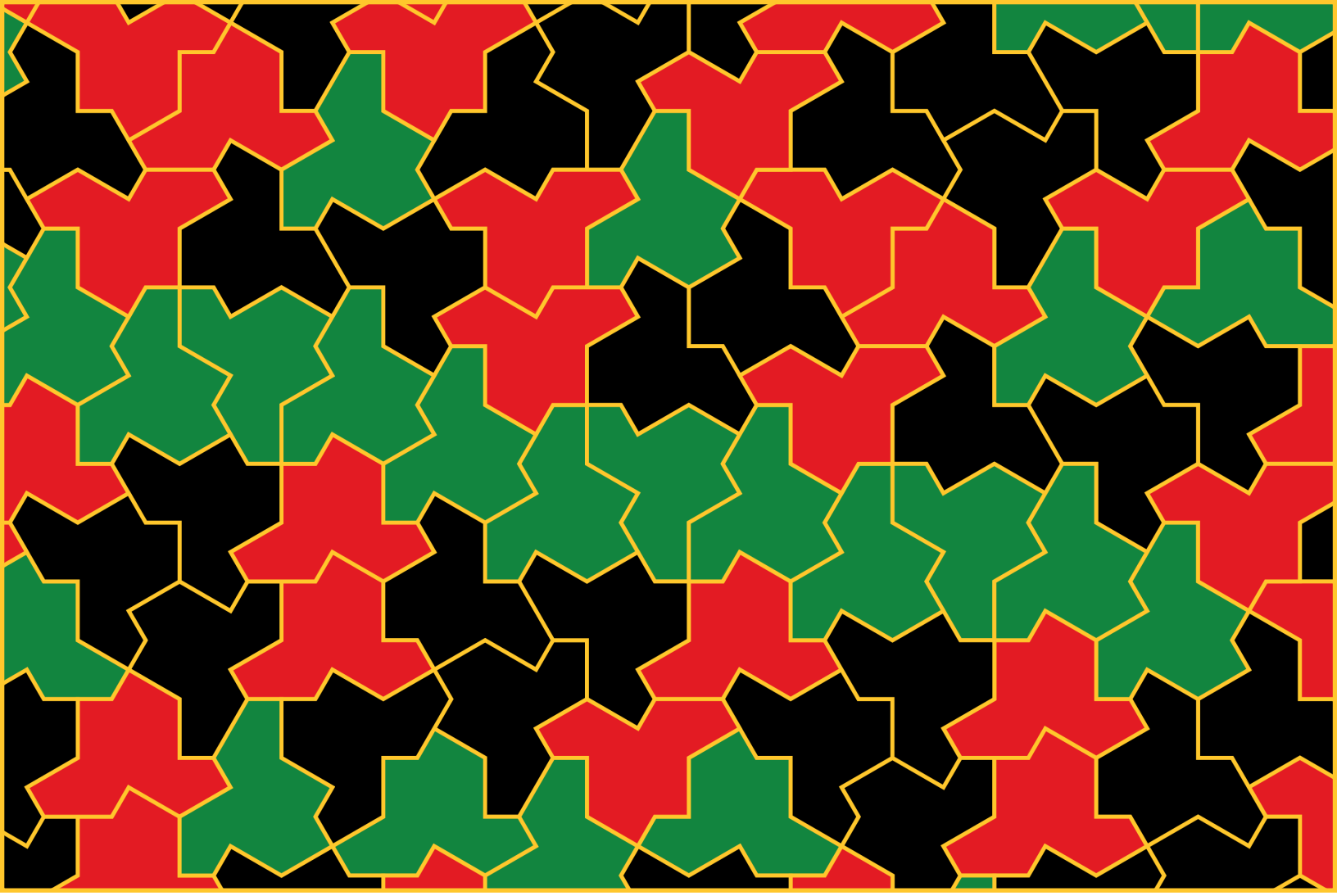

The Effect of Structural Racism on the COVID-19 Planning and Response for Racial and Ethnic Minorities and Other Marginalized Communities: An Ohio Case Study©

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Policy Brief

Executive Summary

Structural racism within governmental institutions was reflected in the response to COVID-19. As defined by[1] Dr. Paula Braveman, Arkin, Proctor, Kauh, and Holms, "systemic and structural racism are forms of racism embedded in systems, laws, policies, entrenched practices that perpetuate widespread unfair treatment of people of color". Braveman et al distinguishes systemic racism from structural racism by stating that "systemic racism emphasizes the involvement of whole systems," whereas "structural racism emphasizes *the role of the structures* (laws, policies, institutional practices, and entrenched norms) which is the system's scaffolding. This brief will provide specific examples of how structural racism,[2] which is the ways that laws, policies, institutional practices, and entrenched norms disadvantage racial and ethnic minority individuals, impacted the COVID-19 response.

For example, the behavior of decision-makers at all levels of government in ignoring scientific information about COVID-19 had devastating effects, which disadvantaged racial and ethnic minority individuals. Structural racism combined with the political determinants of health[3] (systematic process of structuring relationships, distributing resources, and administering power) often took precedence over science and prevented racial and ethnic minority individuals from being healthy. This was illustrated by governmental leaders' refusal to enforce mask requirements for indoor spaces and actions that cast doubt about the efficacy of COVID-19 vaccines. Not only was this problematic for the nation, but also particularly challenging for marginalized communities, which includes racial and ethnic minorities, low-income households, and households whose limited square footage and physical layout made it difficult to self-isolate. The existence of a widespread anti-structural racism policy could have prevented unnecessary deaths, and the disruption of the economic stability and social fabric of communities. States like Ohio provide an appropriate case-study to illustrate this point.

Background

Even before the Covid-19 pandemic, marginalized communities in Ohio suffered disparate health outcomes for chronic conditions like cardiovascular disease and/or infant mortality. Yet, at the state level in Ohio, there has been limited capacity to address health equity issues. Ohio is fortunate to have the Ohio Commission on Minority Health-the first and longest state-level entity in the nation-to address minority health issues, and it continues to function as a leading voice in this area. However, Ohio's state government does not provide adequate funding to the OCMH. Similarly, the Ohio Department of Health Office of Health Equity (ODH-OHE) was established in December 2008 to advise senior leadership on strategies to achieve optimal health outcomes for all Ohioans.[4] The ODH-OHE was disbanded in 2021. While the establishment of this office was commendable, it never had sufficient human and financial resources (2008 to 2021) to be effective. Specifically, the ODH-OHE never had a budget or employed more than two full-time employees. Additionally, as of October of 2021, most of the policy recommendations proposed by the ODH-OHE to address health equity were never codified or accepted.

Therefore, it is not surprising that racial and ethnic minorities continue to experience health inequities in Ohio, as reflected by the ongoing disproportionate burden of poor birth outcomes, environmental hazards, infectious and chronic diseases.

COVID-19 disproportionately impacted marginalized communities in Ohio. For instance, the Health Policy of Ohio's Health Data Brief on COVID-19 Disparities by Race and Ethnicity: September Update[5] states that in 2020, "More Black/African-American Ohioans are over represented in COVID-19 cases, hospitalizations and deaths. More Blacks/African-American Ohioans have died this year with COVID-19 than other leading causes, surpassing hypertension and motor vehicle crash deaths in all of 2018." During the first six months of 2020, there was a tremendous opportunity to implement strategies for COVID-19 in racial and ethnic minority communities. The overwhelming evidence of COVID-19 incidence rates in early 2020, which showed a disproportionate impact on racial and ethnic minority individuals, required the immediate initiation of public health interventions to respond to these inequities and eliminate barriers to resources.

Notwithstanding this need, Ohio's COVID-19 Populations Needs Assessment[6] showed that marginalized communities (Black and African; Latino and Hispanic; Asian and Asian Americans; Immigrant and Refugee; Rural; and People with Disabilities) experienced barriers. Some of the barriers identified in the assessment included:

- Gaps in access to necessary resources;
- COVID-unsafe working conditions in essential jobs;
- Stigma and mental health challenges;
- Lack of personal transportation;
- Racism, xenophobia and able-ism; and
- Specific public health advice inconsistent with community values.

The mission of the State of Ohio health department to protect the health of all people should have resulted in actions to address the specific needs of racial and ethnic minority individuals. There were indeed some good decisions by governmental leaders to protect Ohio citizens, such as the March 19, 2020, ODH Stay at Home Order.[7] However, when it came to proactively acting upon specific recommendations from health equity experts on addressing COVID-19 issues for racial and ethnic minorities, state leadership often fell short. This was an example of structural racism.

Structural racism,[8] which is the ways that laws, policies, institutional practices, and entrenched norms disadvantage racial and ethnic minority individuals, negatively impacted the way governmental entities in Ohio served the public, especially during the COVID-19 pandemic. Moreover, when crises like COVID-19 occur,

structural racism compels these agencies to perform poorly, especially when evaluated against their mission and criteria of their core functions. These failures harm the entire population, but its effects are particularly devastating for marginalized communities, which includes racial and ethnic minority communities. A retrospective-prospective analysis makes this clear by showing how the demands of a raging pandemic does not lessen the impact of how structural racism operates but instead enhances it. The following three examples, briefly summarized below and discussed in more detail later in the brief, illustrate that point.

- On April 9, 2020, the NAACP hosted a nationally televised meeting entitled "UNMASKED: A COVID-19 Virtual Town Hall"[9] to communicate the risks of COVID-19 for minorities. In response to this meeting, the Ohio Chapter of the NAACP requested a partnership with the ODH to communicate the risk of COVID-19 to minority communities. This resulted in the creation of a COVID-19 prevention message for African Americans, jointly developed by the ODH, the Ohio NAACP, and the Ohio Commission of Minority Health. *However, even though the ODH worked to create the message, it declined to disseminate it.*

- The ODH-OHE initiated a series of requests to provide health equity subject-matter expertise during COVID-19 planning activities at the Ohio COVID-19 Emergency Operations Center. *However, these requests to provide health equity subject-matter expertise were never granted.*

- The Ohio Progressive Asian Women's Leadership sent a letter to ODH requesting assistance in correcting the misperception that Asians were responsible for COVID-19. During that time, the Asian community experienced racism, stigma, and attacks related to COVID-19. *The ODH never formally acknowledged or responded to these concerns despite being advised to do so by health equity leadership within the agency.*

Work of the ODH-OHE to Address COVID-19

In March 2020, the ODH-OHE created a series of detailed analytic reports for Ohio's major metropolitan areas to support COVID-19 planning and response efforts. These reports featured data from the CDC Social Vulnerability Index (SVI); BRFSS 500 Cities Project (now CDC PLACES); the Ohio Health Opportunity Index; and MRI/Simmons market research data from the Claritas Corporation. GIS software (i.e., ArcGIS Online) was used to integrate this data to identify census tracts which: 1) reflected high vulnerability for disasters; 2) identified where chronic disease risk factors for COVID-19 co-existed at their highest prevalence rates; and 3) market research profiles of consumer health, purchasing behaviors, lifestyles, and media preferences to develop effective communications. These reports, which included the census tract data described above, were then shared with state leaders and public health leadership in those respective counties.

The analysis of these areas revealed striking disparities. Census tracts with the highest SVI scores and highest prevalence of chronic disease conditions were mostly Black/African American. These findings were shared with ODH leadership with recommendations to immediately initiate prevention activities and the mobilization of healthcare resources. Yet, during this time, the ODH-OHE continued to receive daily summaries from the COVID-19 Emergency Operations Center that lacked a health equity focus and data analysis of those most

impacted by COVID-19.

Additionally, the ODH-OHE organized a new COVID-19 Health Equity Data Workgroup composed of faculty from The Ohio State University College of Public Health, data scientists from Deloitte Consulting, and public health practitioners. From April 2020 to March of 2021, the Workgroup[10] produced major reports and analysis to help state leaders, local public health personnel, and community-based organizations make decisions in response to COVID-19. The reports included:

- Optimal locations for marginalized communities most impacted, including racial and ethnic minority communities, to access COVID-19 testing sites;
- Locations of under-resourced neighborhoods in need of Personal Protective Equipment;
- Identification of neighborhoods with high concentrations of low-wage essential workers who could not easily self-isolate;
- Recommendations on the equitable distribution of COVID-19 vaccines; and
- The first COVID-19 Populations Needs Assessment[11] in the nation, from the perspective of marginalized communities.

Structural Racism and Harm to Ohio's Marginalized Communities

As stated earlier, the Ohio NAACP approached the ODH in April of 2020 to craft a COVID-19 prevention message for African Americans. At that time, African Americans were not fully aware of their susceptibility to COVID-19. This was the result of earlier media stories which suggested that older, White Americans were at the greatest risk. At the Ohio NAACP's request, ODH worked with the Ohio Commission on Minority Health to develop a joint prevention message. Although all three parties (the ODH, NAACP, and Ohio Commission on Minority Health) approved the message, the ODH refused to disseminate it, despite its extensive communication channels and an entire public affairs unit. Instead, the ODH asked the NAACP and Ohio Commission of Minority Health to disseminate the message through their networks, which were much smaller. The ODH also did not provide monetary or staff support for the NAACP and Ohio Commission of Minority Health to disseminate the message, even though ODH has more financial and staff resources than these entities. Despite repeated requests to reconsider this decision, the ODH responded[12] by saying that it would not disseminate the message because the department was focusing on the "*direct operational response to the nascent pandemic.*"

During the same time period, the Ohio Progressive Asian Women's Leadership urged the ODH to help correct racist ideology and stigma against the Asian community regarding the origin of COVID-19. The ODH-OHE even recommended that ODH immediately address this issue, but these recommendations were ignored. There were even attempts by top leaders at ODH to delete these concerns from weekly status reports intended for ODH executive leadership. In both cases, the policies and institutional practices of Ohio's top public health agency

disadvantaged racial and ethnic minority individuals by failing to provide communities with the information necessary to remain healthy, which is not only a core public health function, but also the mission of ODH.

Structural racism was also illustrated by ODH's policies and institutional practices regarding the use of data[13] to assess population health status and community needs and assets. In February 2020, the ODH-OHE assembled a broad-based coalition of minority healthcare providers, statewide commissions, and academia to create a comprehensive COVID-19 response plan for marginalized communities. At that point there were no other state-level groups in Ohio addressing COVID-19 for marginalized communities. Using their expertise, the group created the first COVID-19 Populations Needs Assessment[14] in the nation and developed a set of treatment and risk-mitigation recommendations for marginalized communities in less than three days. The report was immediately given to top health department officials, who refused to acknowledge, use, or reference this report in COVID-19 planning efforts.

It took until August of 2020 before Governor Mike DeWine announced[15] the availability of the final COVID-19 Ohio Minority Health Strikeforce Blueprint.[16] A structural racism analysis shows how laws, policies, institutional practices, and entrenched norms in Ohio and the ODH disadvantaged racial and ethnic minority individuals. The State of Ohio and the ODH took four months to develop a plan to address well-documented health disparities during a deadly pandemic. Yet, the ODH-OHE assembled a broad-based coalition in less than three days to create a report that developed recommendations that documented and provided suggestions for addressing the health disparities. Other state-sponsored COVID-19 planning groups, such as the COVID-19 Health Equity Data Workgroup, also developed recommendations in far less time. While Governor Mike DeWine later announced that racism is a public health crisis,[17] the *failure to immediately adopt a plan to address racial disparities in COVID-19 harmed racial and ethnic minority individuals*. Thus, although the State of Ohio and the ODH stated that addressing COVID-19 disparities and racism were priorities, their policies and institutional practices deprioritized the needs of marginalized communities, particularly communities of color.

As shown by the examples discussed above, the failure of governmental institutions to adhere to their mission[18] and core functions during Ohio's COVID-19 response has negative implications for the entire society, and a devastating impact on marginalized communities. Understanding the negative impact regarding the delay in completing and fully executing the health equity plans to address COVID-19 will never be fully known. However, to eliminate structural racism, governmental institutions must work[19] to understand and fix the human suffering, social disruption of communities and ongoing negative economic impact that results from their delayed COVID-19 response.

Conclusion

A commitment by the ODH to fulfilling its mission of protecting the public and adoption of policies and practices to help those most impacted by COVID-19, would have saved the lives of more Ohioans, especially people of color and other marginalized communities. However, the policies, institutional practices, and entrenched norms of

state government and the state health department disadvantaged racial and ethnic minority individuals and failed to protect them.

Acknowledgements

Johnnie (Chip) Allen, MPH is President/CEO of Health Equity Consulting, LLC and a member of the Anti-Racism Consortium.

Support for this policy brief was provided by the Robert Wood Johns Foundation. The views expressed here do not reflect the views of the Foundation.

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