Talking about Anti-Racism and Health Equity: *Discussing Racism*

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

A grantee of the Robert Wood Johnson Foundation

August 2021

Overview

State Health and Value Strategies (SHVS) in partnership with Health Equity Solutions has created a series of tools to help state officials with the language they use to discuss and write about race and health equity. Included here are definitions and explanations of words and phrases, how to think about their usage, and examples of how they might be applied.

This is a living document that will continue to be updated to reflect and respond to evolving terminology. We also recognize that states may be engaged in defining these terms within their own state policy documents and hope that this can be a helpful, complementary resource.

General Recommendation #1	General Recommendation #2	General Recommendation #3
Use person-first language, i.e., "Black clients" or "Latino enrollees." This is important because when general terms such as "Blacks" or "Latinos" are used, it reduces the person to their perceived or actual racial identity or proximity to power.	Use person-first language, in the context of medical diagnoses. For example, using "people with diabetes" is preferred over "diabetics." Leading with a diagnosis focuses on the medical condition first, rather than the person and can have negative connotations.	Whenever possible, rely on self identification to avoid using a term the individual does not identify with and assumptions based on appearance.

HOW TO USE THIS DOCUMENT

Each definition is followed by:

1. **"Further Context" to offer a more detailed explanation of the definition;**
2. **"Terminology in Action," which is an example of how to use the term in a sentence; and**
3. **"Use these terms when," which offers prompts for ensuring language choices are precise. The combined aim is to help users be precise and intentional in language choices.**

For more health equity terms, see *Talking about Anti-Racism and Health Equity: Addressing Bias* and *Talking about Anti-Racism and Health Equity: Describing Identities and Experiences*.

SYSTEMIC, INSTITUTIONAL, OR STRUCTURAL RACISM:[1,2] A complex system, rooted in historical and current realities of differential access to power and opportunity for different racial groups. This system is embedded within and across laws, structures, and institutions in a society or organization. This includes laws, inherited disadvantages (e.g., the intergenerational impact of trauma) and advantages (e.g., intergenerational transfers of wealth), and standards and norms rooted in racism.

Further Context: Often used interchangeably, systemic racism and structural racism describe how racism is embedded across systems, structures, and institutions and how these work in concert to perpetuate racial inequity. This often manifests as inaction or one-size-fits-all solutions that center white cultural norms. Institutional racism refers to racism embedded in specific policies and practices within and across institution(s) (e.g., universities, hospitals, etc.).

Terminology in Action: A core tenet of the department's health equity work is dismantling *systemic*, *institutional*, and *structural racism*. As such, we have published definitions that explicitly connect health inequity and *structural racism*. A definition and acknowledgment create a shared understanding of what it means to dismantle racism and helps to explain why dismantling racism should be a shared and prioritized goal.

Use these terms when: Describing a system-level cause of health inequities. Exploring how current processes or norms within and across an institution and/or organization contribute to inequities.

PERSONALLY-MEDIATED OR INTERPERSONAL RACISM:[1] Individual-level actions and assumptions toward people due to bias, prejudice, or hate rooted in race. This can be intentional, unintentional, explicit, or implicit, and includes acts of omission (for example, asking someone where they are from based on their appearance).

Further Context: These terms are useful in focusing attention on attitudes and behaviors rather than assuming these attitudes and behaviors to be innate characteristics of individuals.

Terminology in Action: Implicit bias training helps staff learn to identify internal biases and avoid *interpersonal racism* that might result from these biases.

Use these terms when: Describing how a person or group is treated poorly or assumed to be inferior to others in one-to-one interactions.

IMPLICIT OR UNCONSCIOUS BIAS:[3] Prejudices, judgements, or differential treatment of others (positive or negative) connected to underlying beliefs, stereotypes, or attitudes that are acted on without conscious thought, knowledge, or awareness.

Further Context: Often, use of these terms makes assumptions about the motivations and awareness of individuals. Specific acts of racism are more accurately described as interpersonal or personally mediated. Implicit or unconscious bias are terms that are useful when describing the need to assess and interrogate status quo approaches for embedded bias.

Terminology in Action: After identifying disparities in diagnosis and treatment of ADHD, the department required providers to undergo *implicit bias* training and committed to reviewing diagnostic and prescription data quarterly to evaluate whether or not increased attention to *unconscious biases* among providers resulted in more equitable diagnosis and treatment.

Use these terms when: There are unfounded assumptions underpinning the current practice or approach. There is solid evidence that the bias was unintentional. If the evidence is not conclusive, use bias or racism.

INTERNALIZED RACISM:[1] Acceptance (conscious or unconscious) by a stigmatized racial group of negative messages about their abilities, appearance, and value and those of others who look like them.

Further Context: This can manifest in individuals citing individual-level behaviors as reasons for poor health rather than systemic root causes.

Terminology in Action: By choosing a diverse panel of speakers, the state aimed to mitigate *internalized racism* which might affect career choices and limit the success of an initiative to increase the diversity of students enrolling in health training programs.

Use this term when: Referencing ideas or attitudes that reinforce individual-level narratives and ignore larger systems at play.

HEALTH EQUITY:[4,5,6,7,8] Everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography, or any other social barrier/factor.

Further Context: When focusing on racial equity in health, advancing health equity means dismantling the systemic racism that underlies differences in the opportunity to be healthy, including addressing social and economic barriers to positive health outcomes. Since we have never had a truly equitable health care system, progress toward the goal of health equity is often benchmarked by measuring reductions in health disparities.

Terminology in Action: *Health Equity* in All Policies is an approach that incorporates an equity lens in the policy-making process within the executive branch with the goal of addressing structural racism and the related social and economic factors contributing to inequities in health and opportunity.

Use this term when: The people facing disparities are part of a minoritized or historically oppressed group.

HEALTH DISPARITIES:[7,8,9,10] Avoidable differences in health outcomes experienced by people with one characteristic (race, gender, sexual orientation) as compared to the socially dominant group (e.g., white, male, cis-gender, heterosexual, etc.).

Further Context: Measuring disparities can help benchmark progress towards equity.

Terminology in Action: COVID-19 has shown that the standardized collection of granular race, ethnicity, primary language, and disability status (RELD) data is critical to identifying *health disparities*.

Use this term when: Comparing one population's experience to the experience of the population with the greatest social or economic privilege.

HEALTH INEQUITIES:[7,8,9] Differences that are unfair and unjust without comparison to another group.

Further Context: An equity frame[9] connects the dots between disparate outcomes and the disparities in power and privilege in which they are rooted. Focusing on disparities can lead to the assumption that one group's behavior, intelligence, or genetics are the cause of any differences. Focusing on inequities draws attention to the root causes of these differences. For example: Disparate access to health care means that one group has less access than another. Inequitable access to health care means that one group experiences unjust limitations on their access to health care.

Terminology in Action: Racial and ethnic impact assessments are a tool for evaluating the likelihood that a policy will amplify or reduce *inequities* for certain communities.

Use this term when: A population experiences outcomes that are different than expected based on population size or the average outcome.

DISPROPORTIONATE IMPACT:[10,11] Overrepresentation or underrepresentation of a specific group as compared to the group's share (percentage) of the total population.

Further Context: This is another way of talking about injustice or inequity without comparing one group to another.

Terminology in Action: Sexual orientation and gender identity (SOGI) data demonstrates which LGBTQIA+ communities are *disproportionately impacted* by specific conditions or barriers to health to inform policy interventions.

Use this term when: A group is experiencing conditions, events, outcomes, or situations at higher or lower rates than expected when accounting for population size.

SOCIAL DETERMINANTS OF HEALTH (SDoH)[12] are the daily context in which people live, work, play, pray, and age and that affect health. SDoH encompass multiple levels of experience from social **risk factors**[13] (such as socioeconomic status, education, and employment) to structural and environmental factors (such as structural racism and poverty created by economic, political, and social policies). These latter factors are also known as **upstream factors**[14,15] or **root causes** of inequities. Factors closer to the individual level are known as **downstream factors**.

Further Context: SDoH is sometimes used to mean or signal racism or disparities by race. Similarly, "urban" and "low income" are often substituted for Black or Latino(a). Conflating race with income or geography disregards: 1) not all people of color live in urban or low-income households, and 2) disparities by race persist at all levels of income and across locations and are the consequences of systemic racism. In other words, negative SDoH are often caused by systemic racism, but are not synonymous with racism.

Terminology in Action: The agency demonstrated its commitment to addressing *social determinants of health* by collaborating with other agencies to increase access to healthy housing, food, and environments and by ensuring all health initiatives considered the root causes driving health disparities experienced by people of color.

Use this term when: Focusing on factors affecting health beyond the traditional health system and which disproportionately impact certain groups of people as a result of historic and systemic oppression. This term should not be used as a substitute for discussing or addressing racism.

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

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit **www.rwjf.org**. Follow the Foundation on Twitter at **www.rwjf.org/twitter** or on Facebook at **www.rwjf.org/facebook**.

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at **www.shvs.org**.

ABOUT HEALTH EQUITY SOLUTIONS

This guide was prepared by Tekisha Dwan Everette, Dashni Sathasivam, and Karen Siegel. Health Equity Solutions (HES) promotes policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people regardless of race or income. HES works with State Health and Value Strategies (SHVS) to guide the program's health equity work generally while also providing targeted technical assistance to states. HES is based in Hartford, Connecticut and focuses its work outside of the support it provides to SHVS on achieving health equity in Connecticut.

ACKNOWLEDGMENTS

The authors thank GMMB for reviewing and offering insightful feedback on this guide.

ENDNOTES

1. Jones, CP. (2000) Levels of Racism: A Theoretic Framework and a Gardener's Tale. Am J Public Health. 2000;90: 1212–1215.
2. Government Alliance on Race and Equity. Resource Guide: Advancing Racial Equity and Transforming Government. https://racialequityalliance.org/wp-content/uploads/2015/02/GARE-Resource_Guide.pdf.
3. Race Forward Race Reporting Guide, 2015 https://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf.
4. Human Impact Partners. (2019, July). Glossary – *HealthEquityGuide.org*. https://healthequityguide.org/about/glossary/.
5. Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.
6. Braveman P. Health disparities and health equity: concepts and measurement. Annu Rev Public Health. 2006;27:167-94. Review.
7. Braveman P, Gruskin S. Defining equity in health. J Epidemiol Community Health. 2003 Apr;57(4):254-8. Review.
8. Health Equity Style Guide for the COVID-19 Response: Principles and Preferred Terms for NonStigmatizing, Bias-Free Language, CDC (2020). https://canceriowa.org/wp-content/uploads/2020/09/Health-Equity-Style-Guide.pdf.
9. Lawrence Wallack and Liana Winett, "Equity: Communicating the Importance of Everyone Getting What They Need," Center for Public Health Studies, Portland State University, 2016, project report funded by the Robert Wood Johnson Foundation (Grant 72793), Download.
10. CSSP (2019). "Key Equity Terms and Concepts: A Glossary for Shared Understanding." Washington, DC: Center for the Study of Social Policy. Available at: https://cssp.org/wp-content/uploads/2019/09/Key-Equity-Terms-and-Concepts-vol1.pdf.
11. Fong, Rowena. "Disproportionality and Disparities." Encyclopedia of Social Work, 2014. Available at: http://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-899.
12. Human Impact Partners. (2019, July). Glossary – HealthEquityGuide.org. https://healthequityguide.org/about/glossary/.
13. The National Collaborating Centre for Determinants of Health Glossary. https://nccdh.ca/resources/glossary/.
14. Fong, Rowena. "Disproportionality and Disparities." Encyclopedia of Social Work, 2014. Available at: http://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-899.
15. Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olopade, O. (2008). Targeting health disparities: a model linking upstream determinants to downstream interventions. Health affairs (Project Hope), 27(2), 339–349. https://doi.org/10.1377/hlthaff.27.2.339.