Racism as a Root Cause of Disease: Beyond biomedical and behavioral health

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The Covid-19 pandemic increased the collective understanding of the role of public health in the prevention of disease and injury in a population. The public was suddenly made aware of epidemiological concepts of contact tracing, quarantine, and isolation as mitigation measures for infectious disease. Debates swirled in the media around "flattening the curve," face covers, the amount of space needed for physical distancing and when we can get "back to normal."

Just as we were trying to get a handle on the impacts for hospital preparedness and controlling transmission rates, important health disparities began to emerge in morbidity and mortality rates in Black, Latinx, Pacific Islander, and Native American communities. As researchers called for more disaggregated data on transmission rates, public health and social justice advocates reminded us that Covid-19 did not create the disparities in our country. Covid-19 exacerbated the existing social inequities in our communities such as housing, income and food insecurities, lack of legal documentation and health insurance, and the disproportionate amount of communities of color in essential jobs with limited to no leave pay.

The conversations around social determinants of health have increased in urgency as we collectively witnessed the murder of yet another black man, Mr. George Floyd, in Minneapolis, Minnesota by a police officer on May 25, 2020. This heinous act comes on the heels of the senseless killing of Breonna Tayler and Ahmaud Arbery and countless others who suffer from the legacy of white privilege, a legacy that is unfortunately embedded in medical and health institutions. The growing swell of protests nationwide calling for an end to police violence against black bodies, and justice for the victims, is deeper than a call to reform existing institutions. It requires a deeper understanding of the fundamental assumptions that underpin the creation of our modern-day institutions, which include medical and health systems.

Systemic racism extends beyond the current attention on policing. It is embedded within the policies of institutions which historically restricted black residents from equal opportunities to housing through redlining, obtaining education, gaining employment, and building generational wealth. Consequently, they and other underrepresented minorities, disproportionately reside in communities that are deprived of basic resources, further exacerbating the impact of the Covid-19 crisis. We must pay careful attention to the impact of policies that systematically exclude a significant portion of our population from the American dream through less visible, but perhaps even more potent, practices of racism. In order to eradicate racism, however, we must be willing

to do the deeper work of understanding its origins, which provide the foundation for most of the systems in our country.

As public health teachers, scholars and advocates, we must commit to addressing the root causes of disease and injury through a deep, thoughtful, difficult examination of the underlying assumptions of our social, political, legal, economic, educational, and health systems. It is not enough to train our students and future public health leaders to address the biomedical and behavioral aspects of health and wellbeing. It is not enough to teach students that racism is correlated with higher levels of heart disease, obesity, diabetes, infant mortality and cancer in communities of color. No amount of cultural competency training is adequate to address the structural root causes of health disparities. We can start with the disaggregated data on health disparities, but we cannot stop there.

A narrow focus on individual behavior change and/or policy change will not address the root causes of racism. Health equity demands a broader and deeper understanding of the determinants of health in society, including reflection on the historic, political, social, and economic relationships that impact health and wellbeing. For example, a deeper understanding of the historic antecedents of our governance structures in the United States helps us realize that the slave trade did not end with the Emancipation Proclamation in 1863, nor did civil rights actually fix racism in the 1960s. Students must be educated on the 400 years of racism embedded in our institutional policies and practices which continue to result in negative health outcomes in communities of color *today*. Structural racism also leads to a lack of trust in health systems and public health guidance as a result of the Tuskeegee Trials (among others). The lack of trust in our medical and health institutions exacerbates health disparities, which cannot be addressed through a narrow focus on individual behavior. It requires systems change.

Addressing the structural determinants of health implies that we are willing to challenge the entrenched assumptions of race within our fields of endeavor. That doesn't mean "race" doesn't matter. It means going beyond a call for racially/ethnically disaggregated data or treating race/ethnicity as a controlling or noise variable. It means committing to addressing racism as a health crisis. It means providing space in our classrooms for difficult conversations about racism. It means critically challenging "research" that continues to make faulty assumptions about brown and black people. It means taking the step to challenge our own implicit biases. It means continuing to engage in the conversation, even when it's tough.

We call on each of you to be truly committed to addressing racism in all its forms so that our chosen field can contribute to the healing of the soul of a nation. In addition to our efforts to mitigate the Covid-19 pandemic, public health must engage in the more difficult task of eradicating the social disease of racism if we are truly to achieve health equity and justice in the 21st century.