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Before the U.S. House of Representatives
House Committee on Education and Labor
"Inequities Exposed: How COVID-19 Widened Racial Inequities in Education, Health, and the Workforce"

June 22, 2020

Chairman Scott and Members of the Committee, thank you for inviting my testimony. Racism is foundational in the history of the United States and continues to have profound impacts on the health and well-being of the nation. Today, I will define racism and briefly discuss the impacts of racism on health, especially as manifest through the COVID-19 pandemic, and by extension its impacts on education and labor. I also provide three tools for guiding action in addressing the impacts of racism on health: the question "How is racism operating here?"; three principles for achieving health equity; and the International Convention on the Elimination of all forms of Racial Discrimination.

"Race"-associated differences in health outcomes exist. Racial disparities in health outcomes in the United States have been documented across organ systems (heart disease, stroke, cancer, diabetes, asthma, kidney disease), across age groups (infant mortality, maternal mortality, life expectancy at birth), and over time.[1,2,3,4]

In the United States, Black people have higher rates than White people of obesity, high blood pressure, heart disease, kidney disease, diabetes, and asthma. Blacks have the highest age adjusted prevalence of obesity at 49.6% compared to Whites at 42.2%[5]; high blood pressure is most common in Black adults at 54% compared to White adults at 46%[6]; the age-adjusted death rate from heart disease is 208.0 per 100,000 persons for Blacks and 168.9 per 100,000 persons for Whites[7]; prevalence of kidney disease is 3.1% among Blacks and 2.0% among Whites[8]; prevalence of diabetes is 16.4% among Blacks and 11.9% among Whites[9]; prevalence of asthma is 10.7% among Blacks and 8.0% among Whites.[10,1112,13,14,15,16] Racial health disparities are also experienced by American Indian/Alaska Native, Hispanic/Latino, Native Hawaiian and Other Pacific Islander, and some Asian populations.

These racial disparities in health outcomes arise on three levels[12]: differences in quality of health care[13], differences in access to health care[14-16], and differences in underlying exposures and opportunities which make some individuals and communities sicker than others.[17,18,19,20] Mechanisms for differential access to quality health care include insurance, proximity, and representation among physicians.[14]

Zip code is a much stronger predictor of health than is genetic code. Health is not created within the health sector, nor is it primarily determined by genes or individual behaviors. Rather, health outcomes are significantly impacted by social factors. The "social determinants of health" are the determinants of health that are outside of the individual, beyond our genes, and beyond our individual behaviors.[24] They are the contexts of our lives, the conditions in which people are born, grow, live, work and age. They include individual contexts (education, occupation, income, wealth) as well as neighborhood contexts (quality of housing, availability of health foods, availability of green space, air quality, water quality, quality of the schools, availability of work, transportation options, proximity to polluting industries).[25]

The most profound differences between Black people and White people in the United States are in their underlying exposures, opportunities, resources, and risks. Black people have lower average annual income, lower family wealth, poorer housing, live in communities with more environmental degradation, have less access to healthy foods, less access to green space, less access to clean air, and less access to clean water than White people. And this maldistribution of goods, services, and opportunities of society by "race" is not just random.[26]

If the social determinants of health are the contexts of our lives, then the social determinants of equity determine the range of those contexts and which groups live in which contexts.[27] The social determinants of equity include racism, sexism, and other systems of structured inequity. They operate through structures (the "who, "what", "when", and "where" of decision-making); policies (the written "how" of decision-making); practices and norms (the unwritten "how" of decision making); and values (the "why").[28] Of special importance is who is at the decision-making table and who is not, and what is on the agenda and what is not. The health of individuals and communities of color requires unfettered participation of these communities in decision-making processes.[29]

What does the variable "race" measure? The variable "race" in the United States is a very rough proxy for socio-economic status, rougher still for culture, and meaningless for genes, so why is it such a good predictor of health outcomes? "Race" precisely captures the social interpretation of how one looks in a "race"-conscious society.[30] Note that the socially-assigned "race" which is noted on a medical record and becomes part of a health statistic is also the same "race" that a taxi driver notices, or a police officer, or a judge in courtroom or a teacher in a classroom. It is the substrate on which racism has operated throughout U.S. history and continues to operate to this day. Indeed, analyses of CDC data reveal that being classified by others as "White" is associated with large and statistically significant advantages in health status, no matter how one self-identifies.[31]

What is racism? Racism is the 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.[32,33]

Racism is the root cause of "race"-associated differences in health outcomes. There is a wealth of empirical research on how racism adversely impacts physical health outcomes and

mental health outcomes.[34] There are three levels of racism that impact health: institutionalized (structural), personally-mediated, and internalized.[35] Institutionalized racism results in differential access to the goods, services, and opportunities of society by "race" through a constellation of structures, policies, practices, norms, and values. Personally-mediated racism comprises differential assumptions about the abilities, motives, and intents of others by "race" and differential actions based on those assumptions. Internalized racism is acceptance by members of stigmatized "races" of negative messages about their own abilities and intrinsic worth (and the reciprocal internalization by members of dominant "races" of a sense of entitlement).[36]

Of the three levels of racism, institutionalized racism has the most profound impacts on health.[37] This level of racism does not require an identifiable perpetrator since it has been institutionalized in our laws, customs, and background norms. Rather, it often manifests as inherited disadvantage or its reciprocal inherited advantage. Institutionalized racism can operate through acts of commission (*doing*) as well as through acts of omission (*not doing*), and it very often manifests as inaction in the face of need.[38]

Institutionalized racism impacts both material conditions and access to power. With regard to material conditions, examples include differential access to quality education, sound housing, gainful employment, appropriate medical facilities, and a clean environment.

With regard to access to power, examples include differential access to information (including one's own history), resources (including wealth and organizational infrastructure), and voice (including civic and political participation, voting rights, representation in government, and control of the media).[39]

Racism is foundational in our nation's history and continues to have profound impacts on the health and well-being of the nation.[40] The association between socioeconomic status and "race" in the United States has its origins in discrete historical events, but persists because of contemporary structural factors that perpetuate those historical injustices. Structural racism is manifest in legal segregation of housing and schools, discrimination in the labor market, disproportionate incarceration, and unequal justice.[41,42,43,44,45]

Present day practices and policies rooted in institutionalized racism, which include ongoing discrimination in housing and lending markets, redlining, and divestment from poor communities, continue to plague "Black", Indigenous, and other People of Color in the United States and are evidenced by disproportionately high levels of poverty and unemployment, substandard educational settings and opportunities, concentration in poor neighborhoods with unsafe, and under-resourced living environments, overall economic instability, and limited access to quality healthcare.[46]

Racism is the root cause of the disproportionate impact of COVID-19 on communities of color in the United States. The disproportionate Black COVID-19 infection and death rates that are being documented across the United States are due to the ways that racism has structured our opportunities so that Black people are more likely to be infected by the virus (SARS-CoV-2), and the ways that racism has impacted our underlying health status so that

Black people are more likely to experience severe forms of the disease (COVID-19) once infected. It is important to recognize that the disproportionate impact is NOT due to some inherent biological weakness nor some reluctance to comply with public health advisories. Black people are getting more infected with SARS-CoV-2 because they are more exposed and less protected. Black people are dying from COVID-19 at higher rates because they are more burdened by chronic diseases with less access to health care.[47]

Black people are more likely to get infected with COVID-19 because they are more exposed and less protected. Black people are more exposed because they are overrepresented in low-paid frontline jobs (*e.g.*, home health aides, transit drivers, postal workers, sanitation workers, hospital orderlies and custodians, grocery workers, meat packers, and warehouse workers). Black people are also more exposed because they are disproportionately impacted by housing instability, more reliant on public transportation, and live in more crowded home settings and more densely populated communities.[48] Communities of color do not have many opportunities to work from home nor the savings nor paid sick leave to be off the job to preserve their health. Black workers are also overrepresented in low-income, frontline jobs, and more affected by residential, educational, and occupational segregation.[49]

People of color are less protected when doing their low-income frontline work – which has only recently been lauded as "essential" – because they are not provided adequate personal protective equipment to prevent their contracting the virus on the job.

Once infected, Black people are more likely to die from COVID-19 because they are more burdened by chronic diseases and have less access to health care. Black people are more burdened by chronic disease because Black communities are more likely to be disinvested and actively neglected communities of concentrated poverty with poor access to healthy foods including fresh fruits and vegetables; poor access to green space and healthy environments for active living; increased likelihood of proximity to polluting industries which poison the air, soil, or water; and crowded and unhealthy living spaces. These conditions greatly constrain residents from making healthy behavioral choices, resulting in higher prevalence of obesity, high blood pressure, diabetes, asthma, heart disease, and kidney disease (among many other health outcomes), all of which make COVID-19 more severe and potentially deadly.[50]

Black people have less access to timely, responsive, and physically proximate health care services compared to the rest of the United States. During the COVID-19 pandemic, testing sites were first located in affluent communities (with lower proportions of Black residents) and people seeking a COVID-19 test were required to have an order from a primary care physician, which Black residents are more likely to lack. In rural parts of many states, recent hospital closures associated with the failure to expand Medicaid under the Affordable Care Act have exacerbated the lack of ready access to health care.[51] Finally, Black adults in the United States are substantially more likely than White adults to express high levels of concern over the possibility that they will contract COVID-19 or transmit it to others. Those fears are well-founded..

Racism is foundational in the history of the United States and continues to have profound impacts on the health and well-being of the nation. At least eight U.S. counties

(Milwaukee County, WI; Dane County, WI; Allegheny County, PA; Franklin County, OH; Genesee County, MI; San Bernardino County, CA; Montgomery County, MD; and King County, WA) and nine U.S. cities (Pittsburgh, PA; Columbus, OH; Somerville, MA; Medford, MA; Boston, MA; Cleveland, OH; Denver, CO; Indianapolis, IN; and Flint, MI) have declared that racism is a public health crisis.[52,53]

During this COVID-19 pandemic, the unfair disadvantage that racism has structured for communities of color is even more life-threatening than during "normal" times. It is noteworthy that the most profound impacts of racism occur without bias. They manifest instead as inaction in the face of need.

How is racism operating here? The question "How is racism operating here?" provides a useful tool for identifying targets for action by examining the elements of decision-making in our structures, policies, practices, norms, and values, where structures are the "Who?", "What?", "When?", and "Where?" of decision-making (especially "Who is at the table and who is not?", and "What is on the agenda and what is not?"); policies are the written "How?" of decision-making; practices and norms are the unwritten "How?" of decision-making; and values are the "Why?". Following is a brief application of this question with regard to the disproportionate impact of COVID-19 on communities of color.

Structures. The racial segregation of housing structured into our society (see Rothstein R, The Color of Law) results in racial segregation of education (public school funding tied to local property taxes, with poor funding often leading to poor educational outcomes and another generation lost) which then results in racial segregation of occupational opportunities. This accounts for the disproportionate representation of Black and Brown people in frontline jobs (home health aides, sanitation, postal work, drivers, warehouse workers, meat and poultry plant workers, many others).

Another structural mechanism is the well-described school to prison pipeline (unequal administration of discipline in schools, disproportionate suspensions, poorly administered foster care, disproportionately harsh adjudication in juvenile justice systems, over-policing of communities of color, unequal sentencing guidelines, and others) lead to disproportionate incarceration of Black and Brown men and women. Even the limited decarceration of older prisoners and those with pre-existing health conditions during the COVID-19 pandemic has been unevenly applied because of structural barriers to attorney access.

Policies. Many frontline workers in jobs which are now recognized as "essential" are poorly paid with limited paid sick leave and inadequate protection from exposure to the virus (crowded work conditions, inadequate personal protective equipment, limited testing at the workplace). Both Congress and the Occupational Safety and Health Administration can assume stronger roles in addressing these issues.

Practices. The widespread practice (especially early on in the pandemic) of locating testing centers in affluent areas or as drive-up centers or requiring doctor's orders systematically disadvantaged residents in poor areas, with access to cars, and with access to a primary care physician. As a nation, our testing strategies for the virus are still narrowly focused on the

individual in a medical care model, confirming diagnoses for those with symptoms, and as such are only useful for documenting the course of the pandemic, and then only partially. A population-based public health approach to testing would enable us to not only document the course of the pandemic but also to CHANGE the course of the pandemic by implementing public health surveillance approaches to testing probability samples of both symptomatic and asymptomatic persons, followed by community endorsed isolation strategies, contact tracing, and quarantine. These public health approaches to managing the pandemic will benefit all United States residents, but especially those communities that are being most adversely affected by the pandemic.

Norms. Several cultural norms in the United States inhibit widespread acknowledgement that racism exists. Among these:

- Our narrow focus on the individual makes systems and structure invisible or seemingly irrelevant.
- Our a-historical stance acts as if the present were disconnected from the past, and as if the current distribution of advantage and disadvantage were just a happenstance.
- Our widespread endorsement of the myth of meritocracy, that "If you work hard you will make it," acknowledges that most (although not all) people who have made it have worked hard, but ignores the reality that there are many, many other people working just as hard or harder who will never make it because of an uneven playing field (which has been structured and is being maintained by racism, sexism, heterosexism, and other systems of structured inequity).

Values. COVID-19 is a public health problem which has been treated in this country as if it were instead a medical care problem, and as a result it is manifesting as a tremendous challenge to the medical care system. We are at risk of experiencing local scarcities of life-saving interventions including ventilators, intensive care unit beds, and emergency dialysis. When "Crisis Standards of Care" are promulgated by states and by health care systems, they have often reflected a hierarchy of valuation by work role (medical care worker over other essential workers), age (younger people over older people), and existence of chronic diseases (which systematically disadvantages communities of color who bear a greater burden of chronic diseases from living in segregated, chronically disinvested, actively neglected, and environmentally poisoned communities). Suggestions to implement a lottery for the rationing of scarce life-saving resources are often met with skepticism, reflecting a deep-seated commitment to the differential valuation of human life in this country.

Principles for achieving health equity. Health equity is the assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health disparities will be eliminated when health equity is achieved. The three principles for achieving health equity can provide a framework for addressing the short-term and long-term challenges posed by the COVID-19 pandemic.

The "pre-existing health conditions" that put a person at risk of severe disease and death from COVID-19 are overrepresented in communities of color and poor communities as a result of long-term disinvestment and neglect.[54] Delayed responses to the COVID-19 pandemic have

resulted in unprecedented and under-resourced demands on our health care system. With limited medical equipment and fewer resources, health care providers have had to make decisions about COVID-19 treatment in real time at the bedside, regarding which patients will receive life-saving treatment and which patients will not. These decisions used to be made from a distance by our health insurance companies, our economic system, and by residential segregation. During this pandemic, the decisions have become more personal in a whole new way.

Health equity is the assurance of the conditions for optimal health for all people. It is a process, not a magical outcome. The Affordable Care Act (ACA) has been one of the most important steps toward reducing racial inequities in health insurance coverage in the past decade.[55] In the first few years of its implementation, the ACA improved access to health care coverage for low-income communities of color in both states that did expand eligibility for Medicaid under the ACA and states that did not expand Medicaid.[56] However, these health care coverage gains were larger in states that expanded Medicaid. Socioeconomic disparities in health care access narrowed significantly under the ACA. The gap in insurance coverage between people in households with annual incomes below $25,000 and those in households with incomes above $75,000 fell from by 46 percent in states that expanded Medicaid and by 23 percent in non-expansion states.[57]

In Medicaid expansion states, more than 74% of Black adults and 58% of Hispanic adults reported having a regular health care provider in 2018 compared to 71% and 55% in 2013. Gaps in health insurance coverage among racial and ethnic groups narrowed the most in states that expanded Medicaid, and supporting Medicaid expansion in additional states has the potential to improve racial equity in health insurance coverage. The Affordable Care Act also resulted in proportionate declines in uninsured rates among all racial and ethnic groups in the United States. Because uninsured rates in Hispanic communities started off much higher, the health insurance coverage gap between Black people and non-Hispanic white people declined from 11.0 percentage points in 2013 to 5.3 percentage points in 2017. The health care coverage gap between Hispanic people and non-Hispanic white people dropped from 25.4 points to 16.6 points.[58,59]

As we navigate through the immediate health, economic, and social demands of the COVID-19 pandemic, three principles for achieving health equity can provide us with both a moral and practical compass: valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. These principles can serve as a framework for evaluating current and proposed policy solutions, as well as a checklist for identifying gaps in policy where no solutions have yet been suggested. They can also be the basis for decision-making at the health care provider level. There are ways we can operationalize these principles for response to the COVID-19 pandemic.

Valuing All Individuals and Populations Equally

Valuing all individuals and populations equally. We need to consider how to reach all communities with our life-saving messages of social distancing, frequent handwashing, stay-at-home orders and symptoms of COVID-19. We need to enable all individuals to take up these practices. We have to be bold in imagining solutions to the issues raised when we decide to value

all individuals and populations equally. These solutions include connections to community resources to provide housing of previously unhoused individuals in available vacant properties, or, at least, provide hand-washing stations and opening public restrooms for their use.

At the policy level, the most important way to value all individuals and populations equally is by looking at who is at the decision-making table and who is not, what is on the agenda and what is not. When any of us is at a decision-making table, we must look around and ask, "Who is not here who has an interest in this proceeding?" Our job is not just to represent the interests of the missing parties, although that may be a necessary short-term strategy. Our job is to create space for them at the table.

Even now, when Congress is working on the fourth COVID-19 legislative package for the nation, we need to ensure that all voices from communities of color are heard throughout the legislative process. In the short term, that may require active constituent engagement by our elected representatives. In the long term, that may require a more vigorous defense of voting rights and deep reforms of campaign financing to make sure all voices are heard in our democracy.

Communities of color should not be "sacrifice zones" with regard to the COVID-19 response. The decision to disembark infected persons from the Diamond Princess cruise ship in Oakland Bay rather than in San Francisco Bay, given that Oakland has a much larger Black population, is a decision that requires closer examination. The decision to convert Carney Hospital in the Dorchester neighborhood of Boston to be the nation's first hospital solely devoted to the care of COVID-19 patients deprived that predominantly Black neighborhood of access to other medical services and possibly increasing the risk of infection in the area.

At the bedside, decisions about the allocation of life-saving treatments should not be done by the medical professionals directly involved in the patient's care. It is too easy for implicit bias about relative worth based on race or ethnicity, class, gender, language, disability or other characteristic to manifest itself in decision-making when a provider is tired or stressed. If patient prioritization will instead be done by a hospital ethics board, the composition of that board also needs to be examined for balance along axes of difference and power, and community input into the criteria and processes for decision-making should be rapidly sought.

If we really want to value all individuals and populations equally, should we use a lottery system for allocation of scarce resources? At least structured inequity and subjective valuation would be taken out of the decision-making. This is a provocative suggestion. But perhaps the threat of a fair system in which all people would have equal chances at life would stimulate a more rapid production and distribution of life-saving health resources, solving the issue of scarcity.

Recognizing and Rectifying Historical Injustices

The principle manifestation of historical injustices during the crisis of the COVID-19 pandemic is in how segregation of resources and risks, societal devaluation, and environmental hazards and degradation are written into the bodies of people of color and poor people. The

greater health burden borne by these people may not only predispose them to more severe manifestations of COVID-19 itself, but may also disadvantage them in any ethical protocol established for the rationing of scarce health resources. That would be wrong. It would be counter to the health equity principle of recognizing and rectifying historical injustices, putting at double jeopardy those who already bear the brunt of chronic assaults to health. Instead, this principle should lead to the provision of more ventilators, COVID-19 treatment, and health care services in populations with higher pre-existing health burdens.

Recognizing and rectifying historical injustices also requires the collection and disaggregation of data on COVID-19 testing, diagnosis, treatment, and outcome by "race" and ethnicity so that the impacts of those historical injustices can be recognized and addressed.

In the longer term, attention from policymakers to the history of each problem to be solved will always provide useful insight into effective solutions. Understanding how a knot was tied will always help in untying the knot. Our nation is notoriously ahistorical, thinking that the present is disconnected from the past and that the current distribution of advantage and disadvantage is just a happenstance. The long-term application of this principle will involve the large-scale teaching of our full histories as a nation and a commitment to apologize and make reparations for past injustices, recognizing that they continue to have present-day impacts.

Providing Resources According to Need

This principle is perhaps the easiest of the three principles to understand, but often the hardest to implement because it takes a tremendous amount of political will. The first step is to establish a metric of need on which there is wide consensus. In the context of the COVID-19 pandemic, this metric might be the number of diagnosed COVID-19 patients, or indicators of the trajectory of the epidemic (*e.g.*, the doubling time and basic reproduction number of SARS-CoV-2, the virus that causes COVID-19) in a given jurisdiction. It might include projected number of deaths, projected demands on the health care system, current health system capacity, or current levels of resources in an area.

Once a metric of need is established and agreed upon, it would then seem simple to take all available resources and distribute them according to that metric of need. However, even in the clear current situation of New York City, topping off these measures of need all around, there is not a rapid deployment of national resources to the city. Other jurisdictions are holding on to their resources because of the anticipated changes to projected need in a few weeks. The federal government is slow in using its full power to rapidly commission and deploy resources to areas of need. Instead of conducting targeted and fluid mobilization as the pandemic moves across the nation, there appears to be a stance of disbelief and paralysis at the scope of the need.

As often happens, people (and political jurisdictions) never compare themselves to those who have less than what they have. They always compare themselves to those who have more, so they always feel needy. A pre-established metric of need should solve that. But perhaps strong community pressure is also required.

The COVID-19 pandemic will not end in days or weeks. It could be a year, maybe 18 months. By then, the world will have faced immeasurable loss of life. The economy will improve, but it is my hope that these three principles for achieving health equity will be useful in guiding decision-making during these treacherous times. Looking forward, I also hope that they will provide a guide for how we value and treat one another as we build a better, new normal after this devastating pandemic.

Recommendations for Action

The following are specific recommendations for action in the short-term

- **Make it more feasible for more people to safely shelter in place**
    - Mandate that all employers provide at least four weeks of paid leave
    - Increase the federal minimum wage to $15 an hour

- **Make workplaces safer**
    - Fund the Occupational Health and Safety Administration (OSHA) to investigate all workplaces where COVID-19 transmission has occurred
    - Mandate that OSHA promulgate safety guidelines for meatpacking and poultry plants, warehouses, nursing homes and other congregate living communities for seniors, and other workplaces that have already experienced widespread COVID-19 transmission
    - The COVID-19 transmission in these workplaces is not just a labor concern, it is a public health concern because workers return to their homes and communities and where they could further spread the virus
    - Require weekly COVID-19 testing of all workers and residents in these settings, not just COVID-19 testing for those exhibiting symptoms, since it has been estimated that at least 25 percent of persons infected with COVID-19 show no symptoms but can still transmit the virus

- **Make communities safer**
    - Mandate mask-wearing in all public indoor and outdoor spaces
    - Ensure that states accurately collect and report data on COVID-19 antigen testing, hospitalization, morbidity, and mortality to allow phased re-openings to be informed by public health experts using scientific data
    - Ensure that states report all COVID-19 testing, hospitalization, and death data stratified by “race”/ethnicity as well as by zip code
    - Ensure adherence to CDC guidelines in the phased re-opening and re-closing of states, counties, and cities
    - Fully fund the U.S. Postal Service to enable continued delivery of mail and medicines
    - Fund and equip local public health departments to be able to do weekly public health surveillance testing of probability samples of their populations to enable real-time assessment of the current level of COVID-19 infection in their jurisdictions (both symptomatic and asymptomatic), as opposed to using positive test results from symptomatic persons (which lag COVID-19 infection rates by 1

to 2 weeks), hospitalization rates (which lag infection rates by 2 to 3 weeks), or death rates (which lag infection rates by 3 to 4 weeks)
    - Fund free-standing isolation centers for those who test positive for COVID-19 and cannot safely return to their homes (e.g., older people, and vulnerable groups who do not have safe housing options) where their body temperatures and oxygen saturation levels can be monitored twice a day by health care providers who can also make timely transfers to hospitals as needed
    - Invest in the hiring, training, and deployment of local community members to build a diverse contact tracer workforce for their communities

- **Strengthen health care financing and the health care system**
    - Strengthen the Affordable Care Act
    - Expand access to Special Enrollment Periods (SEP) and Open Enrollment periods for the ACA Marketplace plans during the COVID-19 pandemic to all who need access to health care, especially those formerly covered by employer-sponsored health insurance who are now unemployed
    - Hire, train, and deploy more ACA Navigators to enable seamless access to health care coverage through the Affordable Care Act
    - Invest in minority-serving institutions at all levels to increase the number of Black, Latinx, and Indigenous health care providers coming through the pipelines
    - Increase investment in the National Health Service Corps to increase the number of providers in medically underserved areas and make medical education more accessible to students from low-income communities
    - Provide incentives to states that have not yet expanded Medicaid under the Affordable Care Act to do so now, so that all states expand Medicaid during this public health and health care crisis.

- **Protect civic and political participation in the time of COVID-19**
    - Fund states to enable the safe and secure receipt of mail-in ballots from all voters who desire to vote from home in elections at least through the end of 2021

- **Increase the protection of essential workers**
    - Provide N95 masks and protective gowns to all workers upon request
    - This might be more easily achieved if the Defense Production Act is activated with regard to the production of N95 masks
    - Provide hazard pay for all workers providing essential labor during the COVID-19 pandemic
    - Provide at least 4 weeks of paid leave for all workers

The following recommendations include more long-term solutions:

- **Value all individuals and populations equally**
    - Provide for equal protection of voting rights by strengthening the Voting Rights Act and instating provisions for review of changes in voting procedures by all states.

- **Recognize and rectify historical injustices**
    - Apologize for the enslavement of African people and their progeny for generations, acknowledging the role of their coerced unpaid labor to build this country
    - Provide reparations for Descendants of Africans Enslaved in the United States.

- **Provide resources according to need**
    - Massively invest in communities of color that have been historically segregated and disinvested by strengthening investments in quality housing options and schools, employment opportunities, green space and environmental clean-up services for the removal of polluting industries, healthy food access, beautiful recreation spaces, business investment, cooperative land ownership
    - Massively invest in programs to support all families with particular attention to families of color, including one year of paid maternal and paid paternal leave at the birth of each child and strong financial support for children and their families
    - These efforts will be deemed successful when the phrase "disadvantaged child" will have no meaning because it will be unthinkable that any child will be born into disadvantage

- **Measure the impacts of racism on the health and well-being of the nation**
    - Restore the CDC's Racism and Health Workgroup,[60] an official CDC scientific working group
    - Restore the 6-question "Reactions to Race" module as an optional module on the Behavioral Risk Factor Surveillance System (BRFSS) and consider moving the first two questions of the module to the BRFSS Core Questionnaire
    - Include the six reactions to "race" questions on the National Health and Nutrition Examination Survey, the National Health Interview Survey, and other national data collection efforts

- **Launch a National Campaign Against Racism**
    - In 2016, the American Public Health Association launched a National Campaign Against Racism with three tasks: Name racism, ask "How is racism operating here?", Organize, and Strategize to act[61]
    - At least eight U.S. counties – Milwaukee County and Dane County, Wisconsin; Allegheny County, Pennsylvania; Franklin County, Ohio; Genesee County, Michigan; San Bernardino County, California; Montgomery County, Maryland; King County, Washington – and nine U.S. cities – Pittsburgh, Pennsylvania; Columbus, Ohio; Somerville, Massachusetts; Medford, Massachusetts; Boston, Massachusetts; Cleveland, Ohio; Denver, Colorado; Indianapolis, Indiana; Flint, Michigan – have declared that racism is a public health crisis

- **Adhere to the United Nations International Convention on the Elimination of all forms of Racial Discrimination**
    - The International Convention on the Elimination of all forms of Racial Discrimination (ICERD) is an international anti-racism treaty adopted by the United Nations General Assembly in 1965

- The United States signed ICERD in 1966 and the United States Senate ratified ICERD in 1994, so that our country has obligations to comply with this international anti-racism treaty, including submission of periodic reports to the United Nations Committee on the Elimination of Racial Discrimination (CERD)
- In its 2014 Concluding Observations to the third periodic report submitted by the United States government, the UN CERD thanked for the United States for its report and then noted many "Concerns and Recommendations," including those related to disproportionate incarceration, the achievement gap in education, differential access to health care, and residential segregation
- The UN CERD also "recommends that the State party adopt a national action plan to combat structural racial discrimination"
- The UN CERD further "recommends that the State party increase its efforts to raise public awareness and knowledge of the Convention throughout its territory"

- **Support an Anti-Racism Collaborative with eight Collective Action teams:** Following are guiding questions and opportunities for action for each of the Collective Action Teams

  - **Communication and Dissemination**
    Guiding questions: How can we support the naming of racism in all public and private spaces? What tools and strategies are needed to start community conversations on racism?
    Opportunities for action: Develop a communication toolbox: allegories, billboards, films, podcasts, songs, tweets, webinars. Put racism and anti-racism on community agendas: Anti-Racism Conversation, Civic Dinners, Town Hall Meetings.

  - **Education and Development**
    Guiding questions: How can we support training around issues of "race," racism, and anti-racism at educational institutions of all levels? What does effective anti-racism curriculum look like?
    Opportunities for action: Convene anti-racism scholars and activists. Develop curricula for schools of public health, medicine, social work, law. Develop curricula for K-12 education. Publish allegories as children's books.

  - **History**
    Guiding questions: What is the history of successful anti-racism struggle in the United States and around the world? How can this history guide our anti-racism work today? How can we institutionalize attention to history in all decision-making processes?
    Opportunities for action: Teach our full histories: The 1619 Project from The New York Times, textbooks, museums, school curricula, after-school programs. Hire historians to staff City Councils, State Legislatures, U.S. Congress.

  - **Liaison and Partnership**

Guiding questions: What anti-racism work is happening at the community level? What anti-racism work is happening in other sectors? How can we create linkages?
Opportunities for action: Catalog and connect local anti-racism efforts throughout the nation and the world. Draft an anti-racism commitment agreement for communities, businesses, and organizations across sectors.

- **Organizational Excellence**
  Guiding questions: We must consider the ways in which we should answer the following question in each of our environments: "How is racism operating here?" in each of our settings? How do we examine structures, policies, practices, norms, and values?
  Opportunities for action: For example, identify policies that: allow segregation of resources and risks; create inherited group disadvantages and advantages; favor the differential valuation of human life by "race"; and limit self-determination.

- **Policy and Legislation**
  Guiding questions: What are current policy and legislative strategies to address and dismantle racism? What new strategies should we propose?
  Opportunities for action: Catalog formal anti-racism policies adopted by U.S. jurisdictions, including the state of Maryland, Milwaukee County, the state of New Mexico, and Seattle and King Counties in the state of Washington. Develop and disseminate model legislation addressing the many mechanisms of structural racism.

- **Science and Publications**
  Guiding questions: What research has been done to examine the impacts of racism on the health and well-being of the nation and the world? What intersection strategies have been evaluated? What new measures and methods are needed?
  Opportunities for action: Put measures of racism on population-based surveys: the Behavioral Risk Factor Surveillance System (BRFSS), the National Health and Nutrition Examination Survey (NHANES), the Youth Risk Behavior Surveillance Survey (YRBSS); Develop the science and practice of anti-racism.

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