INTRODUCTION

Thank you commissioners and Executive Director Capri Maddox for the opportunity to share remarks with you this afternoon. I am Associate Professor of Community Health Sciences in the Fielding School of Public Health at UCLA and Founding Director of the Center for the Study of Racism, Social Justice & Health. For more than a decade, I have been teaching and conducting research on the health implications of racism and other social inequalities (e.g., homophobia), and working to develop the theory and research approaches needed to improve the rigor with which researchers study health inequities.

The center was launched on October 9, 2017, the inaugural Indigenous People’s Day in Los Angeles, to bring together experts studying the health and healthcare implications of various forms of racism, including anti-black racism, nativism, anti-immigrant sentiment, discrimination on the basis of religion such as anti-Muslim racism/Islamophobia and anti-Semitism, and other forms of social injustice. The Center launched the COVID Task Force on Racism and Equity on March 16th of this year. It is based in the Fielding School at UCLA and housed in the Center, it is co-chaired by Dr. Bita Amani of Charles Drew University, a collaborative endeavor between the two institutions that we are expanding.

I was asked to speak today about systemic racism and inequities in the COVID-19 pandemic. In a recent press conference briefing, director of the LA County Department of Public Health, Dr. Barbara Ferrer stated, "The disproportionately higher number of deaths from COVID-19 among black and brown people is an indication of the impact of racism and discrimination on health and well-being," as cited in the LA Times (“Racism and inequity fuel coronavirus-related death toll among LA County minorities, officials say” by Rong-Gong Lin II, June 9, 2020). Over the last two decades more than a thousand studies have been conducted on the links between racism, health disparities and healthcare disparities in diverse populations. Executive Director Maddox and the Commissioners are to be commended for allowing some of this research inform the work you all must do. It is not possible to cover either topic—structural racism or disparities in the COVID pandemic—comprehensively in the time available to us today, so I will highlight just a few concerns. I am certainly available after this meeting to provide additional information.

For your reference, my comments today draw on more than a decade of research on the implications of racism for health, some of it available in the book I recently co-edited with Derek Griffith (Vanderbilt University), Marino Bruce (Jackson State University) and Keon Gilbert (Saint Louis University), entitled Racism: Science & Tools for the Public Health Professional (American Public Health Association Press, 2019). They also draw on a 2017 report of the National Academies of Sciences, Engineering and Medicine for developing evidence-based, community-
driven solutions that achieve health equity. I will briefly highlight current patterns on COVID-19 that are relevant to our discussion today and draw on the public health literature, including what we have learned from the human immunodeficiency virus (HIV) epidemic, to explain why addressing structural racism is necessary in order to address the disproportionate burden of COVID-19 in communities of color. I will close with two recommendations.

COVID-19 DISPARITIES

As you all know, the Corona Virus Disease of 2019 (COVID-19) is caused by a virus known as Sudden Acute Respiratory Syndrome Corona Virus-2 (SARS CO-V-2). Though originally identified in Wuhan Province, China, the efficiency with which it spreads and its lethality have made it a serious threat to the well-being of vulnerable populations. Los Angeles has a robust public health infrastructure and its response to the pandemic has been more aggressive than that of many municipalities around the country; nevertheless, the burden of disease is high and black and other communities are disproportionately affected. As of yesterday, June 11, 2020, 68,875 cases of COVID-19 had been diagnosed and 2,813 deaths had been recorded in LA County. In LA, as around the nation, stark inequities exist by race/ethnicity. As of June 3, 2020, the UCLA Center for Health Policy Research (http://healthpolicy.ucla.edu/health-profiles/Pages/COVID-19Dashboard.aspx) determined that 24% of COVID-19 deaths in the US (n=21,750 people) occurred among black people among all deaths where the race of the decedent was known, even though black people make up only 13% of the US population. In Los Angeles County as of June 5, 2020, 29/100,000 Latinos, 31/100,000 African Americans and 31/100,000 Pacific Islanders have died of COVID-19, compared to 15/100,000 white people. Given the salience of racism, prevention efforts that focus narrowly only on the virus or on the needs of the overall population while overlooking those of the most marginalized groups. They mask the full magnitude of the problem, and therefore, are unlikely to lead to a more extended and complex epidemic among the most vulnerable members of our society.

The problem is not simply that the virus exists. The problem is that it is transmitted between people and that transmission follows lines of inequality that already exist in our society. COVID-19 inequities are due in part to higher rates of certain underlying chronic conditions in black and brown communities. However, it is important not to normalize the higher rates of deaths that occur in these communities, while ignoring the systemic inequalities that undergird them. Disparities in chronic conditions such as asthma, obesity and heart disease are known to stem from how structural racism acts on the social determinants of health, which include housing, employment, transportation and other causes of the causes of well-being.1,7-9 A more comprehensive strategy would address the underlying social inequalities that cause the disproportionate burdens of chronic conditions that, in turn, contribute to COVID-19 risk. Policies and other interventions that treat structural racism as a root cause of the inequities are most likely to curtail racial/ethnic disparities in COVID-19.5,6

The re-emergence of overt forms of racism that are associated with the US South (e.g., the confederate flags, marches by avowed white supremacists) can obscure the ways in which racism operates in liberal regions like California. So, I often like to start my talks on the west coast by showing hate crimes in California. This chart shows LA data from 2005-2015, a period when many pundits were describing our nation as “post-racial”. These data reveal that hate crimes in Los Angeles persisted with a general downward trend until 2014. With respect to racism (including anti-Semitism) African Americans remain most often targeted, with Jewish and Latino persons also targeted during this period. LGBT persons were also targeted on the basis of perceived sexual orientation and gender identity. Since 2015 rates have increased around the country, and though to my knowledge precise estimates on hate crimes during the COVID pandemic are not available,
anecdotal data suggests likely increases among Asians due to stereotyping and scapegoating of immigrants.

**STRUCTURAL RACISM**

Racism is often defined narrowly as overt interpersonal or institutional discrimination. For instance, racial stereotyping by members of the public is one-way racism operates in an epidemic. However, focusing only on these overt expressions obscures the primary and most influential ways it affects health.

[SIDE #6] In 2016, former president of the American Public Health Association (APHA), Dr. Camara Phyllis Jones, called for the field of public health to lead the nation in eradicating racism, which she defines as “a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what [people] call “race”), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and [thus] saps the strength of the whole society through the waste of human resources.”

[SIDE #7] Racism operates at multiple socioecologic levels; the most influential form of racism is structural racism, which has been defined as, “[t]he totality of ways that systems in society (e.g., housing, healthcare) differentially treat groups based on race/ethnicity. The results may be used to justify continued discriminatory treatment.”

[SIDE #7] Structural racism is the totality of ways that systems in society (e.g., housing, healthcare) differentially treat groups based on race/ethnicity. The apparent “racial/ethnic differences” may actually be used to justify continued discriminatory treatment. For this reason, it is important to focus not on the race/ethnicity of groups, but on the ways that they are treated because of it. Structural racism operates across and within systems (e.g., banking, housing, education), including within the healthcare system contributing to disparities in care and poorer long term outcomes. The aforementioned National Academies consensus study determined that successful community-wide movement toward equity require broad, diverse coalitions focused on the social determinants of health. Importantly, it recommended that the private sector be involved as anchor organizations working in equitable partnership with communities in order to address structural barriers to equity.

**LESSONS FROM THE HIV EPIDEMIC**

During epidemics, racism influences how the epidemic expands, the approaches used to control it, and the narratives about whom it impacts and who is responsible for it. At least two lessons learned from the HIV epidemic can inform efforts to address racism-related disparities in the COVID-19 pandemic. First, mounting evidence of disparities in COVID deaths has raised awareness about the need to facilitate access to testing among some vulnerable populations. Testing is critical for identifying cases and reducing inadvertent transmissions, but it is only the first step of the care continuum. I use the term care continuum to highlight key points at which a patient must interact with the healthcare system in order to attain a good long-term prognosis. For HIV, key stages of the care continuum include getting a diagnostic test, receiving the test results, being linked to HIV specialists, being retained in HIV care, and adhering to prescribed medications. Having access to healthcare, though important, does not address the differential treatment patients may receive within the healthcare system, however, and health inequities are known to occur at every stage of this continuum. To experience disparities in the timeliness, aggressiveness or quality of services at any of these critical stages can lead to poorer long-term prognoses. With infectious conditions such as COVID-19 this risk extends to family members, friends and others with whom the patient interacts.
In general, implicit biases reflecting embedded institutional policies, practices and norms pervade the healthcare system.\textsuperscript{15,16} They lead to systematic differences in how quickly racial/ethnic minority patients receive care and how aggressively their healthcare needs are treated. Implicit biases are not random. They reflect institutional and societal policies and practices. This explains why implicit biases are largely predictable. With an infectious condition such as COVID-19, any delay or suboptimal care a patient experiences has implications not only for the patient, but also for those with whom the patient interacts. Thus, while testing and access to healthcare are important, it is also critical to ensure equity in the delivery of services at each stage of the care continuum.

A second lesson from the HIV epidemic is that while much attention is currently focused on developing a COVID-19 vaccine, the mere existence of treatment or vaccines does not mean that disparities will be eliminated. The evidence from the HIV epidemic suggests the opposite: disparities are likely to be exacerbated if any treatments or solutions that become available are made available without addressing inequities in the social determinants of health (e.g., housing) that already exist in society. African Americans had experienced higher rates of acquired immune deficiency syndrome (AIDS) (i.e., the endstage condition of HIV infection) than their proportion of the US population (approximately 12%) would suggest since the beginning of the HIV epidemic. AIDS than their proportion of the population would suggest since the beginning of the epidemic; however, it was in 1996 when lifesaving antiretroviral therapies (ARTs) became widely available, that the magnitude of AIDS disparities (i.e., the difference between the percentages of AIDS cases among African Americans and whites) changed substantially. Ironically, instead of reducing the black-white differential in the percentage of AIDS deaths over time as might be expected, the introduction and widespread availability of ARTs exacerbated it. Prior to this period, whites accounted for a majority of AIDS deaths as might be expected given their population size. With the introduction of ARTs, however, blacks began to account for a greater share of all US AIDS diagnoses and the magnitude of the black-white disparity grew—not diminished—over time. The racial disparity persists today more than 30 years after the first US cases were diagnosed. As a growing body of evidence indicates, racism is a fundamental cause of such health disparities. Understanding how structural racism undergirds these and other patterns is important for developing effective, equitable strategies for eliminating disparities in the COVID-19 pandemic.

Concerns also exist about the labor implications for workers of color who disproportionately work in settings where they may have elevated risk for exposure to COVID-19. For instance, data from the US Bureau of Labor Statistics for the nation indicate that in 2019 black and Latino workers worked in occupations that now constitute the front lines of the COVID pandemic, but that lack the authority and autonomy to control the terms under which they work:

- 18.2\% of all janitors in the US are black, 31.6\% are Latino; these numbers likely undercount undocumented persons
- 27.5\% of licensed practical and licensed vocational nurses are black
- 37.2\% and 17.6\% respectively of nursing, psychiatric, and home health aides are black and Latino

It is important that businesses, including healthcare organizations, be required to protect the well-being of workers such as these, and that policies and enforcement strategies be put in place to protect them.

I am optimistic about the possibilities of addressing the potential impact of racism on health and healthcare disparities in general and on the COVID-19 pandemic in particular. If unaddressed, racism will exacerbate COVID-19 disparities over time. One example of a possible solution comes from a recent study led by my late colleague, Billy Cunningham. Previously, researchers had
established that among black and white patients under the supervision of white HIV care doctors, black patients received lifesaving HIV medications at later stages of disease than white patients did when they.\(^\text{17}\) This was not true for black and white patients seen by black HIV care doctors; there was no statistical difference in the time to receipt of the prescriptions among black and white patients with black doctors. The purpose of the most recent study\(^\text{18}\) was to see if an information exchange system could the accuracy and efficiency of information exchanged in a patient’s medical record between providers and the labs that perform any requested clinical tests. The results of the study showed that such a system both eliminated disparities and, importantly, contributed to improvements for all patients.

Though there is not time to elaborate on them here, additional recommendations for addressing structural racism’s contribution to COVID-19 and other health disparities that can be implemented immediately include:

- Monitor institutional forms of racism by tracking organizational norms, policies and practices
- Revise intake forms and surveillance documents to understand how inequalities in the social determinants of health limit the ability of individuals to adhere to recommendations
- Re-frame the root causes of COVID-19 disparities to clarify that they are not characteristics of racial/ethnic minority people, but the results of how specific forms of oppression affect them

In conclusion, the evidence from prior epidemics suggests that stark disparities in COVID will persist in pockets of our society unless our intervention strategies target their root causes. Key among them is structural racism. As long as some people remain at risk, our entire society remains at risk.

Thank you for the privilege to offer these remarks. I would be happy to respond to questions.

REFERENCES


