METROWEST HEALTH FOUNDATION

Racism and Public Health: A Connection Rooted in Structural Inequities

The health of a community and of individuals who live in that community is often not determined by genetics or even access to high quality medical care. Research has shown that factors leading to premature death can be broken down as follows[1]:

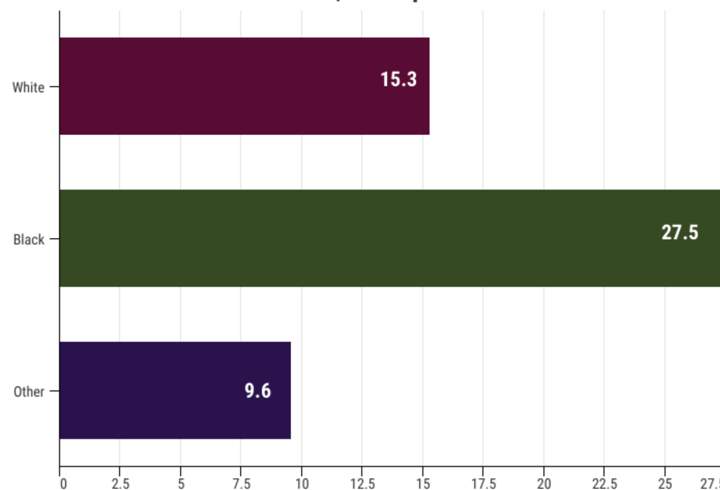
- Healthcare- 10%
- Social and environmental factors – 20%
- Genetics – 30%
- Individual behavior – 40%

These factors are directly influenced by policies, many of which have created structures that advantage some while disadvantaging others. This is where structural inequities and racism intersect with public health. Racism, as defined by Camara Phyllis Jones, Past President of the American Public Health Association, is "a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."

[1] Schroeder, S. (2007). *We can Do Better- Improving the Health of American People.* NEJMA. 357: 1221-8.

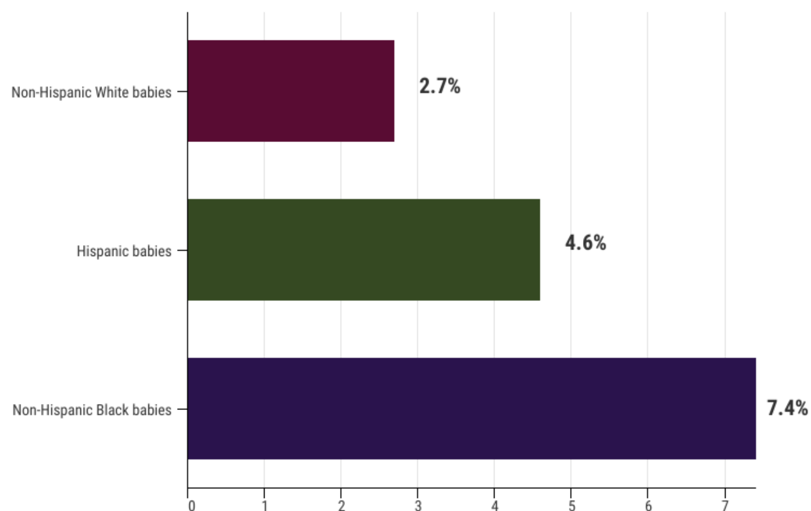
The data is clear- health disparities based on race are all too common in the United States and locally. Eliminating these disparities in health outcomes is a clear call to action and has been for many years. Healthy People 2010, which was published by the CDC in 2000, calls out two overarching goals- one of which is to eliminate health disparities.[2] This remained a goal in Healthy People 2020. Yet to spite the stated intentions, the data in Massachusetts shows that a lot of work remains. Below are just two examples of current disparities in health outcomes.

2018 Massachusetts Number of Diabetes Deaths Per 100,000 Population



Data Source: Kaiser Family Foundation. State Health Facts. https://www.kff.org/other/state-indicator/diabetes-death-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

2017 Massachusetts Infant Mortality Rates



Data Source: Kaiser Family Foundation. State Health Facts. https://www.kff.org/other/state-indicator/infant-mortality-rate-by-race-ethnicity/currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2] Healthy People 2010: Centers for Disease Control. https://www.cdc.gov/nchs/healthy_people/hp2010.htm

Infant mortality rates are an example of poverty and social factors not fully accounting for disparities- living as a Black woman in America, even when one is educated and receiving high quality prenatal care, is a risk factor for infant mortality.[3] Studies have shown that cumulative stress from discrimination and disrespect over a lifetime has a negative impact on infant and maternal mortality to the point where black immigrants who came to the United States as adults do not have the same risk as their children who spent their lives in the United States.[4] It is a clear example of institutional and persistent racism negatively affecting health.

As we think about how to understand the non-genetic factors that influence health - those things that impact the vast majority of health outcomes – we can look to inequities in social determinates of health. Below are a few examples of disparities within social determinates of health:

Social & Economic Factors

MA Median Income
(one-race households)

Non-Hispanic White: $84,988
Black or African-American: $46,925
Hispanic or Latino: $41,995

Source: 2017 American Community Survey

Health Behaviors

MA Self-Report Physical Inactivity

Non-Hispanic White Adults: 21.1%
Non-Hispanic Black Adults: 27.4%
Hispanic Adults: 37.1%

Source: Centers for Disease Control (2015-2018 combined data)

Clinical Care

MA Adults Who Report Not Having a Personal Health Care Provider

Non-Hispanic White: 10.9%
Non-Hispanic Black: 17.1%
Hispanic: 20.4%

Source: Kaiser Family Foundation State Facts (2018)

Physical Environment

MA Exposure of Air Pollution for Vehicles

Non-Hispanic Black: 34% higher than Whites

Latino: 26% higher than Whites

Source: Union of Concerned Scientists (June 2019)

These examples illustrate how structural racism shows up for people of color in Massachusetts. But, they still do not fully get to the root causes of health disparities. The way many public health and medical professionals have sought to understand disparities has shifted over time. Eighteenth and nineteenth century medical professionals explained them with the false belief that basic genetics were vastly different based on race while the narrative that personal behavior and lack of morality were to blame for race-based health disparities

[3] Villarosa, L. (2018). New York Times Magazine. *Why America's Black Mothers and Babies are in a Life or Death Crisis.* https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
[4] Ibid.

prevailed into the 20th century.[5] Both explanations fail to acknowledge the historical and current institutional practices, such as housing segregation that forced people of color into neighborhoods with more environmental risks; lack of safe green space to exercise; lack of affordable healthy food; lack of jobs that pay a living wage; discrimination in educational opportunity; and many more examples that for hundreds of years have advantaged white people and severely disadvantaged people of color. All these policies and institutional norms continue to have health implications for people of color.

Examples of Current Institutional Racism & Health Impacts

Example	Health Impacts
Since 1990 White applicants received, on average 36% more job interview callbacks than Black applicants and 24% more than Hispanic applicants with identical resumes *(1)*	Unemployed Americans are more likely to be diagnosed with depression and to develop stress related conditions, such as stroke and heart disease *(6)*
African-Americans are incarcerated at more than five times the rate of Whites *(2)*	Evidence has shown that for every year spent in prison there is a 2-year reduction in life expectancy; children of incarcerated parents are at higher risk for substance abuse *(7)*
Black students are suspended and expelled at a rate 3x greater than White students *(3)*	Students who are suspended or expelled are more likely to develop sustance use disorders; less likely to finish college; and more likely to be arrested as adults *(8)*
African Americans make up 13% of the population nationally, but more than 40% of the homeless population *(4)*	Homeless individuals have poorer physical health; rates of mental illness are twice that of the general population *(9)*
Studies show medical providers are less likely to deliver effective treatments to people of color compared white people with the same conditions *(5)*	African Americans have the highest mortality rate for all cancers combined compared with any other racial or ethnic group *(10)*

(1) Quillian, L., Pager, D, Midtboen, A & Hexel, O. (2017). Harvard Business Review. Hiring Discrimination Against Black Americans Hasn't Declined in 25 Years.

(2) NAACP Criminal Justice Fact Sheet

(3) US Dept. of Education Office of Civil Rights. Data Snapshot: School Discipline (March 2014)

(4) National Alliance to End Homelessness. https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/inequality/

(5) Bridges, K. American Bar Association. Implicit Bias and Racial Disparities in Health Care.

(6) Robert Wood Johnson Foundation (2013). How Does Employment or Unemployment Affect Health?

(7) Robert Wood Johnson Foundation (2018). Mass Incarceration Threatens Health Equity in America

(8)Krisch, J. (2019). School Suspension and Explussion Doesn't Discipline Kids. It Hurts Them. https://www.fatherly.com/health-science/school-suspension-expulsion-dont-discipline-kids/

(9) American Psychological Association. https://www.apa.org/pi/ses/resources/publications/homelessness-health

(10) Carratala, S. & Maxwell, C. (2020). Health Disparities by Race and Ethnicity. Center for American Progress.

Looking Ahead

The call to action going forward must not only address the immediate causes of health disparities, like access to healthcare and opportunities to exercise and eat healthy foods, but needs to also look at the policies and unwritten norms that have created the conditions for race-based health disparities to exist. It requires public health professionals to work with colleagues in other disciplines as well as to engage community in new ways. Truly eliminating health disparities from the roots will take reframing how we think about issues and engage in finding solutions.

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[5] Bassett, M. & Graves, J. (2018). American Journal of Public Health. *Uprooting Institutional Racism as Public Health Practice.*