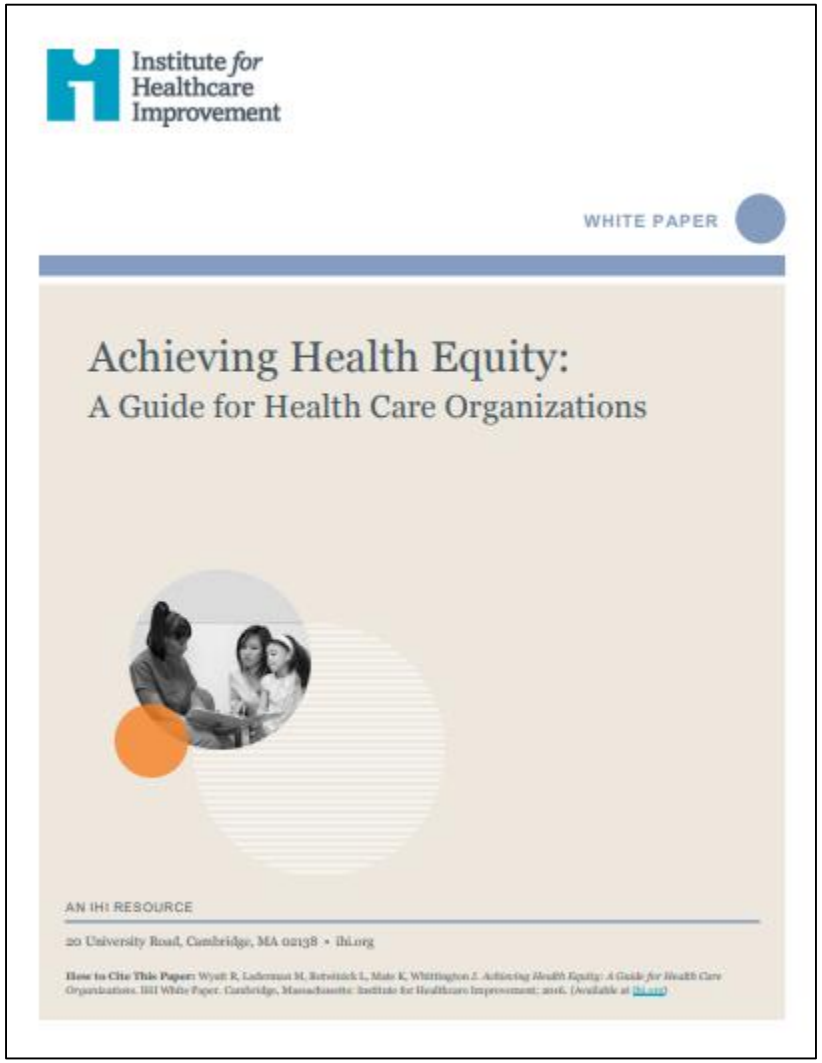
“We will be really misled if we think we can change society without changing ourselves.”

Alice Walker

2018 National Women’s Studies Association

Internal change work

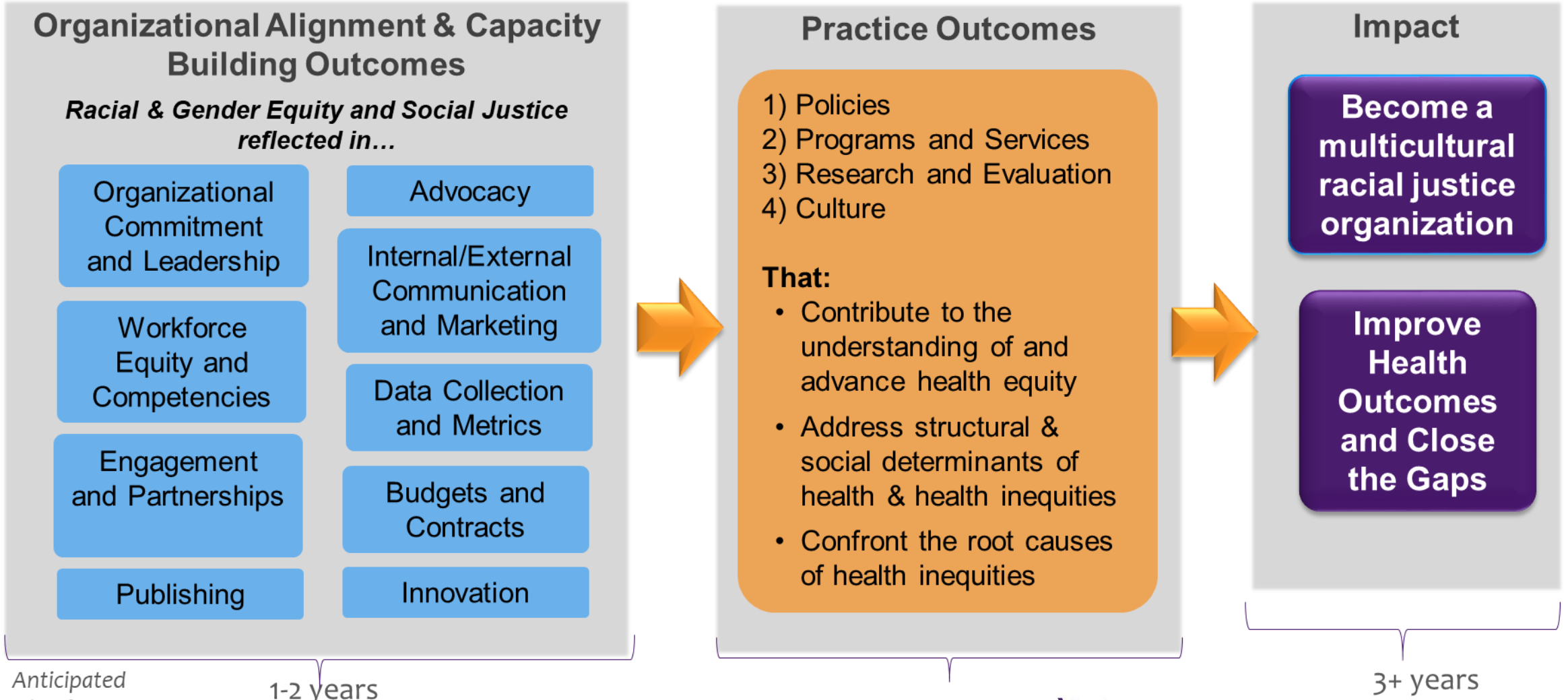
LOCAL AND REGIONAL
GOVERNMENT ALLIANCE ON
RACE & EQUITY



Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

Theory of Change

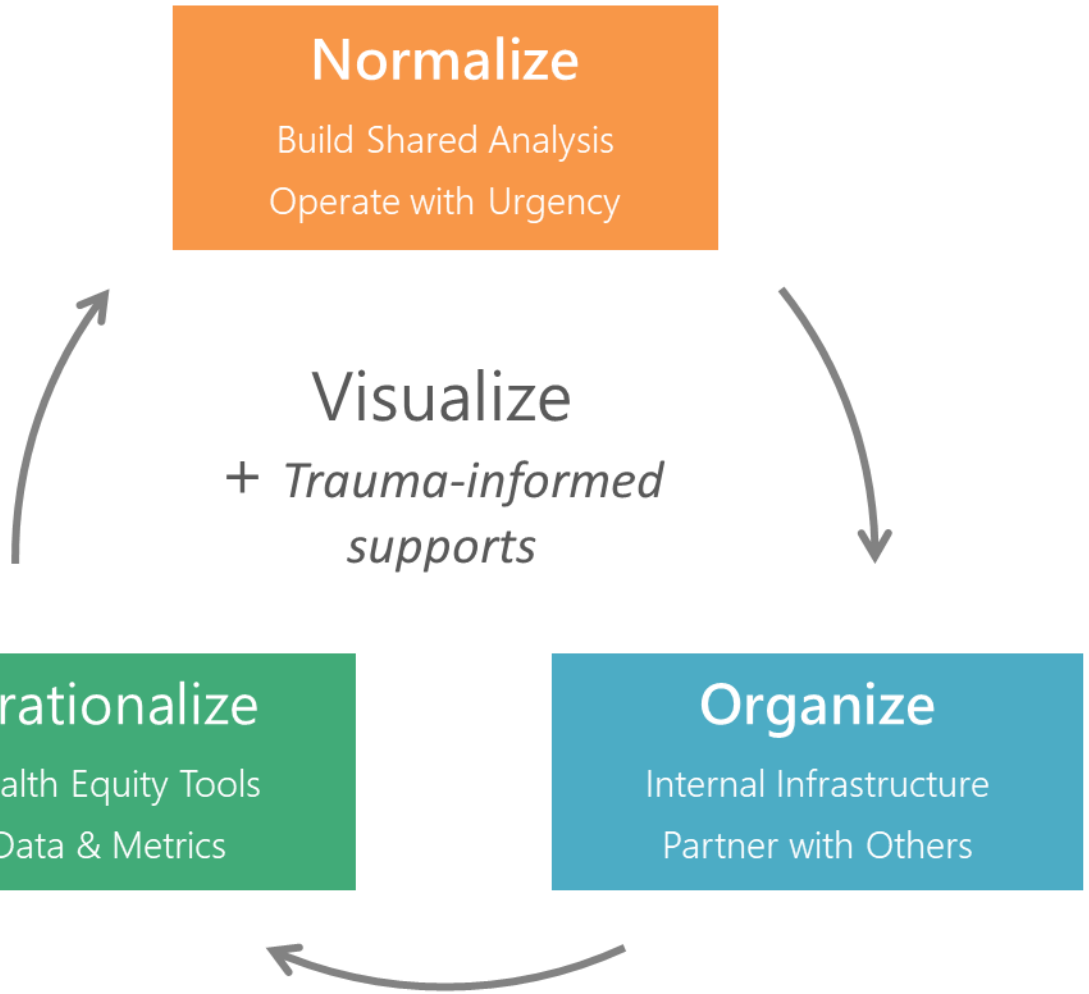
Build Organizational Capacity to Reduce Inequities and Advance Structural & Cultural Change



Transform (Impact Model) Inside - Outside Strategy

Changing practice and culture within our institution

National Best Practice
From RaceForward and Government Alliance on Race and Equity (GARE)



"As part of AMA's health equity journey, I encourage all staff to take full advantage of these training opportunities over the coming years. I ask that supervisors consider the importance of this training to the overarching goals of the AMA and support representation of their BU at the scheduled trainings.

The health equity imperative is integral to the success of all of AMA's work and requires commitment. The greatest demonstration of this commitment is our active participation as leadership."

– Jim Madara, October 2019

Organize Accountability & Inclusion Infrastructure

What's new in 2020?

Note two important changes related to the AMA's Health Equity priorities that apply to all employees:

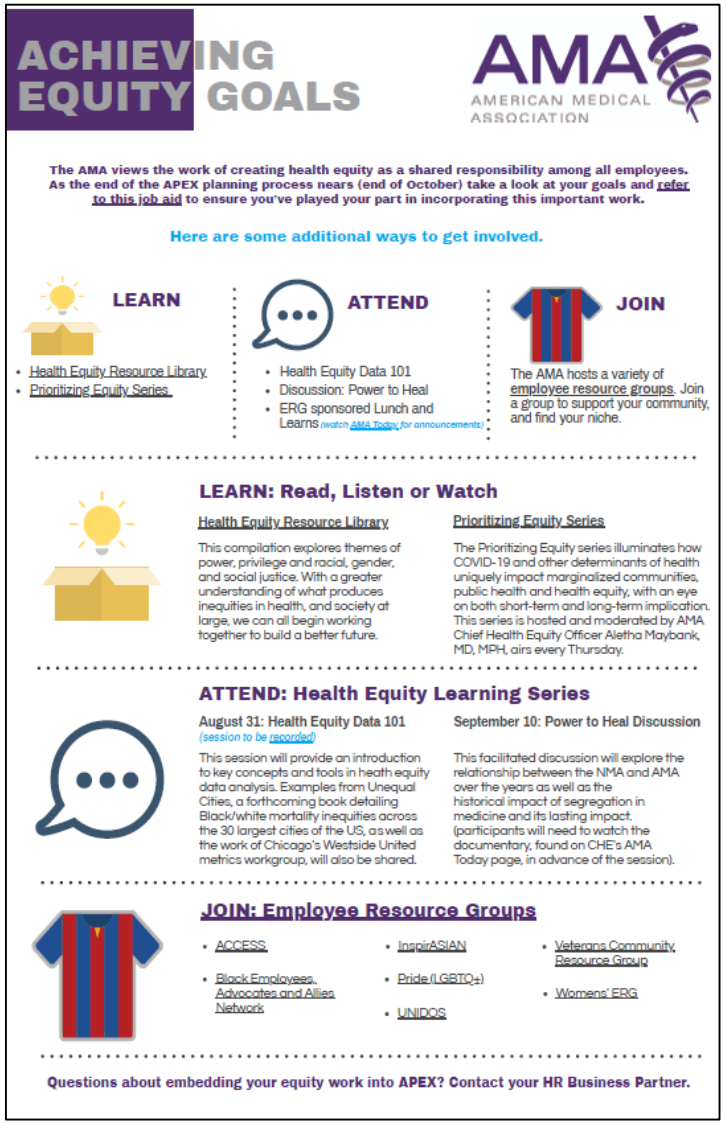
- All employees need to include Health Equity work in their objectives and standards
- The performance factors included on everyone's APEX form now include specific behaviors supporting Health Equity efforts.

Those working directly on equity efforts:

- Health Equity workgroup members, Action Team leaders and members who plan, develop, and implement these activities should write these roles into their APEX objectives and standards for the time served in these roles.
- It's recommended that this goal be weighted at 10% for the time period served (objectives and standards can be updated to reflect a change in roles later if needed.)

All other AMA employees:

- Include a goal in your objectives and standards to support participation in, and integration of, cross-enterprise equity efforts.
- It's recommended that this goal be weighted at 5% and use language such as: *"Advancing Health, Racial, Gender, and Social Equities – participates in health equity related trainings offered to staff; participates, as opportunities are available, in health, racial, gender, and social justice/equity related meetings, trainings, and activities in their Business unit and/or the enterprise."*



ACHIEVING EQUITY GOALS

AMA AMERICAN MEDICAL ASSOCIATION

The AMA views the work of creating health equity as a shared responsibility among all employees. As the end of the APEX planning process nears (end of October) take a look at your goals and refer to this job aid to ensure you've played your part in incorporating this important work.

Here are some additional ways to get involved.

LEARN
- Health Equity Resource Library
- Prioritizing Equity Series

ATTEND
- Health Equity Data 101
- Discussion: Power to Heal
- ERG sponsored Lunch and Learns *(watch AMA Today for announcements)*

JOIN

The AMA hosts a variety of employee resource groups. Join a group to support your community, and find your niche.

LEARN: Read, Listen or Watch

Health Equity Resource Library

This compilation explores themes of power, privilege and racial, gender, and social justice. With a greater understanding of what produces inequities in health, and society at large, we can all begin working together to build a better future.

Prioritizing Equity Series

The Prioritizing Equity series illuminates how COVID-19 and other determinants of health uniquely impact marginalized communities, public health and health equity, with an eye on both short-term and long-term implication. This series is hosted and moderated by AMA Chief Health Equity Officer Aletha Maybank, MD, MPH, airs every Thursday.

ATTEND: Health Equity Learning Series

August 31: Health Equity Data 101 *(session to be recorded)*

This session will provide an introduction to key concepts and tools in heath equity data analysis. Examples from Unequal Cities, a forthcoming book detailing Black/white mortality inequities across the 30 largest cities of the US, as well as the work of Chicago's Westside United metrics workgroup, will also be shared.

September 10: Power to Heal Discussion

This facilitated discussion will explore the relationship between the NMA and AMA over the years as well as the historical impact of segregation in medicine and its lasting impact. (participants will need to watch the documentary, found on CHE's AMA Today page, in advance of the session).

JOIN: Employee Resource Groups

- ACCESS
- Black Employees, Advocates and Allies Network
- InspirASIAN
- Pride (LGBTQ+)
- UNIDOS
- Veterans Community Resource Group
- Womens' ERG

Questions about embedding your equity work into APEX? Contact your HR Business Partner.

Operationalize

How do we ensure our efforts and innovation do not discriminate, exacerbate inequities, or deny care?

What's the data? What does the data tell us? What data are missing?

How have communities (physicians, patients, etc.) been engaged?
Are there opportunities to expand engagement?

Who benefits from or will be burdened by your proposal?
What are your strategies for advancing equity or mitigating unintended consequences?

Who holds the decision-making power and privilege?
Are there opportunities to share/shift power?

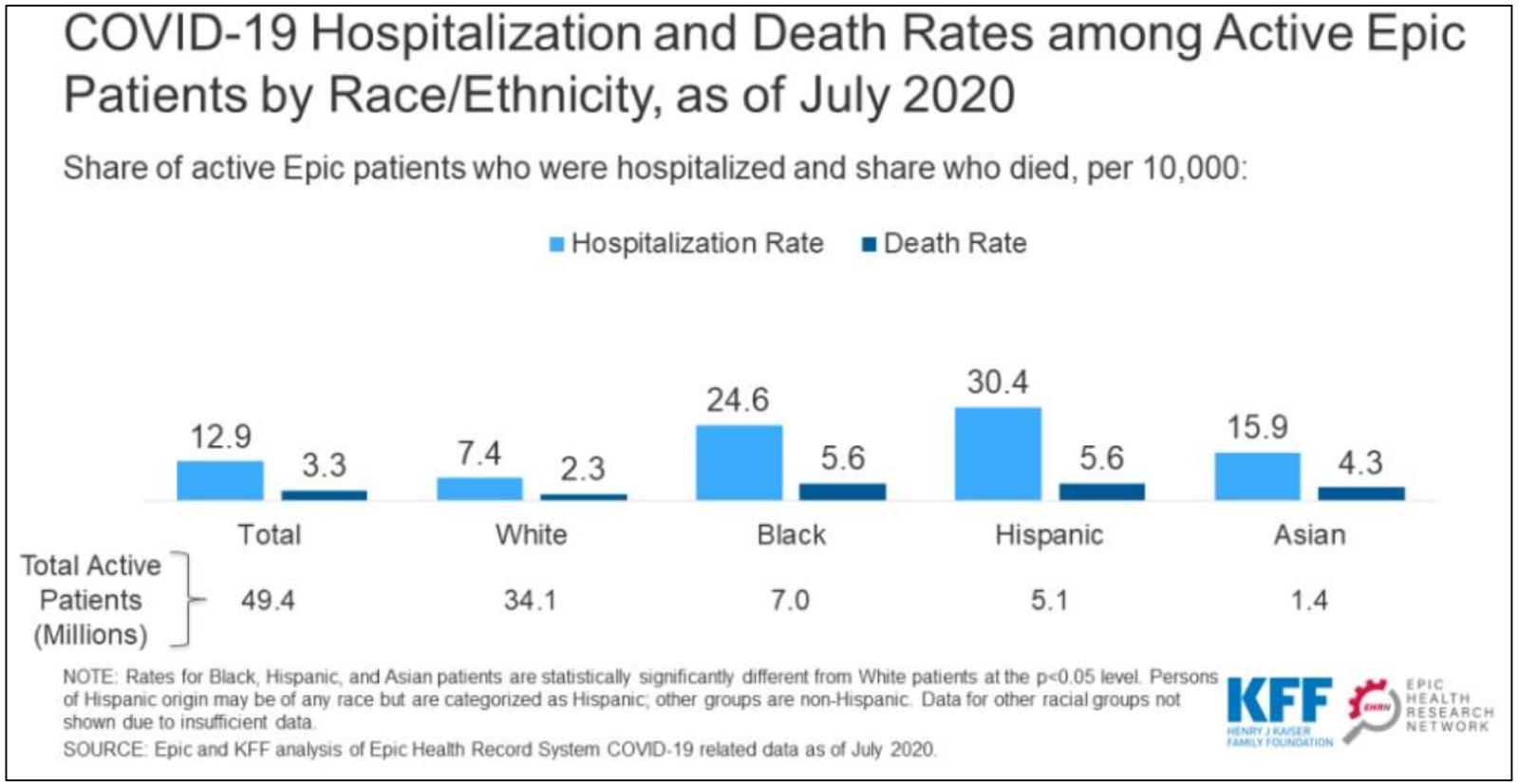
How will you ensure accountability to communicate, and evaluate results?

Adapted from the Racial Equity Toolkit: An Opportunity to Operationalize Equity – Gov't Alliance on Race and Equity

Operationalizing Equity during COVID-19

Lase Ajayi, MD
Member since 2013

Blacks, Latinx, and Native Americans are more likely to have and die from ‘underlying conditions’



Higher rates of

- Diabetes
- Obesity
- Hypertension
- Heart Disease

…and at younger ages

Not a sufficient enough explanation…

COVID-19 mortality data in Chicago show stark inequities by community

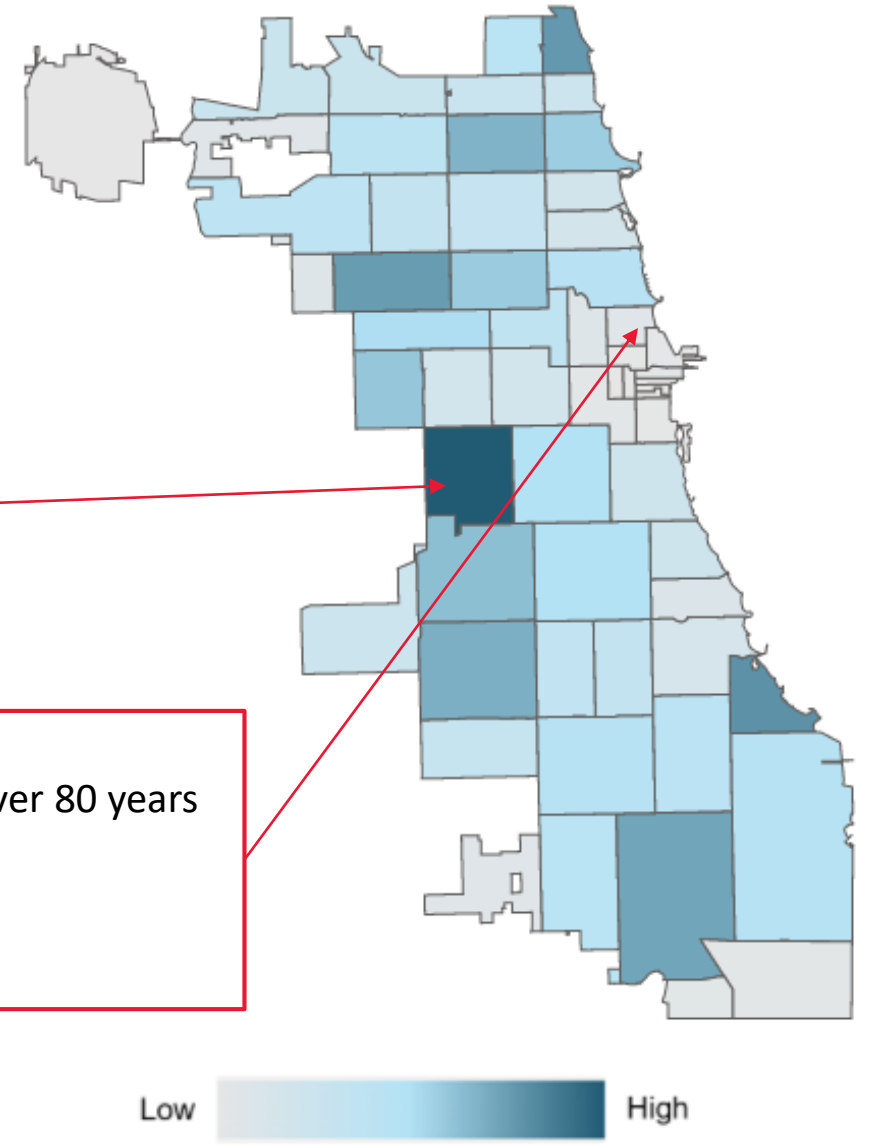
mirroring long-standing structural drivers that manifest in inequities in life expectancy and other epidemiological indicators

ZIP code 60623: Brighton Park, South Lawndale, North Lawndale
More than 95% BIPOC. Life expectancy lowest in N. Lawdale, at 68 years

9.4% positivity for COVID-19
154 deaths, or **1 in 558 residents**

ZIP code 60610: Lincoln Park, Near North Side, Loop, West Town
Less than 35% BIPOC. Life expectancy is among highest in the city, over 80 years

3.6% positivity for COVID-19
10 deaths, or **1 in 3,902 residents**



Source: City of Chicago

bostonglobe.com/2020/05/09/nation/disparities-push-coronavirus-death-rates-higher/

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A new analysis: Coronavirus death rate surged in Massachusetts locations that already faced challenges

Harvard analysis finds mortality rate surged higher in communities with more poverty, people of color, and crowded housing.

By Andrew Ryan and Kay Lazar Globe Staff, Updated May 9, 2020, 3:53 p.m.

133

The work of Nancy Krieger et al has shown that in Massachusetts, the surge in excess death was evident starting in early April, and was greater in city/towns and ZIP codes with:

- higher poverty,
- higher household crowding,
- higher percentage of populations of color, and
- higher racialized economic segregation.

JAMA Network Open

Research Letter | Health Policy

Assessment of Community-Level Disparities in Coronavirus Disease 2019 (COVID-19) Infections and Deaths in Large US Metropolitan Areas

Samrachana Adhikari, PhD; Nicholas P. Pantaleo, MPH; Justin M. Feldman, ScD; Olugbenga Ogedegbe, MD; Lorna Thorpe, PhD; Andrea B. Troxel, ScD

Introduction

Urban counties in large metropolitan areas in the United States are among the most affected by the coronavirus disease 2019 (COVID-19) pandemic, with high proportions of confirmed infection among those who have been tested.[1] While there is growing evidence of disparities by race/ethnicity across neighborhoods,[2,3] the extent to which neighborhood poverty is associated with infection and deaths is not clear. In this cross-sectional study, we examined the association of neighborhood race/ethnicity and poverty with COVID-19 infections and related deaths in urban US counties, hypothesizing disproportionate burdens in counties with a larger percentage of the population belonging to minority racial/ethnic groups and a higher rate of poverty. This study is among the first to investigate such associations in US metropolitan areas.

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

- Areas with high populations of marginalized and minoritized populations that have historically been disinvested in were the hardest hit by the virus early in the pandemic.
- Racial inequities **did not disappear** among higher-income communities, where there was still a **3-fold difference** between predominantly white and predominantly non-white communities.
- Racial inequities are not explained away by income differences

Black people are not to blame for COVID-19.
Black people are not a risk factor.
“Race is not a risk factor…Racism is.” @DrJoiaCrearPerry

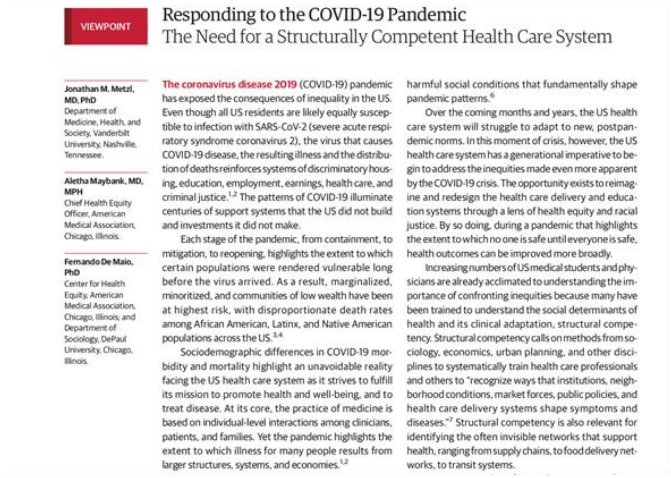
MEMO: RACISM IS A PUBLIC HEALTH CRISIS. HERE'S HOW TO RESPOND.

September 3, 2020

By **Ruqaiijah Yearby** *Professor of Law and Executive Director, Institute for Healing Justice and Equity, Saint Louis University* , **Crystal N. Lewis** *Health Equity and Policy Fellow, Institute for Healing Justice and Equity, Saint Louis University*, **Keon L. Gilbert** *Associate Professor of Behavioral Science and Health Education and Co-Director, Institute for Healing Justice and Equity, Saint Louis University*, and **Kira Banks** *Associate Professor of Psychology and Co-Director, Institute for Healing Justice and Equity, Saint Louis University*

Being explicit

JAMA Article



VIEWPOINT

Responding to the COVID-19 Pandemic
The Need for a Structurally Competent Health Care System

Jonathan M. Metzl, MD, PhD
Department of Medicine, Health, and Society, Vanderbilt University, Nashville, Tennessee.

Aletha Maybank, MD, MPH
Chief Health Equity Officer, American Medical Association, Chicago, Illinois.

Fernando De Maio, PhD
Center for Health Equity, American Medical Association, Chicago, Illinois; and Department of Sociology, DePaul University, Chicago, Illinois.

The coronavirus disease 2019 (COVID-19) pandemic has exposed the consequences of inequality in the US. Even though all US residents are likely equally susceptible to infection with SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), the virus that causes COVID-19 disease, the resulting illness and the distribution of deaths reinforces systems of discriminatory housing, education, employment, earnings, health care, and criminal justice.[1,2] The patterns of COVID-19 illuminate centuries of support systems that the US did not build and investments it did not make.

Each stage of the pandemic, from containment, to mitigation, to reopening, highlights the extent to which certain populations were rendered vulnerable long before the virus arrived. As a result, marginalized, minoritized, and communities of low wealth have been at highest risk, with disproportionate death rates among African American, Latinx, and Native American populations across the US.[3,4]

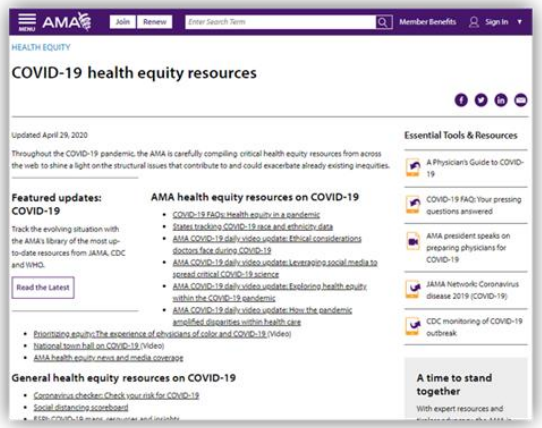
Sociodemographic differences in COVID-19 morbidity and mortality highlight an unavoidable reality facing the US health care system as it strives to fulfill its mission to promote health and well-being, and to treat disease. At its core, the practice of medicine is based on individual-level interactions among clinicians, patients, and families. Yet the pandemic highlights the extent to which illness for many people results from larger structures, systems, and economies.[1,2] harmful social conditions that fundamentally shape pandemic patterns.[5]

Over the coming months and years, the US health care system will struggle to adapt to new, postpandemic norms. In this moment of crisis, however, the US health care system has a generational imperative to begin to address the inequities made even more apparent by the COVID-19 crisis. The opportunity exists to reimagine and redesign the health care delivery and education systems through a lens of health equity and racial justice. By so doing, during a pandemic that highlights the extent to which no one is safe until everyone is safe, health outcomes can be improved more broadly.

Increasing numbers of US medical students and physicians are already acclimated to understanding the importance of confronting inequities because many have been trained to understand the social determinants of health and its clinical adaptation, structural competency. Structural competency calls on methods from sociology, economics, urban planning, and other disciplines to systematically train health care professionals and others to "recognize ways that institutions, neighborhood conditions, market forces, public policies, and health care delivery systems shape symptoms and diseases."[7] Structural competency is also relevant for identifying the often invisible networks that support health, ranging from supply chains, to food delivery networks, to transit systems.

NYT Op-ed

COVID-19 Health Equity Resource Center



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HEALTH EQUITY

COVID-19 health equity resources

Updated April 29, 2020

Throughout the COVID-19 pandemic, the AMA is carefully compiling critical health equity resources from across the web to shine a light on the structural issues that contribute to and could exacerbate already existing inequities.

Featured updates: COVID-19

Track the evolving situation with the AMA's library of the most up-to-date resources from JAMA, CDC and WHO.

Read the Latest

AMA health equity resources on COVID-19

- COVID-19 FAQs: Health equity in a pandemic
- States tracking COVID-19 race and ethnicity data
- AMA COVID-19 daily video update: Ethical considerations doctors face during COVID-19
- AMA COVID-19 daily video update: Leveraging social media to spread critical COVID-19 science
- AMA COVID-19 daily video update: Exploring health equity within the COVID-19 pandemic
- AMA COVID-19 daily video update: How the pandemic amplified disparities within health care
- Prioritizing equity: The experience of physicians of color and COVID-19 (Video)
- National town hall on COVID-19 (Video)
- AMA health equity news and media coverage

General health equity resources on COVID-19

- Coronavirus checker: Check your risk for COVID-19
- Social distancing scoreboard

Essential Tools & Resources

- A Physician's Guide to COVID-19
- COVID-19 FAQ: Your pressing questions answered
- AMA president speaks on preparing physicians for COVID-19
- JAMA Network: Coronavirus disease 2019 (COVID-19)
- CDC monitoring of COVID-19 outbreak

A time to stand together

With expert resources and

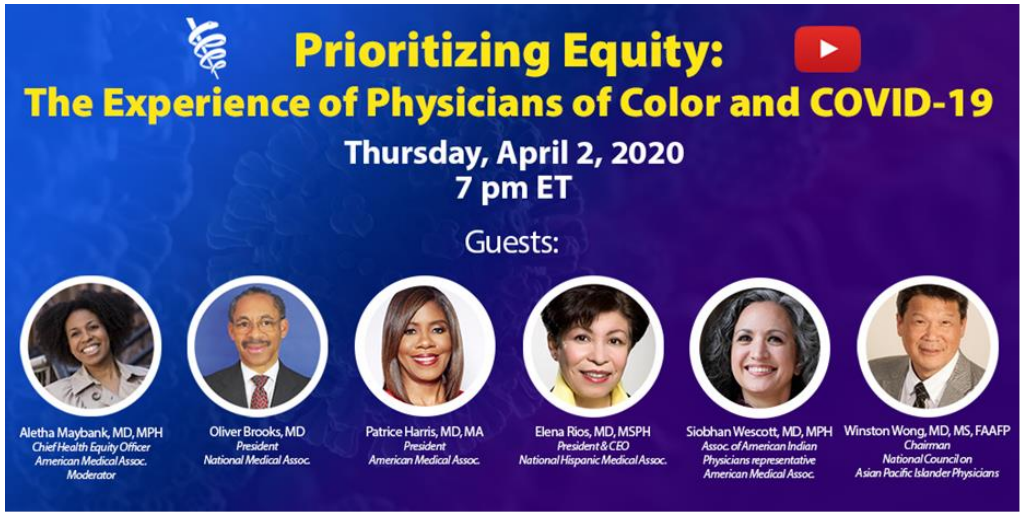
Oprah COVID –19 Series

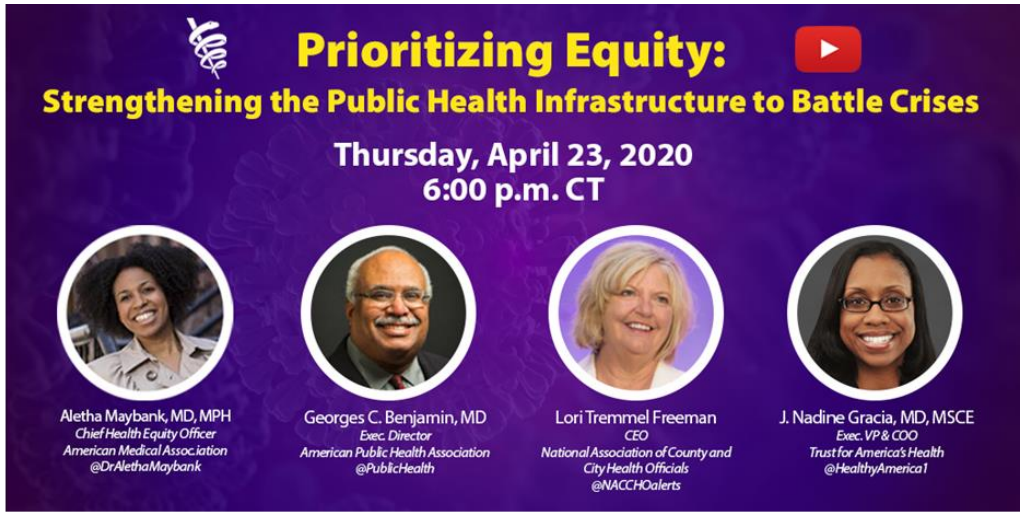
Dr. Aletha Maybank @DrAlethaMaybank · Apr 14
Thank for gift & opportunity @Oprah to elevate racism in health. Thank you for shining light to make injustice visible. #COVID19

Oprah Winfrey @Oprah · Apr 14
.@DrAlethaMaybank founded the first center for health equity for the @AmerMedicalAssn. She seeks to provide underserved populations across the country with resources & access to quality healthcare. Thank you for your work #OprahTalks #COVID19

Show this thread

Centering voices most marginalized





Levering existing neighborhood assets and power

West Side United (WSU) is a collaborative effort of people and organizations who work, live and congregate on Chicago's West Side to make their neighborhoods stronger, healthier and more vibrant places to live. It is comprised of health care institutions, residents, civic leaders, community-based organizations, businesses, and faith-based institutions. To reduce the life expectancy gap between the Loop and Westside neighborhoods by 50% by 2030.

CDFI	Primary Focus
Accion	Small business development
LISC	Based on local "Quality of life plans" – affordable housing, community facilities, retail
Chicago Community Loan Fund (CCLF)	Affordable housing, community facilities, retail, capital and equipment, nonprofits
IFF	Large investments in below-market rate mortgages for nonprofit facilities or affordable housing projects.

Racial Equity Rapid Response

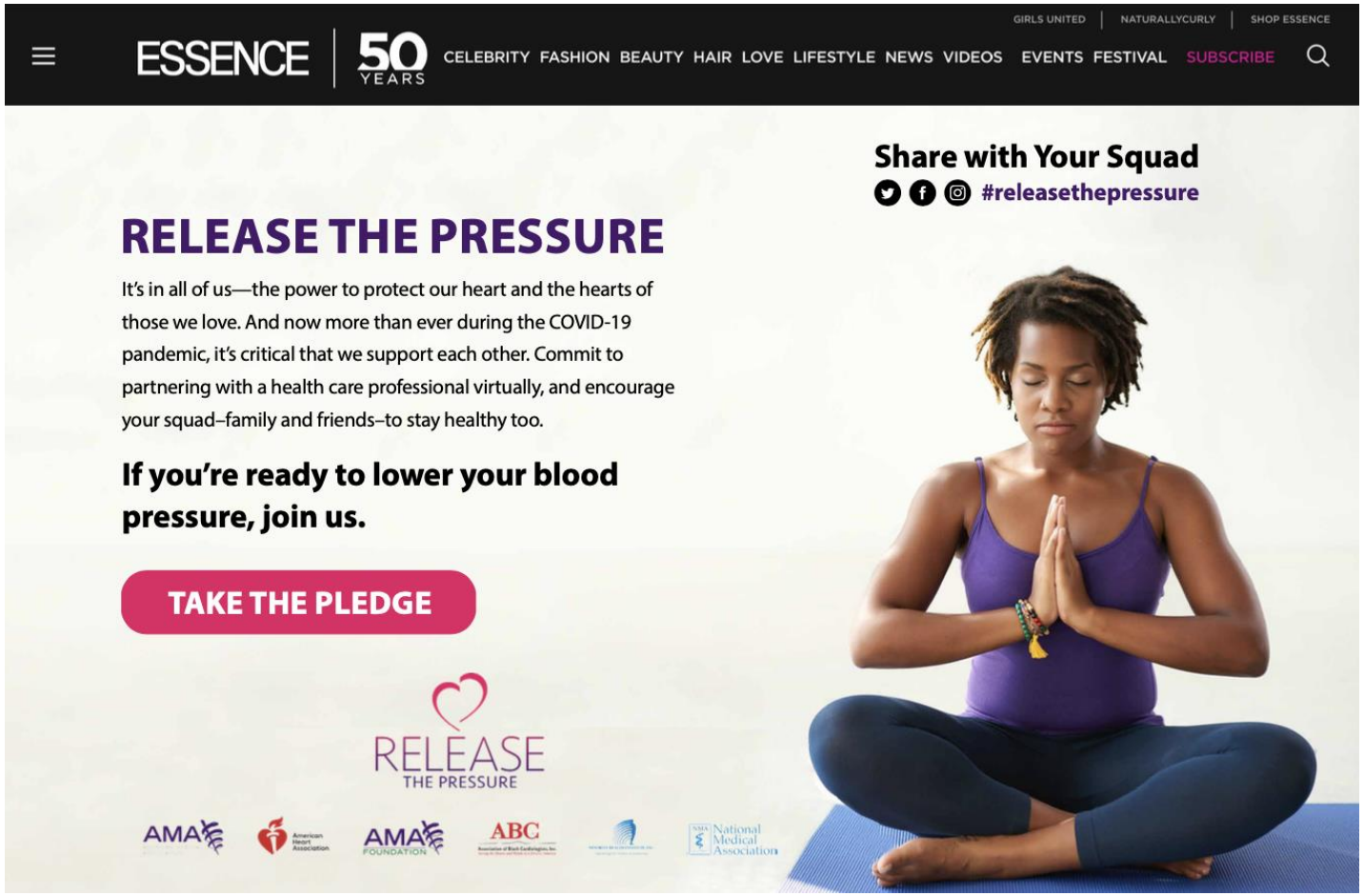
GOALS:

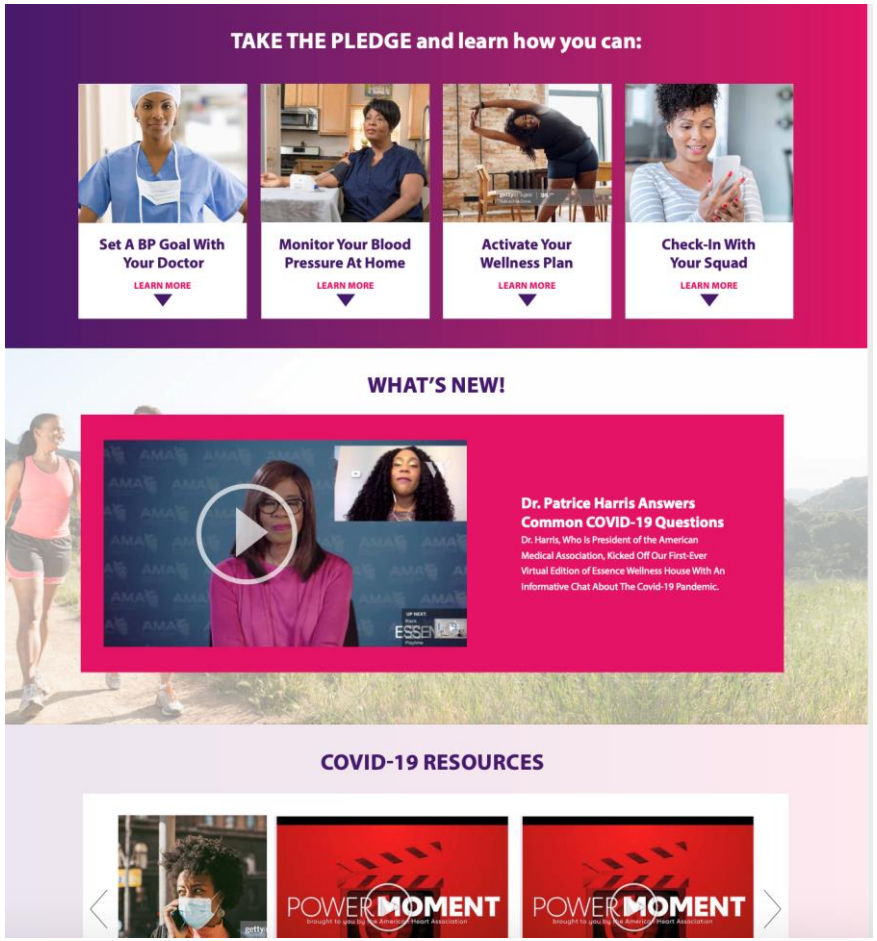
- **Flatten the COVID-19 mortality curve** in Black and Brown communities in Chicago
- **Build a groundwork for future work to address longstanding and systemic inequities** in Black and Brown communities (health, economic, and social)

TACTICS:

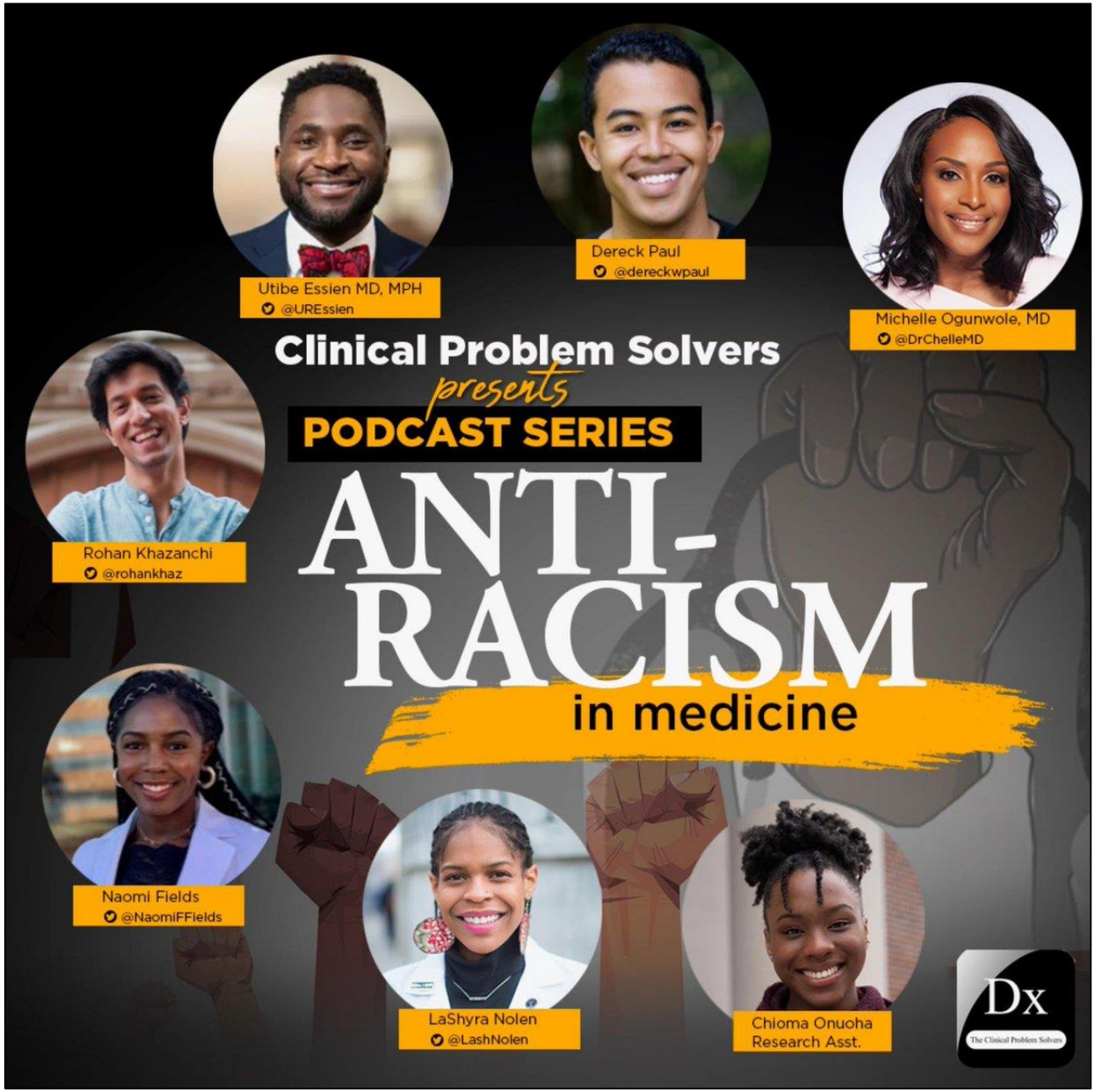
- **Develop a city-wide community mitigation operation** that works hyper-locally in partnership with Black and Brown community organizers and leadership to mitigate CoVID-19 illness and death
- **Listen and respond to community-identified needs** within the context of partnership that is mutual and centered around benefitting, not burdening, Black and Brown communities
- **Marshal data, screening tools, testing, and human resources** needed to respond to community-identified barriers and needs

Partnering with trusted entities





More tools for knowledge and skill-building needed (for all health professions)

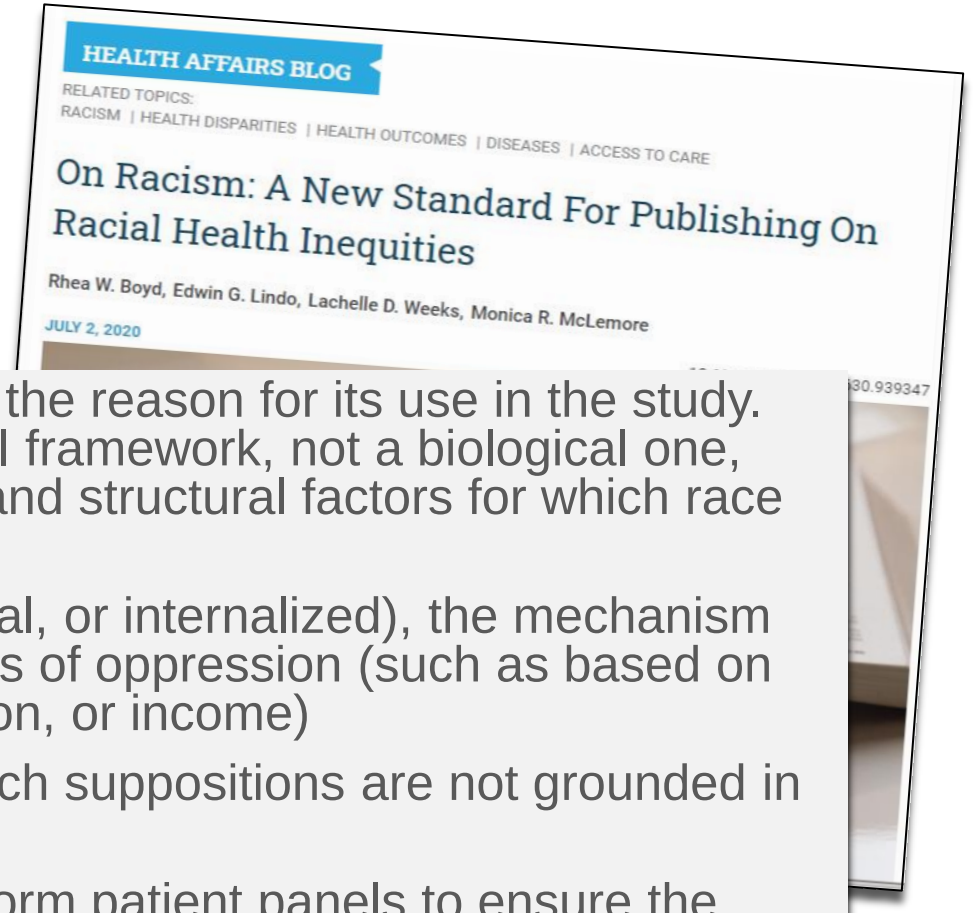


Developing policies

- Health is a human right (“anti-racism is its right bearer”)
- Universal health care
- Diversify the health-care workforce; training inclusive of awareness of racism
- Establish of systems that collect and look at health outcome data by race and ethnicity as well as how racism may be operating (eg, discrimination)
- Equitable access to clinical trails and distribution of vaccine
- Ensure continued access and reimbursement to telehealth options as practices begin to open
- Funding for the public health system infrastructure and health departments
- Investments in rural infrastructure—potable water and plumbing, roads, and Broadband internet access
- Affordable housing, no-cost education, jobs, paid leave

Crear-Perry J, Maybank A. Moving towards anti-racist praxis in medicine. Lancet. 2020 15-21 August; 396(10249): 451–453.

Sharing research
Critical Race Theory & Intersectional Lenses


HEALTH AFFAIRS BLOG

RELATED TOPICS:
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On Racism: A New Standard For Publishing On Racial Health Inequities

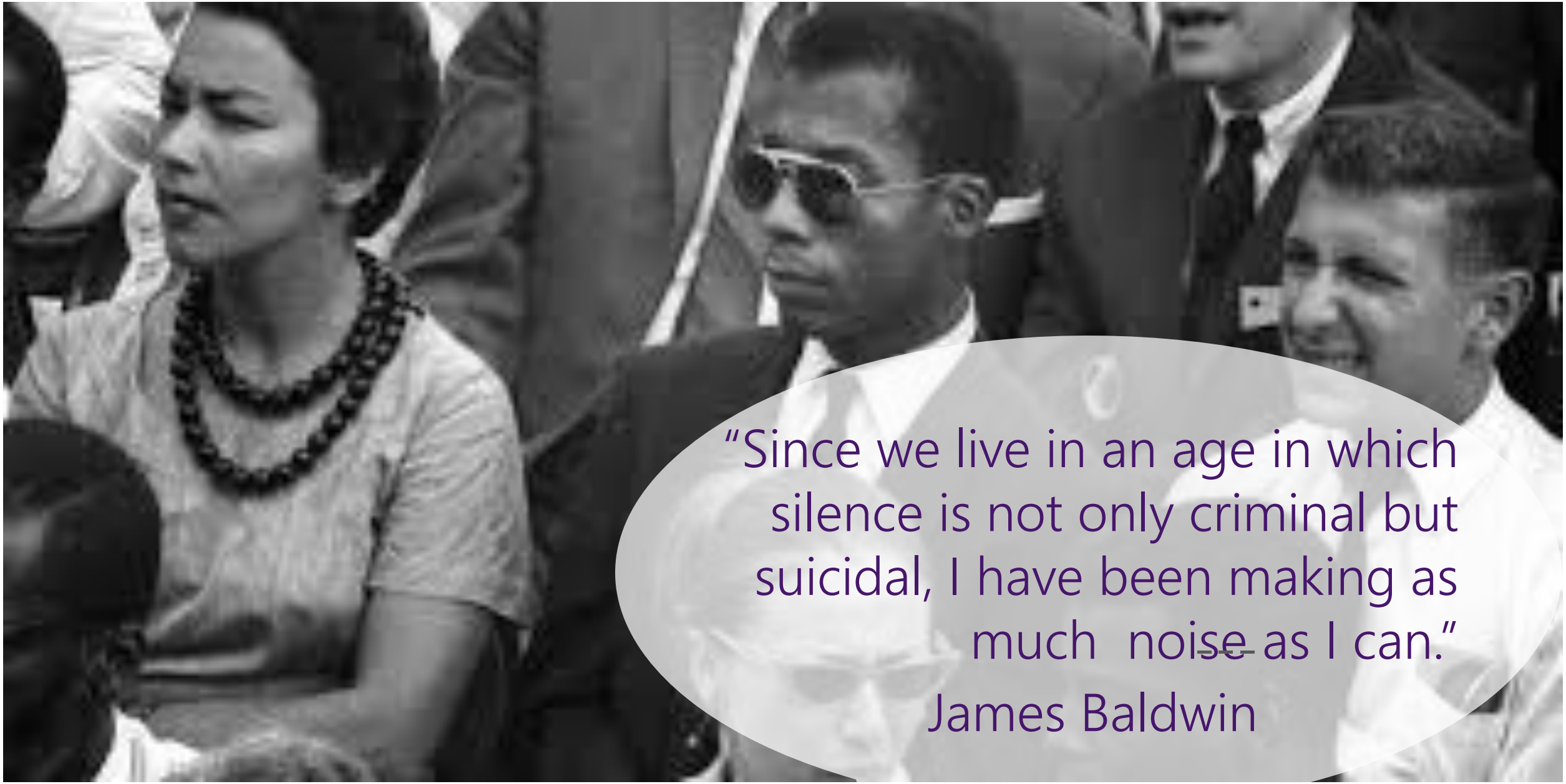
Rhea W. Boyd, Edwin G. Lindo, Lachelle D. Weeks, Monica R. McLemore

JULY 2, 2020

- **Define race** during the experimental design, and specify the reason for its use in the study. Such definitions should be couched within a sociopolitical framework, not a biological one, that explicitly reviews all relevant social, environmental, and structural factors for which race may serve as a proxy measure.
- **Name racism**, identify the form (interpersonal, institutional, or internalized), the mechanism by which it may be operating, and other intersecting forms of oppression (such as based on sex, sexual orientation, age, regionality, nationality, religion, or income)
- **Never offer genetic interpretations** of race because such suppositions are not grounded in science.
- **Solicit patient input**. Use community review boards or form patient panels to ensure the outcomes of research reflect the priorities of the populations studied.
- **Identify the stakes**. “All policy is health policy,” and all research on racial health inequities has implications for broader public policy and clinical practice. Inform readers of these potential applications.
- **Cite the experts**, particularly scholars of color whose work forms the basis of the field’s knowledge on racism and its effects.

"But all our phrasing—race relations, racial chasm, racial justice, racial profiling, white privilege, even white supremacy—serves to obscure that racism is a visceral experience, that it dislodges brains, blocks airways, rips muscle, extracts organs, cracks bones, breaks teeth. You must never look away from this. **You must always remember that the sociology, the history, the economics, the graphs, the charts, the regressions all land, with great violence, upon the body**."

Ta-Nehisi Coates, Between the World and Me



Discussion