conversation

with
Regina Davis Moss, Ph.D.

Although the role of racism in public health has been recognized for more than 30 years, the concept gained increased recognition in the wake of summer protests spurred by high-profile deaths from racial violence and the COVID-19 pandemic, says Regina Davis Moss, Ph.D., M.P.H., MCHES, associate executive director of public health policy and practice for the American Public Health Association. Davis Moss, who presented "Racism and Health" during the International Foundation virtual conference Health Disparities and Social Inequality: The Role of Wellness, explains that racism is the root cause of different disease outcomes for Black, Indigenous and people of color (BIPOC).

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What is the impact of racism on health?

To understand the impact of racism on health, it's important to define what health is. Most believe that *health* is when a person is free of any physical disease, illness or injury. However, it's the state of complete physical, mental and social well-being that determines whether a person is truly healthy.

Public health promotes health, prevents disease and prolongs the lives of entire populations and the communities where they live, learn, work and play. Yet, whether through force, deprivation or discrimination, racism obstructs racial and ethnic populations from fully benefiting from these protections.

Racism is a social concept that assigns value and hierarchy based on the interpretation of the color of one's skin. It is a system that structures opportunities that unfairly disadvantage some individuals or communities while unfairly favoring others.

When public health experts talk about the intersection of racism and health, most think of *interpersonal racism*, which is overt prejudice or acts of bias between individuals. This is the most common understanding of the various forms of racism that occur, and it can certainly have a negative impact on health if a doctor refuses to administer life-saving treatment because of a patient's race.

However, public health professionals are working to prevent the more fundamental factors that are contributing to the ever-rising U.S. maternal mortality rates or premature deaths from heart disease. Those factors include redlining, disinvested communities, precarious employment, scarce access to quality health care or stress exacerbated by discrimination. All are the interplay of a host of historic and ongoing institutional forces shaping inequality in American society.

What is the challenge in understanding and recognizing the impact of racism on health?

Perhaps what makes racism less understandable as a critical cause of poor health outcomes is that many people still believe that race is genetic and makes some groups more susceptible in a biological way. We've mapped the entire human genome and found there's no basis for biological subspeciation. If anything, it further exposes that race is a social construct.

Or perhaps it's the belief held by some that those affected should simply change their behaviors and then they will no longer have poor health outcomes. This tendency toward behaviorist interventions has proved impractical for many or only sustainable for short periods, at best. It also doesn't consider how and why the health disparities occurred in the first place.

Absolutely, everyone should be physically active most days of the week and eat a diet rich in whole grains, fruits and vegetables. But it becomes harder to prioritize this when someone doesn't feel safe in their neighborhood, isn't paid a living wage and can't afford to buy healthy food to eat. Besides, racism goes beyond socioeconomic status. Black women in the U.S. are almost four times more likely to die from pregnancy-related causes than white women. This inequity is seen even among Black women who have earned bachelor's degrees, M.B.A. and law degrees, and more.

The physiological impact of racism on health is a proven scientific concept and, like every public health threat or epidemic, causes more disease, injury or other poor health conditions to occur among specific groups during a specific period than would be expected. Numerous studies have found racism to be associated with unhealthy changes to key biologic systems, resulting in an outsized impact on communities of color over time. Repeated exposure to racial prejudice and discrimination has been linked to poor mental and physical health issues such as chronic stress, high blood pressure, infections and diabetes.

We see this happening in real time with COVID-19. Limited access to primary care physicians in underinvested communities is increasing the likelihood of delayed treatment and more severe disease once a positive case is identified.

Why do disparities persist?

In a recent survey by the Pew Research Center, 70% of whites said racial discrimination is an individual-level problem rather than a systemic and institutional issue. Among Blacks, only 40% responded that the problems that Blacks face are due to systemic and institutional racism, with more saying it is due to prejudice.

This snapshot of racial views in the U.S. highlights that there is not national or widespread acceptance that some groups have access to more opportunities and advantages than others. When we deny that racism exists, we continue the myth that everyone is equally rewarded for their intelligence, skills and achievements and that social class or wealth hasn't played a role in some groups being placed ahead.

Such beliefs are taught early. Studies show that at the age of five, children express the same degree of empathy when they are shown pictures of people—both white and Black— being pricked by a pin. However, by the age of seven, they begin to believe that the white person feels more pain. By the age of ten, the bias is stable and distinct. This complicates support for policies and solutions addressing challenges that other groups face. It adversely affects everything from economic prospects to life expectancy.

Public health investigators use a tool known as the *epidemiological triangle* to help research and combat disease. They identify the external agent, the susceptible host and the environment that supports the transmission of the agent to the host. Racism has been identified as an agent, and combating it requires disrupting the multiple pathways to disease. It requires examining things outside of the doctor's office that are making some people sick and keeping others well. It requires acknowledging and healing the centuries-old trauma of Native American dispossession, slavery, Jim Crow, Mexican land changing hands, internment camps and other legacies that perpetuate racial inequity. It requires collaboration and sustained action with a variety of sectors such as housing, education, economic development and law enforcement.

What can be done to address these issues?

First, we need to be forward-leaning and name racism. We can't make progress if we are in denial or are afraid to use the word. Yes, it's important to talk about implicit bias, disparities, disproportionality and even race. But if we talk about all of those things without saying the whole word, we are not confronting the systems aspect or positioning it as a preventable etiology of inequity. Second, we need to provide health care to BIPOC communities that integrates nonclinical needs and is culturally aligned, safe, high-quality and respectful. Third, we need to look at the full package of what a patient brings to the clinical encounter, which will help change the negative historical narrative of the health care system and begin to engender trust. Fourth, we need to train more people of color in the medical profession and in health research. Studies document that BIPOC practitioners are more likely to practice in underserved communities. They

have also undertaken the scholarly work that forms the basis of the field's current knowledge on racism and its effects.

Last, we should promote strategies like a Health in All Policies approach so we can address the complex factors that drive health inequities. By taking into account the health impact of decisions at the beginning of policy formulation, living a healthy lifestyle is an easy choice.

This all must be undergirded with a science-based national response and the recognition that different groups are situated differently across society relative to various institutions and available resources. We cannot rewrite the past, but we can acknowledge the errors we've made, try to move forward and not repeat them.

It is evident that there is renewed attention and commitment across communities to begin to dismantle the stronghold of social injustice. As we seek to bring equity to communities, it is vital that the elimination of racism and the systems that give permission to its maintenance be a public health priority. This means providing more access to economic opportunities so that struggling families have secure income, increasing budgets so that students attending schools in underresourced communities have the best chance at educational success, ensuring everyone can live in a clean and safe environment, and getting rid of the fallacy of "the zero-sum game." If we continue to allow some groups to be disproportionately sick—or worse—die, it will have tremendous social and economic consequences for us all.

Ultimately, public health practitioners, health care providers and benefits professionals must work together to equitably provide the necessary resources and services so that every person in every community has an opportunity to be free from threats to their health. Our society has advanced when all members are meaningfully engaged and we recognize our collective common interests.

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