PrimaryOne Health

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PrimaryOne Health's mission is to provide access to services that improve the health status of families –including people experiencing financial, social or cultural barriers to health care.

Senate Health, Human Services and Medicaid Committee
Senator Dave Burke, Chair
Tuesday, June 09, 2020 @ 9:30 am
Senate South Hearing Room
Senate Concurrent Resolution 14
Testimony Provided By: Charleta B. Tavares, Chief Executive Officer
PrimaryOne Health

Chairman Burke, Ranking Member Antonio and members of the Senate Health, Human Services and Medicaid Committee, I am Charleta B. Tavares, Chief Executive Officer of PrimaryOne Health. PrimaryOne Health is the largest and oldest Federally Qualified Health Center in Central Ohio. We serve over 48,000 unduplicated patients at 11 and soon to be 12 sites in Franklin and Pickaway Counties. We provide comprehensive healthcare services to individuals who are homeless, un/underinsured and insured including primary care, behavioral health and substance use disorders, dental, vision, pediatrics, OB/GYN, pharmacy, nutrition, physical therapy and other specialty services.

Our patient demographics include:

- 30% = at or below 100% FPL
- 2/3 = Women
- 1/3 = Male
- 1/3 = Limited English Proficient
- 31% = Caucasian
- 37% = African/Black
- 27% = Latinx
- 5% = American Indian/Alaskan Native
- 4% = Asian/Native Hawaiian/other Pacific Islander
- 3% = Homeless
- 2.3% = LGBTQ+

I share this information because I want the members of the committee to understand that we serve the populations who have bared the burden of disease and illness, mortality and morbidity negatively and disproportionately for generations.

Senate Concurrent Resolution 14 declares racism a public health crisis. This resolution asks that the Governor of the state of Ohio to establish a working group to promote racial equity in Ohio. This is not a big ask…but it is a necessary one to move our state towards health equity for all her residents.

The Robert Wood Johnson Foundation's research, as well as that of the American Public Health Association, American Medical Association, National Medical Association and others show that *"…the impact of race on health stems largely from differences in access to resources and opportunities that*

can hurt or enhance health. Additionally, researchers have found that racial and ethnic discrimination can negatively affect health across lifetimes and generations. At the same time, findings from studies in the U.S. and other countries have found that perceived racial/ethnic bias—and the resulting toxic stress—makes an additional contribution to racial or ethnic disparities in health.

To reach a culture of Health, we must both address the socioeconomic factors that affect health and lift the barriers of racism to ensure everyone has the opportunity to be as healthy as possible."[1]

The efforts to "Undue Racism" have been talked and written about for decades and more than a century.

According to Dr. Richard Besser, MD "*Racism and its associated injustices have engendered tragic consequences for people of color including unequal medical care, and discrimination in housing, employment, education, and the justice system. Research shows that this history of individual and structural racism spanning generations denies opportunity to people of color and robs them of their physical and mental health. The life expectancy of people of color is often a decade or more shorter than their white neighbors just a few blocks away, an injustice that has not moved in generations…These health disparities, and often the diseases themselves, stem in part from the stress of being silenced, ignored, oppressed, and targeted for violence—too often by those institutions and individuals entrusted to protect all people*[2].

As a former member of the Ohio Senate and this committee, I recall our nationally acclaimed work to address the disparities in infant mortality in the 130th – 132nd General Assemblies with the chair and my former colleague Sen. Shannon Jones. We looked at the factors that were contributing to the abysmal death rates of African/Black babies and their Caucasian/White counterparts – 2 ½ - 3 times the rate.

The disparities and premature death and disease does/did not stop with African/Black babies…it is seen throughout the lifespan of African/Black populations regardless of social economics, education and zip code. African/Black Ohioans and residents of America are dying prematurely and disproportionately because of who they are.

- African/Black woman is 22% more likely to die from heart disease than a white woman
- African/Black woman is 71% more likely to die from cervical cancer than a white woman
- African/Black woman is 243% more likely to die from pregnancy or childbirth-related causes than a white woman

"*The strongest predictor of health is socioeconomic status (SES). While financial instability is considered the fundamental cause of health disparities, this association between socioeconomic status and health is dependent upon race.*

For instance, the mortality rate for babies born to black mothers with a master's or doctorate degree is far worse than the mortality rate for babies born to white mothers with less than an eighth-grade education. And, black women are far less likely to have breast cancer, yet are 40% more likely to die from it.

[1] Robert Wood Johnson Foundation - Race, Racism and Health
Examining the connections between race, racism and health in the United States.
[2] Statement from Richard Besser, MD, on Racial Injustice, Violence, and Health In America, June 2, 2020

These differences in mortality rate are unrelated to SES. Actually, health disparities are paradoxically greater between middle- to upper-class African Americans when compared with middle- to upper-class whites. Why does upward mobility so minimally alter the health status of African Americans in particular?

This has been a topic of much scientific debate. One possibility is that different genetics lead to different outcomes; however, the degree of health disparity with regard to race does not hold true for most other countries of the world. A more likely factor is that financial stability does not guarantee fewer encounters with discrimination. And, in fact, racial minorities report unfair treatment more frequently in higher SES than lower SES groups.

Structural racism is the biased societal approach to housing, education, employment, healthcare, and criminal justice. As scientists study racial health disparities in depth, a picture begins to emerge that there are bigger, stronger, and more insidious forces at play than economics alone. The psychological stress generated by unfair treatment may trigger a biological series of events that lead to worsened health outcomes in the long term.

For instance, in the 6 months after September 11, 2001, women living in California who were of Arab descent were far more likely to give birth to a low birth weight or preterm infant than in the 6-month time period prior to September 11. As a group, Arab-American women consistently have low rates of low birth weight or preterm infants. These findings lend support to the possibility that increased activation of the stress response system has a tangible effect on health outcomes.

In addition, there is a growing body of evidence that shows it is the chronicity rather than the severity of exposure to unfair treatment that most strongly correlates with higher morbidity or mortality rates. It makes sense that over a lifetime, repetitive discriminatory encounters can exact a heavy toll. In order to address the root cause of racial health disparities, we need to take an honest look back at previous attempts of the government to care for marginalized minority populations.[3]

Regardless of whether we are controlling for gender, age, marital status, region of residence, employment status and insurance coverage, African/Black residents continue to have worse health outcomes in nearly every illness category than Caucasian/White residents. The answer is not simply expanding healthcare coverage. The solutions must be addressed structurally and long-term. We must first acknowledge the effects of structural and institutional racism and its effects on the health status of African/Black Ohioans and people of color if we are going to transform and change the trajectory of the inequities in health outcomes.

What is structural racism?

Researchers have long argued that racism operates at multiple levels, ranging from the individual to the structural (Carmichael and Hamilton, 1967; Jones 2000). The metaphor of an iceberg is useful for describing the levels at which racism operates (Gee et al., 2009). The tip of the iceberg represents acts of racism, such as cross-burnings, that are easily seen and individually mediated. The portion of the iceberg that lies below the water represents structural racism; it is more dangerous and harder to eliminate. Policies and interventions that change the iceberg's tip may do little to change its base, resulting in structural inequalities that remain intact, though less detectable.

[3] Niran S. Al-Agba, MD, How Structural Racism Affects Healthcare
— Only by first acknowledging the effects can we work toward transformative changes

Structural racism is defined as the macro level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups (Powell 2008). The term structural racism emphasizes the most influential socioecologic levels at which racism may affect racial and ethnic health inequities. Structural mechanisms do not require the actions or intent of individuals (Bonilla-Silva 1997). As fundamental causes, they are constantly reconstituting the conditions necessary to ensure their perpetuation (Link 1995). Even if interpersonal discrimination were completely eliminated, racial inequities would likely remain unchanged due to the persistence of structural racism (Jones 2000). In the next section, we describe a few examples of structural racism and their potential connections with health inequities.[4]

I believe SCR 14 is a vital and necessary step to start the examination, discussion and ultimately the development of policies, programs and resources to undue racism in order to promote the equitable health and wellbeing of all Ohioans.

Chairman Burke, Ranking Member Antonio and members of the committee, my testimony and the need to address the callousness of inequitable health outcomes for African/Black Ohioans and people of color who are discriminated against in service and care is personal. We cannot continue to ignore the pain and suffering of those of us who have witnessed, experienced and lost loved ones who have died prematurely and unnecessarily simply because it is too hard, will take lots of time, resources and systems changes or because it is uncomfortable. We are at a pivotal time in our country's history…the question is are we going to be on the right side of healthcare justice or simply bury our heads and hearts in the ground and leave another generation to die and suffer?

Dr. Martin Luther King, Jr. stated at the Medical Committee for Human Rights held in Chicago in March of 1966, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

I choose to believe that Ohio can lead the nation in addressing this life-threatening issue. We can be the first legislature in the country to declare racism as a public health crisis and expeditiously work to tackle its structural and systemic causes. Thank you for your time and attention to this critical issue and I urge the committee to support SCR 14. Mr. Chair, I am happy to entertain any questions.

[4] Gilbert C. Gee and Chandra L. Ford, Structural Racism and Health Inequities manuscript