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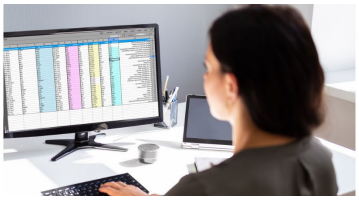


RACISM AS A PUBLIC HEALTH CRISIS
Guidance

Declarations of Racism as a Public Health Crisis

The following questions arose during the Network hosted webinar Declarations of Racism as a Public Health Crisis: Utilizing Declarations to Address Health Inequities. The webinar content included:

- an overview of declarations of racism as a public health crisis and their potential impact
- specific examples of actions committed to or implemented that can set a community on a path for meaningful change
- an analysis of legal and policy opportunities for implementing these declarations and associated efforts to dismantle structural racism and achieve health equity

The webinar and the following Questions and Answers can help guide stakeholders in developing and implementing declarations as well as thinking through broader issues connected to race and racism.

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I. Drafting, Implementation, and Scope

Q: Are there any toolkits that are useful in drafting a declaration of racism as a public health crisis?

A: Salud America! has a toolkit called the Salud America! Action Pack that includes talking points, shareable social messaging, a customizable resolution, and support from an Action Pack coach. The American Public Health Association, however, has an interactive map with links to local and state declarations of racism as a public health crisis. These declarations can serve as models for a variety of jurisdictions and provide examples of common themes and priorities. The Justice Collaborative has also issued a report with five key recommendations for communities taking action to address systemic racism.

Q: Can declarations of racism result in real action to address systemic racism? What types of language can help move the declaration into action steps?

A: Many declarations of racism as a public health crisis are relatively recent, and may not yet have resulted in significant policy changes or documented health improvement. However, the actions and activities committed to in declarations are in process, including the formation of committees, training, and plans to assess whether policies and laws reinforce racism. Some communities that adopted declarations in 2019 or early 2020 have followed up with specific actions, studies, or ordinances.

For example, in 2020 Milwaukee County adopted an ordinance titled "Achieving Racial Equity and Health" that included a commitment to use its racial equity tools to evaluate the impact of decisions related to the budget and processes, policies, and procedures on Black and Brown communities. The Milwaukee County ordinance also created a strategic plan advisory council that meets quarterly, to "provide both input on and support for the implementation of solutions designed to advance Milwaukee County's vision of achieving racial equity and becoming the healthiest county in Wisconsin."

While some declarations simply recognize the serious health inequities facing Black, Hispanic and Latino/a, and Indigenous individuals, other declarations identify and require action or including funding mechanisms that can lead to action. Declarations that include the following commitments may be more likely to lead to direct action:

- require collection and assessment of race/ethnicity date; use this data to inform action
- include accountability mechanisms
- create offices or task forces to oversee action
- prioritize community engagement, support community led initiatives and decision-making
- create policies and programs
- target funding to specific programs or initiatives
- systematized use of racial equity tools

- partner with philanthropy
- evaluate and change current policies, practices and laws that incorporate or promote structural racism and racist outcomes
- develop racial equity action plans

A few examples of action items included in declarations of racism as a public health crisis:

- The Minneapolis City Council resolved to direct funding for small business development, housing, community-based infrastructure, to reverse and repair the harm experienced by Black, Indigenous, and people of color and to "prioritiz[e] BIPOC in redevelopment efforts, and ensur[e] that these communities are not displaced in neighborhood revitalization efforts." The declaration also calls for annual reports on health disparities and recommended actions to eliminate those disparities.
- The Governor of the State of Michigan outlined strategies to combat racism and required state agencies to take specific actions, such as collecting and analyzing health data by race and implicit bias training.
- The Washtenaw County Board of Commissioner identified action items, including increasing the budget for the Public Health Department and Racial Equity Office, setting the county budget using a racial equity framework and community-based budgeting, enacting universal paid leave, and working with law enforcement on use of force policies and antic-racist public safety.

Q: How have public health agencies translated their declaration of racism as a public health crisis into action for their COVID-19 vaccine efforts?

A: Generally, states and localities, even those who have declared racism to be a public health crisis, have been slow to translate declarations into action to promote racial equity in vaccine distribution. The Kaiser Family Foundation has been tracking racial/ethnic demographic data, which has revealed racial and ethnic disparities in vaccination rates in most states. Collectively, people of color have received COVID-19 vaccinations at rates that are generally low relative to their percentage of COVID-19 infection rates, death rates, and overall state population; so far, the opposite trend has been occurring for White people. According to the CDC, data on these disparities is limited: race/ethnic data is only available for 53.7 percent for those who received at least one dose of a COVID-19 vaccine, as of March 2, 2021.

A lack of racial equity may in part reflect the reality that states set the priorities and guidelines for vaccine distribution, which can limit local equity efforts. For instance, as shown in this map by the American Public Health Association, in Connecticut many local councils and boards have declared racism to be a public health crisis. Yet Connecticut's Governor recently shifted to a next in-line age-based priority phase, over vaccinating people with underlying health conditions and essential workers. This has raised concerns about racial equity in vaccine distribution given that people of color have been more vulnerable to COVID-19 in part due to underlying health conditions and essential worker status within certain high-risk industries. This is just one example of how, despite local commitments to addressing racism as a public health crisis, it can be difficult to enact that commitment into COVID-19 vaccination efforts.

Nonetheless, as the COVID-19 vaccine rollout continues there are some examples that might hold promise in jurisdictions that have issued declarations:

- The Governor of Michigan declared racism to be a public health crisis. Michigan has enacted a pilot program to enhance the state's vaccine equity strategy, using the Social Vulnerability Index (SVI). The purpose of the program is to remove barriers to vaccine access for Michiganders over 60 who live in

communities with high SVI and high COVID-19 mortality rates. As relevant here, the SVI uses factors like "minority status and language" as an SVI measure. The SVI, however, is applied within an age-based priority system.

- The Wisconsin Public Health Association (WPHA) passed a resolution declaring racism to be a public health crisis, which some localities have signed on to. Although The Wisconsin Department of Health Services has not issued a declaration, or signed the WPHA's declaration, it is seeking to ramp up its equity efforts. These efforts include: prioritizing vaccine orders for those who provide "services for socially vulnerable people in Wisconsin"; funding efforts to activate organizations to provide culturally competent information to build vaccine confidence; and utilizing mobile vaccine teams and community clinics.
- In Texas, the Harris County Commission declared racism to be a public health crisis. Harris County is working with FEMA to prioritize COVID-19 vaccines for those living in vulnerable zip codes defined by: COVID-19 rates, income, ability to utilize transportation, and access to health care. They are using a weighted computer system to identify these individuals from their COVID-19 vaccination lists. The Dallas County Commissioners Court also declared racism to be a public health crisis but had to abandon their plan to prioritize underserved zip codes for COVID-19 vaccination after the state threatened to withhold vaccine allotments. Dallas County Health and Human Services, however, has engaged in other equity efforts including working with the YMCA to offer in-person vaccination sign-up opportunities in order to reach vulnerable populations.

Q: Are there strategies to help bridge divides on concepts of racism and health equity, such as overcoming resistance, identifying communications strategies, and educating people who do not see the impact of racism in their community?

A: The Network for Public Health Law offers the Becoming Better Messengers training and workshop that identifies strategies for effective public health messaging in a polarized political environment based on Moral Foundations Theory. There are a few things that are important in talking about difficult issues like systemic racism, especially in governmental public health:

- Frame issues according using the moral foundations. Start from a place of assuming that we value the same things. If that statement is true, how would you then go about having a conversation? What language is meaningful to your audience? Be willing to course-correct when you see that your audience is not responsive.
- Use empathetic messaging to reframe, build trust, and find ways to connect. This may mean enlisting trusted partners to help or to have the conversations. Recent research during the pandemic is showing that people are often more influenced by someone who thinks like them who changed their mind about an issue or took a certain course of action, rather than hearing from experts, local leaders, celebrities, or others. Being empathetic also means being curious —try to get the other person's perspective and listen to understand rather than to respond.
- Center equity in your communications. One way to do this is to focus on places, conditions, or systems rather than people. Focusing on people often reinforces the belief that health outcomes are due to personal choices and individual behaviors, when it is systems, conditions, and places that shape a person's opportunities and outcomes. Another way to center equity is to engage in community storytelling—empowering community members to share their stories, connecting people to data, and being empathetic.

There are a number of resources that can assist in developing messaging for different audiences; in addition to Becoming Better Messengers:

- PHRASES: Public Health Reaching Across Sectors, https://www.phrases.org/
- Berkeley Media Studies Group, http://www.bmsg.org/
- Reclaiming Native Truth, https://rnt.firstnations.org/

An article of interest that explores why messaging is so difficult in these times:

- The Role of Cognitive Dissonance in the Pandemic from *The Atlantic.* https://www.theatlantic.com/ideas/archive/2020/07/role-cognitive-dissonance-pandemic/614074/

Q: Do the COVID-19 health equity task forces have diverse membership and reflect the makeup of the communities served?

A: Ideally, health equity task forces have diverse membership and reflect the makeup of the community served, however some orders or actions creating COVID-19 health equity task forces have been vague about the make-up of their membership. Statewide COVID-19 health equity task forces have a variety of membership structures, but commonly include members from institutions led by and serving people of color, state and local health or public health departments, state and local government entities, faith groups, community-based organizations, higher education, and hospitals and health systems.

For example:

- Massachusetts' task force included representatives from several universities, public health departments and centers, churches, and organizations such as the NAACP, the North American Indian Center of Boston, GreenRoots, and the New England Black in Philanthropy.
- The Colorado task force included representatives from the Center for African American Health, NAACP, Hope Communities (a Denver organization supporting refugees, immigrant, and asylum seeking populations), the Southern Ute Tribe, health clinics, disability coalitions, and organizations representing and serving Black, Hispanic and Latino/a communities.

However, only about half of the states with federally recognized tribes included tribal representation on a statewide task force. While public members serving in an individual capacity could help ensure that community perspectives and lived experience informs task force discussion and recommendations, few task forces — those in Colorado, North Carolina, Rhode Island, and Vermont — included a public member.

II. Race, Racism, and Racial Equity

Q: Where can I find information about the proper terminology to use when referring to race and ethnicity?

A: The question as to what terminology to use when talking about race—if terms like "communities of color" and "people of color" are potentially problematic—is a question that is currently being actively debated. Some argue that these terms are inadequate because they lump all people of color together—generally defined as non-white—and in doing so fail to reflect the diverse experiences of individuals within these groups. On the other hand, others see these terms as building opportunities for coalition building across different racial and ethnic groups who may have shared experiences or goals, even alongside many different life experiences and

interests. There is currently no consensus on whether these terms should be abandoned. On the other hand, one clear message that has arisen from this debate is that we should be more thoughtful and reflective of the terminology we adopt. A great resource that explores some of these issues is a recent podcast on NPR "Is it Time to Say R.I.P to 'POC'?" which highlights diverse perspectives on this issue.

The term BIPOC can mean: Black and Indigenous people of color or Black, Indigenous, *and* people of color. Some have argued that the latter meaning of BIPOC should be adopted because it is more inclusive and historically accurate. According to the BIPOC Project the term better captures the specific relationships that Black people and Indigenous people have with "whiteness" and white supremacy. But even though "BIPOC" strives to be inclusive, and to avoid masking inter and intra-group differences among racial groups, it has also generated criticism for lumping diverse individuals together.

Despite differences in perspective on the validity of terms like "people of color" and "BIPOC" there is consensus about some best practices. For example, there is general agreement that it is a best practice to be as specific as possible when referring to a group. For example, if you are talking about an issue like Black maternal mortality a best practice is to simply say "Black women" rather than "women of color." That is, do not use "women of color" as a catchall for talking about a specific group or issue. Another recommended best practice when referring to Indigenous people is to identify an individual by the individual's tribe, nation, or community**.** To the extent possible, it is important to be informed about how individuals articulate their identity. For instance, although the term "Latinx" has increasingly become popular, a recent PEW Research Study found that only 3% of those who identify as Hispanic or Latino/a use that term to describe themselves—most had not even heard of the term.

Organizations have increasingly created style guides that address these issues, including what terms to use/not use, why certain terms are preferred, and the importance of self-identification and specificity. Some examples that might be helpful are: (1) the National Association of Black Journalist Style Guide (which endorses the term people of color over "minority" but does not address BIPOC); (3) the American Psychology Association Style Guide (discussing the need to be "appropriately specific and sensitive to issues of labeling" with examples); (3) the Associated Press Style Book on race-related coverage (discussing how reporting racial identification often requires thinking beyond "simple style" questions and requires "thinking broadly about racial issues"); and (4) the Native American Journalists Association Guide on Reporting Indigenous Terminology (short guide covering terminology applicable to Indigenous people with examples).

In sum, there is legitimate disagreement about terminology to adopt when talking or writing about race/ethnicity. Nonetheless, staying informed about why a term is favored/disfavored, how people self-identify, and striving to be as specific as possible are all considered best practices that we can adopt in our efforts to be inclusive and equitable in our language.

Q: How is racism defined in legal scholarship? How is this definition applied in policy?

A: There is no single unified definition of racism in legal or other types of scholarship. Scholars have defined racism in terms of a system that results in deprivation from social and economic goods. A lot of work has also focused on racism as being centered in constructing stereotypes and cultural representation that result in the "othering" of people who are "non-white." Scholars have highlighted how this "othering" not only props up a system of racial inequality but also has a toxic impact on the psyche of the "other." A study on the negative impacts of the use of Native American themed mascots is a good recent example of this.

A lot of scholarship focuses on some variety of these aspects of racism (the social, material, and cultural dimensions) and how they function to create wide-scale systems of racial oppression for people of color and, conversely, racial privilege for White people. Still, others view racism on a more individualistic level as something in a person's heart.

It is important to be aware of distinctions between legal scholarship and how racism is dealt with through the law. The law prohibits certain defined forms of race-discrimination as opposed to *racism*. Race-discrimination, and what it takes to prove that discrimination has occurred, is a much more narrowly defined concept in law. Regarding how concepts of racism are applied in policy, the Institutional Anti-Racism and Accountability Project has a Race, Research, and Policy Portal, which contains a compilation of anti-racism policy research on several topics. Additionally, The Hogg Foundation for Mental Health declared racism to be a mental health crisis and many organizations have signed the declaration. Although the declaration does not specifically define racism, it contains several examples of policy recommendations to address racism.

Q: What is structural racism? For example, some employers are providing extra paid time off (PTO) for those experiencing vaccine side effects, but other employers require their workers to use their regular PTO. If the latter is structural racism, does it help to call it that?

A: There is not one universal definition of structural racism. Generally, however, structural racism frequently refers to a system of laws, policies, and practices that create a social system of racial inequality. Professor Ruqaiijah Yearby has identified impacts of structural racism on worker protections, which create disparities with respect to the social determinants of health (SDOH). The SDOH are the "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affects a wide range of health, functioning, and qualify-of-life-outcomes and risks."

Economic stability is an important SDOH that is also marked by persistent racial disparities and can include benefits like access to PTO. As an example, the National Partnership for Women and Families recently highlighted that Latinos/as were least likely to have paid-sick leave relative to any other racial or ethnic group—in part due to working in low-wage jobs that do not provide PTO.

The answer to the question of whether different hospital (or employer) PTO practices are indicative of structural racism will depend on the circumstances. Any system where some workers receive additional PTO for COVID-19 vaccine side effects and others do not may very well reflect structural racism. Some questions to ask would include: Which hospitals provide/do not provide extra (or any PTO)? Are there notable racial demographic differences among the hospitals? Are there notable demographic differences in the communities served? If a hospital does provide extra PTO does it provide it to all staff? If not, are staff of color disproportionately excluded and White staff overrepresented among the eligible staff? Answering these questions will help to identify if the denial of extra PTO reflects a policy or practice that reinforces racial inequities.

For employees who do not normally receive any PTO, having this benefit would make it easier for them to get the COVID-19 vaccine and recover from any side effects. Adding this benefit could be a tool to boost racial equity, particularly given the disproportionate impacts of COVID-19 on communities of color.

If you conclude that a practice or policy does reflect structural racism, identifying the issue makes sense if the goal is to advance racial health equity and eradicate structural racism. This may be a difficult task depending on the willingness and openness of the relevant parties to address the issue. Therefore, here are some strategies one can utilize. One way to engage others in thinking about this issue is to frame it in terms of how

extra PTO is beneficial to all. As the authors in this blog argue, granting PTO benefits employers by, among other things, promoting a vaccinated workforce; it also promotes the health of employees.

Additionally, the Network has created an "Equity Assessment Framework for Public Health Law and Policies." The issue of PTO as it relates to the COVID-19 vaccine is, in essence, a public health law policy on the part of the hospitals. Some of the questions raised in the equity framework are: How does a policy address an issue? How are community voices included (in this case the staff)? And how does the policy impact different population groups? This framework can help facilitate dialogue by framing the PTO issue as a public health issue. Doing so may help hospital decision-makers think about their PTO policies as part of a broader effort to promote public health (in contrast to just viewing the issue as human resources issue), and to be more willing to include perspectives and experiences of impacted workers.

Q: Can you direct me to frameworks for nonprofit and governmental organizations seeking to implement anti-racist policies and practices for their internal operations, as well as for their outward-facing law and policy initiatives?

A: The Network does not recommend or endorse particular anti-racism and diversity, equity, and inclusion frameworks. That said, we are pleased to share links to frameworks, tools, and resources that may serve as a helpful starting point for nonprofit organizations and government entities that are seeking to examine and strengthen their inward-facing and outward-facing focus on addressing racism and enhancing racial equity.

Internal Operations

Equity in the Center has developed guidance for those who seek to implement or advocate for racial equity within their organizations. The Awake to Woke to Work publication is an evidence and research-based guide to shifting organizational culture, and was developed in collaboration with over 100 leaders in the fields of diversity, equity, and inclusion, and racial equity.

In addition, Equity in the Center has developed guidance for nonprofit organizations and other entities who seek to hire an equity consultant. In addition to information about what to look in a consultant, the guidance includes recommendations about the questions and conversations that an organization may benefit from engaging with prior to hiring a consultant.

ProInspire has developed a leadership model for racial equity, which it describes as a framework for professional growth that centers equity in leadership at all levels.

External Operations Focused on Policy, Systems, and Environmental Change

- The CDC recently declared that racism is a serious threat to public health, and centralized information about the agency's efforts to address racism as a driver of health disparities.
- National Institutes of Health (NIH) resources on ending structural racism.
- The American Public Health Association (APHA) has published a book that presents facts and tools to support public health professionals in confronting racism. APHA also hosted a 6 part webinar series on advancing racial equity and published a companion discussion guide.
- The Government Alliance on Race and Equity (GARE) has produced a variety of tools and resources.
- The Big Cities Health Coalition offers an equity lens tool, case studies, and blog posts.

- The Network for Public Health Law has developed an equity assessment framework along with case study examples, as well as resources to support racial equity through data integration.
- The Public Health Law Center has developed a framework for focusing on equity and inclusion while working on public health laws and policies, especially in the areas of food systems, active living, and commercial tobacco control.
- ChangeLab Solutions has developed a number of tools, resources and frameworks for advancing racial equity. These tools include a blueprint for changemakers, guidance on equitable enforcement of public health laws (including laws to control and contain COVID-19), planning for healthy communities, and a framework centered in equity for evaluating preemption and local control.
- Public Health Law Research provides a multi-faceted example of utilizing a racial equity framework to carry out and evaluate the role of law in housing equity.

Q: What is health-related quality of life and how is it connected to increasing racial equity?

A: Health-related quality of life (HRQoL) may be defined as "an individual's or group's perceived physical and mental health over time." As soon as early childhood, excessive adversity and toxic stress associated with structural and cultural racism decrease health-related quality of life for many people of color, and in communities of color as a whole.

HRQoL is a measure that may guide resource allocation, inform policy, and facilitate assessment and evaluation of interventions, including legal and policy interventions.

How is health-related quality of life measured?

The Healthy People 2020 initiative included two HRQoL objectives, namely the proportion of adults who self-report good or better physical health, and the proportion of adults who self-report good or better mental health. County Health Rankings and Roadmaps counts quality of life as having equal weight with length of life as the two ultimate health outcomes that it considers when comparing the relative health of counties within a given state. A relatively low or high county health ranking has been used by communities to engage community members and galvanize support for policy change.

One widely-used tool is the CDC's, Measuring Healthy Days tool, a four-item survey incorporated in the Behavioral Risk Factor Surveillance System, or BRFSS. The Healthy Days survey measures (1) a person's perception of their own general health, (2) days within the last 30 days of poor physical health, (3) days within the last 30 days of poor mental health, and (4) days within the last 30 days where activities were limited due to poor physical or mental health.

Other measurement approaches include:

- The Rand-36 or Short Form 36 is a 36 item survey instrument that assesses eight health-related domains: physical functioning, role limitations caused by physical health problems, role limitations caused by emotional problems or mental illness, social functioning, emotional well- being, energy/fatigue/vitality, bodily pain, and general health perceptions. The domains may be combined for a Physical Component Summary and a Mental Component Summary.
- The Pediatric Quality of Life Inventory, Version 4.0 is a measure for children's health-related quality of life.

- The Health Utilities Index (HUI) incorporates cost-effectiveness within the scope of its assessments. A recent systematic review suggested a high degree of variability in HUI measurement approaches, particularly for incapacitated patients, and recommended greater standardization. Efforts to increase standardization of HUI and HRQoL measurements should explicitly consider and recommend strategies to address and minimize implicit bias in their application.
- The Psychological Well-Being Scale, which has a longer version with 42 items and a shorter version with 18 items, measures autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance.
- The Council of State and Territorial Epidemiologists has developed recommended surveillance indicators for substance abuse and mental health.

Can you provide some examples of communities conducting their own health-related quality of life measurements?

Santa Monica, California devised a Well-Being Index, which includes a number of health-related factors. The projects documents and tools are open source to support replication of the project in other cities.

A recent study in Tampa, Florida involved a partnership between an academic center of excellence for health equity, training, and research and a community-based partner, among others. The study involved adult participants used tablets to complete a self-administered survey as part of a community needs assessment. Some of the same researchers also conducted a survey among low-income women with a broader geographic scope in the southeastern U.S.

The New York City Department of Health and Mental Hygiene used data from a phone-based cross-sectional Social Determinants of Health survey to assess the association between racial discrimination and quality of life, as well as the mediating effect of social relationships. The CDC has collected examples of other local health departments and communities that have included health-related quality of life measures as health indicators in their surveillance activities.

Additional research and analysis examining the effects of racism on health-related quality of life, albeit not conducted by communities themselves, is available. Examples include:

- A study of racial and ethnic disparities in health-related quality of life during adolescence.
- The Hispanic Community Health Study/Study of Latinos was a multi-year study focused on four of the largest metropolitan Hispanic and Latino/a populations.
- A 2010 analysis using California Health Interview Survey data examines associations between racial discrimination, Limited English Proficiency, and health-related quality of life among six Asian American ethnic groups in California.

Q: Does the ex-administration's executive order regarding equity communications/workforce training have an impact on the work related to the declarations of racism as a public health crisis? If so, does something need to happen to overturn it?

A: The now revoked “Executive Order on Combating Race and Sex Stereotyping” issued by the previous administration targeted what it identified as “divisive concepts” (*e.g.*, that one race is inherently superior to another race) that it problematically portrayed as standard components of diversity training on racism and sexism. It generally prohibited teaching, training, or promoting “divisive concepts” (and the use of federal funds

to do so) in the armed forces, federal agencies, by federal grantees, and by federal contractors. Although it mischaracterized the nature of diversity trainings on racism, the order had a chilling effect on anti-racism efforts by the impacted entities. By making anti-racism diversity trainings suspect, it stifled opportunities for education and dialogue to facilitate knowledge and shared understandings about the roots of racism.

This Network resource, "An Assessment of the Executive Order on Combating Race and Sex Stereotyping," explains the order's key features. It also addresses in more detail some of the order's fundamental flaws, such as how: "(1) it contradicts core public health findings; (2) it promotes a narrative that portrays diversity trainings that address racism as dangerous; (3) it is ahistorical; and (4) is so vague that it has a foreseeable chilling effect on legitimate trainings."

In January 2021, President Biden issued an "Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government." It revoked the Executive Order on Combating Race and Sex Stereotyping and directed impacted heads of agencies to assess actions taken in relation to it and to "consider suspending, revising, or rescinding any such actions." It also commits the federal government to a policy of pursuing "a comprehensive approach to advancing equity for all" and contains several specific measures for doing so.

Q: With the increased use of artificial intelligence, is there a concern about coded bias (bias in algorithm) and what are jurisdictions doing to address coded bias?

A: This overview article by Sharona Hoffman, a professor of law and bioethics, includes a list of policy recommendations at the end and links to some of her work: Biased AI can be bad for your health – here's how to promote algorithmic fairness.

There have been some attempts to enact laws to promote algorithmic fairness, including the Algorithmic Accountability Act of 2019 (federal, failed) and California's Automated Decision Systems Accountability Act of 2021 (AB 13, currently in committee).

At the local level, the New York City Council was the first to establish a citywide task force to review city agencies' use of algorithms and to assess whether there is any bias and the impact of any such bias.

There is a summary article, U.S. AI Regulation Guide: Legislative Overview and Practical Considerations, from the Jan.-Feb. 2020 issue of the Journal of Robotics, Artificial Intelligence, and the Law that may also provide some insight into actions that have been taken in recent years.

III. Impact on Other Social Issues and Communities

Q: Are there other social ills that lead to health inequities that these declarations could be used to address?

A: Both violence (specifically, gun violence and interpersonal violence) and poverty have been described as, and treated as, public health crises or threats. Declarations could formalize some of the work in these areas (but are not necessary). More recently, Jackson, MS declared classism a public health crisis to address class-based inequalities. This may also serve as an example for other jurisdictions as a way to address social issues shaped by racism without declaring racism a public health crisis.

Q: What is the legal nexus between Declaring Racism as a Public Health Crisis and Affirmative Action?

A: Unless a declaration of racism as a public health crisis or emergency specifically invokes an affirmative action plan or program, there is not any legal nexus between declaring racism to be a public health crisis and affirmative action. The declarations that have been put forth so far have invoked a variety of approaches to address systemic racism. As explained more below, many of these approaches do not constitute "affirmative action" under the law.

Generally, affirmative action plans seek to address a lack of diversity or representation with respect to race, gender, or other underrepresented groups. Traditionally, affirmative action initiatives have been implemented in employment and educational settings. Affirmative action plans have historically differed in their purpose including: to correct a historical injustice, to provide diverse mentors, to promote richer educational or work environments, or to remedy past discrimination.

From a legal perspective, one of the biggest questions is whether the government's use of an affirmative action plan that utilizes racial categories is constitutional under Equal Protection Clause of the Constitution. A government's race-based affirmative action program triggers the most rigorous standard of judicial review; for purposes of equal protection law, race is a "suspect classification." The Supreme Court of the United States has held some affirmative action measures to be constitutional. Importantly, however, the Court has also held certain measures, such as racial set-asides (quotas) in education admissions, a race-based point system that made race the decisive factor in higher education admissions, and racial set-asides for certain contracts to be unconstitutional. There are also other legal considerations. For instance, some states like Washington and California have implemented state bans on affirmative action in areas such as public employment, public contracts, and public education.

In contrast, declarations of racism as a public health crisis have generally not invoked affirmative action plans within the traditional meaning of the term. Rather, the declarations have called for a variety of measures to achieve equity in public health. This issue brief by the Network on State and Local Efforts to Declare Racism a Public Health Crisis explains the diverse approaches taken. For example, to address racism as a public health crisis many declarations have: called for improvements to their organizational policies or practices, committed to identifying specific partnerships and collaborations, and set goals for identifying a specific issue focus to combat systemic racism. Other measures also include a commitment to get solutions driven by data on racial inequities, creating an office of health equity and racial justice, affirming a commitment to end city-wide racial and social disparities, and the creation of a Black Leadership Advisory Council to undo and prevent discrimination and racial inequality.

These strategies are not "affirmative action" as traditionally defined under the law, although they share a goal of achieving racial equity. As such, such strategies should be permissible even in states that have banned affirmative action. In contrast, race-based affirmative action plans will be subject to the heightened standard of review and would be unlawful in the states that have banned affirmative action. For such reasons, the inclusion of an affirmative action plan would, from a legal perspective, require more justification and would be a more challenging means of advancing racial equity.

Q: How do the declarations of racism as a public health crisis impact people who have a disability?

A: At its core, this question is an inquiry into how the declarations address intersectional discrimination against people who belong to more than one historically marginalized group. For example, this resource by the Learning Disabilities Association of America, discusses research showing that Black students are less likely to receive high quality special education services than their White peers, despite "similar levels of academic

performance and behavior." This illustrates how the question of whether these declarations address intersectionality when addressing systemic racism, including the experiences of people of color with a disability, is an important one.

Although states, local governments, and public health associations have increasingly declared racism to be a public health crisis or emergency, few of these declarations explicitly address the issue of intersectionality when laying out the problem of racism. As explained in this Network resource "Systemic Racism and Intersectionality: To Get Practical, We Need to Get Theoretical," Kimberly Crenshaw initially developed the concept of intersectionality to draw attention to the reality that individuals often simultaneously experience multiple forms of discrimination that arise from intersecting features of their identify. She compares this type of discrimination to being hit from multiple directions at a traffic intersection. To focus only on one injury (race) is to ignore other interconnected injuries (*e.g.*, disability discrimination, gender discrimination, LGBTQ discrimination) that people of color may experience.

To put it plainly, things like systemic racism and disability discrimination are not either/or phenomena. Nevertheless, many who have issued formal statements declaring racism to be a public health crisis do not explicitly address intersectionality. Some, however, do. Here are some examples with the specific language highlighted acknowledging intersectionality and/or disability discrimination:

- **State of Michigan (8/5/2020)** (Executive Directive): Commits to using enhanced data analysis to examine "how racial disparities in societal, economic, environmental, and behavioral factors **intersect to affect access to resources that promote good health**, including good jobs, access to healthy and affordable food and housing, equitable transportation options and excellent public education."
- **City of Denver, CO (6/8/2020)** (Proclamation): Recognizes that "racism manifests in distinct ways across **other social intersections including** gender identity, sexual orientation, class, **disability**, immigration status and age, and collectively reinforces the racial hierarchy throughout these intersections which weakens the strength of our entire humanity."
- **City of Ventura, CA (7/13/2020)** (Resolution): Preamble acknowledges the importance of intersectionality and disability to the public health crisis of racism stating: "WHEREAS, the Black Lives Matter movement, like the civil rights and other movements before it, has effectively articulated the **injustices that exist at the intersections of race, class, and gender** . . . . WHEREAS other marginalized communities including . . . **people with disabilities are more likely to be subject to unjust treatment** by law enforcement, especially where training is inadequate and supervisors are not committed to equal treatment of all persons . . . .
- **State of Minnesota (7/20/2020)** (House Resolution): WHEREAS, racism is complex and **it is imperative to employ an intersectional lens** and approach that considers the unique ways that racism intersects with **disabilities**, immigration, gender, documentation status, and LGBTQ+ communities . . . WHEREAS, **racism is a public health crisis affecting our entire state and a comprehensive and intersectional approach is necessary to address the crisis.**

These are examples of good first steps. More work needs to be done, however, to address the intersection of race, disability, and other factors. Even if a declaration fails to include these considerations in their initial statements, advocates can work to show how these factors are relevant to efforts to end systemic racism.

Q: What are some examples of actionable policy for expanding access to care to all residents including immigrants and essential workers?

A: Below are some examples of laws and policies that have been adopted that target the general population, immigrants, and essential workers. Many of these examples have arisen in the context of COVID-19, but also have larger implications for strategies on how to continue to expand access to healthcare.

Expanding Access to Health Care (General Population)

- The American Rescue Plan (ARP) contains numerous provisions expanding access to care, that will impact residents, immigrants, and essential workers. The Kaiser Family Foundation has summarized some of the key provisions of the ARP impacting the Affordable Care Act (ACA) and Medicaid. These include: temporary expansion of ACA subsidies; adding incentives for states to expand Medicaid if they haven't already done so Medicaid expansion has not only reduced overall uninsured rates in Medicaid-expansion states but also has had a greater impact on reducing racial disparities in insurance rates); allowing states to expand Medicaid and Chip coverage of up to 12 months for post-partem women; eliminating cost-sharing for COVID-19 testing; and granting COVID-19 relief funds for rural Medicaid, CHIP, and Medicare providers. The ARP also contains provisions to support mental health and substance use disorder services.
- The Kaiser Family Foundation tracks state policies to increase COVID-19 testing treatment providing an interactive map of states that have adopted such policies. For example, states have waived cost sharing for COVID-19 treatment and expanded access to treatment through telehealth services.

Expanding Access to Health Care (Immigrant Populations and Essential Workers)

- California created a system to provide equitable access to COVID-19 vaccines to farmworkers, which is a community that has a significant immigrant population. It did this by having the county health department conduct pop-up vaccination clinics that are hosted by growers and therefore easily accessible to workers. Vaccine registration is also organized by the employer or organizer–eliminating the need for online registration or long wait times (while also reducing issues related to broadband access or language barriers). In March 2020, the federal government designated farmworkers to be essential workers.
- A few states provide health insurance coverage to undocumented immigrants. For instance, the "Cover All Kids" bill in Oregon made the Oregon Health Plan available to children and teens who are: younger than 19 years old, irrespective of their immigration status (including undocumented or Deferred Action for Childhood Arrival recipients), and who meet other criteria such as an income threshold of up to 305 percent of the federal poverty level.
- With respect to immigrants, federal law generally limits eligibility for certain federal benefit programs like Medicaid to "qualified immigrants". Qualified immigrants include legal permanent residents (LPR), who generally have a five-year waiting period after obtaining LPR status, or other groups like refugees and asylees. This leaves out undocumented people or others who do not meet these criteria. Federal law does allow states to provide some federally funded health benefits to those who are not "qualified immigrants." The National Immigration Law Center has created a map of states that provide these benefits (*e.g.*, prenatal care under the Children's Health Insurance Program to women regardless of status). The map also shows state-funded programs that provide specific coverage for immigrants.

- California expanded sick leave to provide supplemental COVID-19 paid sick leave for essential workers. California initially offered paid sick leave to essential food-sector workers and then expanded leave for other essential workers. California just recently again expanded paid sick leave protections in numerous ways (*e.g.*, who is a covered employee, duration and hours, qualifying reasons). Offering paid sick leave makes health care more accessible to essential workers by allowing them to take time-off to deal with COVID-19 related health care issues including vaccination and illness.

SUPPORTERS

Support for the Network provided by the Robert Wood Johnson Foundation. The views expressed in this document do not necessarily reflect the views of the Foundation.

This FAQ was developed by April Shaw, Betsy Lawton, Dawn Hunter, Jill Krueger, and for the Network for Public Health Law, with research assistance by Madeline Kim, Public Health Associate, Network for Public Health Law. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.

May 2021