NEW YORK STATE PUBLIC HEALTH ASSOCIATION

Envisioning Healthy People in Healthy Places

STATEMENT OF POLICY

A Call to Action: Racism is a Public Health Crisis

Mission: The mission of NYSPHA is to promote and protect the public's health through professional development, networking, advocacy, and education.

Vision: Strengthening public health and taking action to make New York the healthiest state.

Problem Statement

Racism causes health disparities through individual and systemic discrimination present in the social and economic environment in which people live and work, and through implicit and explicit biases in the healthcare system. Recognizing racism as an ongoing cause of health disparities is not new to public health. However, racism's continued impact on health has not been adequately addressed by public health organizations. This shortcoming has been dramatically highlighted by recent episodes of police violence and COVID-19's disproportionate impact on racial and ethnic minorities. In too many areas, the link between racism and health has been ignored and not prioritized. Simple recognition of a problem is not enough. The public health system needs to lead the way in urgently addressing the ways in which racism impacts the health of New York communities.

Position Statement: A Call to Action

The New York State Public Health Association (NYSPHA) declares racism to be a public health crisis. Addressing racism is central to eliminating health inequities and should be central to public health practice and research. NYSPHA urges its members and partners in the public health system to critically examine policies and programs that determine socioeconomic status and access to quality education, healthcare, housing, and employment, and that influence individual behavior, disease, and health status. NYSPHA and its members and partners should seek policy changes to address health disparities caused by structural racism.

This is a call to action for NYSPHA and New York's public health system, acting independently and in collaboration. Specifically, NYSPHA collectively, its members individually, and its partners should:

1. Engage community leaders at the local and state levels to secure declarations on racism as a public health crisis and advocate for concrete actions to reduce inequity. For example, NYSPHA has written to New York Governor Hochul to urge her administration to declare racism as a

public health emergency.

2. Actively partner with historically underrepresented populations, including communities of color, to seek input, set priorities, create change, and improve health outcomes. For example, NYSPHA has been an active partner with the NAACP and others in a consortium seeking to ban the sale of menthol-flavored cigarettes in New York State. Big Tobacco has historically targeted advertising of menthol-flavored cigarettes to the Black population.

3. Educate public health professionals to critically analyze causes of adverse health outcomes and to delegitimize explanatory models that equate race and genetics or that rely solely on behavioral explanations for poor health outcomes. For example, many NYSPHA members are public health educators. They should assure that issues of racism on public health are highlighted in public health curricula.

4. Foster equitable collaboration among local and state governments, higher education, community and social change organizations to include health equity and racism in achieving the goals of the NYS Health Across All Policies initiative (New York State Department of Health, 2021).

5. Assure federal, state, and local agencies secure funds for public health programming that seek to address health inequities caused by racism. For example, NYSPHA has highlighted racial/ethnic health disparities in its advocacy with the governor and legislature.

6. Prioritize research on health inequities caused by structural racism led by scholars with lived experience and training in health disparities research methods. For example, as part of an APHA initiative, NYSPHA is currently funding an early career public health professional and educator of color to conduct research on health disparities.

7. Dedicate resources to routinely collect and publish data relating exposures to structural racism to inequities in the criminal justice system. For example, data on police violence should be collated and publicized on a statewide basis in New York.

Justification/Context

Racism and race are not the same. Race is a social construct with no basis in biology; racism is a social system that has negative implications where one race faces discrimination. Historical dynamics such as slavery, segregation, displacement, labor exploitation, redlining in housing, together have had multi-generational effects on Black, Indigenous, Latinx, and Asian communities. Discriminatory practices have contributed to poverty, chronic stress, and unequal opportunities for homeownership and wealth accumulation, all of which impact health. Racism results in discrimination, residential segregation, and health disparities. Racism has negative implications for educational opportunities, socioeconomic status and health care resources that offer optimal health. Health outcomes directly related to racism result in higher infant mortality, obesity, increase in heart disease and stroke (García and Sharif, 2015).

Racism permeates the health care system and is evident in the differences between Blacks and Whites in measures of health and of healthcare access. In 2019, 11.4% percent of Blacks did not have health insurance when compared to 7.8% percent of non-Hispanic whites (Artiga, 2021). There is considerable research that supports that stress associated with experiencing racism can have long-lasting physical and health effects. Stress elevates blood pressure and weakens the immune system, which raises the risk of developing long-term health conditions. Racism is associated with higher rates of stress, which increases a person of color's risk of developing high blood pressure and heart disease (American Psychological Association, 2022). Chronic health conditions are more prevalent among Blacks when compared to

Whites. Black adults are more likely to have hypertension, heart disease, diabetes and strokes when compared to whites (Centers for Disease Control and Prevention, 2017).

Black children when compared to White children suffer from asthma at a greater rate, 12.6 percent vs. 7.7 percent, based in large part to environmental conditions where they live and play, and poor health care access. Eighty percent of Black women are obese when compared to 64.8 percent of White women, due in part to poor access to nutritious foods and safe opportunities to exercise, leading to higher rates of chronic illnesses. In 2018, Blacks received fewer mental health services than their white counterparts, 8.7 percent vs. 18.6 percent, and received prescription medication at a lower rate than Whites, 6.2 percent vs. 15.3%, a result of differences in health care access and insurance. The mortality rate among Black infants is 11%, almost twice the national average, due to poorer access to prenatal care. Blacks have the highest mortality rate for all cancers combined than any other racial and ethnic group (Carratala, 2020).

Recent historical events have provided two stark examples of the health of minorities being adversely impacted by factors related to racism. First, during the COVID-19 pandemic, Blacks and Hispanics were hospitalized at 2.8 times the rate of Whites and were approximately twice as likely to die from COVID-19 (Artiga et al., 2021). This is a result of multiple factors including reduced access to COVID-19 vaccination and treatment and to policies that led these minority groups to live in crowded, multi-generational homes; work in essential jobs (e.g., hospital workers); and use public transportation rather than being able to follow prevention protocols such as working from home or self-isolating, away from other family members, if ill (Martin, 2021). Asian Americans have been the targets of COVID-19-related discrimination and violence (National Institutes of Health, 2020).

Second, structural racism is clearly reflected in data and events involving police brutality and racial bias. Black men are about 2.5 times more likely to be killed by police over the course of their lives than White men, and Black women are about 1.4 times more likely to be killed by police than White women. Among all groups, Black men face the highest lifetime risk of being killed by police (Edwards et al., 2019). In 2014, with Eric Garner's death, and in 2020 with the death of Daniel Prude, New York State was the site of two high-profile instances of police brutality targeting Black men.

Many other public health organizations have expressed concern about racism as a public health problem. The American Public Health Association has declared: "Racism 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 (American Public Health Association, 2021). In April 2021, the director of the CDC, Rochelle Walensky, declared racism a public health threat that is both interpersonal and structural, and that negatively affects the mental and physical health of people and thereby affects the health of the country (Centers for Disease and Prevention, 2021). In October 2021, the New York City Board of Health declared racism a public health crisis, citing the long history of structural racism that has negatively impacted the care of their population and the institutions needed for that care. The Board highlighted discriminatory practices that affect housing, employment, education, health care and legal systems and lead directly to health inequities (New York City Department of Health and Mental Hygiene, 2021).

In conclusion, racism is not just the discrimination practiced against one group based on the color of their skin or their ethnicity, but the structural barriers that differentially influence social determinants of their health: where they live, where they work, where their children play, and where they worship and gather in the community. We urge more recognition of and action to mitigate relevant "upstream" factors and policies that influence individual behavior, disease, and health status.

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Record of Action

02/08/22 – Adopted by the NYSPHA Policy and Advocacy Committee (PAC)
02/23/22 – Approved by NYSPHA Board of Directors