Weitzman Institute
2023 VIRTUAL Symposium

Keynote Presentation #2
"Little Has Changed":
Equity Scholar Addresses the Long-term Impacts of Segregation and Racism on Neighborhood Poverty and Minority Health

SPEAKER:
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AFTERNOON KEYNOTE

Mental Health Equity, Primary Care and the Built Environment

On May 17th, 2023, the Weitzman Institute invited renowned leaders, clinicians, and researchers to address challenges to health equity and justice within the healthcare system. Afternoon keynote speaker, **Dr. Brian Smedley** brought his years of expertise in working towards health equity. He is currently serving as an Equity Scholar at the Urban Institute.

In his keynote, Dr. Smedley emphasized the importance of addressing health inequities that affect people of color, especially considering the recent outbreak of COVID-19, ongoing racial injustice, and the resurgence of overt racism in our society. He also focused on the impact racism and segregation have on the health of neighborhoods and the role policymakers and health professionals can take to produce health, well-being, and equity for the most vulnerable communities. For example, he suggested inverting the microscopic lens and **"working upstream, addressing societal and political determinants of health to reduce population level risk."**

Health and Racism

Prior to delving into the effects of segregation and racism, Dr. Smedley denoted that "health is more than just eating a good diet, exercising and going to the doctor. It is, in fact, a production of society, reflecting our policies, our practices, and our values as a society." Health is attained through opportunities for educational attainment and economic mobility which are fewer in segregated communities of color. Dr. Smedley described that segregation and under-resourced neighborhoods have multigenerational effects on a range of health outcomes. For example, living in poorer neighborhoods can lead to increased incidence of cancer, infectious diseases, and epigenetic effects that are passed to subsequent generations.

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To fully understand our nation's history of segregation, Dr. Smedley included Camara Phyllis Jones' definition of racism as **"a system of structuring opportunity and assigning value based on phenotypic properties."** He focused on four types of racism:

1. **Structural racism** creates long-lasting inequalities within institutions. The most prominent example is residential segregation which decides the quality of education, economic mobility, air quality, etc.
2. **Institutional racism** comes in the form of discriminatory policies and practices within institutions which restricts and harms racial minorities. For example, Stop and Frisk was a policy that warranted police search of individuals without probable cause, resulting in 90% of those searched being black and brown men.
3. **Individual mediated racism** comes from individual discriminatory actions. This form is what most people think of when using the term racism and includes hate speech and crime.
4. **Internalized racism** that affects the mental health of minorities as they are taught to believe in negative stereotypes, leading to a lack of power and feeling of hopelessness. This form of self-inflicted oppression can lead to denying aspects of one's own cultural identity and conforming to the dominant culture.

These forms of racism have created segregated and economically iterated neighborhoods. The differences between unhealthy and healthy communities are similar to the characteristics of segregated and economically iterated neighborhoods respectively.

The History and Long-Lasting Impacts of Segregation

The effects of segregation and redlining still last today. The economic disinvestment within these communities has led to significantly greater economic inequality. For example, 75% of neighborhoods that were redlined 80 years ago still struggle economically.

Some of the characteristics of unhealthy, segregated communities include crime, violence, toxic hazardous waste, a lack of parks, limited affordable housing, and a lack of healthcare services.

Dr. Smedley argued that the racial segregation across neighborhoods that exists today is not due to economic forces, as some believe, but due to federal policies that encouraged segregation over the past 60 years. For example, the government continued to prevent integration within communities through the process of redlining which persisted in the 1950s. Redlining occurred when the federal Home Owner's Loan Corporation would designate levels of risk of investing home mortgages within communities. Dr. Smedley signified that neighborhoods with the highest risk were always African American communities. Furthermore, racial zoning and covenants prevented homeowners from selling property to racial and religious minorities, and federal housing programs offered subsidies to create white only suburbs. Tax exemptions were also given to institutions that enforced segregation.

Dr. Smedley emphasized that although segregation has been outlawed by law, the depth of residential segregation is apparent in our cities. The chart to the right uses data compiled by demographers to compare the levels of residential segregation in apartheid era South Africa relative to several major cities in the United States.

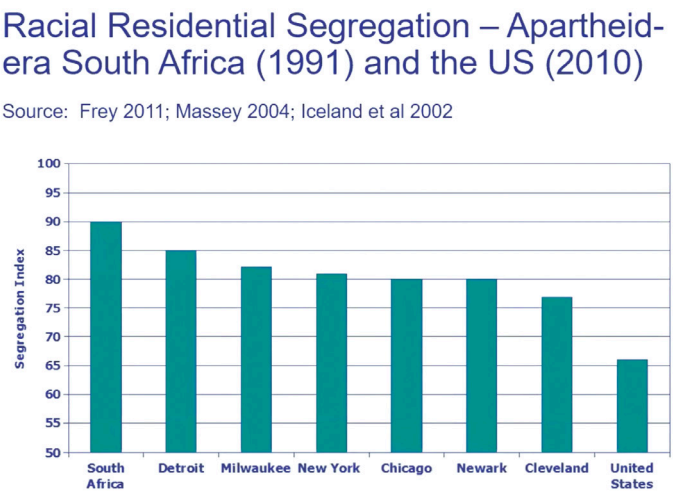


Figure 1. Racial Residential Segregation—Apartheid-era South Africa (1991) and the US (2010).
Source: https://vimeo.com/828027341/63f1d92800?share=copy

The chart uses the Dissimilarity Index which is the percentage of two population groups that would need to move to create complete integration. As of 2010, several U.S. cities were not far behind the level of segregation found in South Africa. Dr. Smedley found that **"little has changed, despite our laws changing to outlaw such practices."**

He also explained that segregation restricts socioeconomic mobility and concentrates poverty, isolating people of color from the resources needed to uplift them. Data from the U.S. Census showed that 10% of white Americans live in medium or high poverty concentration neighborhoods while 45% of African Americans live in medium or high poverty tracts. Dr. Smedley suggested that the characteristics of unhealthier neighborhoods are heavily associated with the concentration of poverty and disinvestment in these neighborhoods. For example, African Americans are five times less likely to live in census tracts with a supermarket than their white counterparts. Additionally, these communities have fewer green spaces and parks and higher exposure to environmental health hazards.

Controlling for economic factors, 30% of poor white Americans live in medium or high poverty tracts while roughly 67% of African Americans live in medium or high poverty tracts.

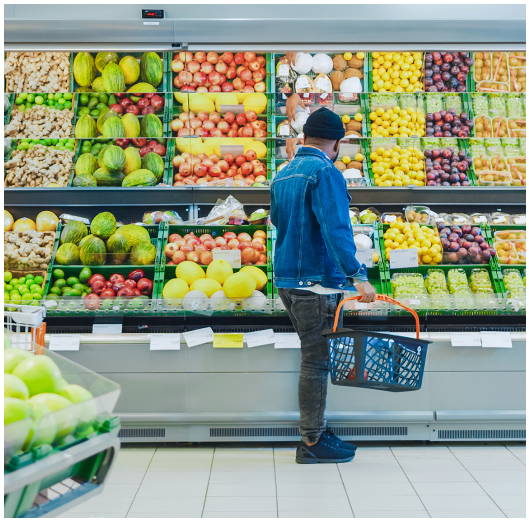
However, it is important to note that the disproportionate poverty concentration is not a result of economic differences between racial groups. Controlling for economic factors, 30% of poor white Americans live in medium or high poverty tracts while roughly 67% of African Americans live in medium or high poverty tracts. Using this data, Dr. Smedley demonstrated that **"housing mobility, the choice of where one lives, has been far greater for poor white Americans historically and even today, than it has been for poor Latinx and African-American families."**

Investing in Places and People: Science to Policy to Practice

Dr. Smedley offered a framework to solve the disproportionate concentration of neighborhood poverty. His framework relies on sustained investment in preventative measures across multiple sectors and based on a multi-generational strategy, as these inequities can last for generations. Similarly, because health inequities cross sectors, it cannot be solely addressed by our healthcare systems.

Dr. Smedley identified that policy strategies that have worked in the past are based on place-based and people-based investments.

Place-based investment includes attracting more health resources to under-resourced neighborhoods. For example, in an effort to address food insecurity, the **Commonwealth of Pennsylvania** offered tax breaks through the Fresh Food Financing Initiative for grocery stores to relocate in food deserts, resulting in job growth in these neighborhoods, improved nutritional options, and increased profit for the grocery store chains.



It also focuses on improving the physical environment such as improving air quality, expanding availability of open space, and addressing other environmental impacts. Investments in these non-health areas are equally as important as they impact health and well-being.

People-based investment involves giving resources to people that live in under-resourced communities such as preschool and housing options. These investments are as necessary as place-based investments in improving the health and economic opportunity for marginalized communities. For example, on the topic of housing, rental assistance and housing vouchers act as investments from the federal government, however, those using these resources confront various barriers such as discrimination from landlords and a concentration of poverty in available housing.

Dr. Smedley highlighted the **Moving to Opportunity** study, which examined the effects of housing vouchers that were available exclusively to neighborhoods with higher concentrations of poverty relative to neighborhoods of low concentrations of poverty. The study found benefits to having access to neighborhoods with low concentrations of poverty which bolstered health outcomes, educational attainment, and economic mobility.

It is important to note that although people-based investments are needed, place-based investments act as a prerequisite as they act as a preventative measure. Dr. Smedley argued that we need to focus on decreasing worsened conditions in high poverty neighborhoods first, but accompanying people-based investments such as housing choice programs offer added support.

The Role of a Health Professional

To Dr. Smedley, health professionals have the responsibility to advance the political and social determinants of health. A way to accomplish this is by talking to elected officials, but also understanding the role of community in patient lives. Dr. Smedley highlighted that patients may not return to a community conducive to their physical and mental health after their healthcare visit.

Lastly, Dr. Smedley mentioned the **U.S. Surgeon General's Framework for Workplace Mental Health and Well-Being**, which offers a potential solution to how health professionals can interpret and improve patient lived experiences. The diagram at right describes the framework's five components which include protecting people from harm, providing opportunities for connection, ensuring work-life harmony, communicating to people that they matter, and increasing opportunities for growth. By prioritizing these basic necessities, Dr. Smedley argues that policy makers and health professionals promote health and well-being substantially at the community level.

Figure 2. U.S. Surgeon General's Framework for Workplace Mental Health and Well-Being.
Source: https://www.hhs.gov/surgeongeneral/priorities/workplace-well-being/index.html

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For More Information

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