J. Bianca Roberts, M.D., Dignity Health's family practice department chair, returned to her South Sacramento community to make it a healthier place.

HEALTH

The Impact of Race

People of color have disproportionately contracted COVID-19—but that is just the most recent health disparity.

BY THEA MARIE ROOD

One of the most curious—yet widely acknowledged—characteristics of COVID-19 is its ability to reveal an issue in a way many of us have never considered before. The virus has been devastating, but it's also functioned as a glaring flashlight on our society's biggest, deepest problems, even those we seek to hide or downplay.

This may be especially true with regard to race—and while inequities in how people of color are treated at the hands of police are garnering the biggest headlines right now, there is an equally life-threatening issue: the way the color of our skin, and the ZIP code in which we live, directly affects our health and well-being—and can significantly shorten our lifespan.

Racial disparities with regard to COVID data exploded earlier this year, as researchers quickly determined people of color are nearly three times more likely to catch the virus, five times more likely to be hospitalized and twice as likely to die. "Latinx, African Americans and Pacific Islanders are disproportionately infected by COVID," says Hendry Ton, M.D., UC Davis associate vice chancellor for equity, diversity and inclusion. "They are also dying because of COVID at greater rates than we would anticipate given the overall population."

Why? Well, experts who study these issues say it is tragic, but not surprising. "COVID-19 ripped the Band-Aid off structural inequities in our society and health care systems," says Stephen Lockhart, M.D., Ph.D., Sutter Health's chief medical officer. "It's known as the new coronavirus, but what it's exposing is not new."

This month, we look at the factors that increase the risk of COVID, but also the centuries-long practices that have resulted in higher rates of all disease for people of color—as well as maternal death in Black women—and what some dedicated medical professionals are doing about it.

HISTORY OF MEDICAL BIAS—"The relationship between the medical field with Black people and people of color has often been racist," says J. Bianca Roberts, M.D., Dignity Health's family practice department chair. "Experts in medicine are telling the community what to do, how to be safe, and there is a lot of mistrust."

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Roberts, who also serves as the Health Equity Advisory Committee chair for the Sierra Sacramento Valley Medical Society, gives several examples. Forced sterilizations, primarily of people of color, went on for most of the 20th century, only ending in the 1980s. They happened in Mississippi and other parts of the Deep South, under the guise of appendectomies, but also in California, where 20,000 men and women were sterilized without their consent and often without their knowledge. Another example is the Tuskegee Study, which began in the '30s and ran 40 years: Black men were told they were being treated for syphilis, but in reality, their disease was left to run its course so physicians could study its progress.

Lastly, Roberts cites a recent article called "Hidden in Plain Sight," which appeared in the June issue of the New England Journal of Medicine, that suggests the diagnostic algorithms that "adjust for race" and have been used by physicians for decades actually direct attention and resources to white patients and significantly reduce the care of patients of color. They include kidney and lung function calculations, for instance, that show Black patients in particular can have lower acceptable numbers than whites. "It puts us further down a kidney transplant list," Roberts says. "It means a Black patient with lung issues isn't treated as aggressively."

This type of bias also explains why maternal death rates are twice as high for women of color—particularly Black women—than their white counterparts, a statistic that crosses all education and income levels. "It's very dangerous to be a pregnant Black woman in America," says Lockhart.

"IT'S VERY DANGEROUS TO BE A PREGNANT BLACK WOMAN IN AMERICA," SAYS STEPHEN LOCKHART, M.D.

Experts also emphasize these disparities cannot be explained by genetics, despite centuries of research that tried—and failed—to prove genetic differences between Caucasians and people of color. "Race is a social construct, not genetic," Roberts says. "The Human Genome Project has shown we are 99.9% alike."

SOCIOECONOMIC FACTORS—If it isn't genetics, then, what explains those "underlying health conditions" that we blithely accept about populations of color in just about every health story?

"It's not about the color of your skin—it's truly about what happens in our society," confirms Bechara Choucair, M.D., Kaiser Permanente's chief health officer. "The reality is for too long inequality has existed for people of color in this country. …This is our moment in time to address this."

In fact, a slew of studies show non-white patients routinely receive poorer quality health care for very concrete reasons. "No. 1 is language and communication," says Ton. "And No. 2 is bias within the health care delivery system. Health access is also a big challenge. In communities of color, the rates of health insurance are much lower, especially since (insurance) is tied to jobs."

There is also important history to these communities: Many were determined by "redlining" that prevented people of color from buying in more economically stable neighborhoods that include "walkways, places to play, grocery stores," says Roberts. "Taxes from those (higher income) com-

munities also go into the schools…which impacts their education and health literacy." She adds that in a neighborhood like South Sacramento, where she grew up in one of the infamous ZIP codes that predict a lower life expectancy, "another issue we see is there are higher rates of asthma and allergies, other lung issues, in people of color because there is more pollution."

THE EVERYDAY BURDEN OF RACISM— Studies also show that just living your life in a society where you and your loved ones are considered "minorities" and may not be given the same opportunities and protections as other racial groups takes a toll—even for people who seemingly have overcome barriers and achieved success. For example, Roberts went to medical school because she wanted to return to her South Sacramento community and make it a better, healthier place. "But I can walk in a room (of other physicians) and a doctor of color still is not assumed to be a doctor, too," she says. "At UC San Diego, where I was a student, I was pulled over by campus police. 'What are you doing here?'"

Similarly, Lockhart has personal reactions. "I'm 62 and I'm Black," he says. "I experienced the civil rights movement, the protests, the tear gas, the loss of life, the police violence—and here we are again. I feel like I have PTSD.…As the great Charles Barkley has said, 'Being Black in America is exhausting.'"

Lockhart's and Robert's feelings are borne out by research, says Ton. "Racism in and of itself can be damaging—it increases stress levels and cortisol and it can impact mental and physical health."

WHAT'S TO COME— Despite these barriers and biases, equity health professionals are actually hopeful and, ironically, credit COVID with bringing many of these decades-long issues to light.

As a result of this new intensity, all the Sacramento-area health systems are currently taking a deep dive into forming community partnerships and opening up dialogues with diverse and underserved groups. They are also forming health equity initiatives and ramping up training for physicians and other health care providers. They are making great effort to involve people of color in research trials. Lastly, they are using their formidable institutions to affect the neighborhoods they are embedded in—by hiring locally, sourcing locally and working with small businesses owned by people of color.

"Health systems employ thousands of people. We need to think about how we're getting money to redlined communities, who we are hiring, because we can do something incredible and change the socioeconomic reality of a family," says Ton.

There is also direct investment in what may not immediately seem like a medical concern, such as Kaiser's $200 million affordable housing initiative. "There is an interconnection between health and the community…where people live, learn and play," says Choucair. "We strongly believe health care organizations have a special and unique role in lifting people up."

Even on a personal level, there seems to be a sense that societal change—frustratingly long in coming—may finally be here. "I see this as an awakening, especially among young people," Lockhart says. "It's not just about Black or Brown people, because everyone, particularly young white people, are seeing it as human rights. And are saying, 'This is not the world I want to live in.'" SM