Getting to the Root Causes COVID-19 Case Studies

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American Medical Association
African American Case

- Patient: Robert Thomas 56 y/o M
- PMH: Type 2 DM and HTN
- HPI: Presents to ED unconscious after hypoglycemic episode. Vital signs are within normal limits. Tests positive for SARS-CoV-2 upon admission.

- Personal Factors:
  - Education: Masters in Education
  - Employment: Food vendor
    - Laid off during pandemic
  - Living situation: Travels between two homes - one with 84-year-old father in NYC co-op
  - Transportation: Public
  - Most family members are far away in other states

- Magnifiers of Health Inequity:
  - AA more likely to have T2DM
    - Increased risk of contracting COVID-19
    - Increased risk related to higher levels of chronic stress
  - AA disproportionately affected by layoffs during the pandemic
  - AA rely more heavily on public transportation
    - Increasing risk of COVID-19 exposure
  - AA more likely to receive poor quality care
    - Mr. Thomas was not given insulin for 5 days of his hospital stay
Immediate causes and considerations

• Myths, misinformation, and lack of clear messaging
  • Crisis in national leadership and risk communication
  • Invisibility of public health leadership
  • Public health infrastructure fault lines – tremendous disinvestment
• Healthcare system experiences in equities
  • Segregated – affects quality of care, payment types, location
  • In times of ‘rationing’ – physician bias & discrimination exacerbated
  • Lack of trust
• Inequities in health outcomes
• Inequities in social drivers of health
  • Overcrowding, isolation of elderly, reliance of public transportation, more exposure to service jobs
Causes of the Causes
Institutionalizing Anti-Blackness

- Dehumanization of people of African Descent
- Chattel property
- 3/5 of a Human
- Established Slave Codes

ENSELAVEMENT OF AFRICANS 1619 - 1865
- Development of Black Codes
- Sharecropping
- Mass Lynchings

RECONSTRUCTION 1865 - 1877
Codified Racial Segregation in Law
- Developed Institutionalized practices for de jure segregation
- Depictions of Black Caricatures
- Mass Lynching

JIM CROW PERIOD
1890 - 1965

Civil Rights Acts
- Advent of Globalization.
- Systematic Dismantling of Black Power Movement
- Mass Police Killing

CIVIL RIGHTS
1965 - 1980

Mass Incarceration
- War on Drugs
- War on Gangs
- Disproportionate Police Surveillance
- Stop and Frisk
- Operation Clean Halls
- Mass Police Killings

PRESENT DAY
1980 – Present
Redlining Practices and Policies
Forced segregation and the deprivation of resources
Forced Segregation and Integration of Health Care
Impacts on the workforce and health outcomes still present
Structural Context: Case 1
Navajo Nation COVID-19 Case

- Patient: Ashley Martinez, 50 y/o F
- PMH: HTN and TYPE 2 DM
- Symptoms: Fever, dyspnea, and anosmia
- Complicating Factors: Deficient access to medicine and continuity of care, two hour drive to and from hospital, need for further transport

**Magnifiers of Health Inequity:**
- Limited access to fresh foods
- 10% of NN without electricity
- 30/40% of NN without running water at home
- Contaminated water supply and buildings
- Increased chronic disease burden as a result of these factors
Immediate causes and considerations

- Myths, misinformation, and lack of clear messaging
  - Crisis in national leadership and risk communication
  - Invisibility of public health leadership
  - Public health infrastructure (IHS) fault lines – tremendous disinvestment
  - “Invisibility” in data collection & media
- Healthcare system experiences in equities
  - Affects quality of care, location, shortage of physicians
  - In times of ‘rationing’ – physician bias & discrimination exacerbated
  - Lack of trust
  - Lack cultural responsiveness and relevance
- Inequities in health outcomes
- Inequities in social drivers of health
  - Distant healthcare facilities, transportation, lack of consistent food and water, unemployment
Navajo Nation COVID-19

Across the Navajo Nation

- Total population: 332,129
- Life expectancy: 74 years
- Prevalence of diabetes: 22%
- Population living below national poverty line: 38%
- Unemployment rate: 55.9%

https://www.pih.org/country/navajo-nation

<table>
<thead>
<tr>
<th>Federally Funded Healthcare Programs (Excluding US)</th>
<th>2002</th>
<th>2011</th>
<th>2013</th>
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<tr>
<td>IHS</td>
<td>$1,914</td>
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<tr>
<td>Medicare</td>
<td>$6,823</td>
<td>$11,220</td>
<td>$11,220</td>
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</tbody>
</table>

Source: James, Nathan: *The Federal Population Buildup: Overview, Policy Changes, Issues, and Options*; Congressional Research Services, April 15, 2014 (Secondary Data)

* A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country. United States Commission on Civil Rights, July 2003 (Secondary Data)

Medicare Enrollment – National Trends 1966-2013, Data accessed from CMS.gov November 2015 (Primary Data)
Dine’ Cultural Context of Well Being

- Individual’s actions and behaviors influence the balance of the intrinsic core values tied to the domains of knowledge or their internal constitution; nitsahakees (mental), ats’os (body), ani’(heart, mind) and hoghan haz’angi (home-place). Balance is characterized by a person’s thinking free from stress, being in line with the morals placed in the four areas of knowledge, the body nurtured with health, being secure in their sense of belonging in a family, community, and comfortably secure in their home and environment. This balance is called hozhoogo na’adah being able to walk in the light of the Holy Ones with health, peace and harmony in the family, community and home-place.

Time-Lapse of United States land seizure of approximately 1.5 billion acres from 1776 to present
CONTEXT

Historical, political, and cultural
Lack of proximity to the injustice

Not visible to CEOs, physicians, C-suite occupiers
“Because of advances of medical knowledge, the medical school curriculum has become so crowded that the social importance of preventive medicine and public health is seldom emphasized. This creates a blind spot which often persists throughout professional life and results at times in misunderstanding between the practicing physician and the constituted health authorities of the community.”

J. A. Miller, George Baehr, and E.H.L. Corwin, 1942
Ecosocial Theory
Nancy Krieger, PhD
America: Equity and Equality in Health 3

Structural racism and health inequities in the USA: evidence and interventions

Zinzi D Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett

Despite growing interest in understanding how social factors drive poor health outcomes, many academics, policymakers, scientists, elected officials, journalists, and others responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities. In this conceptual report, the third in a series on equity and equality in health in the USA, we use a contemporary and historical perspective to discuss research and interventions that grapple with the implications of what is known as structural racism on population health and health inequities. Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources. We argue that a focus on structural racism offers a concrete, feasible, and promising approach towards advancing health equity and improving population health.

Introduction

Racial and ethnic inequalities, including health inequalities, are well documented in the USA (table), and have been a part of government statistics since the founding of colonial America. However, controversies abound over explanations for these inequities. In this report, we offer a perspective not often found in the medical literature or taught to students of health sciences, by focusing on structural racism (panel 1) as a key determinant of population health. To explore this determinant of health and health equity, we examine a range of disciplines and sectors, including but not limited to medicine, public health, housing, and human view—one that identifies and seeks to alter how such racism contributes to poor health—is required to understand, prevent, and address the harms related to structural racism. There is a rich social science literature conceptualising structural racism, but this research has not been adequately integrated into medical and scientific literature geared towards clinicians and other health professionals. In this report, we examine what constitutes structural racism, explore evidence on how it harms health, and provide examples of interventions that can reduce its impact. Our central argument is that a focus on structural racism is essential to advance health equity and improve population health.
Racism is a System of power and oppression that structures opportunities and assigns value based on race, unfairly disadvantaging people (racial oppression), while unfairly advantaging others (racial privilege & supremacy).

Internalized-Interpersonal-Institutional-Structural
“To understand the root causes of the pathologies we see today, which impact all of us but affect Brown, Black and Poor people more intensely, we have to examine the foundations of this society which began with COLONIZATION.... Colonization was the way the extractive economic system of Capitalism came to this land, supported by systems of supremacy and domination which are a necessary part to keep wealth and power accumulated in the hands of the colonizers and ultimately their financiers.” — Dr. Rupa Marya
“Johan Galtung introduced the term “structural violence” in 1969 to explain the process by which social institutions caused harm to individuals or groups by preventing them from reaching their potential or by depriving them of the resources they need to survive.”
8 of the 10 Leading causes of death linked to early traumatic exposure...

As are over 40 health conditions
Participants who suffered three or more adverse childhood experiences had much higher rates of:
- Substance abuse
- Domestic violence
- Suicide attempts

Were more likely to have:
- Dropped out of school
- Divorced
- Diabetes
- Obesity
- Cancer
- Heart disease
Dominant narratives, embedded in our institutions and culture, represent voices reinforcing social relations that generate social, political, and economic inequality and racial injustice, marginalizing or silencing the voices of social groups with limited power. These narratives shape consciousness, meaning, and explanations of events.

Their effect is to **obscure power (and responsibility)**, divide populations with common concerns, enforce compliance, and ensure that opposing visions of society's future do not become reality.
Narratives Shape Our Beliefs
...dominant narratives undermine health equity

• Racial and class inequities are “unfortunate, but not necessarily unjust”
• Self-determining individuals make right or wrong “lifestyle” choices (Rendering political, structural, and social determinants of health inequities invisible)
• Cultures of oppressed and marginalized racial and ethnic groups are responsible for and blamed their own poorer health outcomes
• Pick ourselves by our bootstraps
• Creates "othering” and “belonging”
Use Power and Privilege
Advocate to create narrative, structural, and policy change

#NYCHealthEquity
To move forward, it is important for our leaders to understand the ubiquitous nature of racism and its historical lineage across all nations. The devastating effects of slavery, colonialism and resource-driven conflict have been well-documented, yet we have not done enough to challenge the ideology of racial hierarchy that supported and sustained these ills. To this day, we still see a world where the nations that benefitted the most from the slave trade and colonial ambition remain the most economically and technologically developed. These countries, paradoxically, are often the most reluctant to confront or discuss the impact race has on the day-to-day lives of their citizens.
Physicians’ powerful ally in patient care