Black Lives Matter: A Commentary on Racism and Public Health

The recent nonindictments of police officers who killed unarmed Black men have incited popular and scholarly discussions on racial injustices in our legal system, racialized police violence, and police (mis)conduct. What is glaringly absent is a public health perspective in response to these events.

We aim to fill this gap and expand the current dialogue beyond these isolated incidents to a broader discussion of racism in America and how it affects the health and well-being of people of color.

Our goal is not only to reiterate how salient structural racism is in our society, but how critical antiracist work is to the core goals and values of public health. (*Am J Public Health.* 2015;105: e27–e30. doi:10.2105/AJPH. 2015.302706)

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> "The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy."
>
> –*Dr. Martin Luther King, Jr.*[1]

"I can't breathe." "Hands up." "Black lives matter." These statements developed in reaction to the recent deaths of Eric Garner, an unarmed Black man strangled to death by police in Staten Island, New York, and Michael Brown, an unarmed Black adolescent shot to death by police in Ferguson, Missouri.[2] To racial scholars, activists, and many community members, these preventable deaths were only two recent examples of the stark racial injustices that have plagued our country's history. In both instances, the White police officers responsible for the deaths were neither charged with any crime, nor taken to trial.[3] However, despite the national and international media attention these cases drew,[4] they are by no means isolated incidents.[5] Moreover, despite the media's disproportionate focus on cases involving men,[5,6] intersectional analyses demonstrate that racialized police violence and misconduct are inflicted upon women and transgendered persons of color as well.[7–11]

These cases bring to light how racism, defined as a "system of structuring opportunity and assigning value based on race, that unfairly disadvantages some individuals and communities," and advantages others,[12(p10)] affects the daily realities in communities of color. As public health professionals, we are committed to achieving optimal health for all. Thus, these violent, premature deaths of people of color should enrage us because they directly oppose the vision of *Healthy People 2020*, "A society in which all people live long, healthy lives."[13] Therefore, our commentary calls upon our field to recognize the pervasive role of racism in public health and to reshape our discourse and agenda so that we all actively engage in racial justice work.

Our position is not a new one.[14–22] In 1998, the American Public Health Association (APHA) released a policy statement on the disproportionate impact of police violence on people of color.[20] This statement recommended strategies for reversing the trends; however, to date, there has been no record whether these policy recommendations have been implemented.[23] The relevance of the 1998 APHA statement to the most recent incidents of racialized police violence is chilling. Yet, almost two decades later, explicit conversations about racism remain glaringly absent from most mainstream public health discourse.

Although our commentary was motivated by the recent nonindictments in the Garner and Brown cases,[2-3] we intend to expand the conversation beyond these individual high-profile cases to discuss racism and public health more broadly. Specifically, our goal is to emphasize how race and racism in our society are central to the field of public health. The intent of our commentary is to (1) acknowledge racism as a critical public health concern, (2) distinguish between the constructs of race and racism for public health, (3) discuss the pervasiveness of structural racism in our society, and (4) offer calls to action.

CONFRONT RACISM AS A PUBLIC HEALTH CONCERN

First, we assert that racism as a social condition is a fundamental cause of health and illness.[24] As a growing body of research shows, racism is a social determinant of health[12,14–19,21,25–31] that perpetuates and exacerbates the very trends our field works to reverse. Therefore, public health, at its core, is antiracist work.

Health disparities, discrimination, and residential segregation, which are topics familiar to public health researchers, are by-products of racism.[12,15,17] Yet, these topics are often discussed without explicit acknowledgment of their connection to racism. Undermining or disguising the impact of racism on racialized health disparities enables the perpetuation of these inequities.[12] Moreover, to improve health outcomes, racism must be addressed not only by those whose work directly pertains to racialized health disparities or those who are racial/ethnic minorities themselves, but by all public health professionals. In many ways, our stance mirrors the position by Krieger on the role of poverty in health research.[32] Krieger describes the "intellectual responsibility" epidemiologists have to study the role of poverty on health outcomes, whether they consider themselves social epidemiologists or not.[32(p659)] Moreover, she asserts that epidemiologists "cannot afford to ignore poverty" irrespective of their specific topics of interest, because this would

jeopardize the scientific rigor of their work.[32(p658)] As public health researchers, students, and practitioners, we have a similar responsibility to directly confront, analyze, and dismantle racism.

Healthy People 2020 explains,

> achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[13]

Therefore, we posit that we will continue to fall short of local, state, and national goals to eliminate racialized health disparities if we ignore the multifaceted ways in which racism, as a societal epidemic, plays a dominant role in our communities.

RACE IS NOT RACISM

Second, race and racism are not interchangeable constructs. Each needs its own distinct conceptualization, measurement, and analysis for public health research.[17,19,33,34] Race is a social construction with no biological basis, whereas racism refers to a social system that reinforces racial group inequity.[12,35] Racialization is the process by which meaning and value are ascribed to socially determined racial categories, and each racial category occupies a different position in the social hierarchy.[35,36] For example, being Black (a race category) does not tell us much about one's health risks. However, being Black in America (a racially stratified society) has negative implications for educational and professional trajectories, socioeconomic status, and access to health care services and resources that promote optimal health,[37,38] which in combination, may reduce or exacerbate health risks. In a racially stratified society, White lives are inherently valued over Black lives.

Racism, defined earlier, is a system based on race that unfairly disadvantages some individuals and communities, and advantages others.[12] The health consequences of living in a racially stratified society are illustrated by a myriad of health outcomes that systematically occur along racial lines, such as disproportionately higher rates of infant mortality,[39] obesity,[40] deaths caused by heart disease and stroke,[41] and an overall shorter life expectancy for Blacks in comparison with Whites.[42] Thus, we argue that racialized health disparities are a consequence of racism, not race, per se.

Although both race and racism are relevant to health, typically only race is included as a research question, variable, or topic in most health studies.[12,15,17] Race, as it is conventionally conceptualized and operationalized in public health research, is not an adequate proxy measure for racism.[17,33,34] In addition, controlling for race in statistical analysis is a common practice in public health research and the research of other health professions. However, doing so will not advance our thinking about the impact of racism on health.[17,33,34] It is imperative that we improve our understanding of the mechanisms that potentially link racism to racialized health disparities.[12,19,29]

RACISM IS STRUCTURAL

Third, racism can include interpersonal acts of discrimination, but it is not limited to individual acts of bias.[35,43] Racism goes beyond individual attitudes or interpersonal exchanges and extends to structural factors such as institutional policies and societal norms.[35] A race-conscious approach to public health examines how racism operates at the individual, institutional, and societal levels to affect health outcomes.[14,15] Many widely used socioecologic frameworks recognize the dominant influence of structural factors on health outcomes.[44] For example, McLeroy et al. argues for closer examination and understanding of the existing power structures that may impede otherwise well-intentioned public health interventions.[44] We must recognize racism as a powerful, structural force that restricts the attainment of optimal health for all.

To this end, we urge for more consideration of the relevant "upstream" factors[45,46]—that is, "features of the social environment, such as socioeconomic status and discrimination, that influence individual behavior, disease, and health status"[46(p340)]—to recognize how structural racism operates. These factors include the entrenched racism in our legal, social, and political systems that enable police officers to disproportionately stop people of color, often without cause, and who do so with greater use of force without any repercussions.[47] Police violence is only one example of how structural racism functions in our criminal justice system.

Mass incarceration of people of color further exemplifies how structural factors, such as racial inequity and discriminatory practices within our criminal justice system, perpetuate racialized health disparities. Current estimates are that one in three Black men will be behind bars at some point in their lifetime.[48] The mass incarceration of Blacks is largely the result of institutional policies in our police and judicial systems, which includes aggressive enforcement of low-level drug crimes and mandatory harsh sentencing laws that disproportionately affect Blacks.[48–50] The consequences of mass incarceration extend beyond a prison sentence. Once released, individuals with a criminal record lose eligibility for social programs,[50] experience voter disenfranchisement, and face discrimination when seeking housing and employment, all of which are deleterious for the health and well-being of individuals, families, and communities.[50–52]

Although a more detailed discussion goes beyond the scope of this commentary, we recognize that the adverse health effects of structural racism are not limited to the criminal justice system. Prominent examples of structural racism also include residential segregation[38] and the digital divide,[53] which result in systematic disadvantages among people of color. Therefore, current efforts to reduce racialized health disparities will have limited impact without serious consideration of relevant structural factors.[44]

CALLS TO ACTION

Racism permeates our everyday lives, even if we do not readily acknowledge its power or pervasiveness.[35] We argue that addressing racism is central to eliminating racialized health disparities, and therefore, should be central to public health research and practice. We echo the principles of an "open society,"[22(p5)] one that is based on social justice that recognizes the equal value of all lives. We believe that collective efforts can help evoke social change and more generally reduce racialized health disparities and inequality.[54]

Inspired by, and in solidarity with, other position statements[20,55–59] on racialized police violence, we call on our colleagues to mobilize and

strategize a reformed public health agenda that recognizes the connection between structural racism and racialized disparities in health. Implementation of this agenda requires a multipronged, multilevel, and interdisciplinary approach. However, as public health professionals, we are uniquely positioned to facilitate the following responses.

Training

Consistent with our argument that the field as a whole needs to confront racism, we advocate for the integration of race-conscious curricula[60,61] in public health programs based on the social justice principles and history of public health. These curricula can include models, theories, and methodologies that explicitly recognize racial injustice as a threat to health.[14,18,62,63] Such an approach to training frames public health as inherently antiracist work, which has broad implications for the future public health workforce, both within and beyond academia.

Research

To advance our understanding and analysis of race, racism, and health, we call for more support of racism-related research. Potential sources for support include, but are not limited to, the National Institutes of Health and the Association of Schools and Programs of Public Health. A racism-focused research agenda can include the collection and provision of the data[47,64] necessary for developing and testing measures of racism, as well as delineating relevant pathways for health.[19,27–29,65,66]

Community-Engaged Advocacy

Public health researchers and practitioners must actively engage with communities of color to deepen our understanding of the pervasive and complex ways that structural racism affects individual and community-level health.[67] One strategy for fostering strong community partnerships is genuine pursuit of the Centers for Disease Control and Prevention Principles of Community Engagement.[68] Furthermore, we urge public health professionals to go beyond merely documenting health disparities and disseminating findings in scientific forums, and expand our professional responsibility to include community advocacy. We must stand with our community partners to advocate for relevant policies that improve health in communities of color, and support local, state, and federal initiatives that advance social justice.

CONCLUSIONS

We have (1) emphasized racism as a key fundamental cause of health that is crucial in the work of any public health professional, (2) discussed the importance of distinguishing between race and racism in public health work, and (3) described how racism goes beyond any isolated incident because it is structural.

A public health agenda, guided by the principles of social justice and equity, provide promising prospects for reversing the current inequalities. The tragic deaths of Eric Garner and Michael Brown remind us that as public health professionals we must critically evaluate our work, our values, and our impact vis-à-vis racism. We are convinced that we have an ethical and professional responsibility to address racism as an inherent component of health equity and optimal health for all. We believe that Black lives matter and that the field of public health can guide the nation toward ensuring they do. ■

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