How Does the Law, Past and Present, Affect Health Equity?

Full Script

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Introduction & Presentation Overview

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Welcome to the Public Health Law Academy's training, How Does the Law, Past and Present, Affect Health Equity? This training is Part 1 in a two-part series exploring the social determinants of health, health equity, and the law and is brought to you by ChangeLab Solutions and the Centers for Disease Control and Prevention's Public Health Law Program.

Health departments and organizations play many roles: employers, regulators, data collectors, service providers, educators, and funders – to name a few. All of these roles and everything that a health department does, can – and should – be used to advance health equity. However, in order to promote health equity, it is important to first understand how laws drive structural discrimination, and more specifically, structural racism, which creates and reinforces health inequities. Then we can use this knowledge to address laws and policies within public health that have contributed to multigenerational harm.

This two-part series is meant to serve as a foundation for all Public Health Law Academy trainings, including our module, "Public Health Law: Past and Present," which illustrates some of the important ways that public health law can positively impact health. This series of trainings focuses on how many of our laws have also harmed communities and explores how we can use public health to remedy those harms and improve health equity. We encourage you to engage in this material and think about where, in your practice, you can use the tools of law and policy to promote health equity.

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Before we begin, we remind you that the information provided in this training is for informational purposes only and does not constitute legal advice. ChangeLab Solutions does not enter into attorney-client relationships.

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Furthermore, while every effort has been made to verify the accuracy of these materials, legal authorities and requirements may vary from jurisdiction to jurisdiction. The contents of this presentation have not been formally disseminated by the Centers for Disease Control and Prevention and should not be construed to represent any agency determination or policy. Always seek the advice of an attorney or other qualified professional with any questions you may have regarding a legal matter.

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Before diving in, we want to acknowledge that this training touches on content that is equal parts critical, complex, and urgent.

We'll be offering examples to illustrate how discrimination has contributed to the inequities we see today. Many of these examples feature violence, racism, and violations of civil rights guaranteed by the US Constitution. We recognize that each viewer comes to this discussion with unique life experiences, so different parts of this module may carry different meaning and impact.

We encourage you to take breaks or step away as needed, and to move through this material at a comfortable pace.

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We want to provide a quick overview of what we'll discuss today and thought it might be helpful to start by saying a few words about what this session isn't. This session is *not* a step-by-step guide that will teach you in under an hour all you need to know about achieving health equity. If only it were that simple. The reality is that this is a complex subject, and there is no single playbook for doing or achieving equity. It is also not a diversity, equity, and Inclusion training.

Our goal for this session is to:

- First, do some level setting and answer the question, "What is health equity?" by laying a foundation of key concepts related to health equity and structural discrimination and discussing existing frameworks, including the CDC's 10 Essential Public Health Services. Because structural racism is the root cause of many inequities we see today, we focus specifically on redressing anti-racist policies, and particularly anti-Black policies; however, we acknowledge up front the pervasiveness of discrimination based on other classifications of race, as well as gender, ability, national origin, and sexual orientation.
- Second, we will explore how structural racism is rooted in our country's legal legacy and history.
- Then, we will take a deeper dive into examining how our laws, both past and present, contribute to the health inequities and multigenerational harm we see today.
- Finally, we will begin to explore how inequities can be repaired. As part of this discussion, we will distill some of the key themes and takeaways into guiding principles that practitioners can incorporate into their efforts to dismantle structural discrimination and advance health equity.

I want to emphasize that we see this as the start of a conversation, which we hope you all continue in your own public health efforts. Part 2 of this training series, which we won't talk about today, builds on today's training and offers resources and tools to incorporate into your work.

We recognize that many folks taking this training may be at different stages and have different priorities – and even differing opinions – when it comes to health equity. From a public health perspective, it is critical that we as practitioners take an equity-focused approach. As we discuss shortly, this is essential to improve population health outcomes rather than widen disparities.

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Throughout this training, we encourage you to think about how to ensure that health equity is centered on your work. As we go through the training, we provide an equity icon that designates equity practice tips, like the one on the left side of this slide. We use it to highlight opportunities to apply equity-promoting strategies in your day-to-day work. We also encourage you to think of examples from your own experience.

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Let's begin with the first set of questions: What is health equity, and why does it matter for public health practice? We'll define some of these terms in a moment, but I wanted to first say a few words about public health.

For decades, the approach in public health to improving health has been to "move upstream" – that is, to move solutions toward addressing the root causes of health problems. For example, public health efforts have focused on preventing obesity and heart disease by creating environments that support physical activity and provide access to healthy food.

But despite many successes, health outcomes for some populations have not improved enough. In fact, in some cases, health disparities have increased at alarming rates. Without understanding and directly addressing how our laws and policies affect the health and well-being of people differently, public health, despite its best intentions, will contribute to the widening of health inequities.

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Consider, for example, maternal and infant health.

The United States leads the world in medical research and spends more on health care than any other country in the world. In particular, we have seen significant medical breakthroughs in maternal and infant health in past decades. Yet a newborn is more likely to survive in countries like Cuba, Poland, and Slovakia than a baby born in the United States. Why this disconnect?

When we look at the data closely, we see that this is because particular groups of Americans disproportionately bear the burden of higher mortality rates. In 2017, the *Nation* published an article posing and examining the question, "What's Killing America's Black Infants?" It found that "across the United States, black infants die at a rate that's more than twice as high as that of white infants. The disparity is acute in a number of booming urban areas, from San Francisco – where black mothers are more than six times as likely to lose infants as white mothers – to Washington, DC. In the capital's Ward 8, which is the poorest in the city and over 93 percent black, the infant-mortality rate is 10 times what it is in the affluent, predominantly white Ward 3."

What accounts for these stark differences in maternal and infant health outcomes? Keep this question in mind during our discussion today, when we talk about some of the key factors that affect health outcomes and are beyond an individual's control, including the compounding effects of experiencing racism and other social determinants of health.

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"Social determinants of health" is a term that may be very familiar to many of you steeped in public health research or practice. To ensure we're all on the same page, the Centers for Disease Control and Prevention defines the social determinants of health as "the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems."

We know from public health research that environmental factors – including the social determinants of health – not only account for about 50% of a person's health status, but they influence all of the other factors that affect health, including access to quality health care and health behaviors. The major effect that the social determinants of health can have on people's health, well-being, and quality of life underscores why efforts to improve these larger systemic and structural forces can have such widespread benefits.

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In August 2020, the US Department of Health and Human Services launched Healthy People 2030, its 5th – and most current – iteration of the Healthy People Initiative ("a federal initiative that provides 10-year, measurable public health objectives and tools to help track progress toward achieving them").

Healthy People 2030 centers health equity and identifies five domains in which social determinants of health can be grouped: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

Throughout today's training, we'll explore how the social determinants of health – which include safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; and access to nutritious foods and physical activities, to name a few – are important to people's health, well-being, and quality of life.

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The law plays a powerful role in determining the distribution of money, power, and resources, which in turn shapes the social determinants of health. We address the law in more depth in Part 2.

The National Academies of Sciences, Engineering, and Medicine, among other institutions, have acknowledged that law and policy are directly linked to the social determinants of health. Because of this interconnectedness, we now recognize the law as a determinant of health. Public health law professor Larry Gostin coined the term "legal determinants of health" because it "demonstrates the power of law to address the underlying social and economic causes of injury and disease."

We will explore how the law, past and present, has shaped differences in health outcomes and continues to do so.

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Let's take a few minutes to consider how using law and policy to address the social determinants of health while working in partnership with other sectors of government and the communities they serve aligns with public health practice.

The 10 Essential Public Health Services provide a framework for describing and assessing the quality of public health practice in the United States. They are important because they provide the structure for voluntary public health accreditation and are reflected in the National Public Health Performance Standards. The 10 Essential Services expand on the three core functions of public health that were established in 1994.

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Those functions are assessment,

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policy development,

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and assurance.

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This recent update to the 10 Essential Public Health Services strengthens their focus on equity. According to the CDC, "To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression."

In the context of the social determinants of health, these services can take shape in a variety of ways. When assessing and monitoring population health, for example, you might foster relationships with communities and multisectoral partners in community health assessment efforts. If your agency is trying to use legal and regulatory actions designed to improve and protect the public's health, this may involve developing strategies to ensure the enforcement of existing regulations and laws with an impact on health, such as housing and health codes to prevent childhood lead poisoning.

In Part 2, we take a deeper look at how this works in practice. But for now, I will briefly illustrate how the law is a factor that affects health.

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This map shows life expectancy along a highway in California. The highway runs through multiple counties, with multiple freeway exits that illustrate a wide range of life spans, ranging from 75 years to 87 years.

How might differences in the law have created differences across jurisdictions? Merced County has some of the highest life expectancy rates (87 years and 78 years) in comparison to Fresno, for example, where the life expectancy off exit 132 is 75 years. What might account for these differences?

Merced County law may include specific regulations about housing, zoning, smoking, road safety, or clean water that Fresno County does not. Or maybe Merced County and Fresno County have the same laws, but they differ in how those laws are implemented or enforced.

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Stark differences exist *within* jurisdictions too. Zooming in on Fresno County, we learn that there are neighborhoods which are within miles of each other. Yet the life expectancy for residents living off exit 140 (84 years) is 9 years more than residents living off exit 132, where the life expectancy is 75 years. Why?

Perhaps there are historical (like redlining policies, which we will talk more about later in this training), environmental (such as air quality), and socioeconomic (like poverty rates or educational disparities) factors that might affect health outcomes. For that reason, we'd also want to learn about some of these contextual factors that may be shaping health disparities within and across jurisdictions.

Keep these questions around what policies and forces may have created these differences in mind. These are some of the questions this training seeks to address. We'll return to the example of Fresno and explore some of the root causes of these differences there later in the training.

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Let's pause for a question. Individual choices determine our health outcomes far less than we think. True or false?

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The answer is "True." Differences in health outcomes across populations are the result of many factors beyond any one individual's or population's control that compound over time.

Consider differences in smoking rates, for example, which are not entirely the result of individual choices to smoke. It is not by coincidence that tobacco retailers are disproportionately concentrated in low-income neighborhoods or that the tobacco industry intentionally targets people of color in marketing campaigns.

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We know from public health research that there are differences in health outcomes – what are often referred to as "health disparities." The CDC defines health disparities as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that have been disadvantaged by their social or economic status, geographic location, and environment."

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Margaret Whitehead, an influential researcher on social inequality, expands on the concept of health disparities in her writing on health inequity. She adds a moral dimension to the concept by defining health inequities as "differences in health, which are not only unnecessary and avoidable but, in addition, are considered unjust and unfair."

People tend to use the terms "health disparity" and "health inequity" interchangeably, but we want to be clear about the underlying concept. When we talk about health inequity, we are not merely talking about different health outcomes between populations. We're talking explicitly about differences that are avoidable, unfair, and unjust.

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The inequitable distribution of healthy environments, economic resources, and opportunities can also compound and lead to repeated exposure to stress that can have a negative impact on the brain and body. The term "weathering" was coined by Dr. Arline Geronimus in 1992 to describe the deterioration of health from the effects of cumulative socioeconomic disadvantage.

The term "allostatic load" refers to the wear and tear on the body from chronic exposure to stress. Dr. Geronimus used the measurement of allostatic load to measure the impact of weathering. While some stress is natural and can even help us develop healthy stress responses, researchers have found that high allostatic loads (such as from adverse childhood experiences, which the CDC defines as "potentially traumatic events that occur in childhood," intergenerational trauma, and racism) accelerate deterioration of health.

With this in mind, we can begin to understand how repeated exposure to discrimination can compound over time and manifest in the body, contributing to some of the health inequities we see today, including the stark racial differences in birth outcomes that we discussed earlier.

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A 2006 study published in the *American Journal of Public Health* found that Black people "experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization" and that these effects were particularly acute among Black women because of "double jeopardy" – gender and racial discrimination.

Characteristics like race, class, gender, sexual orientation, and ability don't exist as separate categories. They mutually reinforce each other and are entirely interconnected.

Professor Kimberlé Crenshaw explains this as "intersectionality," or "a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LGBTQ problem there."

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Now that we know more about health *inequity*, we'll discuss what we mean when we say health *equity*.

There are many definitions; however, one frequently cited definition that captures the complex nature of health and health equity is from Dr. Paula Braveman, one of the nation's leading experts on health equity and health disparities. She explains, "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." It means everyone has access to the resources and opportunities they need to thrive, regardless of characteristics like race, ethnicity, gender, or sexual identity.

At the core of equity is a focus on fairness, justice, and opportunity.

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In order to move toward true equity, we must understand the difference between equity and equality.

The image here illustrates this difference in a helpful way. The image at the top is an illustration of equality. An intervention focused on equality would apply the same one-size-fits-all solution to everyone in this image, regardless of need. Here this is illustrated by giving these four individuals the same bicycle. That sounds pretty good so far. But take a closer look.

The bicycle may be a good fit for the two individuals in the middle, but what about the child in the wheelchair on the left? And how about the child on the right, who struggles to reach the pedals? This scenario demonstrates how an equal approach – even a well-intentioned one – doesn't necessarily benefit everyone equally. The two individuals in the middle might be well on their way, while those on either side are left behind. An equitable approach means focusing on ensuring that people have what they need to thrive. And beyond that, it acknowledges the reality that not everyone starts off at the same place. What one person or population needs might be different from what another needs.

When we fail to design projects or interventions with equity in mind, there is potential for our efforts – again, even well-intentioned ones – to not only maintain inequity but in some cases to actually widen it. In the illustration for equality, providing a bike to everyone will give the two individuals in the middle the means to take off, while those on either side are left even farther behind.

Still, this example, which suggests that giving each person a bike suited to their individual needs achieves equity, has some significant limitations. First, although bicycles can be built for some people who use wheelchairs, there are many other people with disabilities for whom even modified bicycles are not an inclusive or accessible form of transportation. A more equitable intervention would allow each person to choose from an array of vehicles and determine the one that works best for their needs. Additionally, this example has left out the broader structural conditions within which each individual is traveling. Do they have access to a bike lane? How much car traffic is in their neighborhood? What about air pollution? And how far do they have to travel to get where they need to go? Equitable interventions must address these questions, providing not just an accessible vehicle but aiming to change the conditions that make it unsafe or more difficult for some individuals to get on a bike in the first place.

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Having a shared understanding of health equity is critical. We can't improve health for everyone without taking an equity approach. How organizations and teams talk about inequities will shape the approaches they use to advance health equity. A project explicitly focused on improving health equity might take a very different direction than one that's focused more generally on improving health for everyone.

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Let's pause for another question. Adopting an equal approach to health benefits everyone equally. True or false?

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The answer is "False." Remember the bicycle example. An intervention focused on equality would apply the same one-size-fits-all solution to everyone in the image regardless of need. An equitable approach means a focus on ensuring that people have what they need to thrive. Beyond that, it acknowledges the reality that not everyone starts off at the same place. What one person or population needs might be different from what another needs.

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Why is health equity important to public health practice? We'll take a deeper dive into this question in Part 2 of this training series, but it's important to address here as well to provide some additional context around the rest of our conversation.

There's certainly a moral argument to make here about ensuring everyone has access to the resources and opportunities they need to thrive, regardless of characteristics like race, ethnicity, gender, sexual identity, and more. And there's also a very practical point: as public health practitioners, we have to focus on equity in order to correct disparities, rather than widen them, and to improve health outcomes at a population level, which is the whole point of public health.

We know that from an evaluation perspective, populations with worse health outcomes also stand to benefit the most from public health interventions (if done well). Not only are health outcomes deeply influenced by institutional and structural forces that shape access to opportunities and resources needed to thrive, but when individual populations suffer, society as a whole suffers.

At a time when health departments are stretched thin and resources are limited, it is particularly important to take an approach that targets resources with an equity lens in order to ensure resources are directed in a way that can yield the greatest impact. Many preventable health problems share the same root causes, so identifying intersections, sharing expertise, and joining forces can benefit everyone.

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This has been a lot of content and terms to run through right off the bat, so let's take a moment to pause and process what we just discussed.

Here are some of the key takeaways we hope you will keep in mind during the rest of the training and in your public health work:

- An understanding that health equity means social justice in health – that everyone has access to the resources and opportunities they need to thrive, regardless of characteristics like race, ethnicity, gender, sexual identity, and more.
- Individual choices determine our health outcomes far less than we think.
- Law and policy are key determinants of health.
- Designing and implementing laws and policies with health equity in mind is vital. Otherwise, we run the risk of failing to improve population health outcomes or, worse, exacerbating health inequity.

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To understand how some of these inequities came about, we need to explore the underlying laws and policies that have led to these outcomes. Some have *explicitly* created differential treatment and outcomes based on race (such as separate but equal public policies, racial covenants, and government-sanctioned land takings), while others have appeared "race neutral" – that is, although the policies did not explicitly state that people of different races were being treated differently, that was the true intent and effect. These supposedly race-neutral policies are equally powerful in driving some of the broad determinants that shape many health inequities today.

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To help illustrate the development of laws and policies that have perpetuated structural discrimination and contributed to present-day health inequities, we have included the gavel icon (depicted here) on each of the slides that discuss those laws.

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Before diving in, let's pause for a question. While understanding the legal legacy of structural discrimination is important, it is not directly related to public health practice today. True or false?

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The correct answer is "False." As we'll explain on the next slide, understanding the history is so important to the practice of public health today for three key reasons.

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First, the legacy of unjust laws and policies is still with us today and contributes to growing health inequity.

Second, many health departments work with communities that face deep challenges – for example, income inequality, growing distrust of government and institutions, the effects of changing climate and health, falling life expectancy, and widening health inequity.

And finally, understanding and acknowledging this history is essential to redressing structural discrimination and achieving health equity. It is important to first understand how laws drive structural discrimination (we'll address this in a moment). Then we can use this knowledge to dismantle the structures that reinforce health inequity, including the laws and policies within public health that have contributed to multigenerational harm. As we'll discuss more in the final part of this training, failing to do so may result in selecting interventions that are at best ineffective or at worst harmful.

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We often think of discrimination as something that occurs on an interpersonal or individual level – adverse actions taken against someone as the result of individual prejudice or bias, such as racism, sexism, xenophobia, or homophobia. Many of the examples we discuss today, however, are forms of structural discrimination, which occurs when systems (rather than individuals) unjustly deny wealth, opportunity, power, or government representation on the basis of characteristics such as race, gender, sexual orientation, social class, and immigration status. It accounts for how multiple dimensions of identity and interlocking systems of oppression shape individual experience.

Today, we'll take a look at some of the ways in which one form of discrimination, structural racism, operates through policies, cultural norms, and institutional practice.

Note that the examples we highlight in the subsequent slides are by no means an exhaustive or all-encompassing list. To illustrate how laws drive health inequity, we focus on the experiences of Black and indigenous people; however, we recognize that other communities (including communities of color, LGBTQ communities, individuals with disabilities, communities with low socioeconomic status, women, and immigrant communities) have experienced unequal treatment under the law that leads to negative health consequences. Our hope is to walk through a few examples to illustrate how our laws, both past and present, have led to widening health inequity. We encourage you to examine similar histories in your communities and how the law has unfairly and repeatedly harmed groups experiencing the disproportionate impact of health inequity.

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We'll explore some of the tangible and powerful ways that health departments and their partners can address structural discrimination, but here are some initial guiding questions that we encourage you to revisit whenever thinking about the potential equity implications of public health efforts.

Of course, this is a simple exercise that cannot capture all the nuances of promoting health equity in your work, but it can provide a helpful starting point for ensuring that public health efforts do not cause unintended negative consequences or exacerbate health inequity.

- First, ask who has been harmed by the law or left out of the policymaking process? How have certain populations experienced disproportionate rates of health harms as a result of unjust systems and structures? Understanding the legal history and how it has created systems and policies that perpetuate inequity is essential to answering this first question.
- Second, who stands to benefit from a particular policy, and how exactly would they benefit? Are they benefiting at the expense of others? Voting laws are an illustrative example. Without representative government and meaningful input from people who have historically been – and continue to be – disenfranchised, laws and policies will continue to disproportionately benefit those who have greater power to participate in and influence legal and political processes.
- Finally, what actions can be taken to redress inequity? How might laws and policies be tailored to minimize potential negative consequences and maximize benefits for people experiencing health inequity? We'll unpack this more later in this module, but again, understanding the history is important to avoid making the same mistakes of the past.

I also want to make another plug for legal epidemiology, which we mentioned earlier, as a way to study the impacts the law has on health. If you're interested in learning more about scientific approaches to tracking and analyzing how certain laws and policies can affect health, we encourage you to check out our three-part legal epidemiology training series, which is also part of the Public Health Law Academy.

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Before moving ahead, I have a reminder about content in our training. We are about to cover historical events such as:

- the Indian Removal Act of 1830 (and the Trail of Tears),
- assimilationist and elimination policies of the 19th and 20th century (including the Boarding School Experiences), and
- Jim Crow era laws and violence, as well as other examples.

The content is graphic and intense.

We are committed to confronting even the most disturbing parts of our public health law history because doing so is critical for:

- correcting social injustices in the future by guaranteeing constitutional and human rights,
- rebuilding trust with the communities we serve as public health practitioners, and
- ensuring that health equity is centered in all our public health activities.

Please move through this material at a comfortable pace and pause as needed.

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Let's take a closer look at the deeply entrenched roots of structural discrimination in our laws and how these laws – both past and present – have contributed to the inequities we see today.

We'll start the conversation with the founding of this country, focusing on the generations of genocide committed against Native Americans, starting when the first European colonizers settled in what is now the United States.

Researchers explain that this colonization and genocide laid the foundation for "both legal and tacit systems of racial oppression" that still exist today and account for why some groups – including American Indians and Alaska Natives – experience the highest rates of inequity across all key indicators of health.

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In addition to hundreds of years of violence, genocide, and disease, the United States further perpetuated structural discrimination through forced land acquisitions. In 1830, for example, President Andrew Jackson passed the Indian Removal Act, which forced thousands of Native American families to relinquish more than 25 million acres of fertile, lucrative farmland in the East, uproot their communities, and relocate to "Indian Territory" (which is now the state of Oklahoma). More than 4,000 died from starvation, extreme weather, and disease in what became known as the Trail of Tears.

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The Indian Removal Act came on the heels of the Civilization Fund Act of 1819, which led to a series of assimilationist and eliminationist policies intended to "fix" the country's so-called Indian problem. These policies, and the series of seminal Supreme Court decisions that ensued, are stark examples of government-sanctioned violence against American Indians and Alaska Natives, wholesale land takings, and removal of entire nations from their homeland.

The consequences of these racialized, assimilationist, and eliminationist policies can still be seen today. For example, they are embedded in Native American tribal governments' separate political status – and the federal government's failure to uphold its trust responsibility – and account for why tribal nations are often isolated on reservations or small parcels of land in remote areas of the United States.

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For example, they are embedded in American Indians' separate political status – and the government's failure to uphold its trust responsibility – and account for why American Indian nations are often isolated on reservations or small parcels of land in remote areas of the United States.

It is important to acknowledge the unique political status of American Indian and Alaska Native people because of the federal government's trust responsibility – a legal principle, dating back to the founding of this country, that requires the federal government to support tribal self-government and economic prosperity, protect tribal land and resources, and ensure the survival and welfare of American Indian and Alaska Native tribes and people.

However, the federal government's continued failure to uphold its legal trust responsibility is well documented, including in the United States Commission on Civil Rights 2018 report (pictured here). One of the key recommendations in the report included the following: "The United States expects all nations to live up to their treaty obligations; it should live up to its own."

Unfortunately, when we look at the legal history all the way to the present day, we see that this is not the case.

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One of the more immediate effects of the assimilationist policies of the 19th and 20th centuries was that they led to the Indian boarding school era when children as young as 4 and 5 years old were removed from their homes and sent to off-reservation boarding schools created to "destroy and vilify Native culture, language, family, and spirituality."

This account describes a typical experience:

"Students were stripped of all things associated with Native life. Their long hair, a source of pride for many Native peoples, was cut short, usually into identical bowl haircuts. They exchanged traditional clothing for uniforms and embarked on a life influenced by strict military-style regimentation. Students were physically punished for speaking their Native languages. Contact with family and community members was discouraged or forbidden altogether. Survivors have described a culture of pervasive physical and sexual abuse at the schools. Food and medical attention were often scarce; many students died. Their parents sometimes learned of their death only after they had been buried in school cemeteries, some of which were unmarked."

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I want to highlight the research that Dr. Donald Warne and Dr. Denise Lajimodiere have done around the psychosocial influences of American Indian health inequity and spend the next few slides walking through their model, which powerfully shows how structural discrimination, violence, and intergenerational trauma experienced throughout the history of colonization have contributed to the chronic disease inequity among American Indian and Alaska Native communities today.

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Poor mental health outcomes – including adverse childhood experiences – are a strong predictor of risk for numerous chronic and behavioral health conditions, including heart disease, diabetes, cancer, depression, suicide attempts, and tobacco use.

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Although this is not represented in the diagram, I want to call out the impact that historically racist policies, like those leading to the American Indian boarding school experience, had on educational attainment – a key determinant of health. Today, we see stark inequity between American Indian students' educational outcomes and that of nearly all other racial groups. According to the National Conference of State Legislatures, for example: "Native students perform two to three grade levels below their white peers in reading and mathematics. They are 237 percent more likely to drop out of school and 207 percent more likely to be expelled than white students."

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The historical trauma of genocide, land displacement, and continually broken promises from the U. government has forced many American Indian communities and people into poverty, which has led to increased rates of dependency on federal food programs like the Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Food Distribution Program on Indian Reservations (FDPIR), which have not always been associated with the health benefits they are today. For example, while the FDPIR has improved its nutritional quality in recent years, the food choices historically offered were not healthy, and researchers believe they have contributed to the rise of chronic disease and mortality rates among American Indian populations.

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As adverse childhood experiences are associated with lifelong health problems, they are strongly linked to adverse adulthood experiences. For example, 98% of people incarcerated in US prisons experienced at least one adverse childhood experience (ACE). This and adverse adult experiences, including poverty, racism, and substance abuse, lead to high prevalence of depression, anxiety, and poor health outcomes. These social circumstances also weaken the social fabric of families, leading to continued intergenerational health inequity.

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At the same time that legally sanctioned genocide, violence, and cultural destruction were being inflicted on American Indians, men, women, and children were violently removed from their homes and lives in West Africa and transported in ships across the Atlantic Ocean to the British colonies, where they were auctioned, enslaved, and forced to abandon their families, religion, language, and culture. This is what happened if they survived the journey, in which they were forced to inhabit claustrophobic and unsanitary conditions on ships. Millions died following their abduction during transport to the Americas. If they survived, they were quickly met by unfamiliar diseases introduced to North America by European colonists, such as cholera and smallpox.

Once people were formally enslaved, they were unlikely to experience significantly healthier living conditions as enslavers viewed them as property rather than human beings. Disease and infection were part of everyday life. Black enslaved women were also the subject of violent medical experiments and were often viewed by enslavers as having the primary role of producing children, which enslavers would often violently separate from them for punishment or profit. As was the case for the historical trauma inflicted on American Indians, the violent legacies of slavery persist today.

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The early institution of chattel slavery went on for more than 240 years, until the end of the Civil War or the ostensible end of slavery, when Congress passed the Reconstruction amendments. These laws amended the US Constitution to prohibit slavery and involuntary servitude (the 13th Amendment), except for those convicted of a crime (a loophole that permitted white industrialists to "lease" incarcerated people into forced labor and that legal scholars link to the intentional and deeply rooted racial inequity in our criminal legal system) and also prohibited voting discrimination on the basis of "race, color, or previous condition of servitude" (the 15th Amendment).

During this time, Congress also passed the Civil Rights Act of 1866, prohibiting not only legal bondage but any "badge of servitude," including "limitations on the right of former slaves to buy, sell, or rent property."

It was also during this time that newly freed people in the South were promised 40-acre tracts of formerly Confederate land through an order by Major General William Tecumseh Sherman, which he issued after conferring with 20 Black ministers. This order would be later recognized as the earliest reparations to enslaved Americans.

Slide 52

Newly freed slaves never received this promise because four months after General Sherman issued this order, President Lincoln was assassinated. Vice President Andrew Johnson immediately overturned Sherman's order, marking the abrupt end to "the only real efforts this nation ever made to compensate black Americans for 250 years of chattel slavery."

As Nikole Hannah-Jones wrote in the *New York Times* article, "It Is Time for Reparations": "The way we are taught this in school, Lincoln 'freed the slaves,' and then the nearly four million people who the day before had been treated as property suddenly enjoyed the privileges of being Americans like everyone else. We are not prodded to contemplate what it means to achieve freedom without a home to live in, without food to eat, a bed to sleep on, clothes for your children or money to buy any of it."

Slide 53

Meanwhile, the Homestead Act of 1862 gave away 246 million acres of land in the West – approximately 10% of all the land in the US – to more than 1.5 million white families.

This property established a legacy of intergenerational wealth for the approximately 46 million American adults alive today – nearly 20% of all American adults who descend from those homesteaders. As historian Keri Leigh Merritt points out: "If that many white Americans can trace their legacy of wealth and property ownership to a single entitlement program, then the perpetuation of black poverty must also be linked to national policy."

The same can be true for the American Indian tribes that were displaced from their ancestral lands and forced onto reservations to make way for homesteaders.

Slide 54

Yet even in the face of interpersonal, structural, and institutional racism and violence. Black Americans persisted. Journalist Nikole Hannah-Jones notes, "Despite the odds, some managed to acquire land, start businesses and build schools for their children." "However," she goes on to say that "it was the most prosperous black people and communities that elicited the most vicious response."

Black farms were stolen, shops burned to the ground. Entire prosperous Black neighborhoods and communities were razed by white mobs from Florida to North Carolina to Atlanta to Arkansas. One of the most infamous of these, and yet still widely unknown among white Americans, occurred in Tulsa, Oklahoma, when gangs of white men, armed with guns supplied by public officials, destroyed a Black district so successful that it was known as Black Wall Street.

Slide 55

Black Americans who managed to escape theft and violence bumped up against laws that continuously limited their wealth accumulation.

In the South, states and localities passed Jim Crow laws curtailing voting rights for African Americans; requiring segregated housing, schools, and public places; and allowing broad and purposeful discrimination in all aspects of life.

Slide 56

Hoping to escape Jim Crow laws and lynchings in the South, an estimated 6 million Black Americans left the South between 1916 and 1970 in what is commonly referred to as the Great Migration of the 20th century.

Slide 57

However, they ran into structural discrimination in the North as well. In the early years of the Great Migration, migrants primarily moved into white neighborhoods (rarely living in neighborhoods more than 30% Black). However, this changed when municipalities began adopting racial zoning codes.

Cities like Baltimore used zoning to impose racial segregation based in part on the unscientific notion that African Americans were more likely to carry communicable diseases.

Slide 58

It is worth pointing out that zoning codes based on these unsubstantiated public health arguments are a disturbing example of how public health law and policy have contributed to and helped codify structural discrimination that is responsible for much of the inequity we see today.

Before continuing with the rest of the history, I'll pause to explain that this point is important for two main reasons. First, it demonstrates that housing policy is health policy. And second, it centers the role of government public health practitioners in redressing inequity that may not seem directly related to health. Just as public health played an essential role in the housing policy of the 19th and 20th centuries, it needs to play an essential role today. If we, as public health practitioners, are serious about addressing racial health inequity, then it is critical that we engage with housing and the legacy of segregation.

Slide 59

Zoning laws in the context of racial segregation in the North was not the only way in which public health was weaponized. It was also weaponized by public health officials and departments, as was the case in Los Angeles in the late 19th and early 20th centuries.

Professor Natalia Molina points out in her book F*it to Be Citizens? Public Health and Race in Los Angeles, 1879–1939*, that the city's health officials had a "long tradition … of tracing any blemish on the pristine image of Los Angeles – including all forms of disease and any manner of disorder – to the city's marginalized communities." Neighborhoods home to Los Angeles's Chinese, Japanese, and Mexican populations were "separately and serially targeted as "rotten spots." The city's health officials portrayed these people as "threats to public health and civic well-being" and dedicated disproportionate effort to policing these groups rather than focusing on the real causes of communicable disease in the city, which included exposure to raw sewage, malnutrition, and inadequate medical care.

Officials used the racially coded language of public health to depict Japanese immigrants as a threat to white Americans. As an example, they argued that worrisome food-borne illnesses such as typhoid fever were connected to the types of produce the Japanese farmed, despite only few cases of typhoid reported during this time. Health officials in Los Angeles pushed for food vending ordinances that would directly target Japanese farmers and vendors. They similarly passed an ordinance that extended the power of the health department's fruit and vegetable division, strengthening their ability to "monitor Chinese vendors more closely." In the 1920s, high infant mortality rates in Los Angeles's Mexican communities were not linked to the county's limited resources and underdeveloped infrastructure. Instead, the county health department blamed the Mexican parents' "cultural habits and overall ignorance."

These examples from Los Angeles demonstrate how the weaponization of public health by public health officials not only codified racist beliefs and advanced racist agendas to control and police immigrant populations. It also allowed health officials to absolve themselves of addressing the root causes of health inequity in the city and county by placing the blame on individuals within these immigrant groups. Understanding this history also allows for one to better understand how these gross mischaracterizations of immigrant groups by health officials may have seeded the origins of mistrust in government officials and health officials in particular among these groups.

Slide 60

I want to highlight that zoning laws were used to marginalize communities of color despite the 1917 US Supreme Court's decision in *Buchanan v. Warley*, which struck down explicitly race-based zoning as unconstitutional. Similar to the Reconstruction amendments of the late 19th century, the decision seemed to be a legal victory. However, the decision allowed structural discrimination to take on new forms.

Slide 61

Racially restrictive covenants – or legal language in deeds prohibiting the sale or rental of properties to people of color – were a stark illustration of new forms of structural discrimination. This map is an example from Innis Arden, a northern suburb of Seattle, that expressly prohibited anyone who was not white from occupying any property there unless they were "a domestic servant actually employed by a person of the White or Caucasian race where the latter is an occupant of such property."

Equally troubling is that racial covenants remain in the fine print of many residents' deeds today. Although the Supreme Court ruled in 1948 that racial covenants were unenforceable and the Federal Fair Housing Act of 1968 made the practice of writing racial covenants into deeds illegal, they remain a common clause.

Slide 62

At the same time that racial covenants were being written into deeds, the federal government was implementing the New Deal loan programs. While FDR's New Deal is generally celebrated in our American history books as restoring faith in the economy and helping the nation through the Great Depression, it was also a powerful tool for fueling residential segregation in northern cities and furthering structural discrimination, which we'll explore more on the next slide and in the subsequent segment.

Slide 63

As part of the New Deal, the federal government established the Federal Housing Administration (FHA) in 1934. The FHA is now part of the Department of Housing and Urban Development (HUD).

In an attempt to "increase – and segregate – America's housing stock," the FHA refused to insure mortgages in and near neighborhoods where Black people lived, a policy known as redlining because these neighborhoods were literally "redlined" on maps. At the same time that Black homeowners were being denied loans, the FHA was subsidizing developers who were "mass-producing entire subdivisions for whites – with the requirements that none of the homes be sold to African-Americans." The FHA's justification for this was the idea that if African Americans moved to these suburbs, housing values would decrease, and until 1948, its underwriting manual identified African Americans as "undesirable and unreliable" buyers. The FHA ensured that Black families could not obtain loans to buy homes in neighborhoods where Black people lived, and they couldn't move into the suburbs either. They were therefore almost entirely excluded from the promises of the New Deal – repercussions that, as we'll discuss shortly, are still being heavily felt.

Slide 64

This was further perpetuated by the GI Bill following the end of World War II. In the 1940s, the GI Bill reinforced this segregation through low-cost, government-backed housing mortgages for white veterans. Once again, the FHA supported racial covenants in new developments and sent agents to intimidate lenders willing to work with Black prospective home buyers. Combined with the New Deal program's explicit exclusion of Black home buyers, these policies ensured that more than 98% of all federally insured home loans between 1945 and 1959 went to white homeowners in newly constructed suburbs.

Slide 65

It is not surprising then that 350 years of violence, theft, and legal discrimination against Black people culminated in the race riots of 1967 and the civil rights movement. Pictured on the slides are some of the key figures in the 1963 March on Washington, including John Lewis, Martin Luther King Jr., James Farmer, A. Philip Randolph, Roy Wilkins, and Whitney M. Young Jr. – also known as the Big Six.

Slide 66

The Kerner Commission's report was commissioned by President Lyndon Johnson in 1967 to study the roots of the civil unrest (which, after several years of racial riots, had come to a head that summer) and to identify ways to prevent ongoing violence.

The report concluded that the United States "was moving toward two societies, one black, one white – separate and unequal" and blamed housing segregation for the riots and determined that "white institutions created [the ghetto], white institutions maintain it, and white society condones it" and called for a fair housing law.

Slide 67

The Kerner Commission report findings, coupled with the aftermath of Martin Luther King Jr.'s assassination and the ensuing civil unrest across the country following his death in spring 1968, led to the Civil Rights Act of 1968. This momentous legislation included the Fair Housing Act directing the government to affirmatively further fair housing by prohibiting discrimination concerning the sale, rental, and financing of housing based on race, religion, and national origin. This was later expanded to include sex (since 1974) and people with disabilities and families with children (since 1988).

Slide 68

On the face of it, the civil rights movement ushered in the end of legal discrimination. However, as Nikole Hannah-Jones astutely reminds us, "Civil rights laws passed in the 1960s merely guaranteed black people rights they should have always had."

And, in fact, many of the social, economic, and health inequity we saw over 50 years ago still look the same today. As national demonstrations calling for an end to structural violence have made unequivocally clear, Black, indigenous, and other people of color continue to face discrimination, social exclusion, poverty, disenfranchisement, structural violence, and inequity in opportunities for education, jobs, and housing. This continued inequity was illuminated by the pandemic, which disproportionately killed and sickened more Black and brown people in this country because of inequity across the social determinants of health.

Slide 69

Let's review what we have covered with a couple of questions. First: The legacy of unfair and unjust laws and policies is still with us today and contributes to growing health inequity. True or false?

Slide 70

The answer is "True." Remember the research that Dr. Donald Warne and Dr. Denise Lajimodiere have done around the psychosocial influences of American Indian health inequity and how a history of genocide, unfair treatment under the law, and intergenerational trauma have contributed to the chronic disease inequity among American Indian and Alaska Native communities today. We'll be walking through another example shortly: looking at the impacts of redlining on chronic disease outcomes and inequity across the social determinants of health.

Slide 71

Here's the second question: "Which of the following are examples of structural discrimination?"

A. American Indian boarding schools
B. Jim Crow laws
C. New Deal loan programs
D. A and B
E. A, B, and C

Slide 72

If you picked E, you're correct. As we discussed, the American Indian boarding school experience, Jim Crow laws, and New Deal loan programs are all examples of structural discrimination.

Slide 73

Okay, we just covered a lot of painful and heavy content to take in, so I want to take a moment to pause and process this history.

As you're processing, we've highlighted some of the important takeaways from this section:

- First, structural discrimination in our laws is pervasive throughout our history.
- Second, what have seemed like legal "wins" on their face have not been enough to stop other forms of structural discrimination in our laws to take shape.
- And finally, our history reveals that we live in a vastly unfair – yet legal – system that has benefited white Americans for generations, at the cost of political, social, and economic oppression for communities of color.

Slide 74

How does this all connect to today's health inequity? We're going to walk through the next few slides to illustrate the point that is central to our conversation today: why it is so important to understand how laws, both past and present, have contributed to multigenerational harm.

Whether as a public health professional, you are researching asthma data, working on tobacco control in multi-unit housing, conducting code inspections, or even working on school wellness, it is important to understand how laws, both past and present, have contributed to multigenerational harm. If we don't understand this history, then we might select interventions that are at best ineffective or at worst actually harmful. For example, an asthma researcher might note that Black communities have higher rates of asthma because of genetic differences, which reinforces long-refuted and disproven theories about biological race, instead of this legacy of racism in housing policies, such as redlining and building highways or high-polluting factories near Black neighborhoods, that negatively affect health.

The next few slides help to illustrate this point. We use redlining as an example of a law that has perpetuated structural discrimination and contributed to multigenerational harms across key determinants of health and chronic disease outcomes.

Slide 75

Let's consider Baltimore as a case study in redlining. I'm not singling Baltimore out. It just happens to have the data available for a good case study. This same story can be seen in communities across the country. We talked about redlining a bit earlier, but I want to provide more context about how the effects of government policy perpetuating structural discrimination are still felt today.

Eighty years ago, a federal agency, the Home Owners' Loan Corporation (HOLC), created "Residential Security" maps of major American cities. Maps such as the one shown on this slide document how loan officers, appraisers, and real estate professionals evaluated mortgage lending risk during the era immediately before the surge of suburbanization in the 1950s. Neighborhoods considered high risk or hazardous were often redlined by lending institutions, denying them access to capital investment that could improve the housing and economic opportunity of residents. Redlined neighborhoods were those that were predominantly made up of individuals who identified as African American, Catholic, Jewish, and immigrants from Asia and southern Europe.

The Federal Housing Administration institutionalized the system of discriminatory lending in government-backed mortgages, reflecting local race-based criteria in their underwriting practices and reinforcing residential segregation in American cities. The *Underwriting Manual* of the Federal Housing Administration wrote that "incompatible racial groups should not be permitted to live in the same communities," meaning that loans to African Americans could not be insured. That manual contained federal agency policy.

The discriminatory practices captured by the HOLC maps continued until 1968, when the Fair Housing Act banned racial discrimination in housing. Through these practices, investment opportunities were leached from inner-city neighborhoods.

Note that this information is pulled from great work by the National Community Reinvestment Coalition and *The Color of Law* by Richard Rothstein.

Slide 76

We have zoomed into the legend on the residential security map to highlight the color coding that corresponds to grades assigned for mortgage lending risk. Green and blue are used for first and second grades for neighborhoods that were considered more desirable. Areas in yellow (third grade) were identified as neighborhoods that were "declining," and fourth grade that were considered "hazardous" were redlined – or colored in red.

Now we'll zoom back out to walk through the ramifications of this map and the values it assigned to neighborhoods.

Slide 77

Some neighborhoods in Baltimore have seen policy-driven disinvestment and marginalization since redlining began in the 1930s. Even after housing discrimination became illegal, when it came to making decisions about where to invest in vital resources like public park space, areas once deemed "desirable" by HOLC were more likely to see investment, while neighborhoods where Black and Latino residents lived were less likely to have trees and green space, contributing to park congestion and higher temperatures in Baltimore's formerly redlined areas. Depressed land values and discriminatory policy decisions around land use also targeted redlined areas – and therefore the people who live there – for high-polluting industries and constructing highways.

We highlight this to reinforce the connection between redlining and health outcomes. Policy systematically locked people of color out of homeownership and concentrated them in redlined areas. Investment, resources, and opportunity subsequently followed white folks into the suburbs and dried up in redlined areas. The result is structural and community conditions that lead to poor health outcomes.

Slide 78

To help explore how redlining advanced discrimination, I've simplified the color-coded grading on this 1937 residential security map of Baltimore. I've combined the first and second grade areas (identified respectively as the "best" and "still desirable" neighborhoods) together into one large green-shaded region at the top. I've labeled this and also added a label pointing to the fourth-grade area, shaded in red, and representing the areas deemed hazardous near the bottom.

Slide 79

Now we're introducing another layer of data: the area outlined with a purple dotted line was documented in 1930 as having a population that was majority Black, immigrant, or individuals with mixed-race parents. The region of this demographic mix is almost completely within areas graded as third and fourth grade, either declining or hazardous.

This illustrates how neighborhoods in Baltimore predominantly made up of communities of color were redlined and therefore denied access to capital investment that could improve the housing and economic opportunity of residents.

Slide 80

Finally on this map, we've added red lines to show where highway construction divided and isolated the third and fourth grade areas. Note that these highways almost completely go around the first and second grade areas, creating a physical barrier between neighborhoods that are majority Black, immigrant, or mixed race and more highly resourced white neighborhoods.

Slide 81

In this version of our Baltimore map, we've placed the green overlay of the first and second grade region on top of a race distribution and density layer. Darker-shaded regions are predominantly Black residents and lighter-shaded regions are predominantly white residents. We have highlighted two specific examples:

- One neighborhood that is just outside the green desirable area has a population that is 87.4% Black.
- One neighborhood within the green desirable area has a population that is 74.9% white.

This data show how policies reinforced segregation across the city. Today, families in the neighborhoods that were historically graded as declining and hazardous are predominantly nonwhite and can face overwhelming odds.

Slide 82

Let's consider property-based wealth for the Baltimore homeowners in these two examples:

- In the mostly Black neighborhood just outside the green desirable area, the median home price is between $25,000 and $90,000.
- By comparison, in the mostly white neighborhood within the green desirable area, median home price is between $465,000 and $590,000.

These data show how policies that lead to increased resources going to mostly white neighborhoods instead of mostly Black neighborhoods affected property values. Homeowner families in neighborhoods outside the historically desirable areas have significantly less property-based wealth: their homes are from 5 to 20 times less valuable than those in the desirable areas. Property values are often used to determine future resourcing, perpetuating this inequity.

Slide 83

Moving on to employment and opportunity, we can see discrepancies between the two neighborhoods:

- In the mostly Black neighborhood just outside the green desirable area, average annual income is less than $40,000 and the unemployment rate is between 13.3% and 17%.
- In the mostly white neighborhood within the green desirable area, average annual income is greater than $120,000, and the unemployment rate is between 2.8% and 5.4%.

These data show how policies can affect access to employment and income. On average, people in neighborhoods outside the historically desirable areas have to get by on less than one-third of the income with family members being as much as five times more likely to be unemployed.

Slide 84

Let's not forget education in our comparison of the two neighborhoods. Policies that determine school funding are deeply rooted in historical inequity like neighborhood segregation. The quality and upkeep of school facilities is related directly to the wealth of the surrounding community. Moreover, where students go to school influences their educational outcomes, whether they are suspended from school, and whether they go on to receive a postsecondary education:

- In the mostly Black neighborhood just outside the green desirable area, 6.6% of students have a suspension and 14.3% of adults hold a bachelor's degree.
- In the mostly white neighborhood within the green desirable area, only 1.4% of students have a suspension and 33.4% of adults hold a bachelor's degree.

This data show how policies can affect access to education and opportunity. Residents in neighborhoods outside the historically desirable areas are half as likely to have a bachelor's degree, and their children are almost five times more likely to be suspended from school.

These disparities are significant because, education is a key social determinant of health: educational attainment is directly related to better health outcomes and longer life expectancy. Research shows that by age 25, individuals with a high school diploma can expect to live 11 to 15 years longer than those who did not complete high school.

Slide 85

On our Baltimore map, we've added locations of gun violence between 2011 and 2015, shown by bright red dots. These data sit atop the green first and second grade region and the race distribution and density layers we've been using in the previous few slides. We've kept the arrows pointing to our two example neighborhoods to consider while looking at the gun violence statistics.

Gun violence is so prevalent in predominantly Black and formerly redlined neighborhoods that the red markers on the map actually overlap two or three times over to form large clusters. People who live in those areas experience double the rate of being victimized by violence violent victimization and are significantly more likely to have had adverse childhood experiences.

Slide 86

In addition to gun violence, let's consider some other indicators of health: rates of chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD) and life expectancy:

- In the mostly Black neighborhood just outside the green desirable area, 10.4% of residents are diagnosed with COPD, 8.7% are diagnosed with coronary heart disease, and life expectancy is between 67.2 and 68.8 years.
- In the mostly white neighborhood within the green desirable area, 4.5% of residents are diagnosed with COPD, 4.2% are diagnosed with CHD, and life expectancy is between 79 and 89.6 years.

Data from 2016 and 2017 reveal that people in the historically redlined areas are twice as likely to have COPD and twice as likely to have CHD. Life expectancy data from between 2010 and 2017 show that a child born in these neighborhoods can have 20 years' shorter life expectancy than a child living 5 miles away on the other side of the interstate highway.

The lack of grocery stores and greater concentrations of tobacco and alcohol outlets (such as liquor stores) mean less access for residents to nutrient-dense foods and greater exposure to harmful substances. The close proximity of highways and high-polluting businesses and factories create environmental hazards exacerbated by the lack of resources to build safe playgrounds and parks, so these areas are less walkable and have fewer areas for safe outdoor play.

The strong correlation between neighborhood and health reinforces how individual lifestyle choices are not enough to explain or overcome structural inequity, and public health strategies that target only individual choice and ignore the social determinants of health will inevitably fail to sustain change on a systemic level.

Slide 87

Let's revisit this map of California's Central Valley, which we talked about at the start of this presentation. What factors might have created the stark differences in life expectancy in Fresno County (84 years versus 75 years)?

If you said that redlining or residential segregation was one of the factors, that is correct. We talked about the impacts of redlining in Baltimore, but it is important to remember that this form of structural discrimination happened repeatedly across our country.

According to an article in the Atlantic, "Fresno's Mason-Dixon Line: More Than 50 Years after Redlining Was Outlawed, the legacy of discrimination can still be seen in California's poorest large city." Fresno has higher rates of poverty because of an extended history of discrimination.

In 1918, Fresno's zoning rules designated South Fresno for high-polluting businesses and affordable housing. This meant that the city's poorest residents shared neighborhoods with the dirtiest factories. And while Fresno's segregation policies began as a targeted attack on Chinese immigrants, this segregation evolved over time to disenfranchise Latino and Black residents. Black Americans moved to Fresno in greater numbers after World War II, and they did not have much of a choice except to move to these polluted neighborhoods in Southwest Fresno.

The construction of Highway 99 in the 1950s further isolated Fresno's southwest by destroying 20 blocks of existing housing and physically separating the west side and the rest of Fresno.

This pattern of segregation continued in the following decades, with Fresno's leaders concentrating the city's wealth and development in more affluent, predominantly white neighborhoods in the north. Neighborhoods in the north were given shopping malls, hospitals, and college campuses, while neighborhoods in the southwest were given slaughterhouses and meatpacking plants.

We encourage you to think about how these disparities may play out in your own neighborhood and do some digging on whether similar policies were ever at play.

Slide 88

So, what does this all mean? I hope these examples help illustrate what structural racism is, how it drives health inequity today, and that structural racism is a deeply entrenched part of our past and present as a nation. If there is one takeaway that we hope you remember from this training, it is that in order to achieve health equity, we as public health practitioners must address structural racism and cannot focus on individual choice alone.

Slide 89

Meaningful change requires naming, confronting, measuring, and directly addressing the impacts of racism on the health and well-being of the nation. Public health advocates, along with cities and states across the country, are declaring racism a public health crisis and reevaluating the role of police. This is an important first step, but more is needed.

It also requires an intersectional anti-racist approach in our work. We talked about intersectionality earlier in explaining the effects that double jeopardy can have on Black women's health. As a quick refresher, intersectionality acknowledges that the ways we label people as "other" so characteristics like race, class, gender, sexual orientation, and ability don't exist as separate categories. They mutually reinforce each other and are entirely interconnected.

I want to also reiterate that while we walked through one example – focusing on the legacy of racism in housing law and economic policy – this story is, unfortunately, not limited to Black communities. It traces back to the founding of this country and the generations of genocide of indigenous people. It is also one that interned Japanese Americans during World War II, forcibly removed 2 million people of Mexican descent (the majority of whom were American citizens) during the Great Depression, and a legacy we still experience today. These examples are not limited to actions or events at the national level. As we discussed in the example earlier from early 20th-century Los Angeles, racism via public health justifications was also advanced at the local level to demean, diminish, and discipline immigrant communities.

Slide 90

Before we close, I want to revisit the guiding questions from the beginning of this discussion.

Slide 91

By unpacking the legal history, we can begin to understand answers to the first two questions: Who has been harmed or omitted? And who stands to benefit, and how?

When it comes to the third – How can inequity be repaired? – understanding the history is important, but let's explore some concrete guiding principles.

Slide 92

As practitioners, how can we begin to address or repair long-standing inequity? In the next few slides, we'll share some guiding principles to consider in your health equity work.

To help illustrate this in a more concrete way, we'll walk through a hypothetical example of a public health practitioner working through applying these principles to promote equitable park access for residents. While the example focuses on equitable park access, we encourage you to think about how you might incorporate these strategies into your own areas of work.

Slide 93

So let us introduce you to Omari. Omari leads a team focused on research and policy within the division of chronic disease and injury prevention in Innovation County's Health Department. Omari's supervisor recently shared a parks needs assessment report produced by the county's Department of Parks and Recreation. The report found that Innovation County is relatively poor in parks compared to other similarly situated counties in the United States. The needs assessment report also identifies, prioritizes, and provides estimated costs for potential park projects within each of the county's study areas.

Intrigued by the report's findings and recommendations, but also concerned by its lack of coverage of the public health and health equity perspective, Omari's supervisor has asked him to lead the production of a complementary report to provide further information on the important relationship between parks and public health in the county.

Let's pause here to explore the first main takeaway and strategy: addressing the root causes of poor health.

Slide 94

Addressing the root causes of poor health means addressing social, economic, and environmental factors like education, employment, income, housing, community design, family and social support, community safety, and the environment. All of these – and other factors – influence our everyday health.

Slide 95

Omari sees this project as an opportunity to shed light on equitable park access as one of the root causes of poor health and inequitable health outcomes across Innovation County. He is familiar with the literature around community design, the environment, and park access and their role in shaping the health of community residents.

Omari is also familiar with the local data on selected health outcomes, demographic characteristics, and socioeconomic conditions in communities across the county, but he hasn't explored these data in relation to park space per capita. Given the existence of the parks needs assessment and existing public health and demographic data, Omari decides that additional community engagement is not necessary at this stage. After his team has explored the data in relation to park space per capita, Omari is excited to share preliminary findings and recommendations at a local community meeting.

Ok, let's pause again in this example to explore the next takeaway and strategy.

Slide 96

The next step is naming racism and identifying the multiple levels, including interpersonal racism, which occurs between individuals (and is what we have often been taught to think of when we picture what racism looks like); institutional racism, which occurs within institutions and systems of power; and structural racism, which operates between institutions and throughout society.

Equally important to remember is that racial inequity exists across (and at the intersection of) all other markers of difference: gender, sexual orientation, and ability, among other individual and social classifications. As such, anti-racism work is not at the exclusion of other forms of discrimination and is critical to addressing structural discrimination and improving health equity.

Slide 97

Returning to our scenario, at the community meeting, Omari and his team explain how institutionalized racism has led to inequity in park access across Innovation County, which has produced health inequity in communities of color that have less park space per capita compared to neighboring communities with predominantly white residents in the county. Omari notes that these patterns of disinvestment and neglect by the county's government officials not only must end, but also be rectified with increased investment in park spaces and other health-promoting amenities.

The crowd in attendance erupts in cheers and claps. One community member stands up and thanks Omari for recognizing the role that the structures and systems have played in creating inequity as opposed to blaming individuals for their health shortcomings.

Slide 98

Remember that individual choices determine our health outcomes far less than we think. Sometimes people blame poor health on the individual choices that people make every day. But their health is also determined by the overlapping systems that influence their everyday lives. It is critical to shift to thinking about changing systems and structures that unfairly and unjustly contribute to poor health.

Slide 99

Adopting a systems-thinking approach is connected to another important takeaway, which is acknowledging our role in creating and perpetuating inequity while also making a case for correcting those injustices through the tool of policy. Communicating clearly about the history of policy and public health also helps shift the frame to systems thinking and away from the idea that individuals alone bear the responsibility for poor health caused by long-term systematic harm. Acknowledging how government interventions, including inequitable laws and policies, have had, and continue to have, negative impacts that affect communities is also a necessary first step toward rebuilding trust.

We cannot begin to repair these wounds of broken trust without first naming them, but then also following up with a plan to course-correct that prioritizes continued engagement and allows for accountability. As you all know, health is much more than simply genetics, individual choices, or even access to health care. The legacy of inequitable laws and policies is still with us today and contributes to growing health inequity.

Slide 100

Let's come back to Omari. After the crowd has calmed, Omari steps back up to the mic excited to share his team's recommendations in the draft report. He is ready for more applause and approval from the community residents in attendance.

Omari begins to share the recommendations, which include building a new park in a neighborhood with the lowest park space per capita in the county and with higher-than-average rates of premature mortality from cardiovascular disease and diabetes. The recommendations also included limited investment in a neighboring community with ample park space per capita but faced similar health challenges.

To Omari's surprise, the preliminary recommendations were met with frustration and skepticism. Residents from the community with ample park space per capita shared that they needed more investments to ensure that residents felt safe visiting the parks. It wasn't enough that the park space was there; concerns around community safety kept many residents from using the park space.

Residents from the park-poor community, who held deep feelings of mistrust in county government due to a history of neglect and underinvestment, expressed concerns that the building of a new park in their neighborhood would lead to gentrification and displacement of long-time residents, who were primarily renters. They were concerned about insufficient renter protections currently in place.

Residents also were disappointed that no mention was made of the role of law enforcement in deterring use of the existing parks. Residents, particularly youth of color, felt targeted by local law enforcement when visiting parks in groups. They shared that the presence of law enforcement hadn't necessarily signified a greater sense of safety in parks.

As a whole, residents expressed fear that the public health department didn't have their best interests in mind and pointed to prior instances of public health being wielded as a shield to justify the enforcement of harmful policies that did more to undermine the public's health than protect it.

Although disheartened by the community's response, Omari and his team decided to regroup and reflect on their experience to better understand where things might have gone wrong.

Slide 101

Let's examine how Omari's team fell short on this strategy. We mentioned earlier that because there was so much existing data, Omari's team decided to move forward with their report without additional community engagement. This error prevented them from using a healing-centered and trauma-informed approach.

We can hear in the expressed frustrations of residents a desire and need for the Innovation County Health Department to better recognize, understand, and respond to the trauma that residents have endured, whether resulting from police action, community violence, or institutional violence through past neglect and disinvestment.

Rather than holding time in the production of their report to listen to and gather feedback from community members, Omari's team offered solutions that were grounded in quantitative data but were not also grounded in the lived experiences of residents. And so, they were met with skepticism and fear and ultimately fell short of securing community support.

Slide 102

Centering communities in our work is an important takeaway and strategy for this work. To help build more resilient communities, we use a healing-centered approach. Resilience is the ability of a person or community to successfully function or adapt in the face of significant adversity or threat.

A trauma-informed approach involves understanding, recognizing, and responding to the effects of trauma on a person's and community's well-being and behavior. We do this with the understanding that while trauma may affect a person or community, there are also protective factors at play that build resilience. Among them are neighborhood social cohesion, community safety, and effective schools.

Slide 103

So what does this case study illustrate? Or in other words, what are some important lessons from Omari's example about advancing a health equity approach to parks access that is anti-racist?

First, it can be difficult to identify and address root causes using policy solutions by solely relying on quantitative data without also engaging community residents to better understand their lived experiences and visions for their community's future.

Although perhaps well intentioned, an effort championed by a government institution can be perceived as more harmful than good, particularly when there is a history of prior harm that goes unacknowledged. But the work doesn't end at acknowledgment. One must also do the work in partnership with the community to redress these harms in an equitable manner.

To learn more, we encourage you to check the "Supporting Equitable Community Engagement" resource, which is available through the Public Health Law Academy, as well as our Part 2 module, which discusses these core concepts and takeaways in more depth.

Slide 104

Before we close, let's review with one final question.

Which of the following are important elements in repairing inequity?

A. Addressing the root causes of poor health

B. Supporting community resilience

C. Acknowledging past harms

D. A and C

E. A, B, and C

Slide 105

If you picked E, that's correct. As we discussed, addressing the root causes of poor health, supporting community resilience, and acknowledging past harm are all important elements in developing and implementing laws and policies that repair inequity.

Slide 106

To close, let's recap what we discussed.

- First, we learned what health equity is, so we can further explore how to achieve it.
- Next, we reviewed historical examples of structural discrimination and how this has continued into the present day.
- We also learned how discriminatory laws and policies have directly caused or perpetuated persistent health inequity.
- And finally, we identified some guiding principles that can help address or repair inequity.

Slide 107

Before we conclude, here's some brief background information about the content providers.

ChangeLab Solutions is a nonpartisan, nonprofit organization that uses the tools of law and policy to advance health equity. They partner with communities across the nation to improve health and opportunity by changing harmful laws, policies, and systems. Their interdisciplinary team works with public health lawyers; state, tribal, local, and territorial health departments; other government agencies; community organizations; and local institutions to design and implement equitable and practical policy solutions to complex health challenges.

Slide 108

The mission of CDC's Public Health Law Program (PHLP) is to advance the use of law as a public health tool. The program does this by creating tools that can be used to influence public health outcomes through, for example:

- Training and workforce development
- Communication and partnerships
- Legal epidemiology,
- Research innovation and translation

PHLP does all of this to serve CDC programs, as well as state, tribal, local, and territorial communities.

To submit a request or to learn more about public health law, you can visit the program's website at www.cdc.gov/PHLP.

Slide 109

Individuals who work as public health practitioners, lawyers, and policy experts in state, tribal, local, and territorial (STLT) health departments need measurable skills to move their careers forward. The CDC's Public Health Law Program developed the Public Health Law Competency Model to help guide practitioners in career trajectories. This module of the Public Health Law Academy covers the four competencies listed on this slide, to build skills for public health practitioners in public health law. We want to note that these are not the objectives for this course but are general public health law competencies suitable for the workforce and public health students.

The four competencies are:

- Defining basic constitutional concepts that frame the everyday practice of public health.
- Describing public health agency authority and limits on that authority.
- Identifying legal tools and enforcement procedures available to address day-to-day (non-emergency) public health issues.
- Distinguishing public health agency powers from those of other agencies, legislatures, and the courts.

This training is intended for public health professionals at all levels of their career, from students to entry-level staff to supervisors and executive-level managers.

Slide 110

This slide acknowledges that this training was made possible in part by a Cooperative Agreement with the CDC and that the views expressed in the training do not represent the official policies of HHS.

Slide 111

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Slide 112

Thank you for attending our training!