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Prioritizing Equity video series: Redistributive justice

29-37 minutes

In this Jan. 24, 2022, edition of the [Prioritizing Equity](#) series, leaders discuss redistributive justice and its impact on the health of patients and communities that have been socially and economically marginalized and minoritized.

- **William A. (“Sandy”) Darity Jr., PhD**—Professor of Public Policy, African and African American Studies, and Economics and the director of the Samuel DuBois Cook Center on Social Equity at Duke University
- **Ivelyse Andino**—Founder and CEO of Radical Health
- **Eugene Richardson, MD, PhD**—Assistant Professor of Global Health and Social Medicine at Harvard Medical School
- **Aletha Maybank, MD, MPH**—chief health equity officer, senior vice president, Center for Health Equity, American Medical Association

Jan. 24, 2022

Dr. Maybank: Welcome everybody to Prioritizing Equity, to today's session. My name is Dr. Aletha Maybank, chief health equity officer at the American Medical Association. In today's discussion, we will discuss how redistributive justice connects to health equity and explore what it looks like in practice for your patients and communities. We are really pleased to be joined by three outstanding health leaders and, just leaders in general, in this country and change makers and legends as well. They will share their unique experiences and expertise in researching, documenting, implementing redistributive justice practice in the context of health and well-being. They will bring forth concepts and ideas that really anchor the importance of eliminating structural inequities, deepen our understanding of what really creates health and broaden our vision of these solutions and processes to really advance health equity as well. And so, I'm honored to welcome the three voices.

We have Ivelyse Andino, who is founder and CEO of Radical Health. Just raise your hand a little bit. Great. We have Dr. William “Sandy” Darity, Jr., who is professor of public policy, African and African American studies and economics, and the director of the Samuel DuBois Cook Center on Social Equity at Duke University. And we have Dr. Eugene Richardson, who is assistant professor of global health and social medicine at Harvard Medical School, as well as his co-chair, that's how I met him, of the Lancet Commission on Reparations and Redistributive Justice. So, welcome all of you today. Again, really excited to be here with you all. I usually just open up during this time of COVID, just asking people kind of, where are you physically and how are you doing at this stage in the pandemic? I think it's still fully relevant to all the work that we're doing. Ivelyse, can we start with you?

Andino: Of course, it's a pleasure to be here and it's such a great company. I'm coming to you all from the Bronx, the south Bronx specifically, where it is not only where I was raised but it's home and headquarters to the work. And I think it's just a great question of how we're doing. If I'm honest, it's been a year and probably a really tough year, both professionally and personally. And so, I'm doing well and excited. And maybe not too excited but let's see what the next year brings, excited to see what's coming up.

Dr. Maybank: Great, thank you. Sandy?

Dr. Darity, Jr.: Hi, I'm located in Durham, North Carolina. Because I'm a faculty member at Duke University, we have had a surge in cases recently like many other places in the country. So, it's a bit uncertain about how the pandemic is going to proceed locally. But for the moment I'm doing okay as are my family members. As far as we know, no one has contracted the disease recently and we're trying to do our best to stay healthy. But it's

been a tough year but I'm grateful that we're among the folks who are still around and able to try to contribute.

Dr. Maybank: Absolutely, thank you. Gene?

Dr. Richardson: Thanks so much, Dr. Maybank. It's an honor to join all of you today, especially William the goat Darity, who is a hero of mine. I'm just finishing a block. I work as an infectious disease consultant at the Brigham and Women's Hospital in Boston and so I'm just finishing a two-week block. I've been seeing the rise in cases and I'm lucky in that I usually only do these blocks once every three months but I want to give a shout out to our fellow health care workers that are really bearing the brunt of this pandemic and seeing the burnout and suffering through it and providing really good care for our fellow citizens.

Dr. Maybank: Thank you for that and just to continue Gene, with your context of being a physician and the nature of the conversation today around inequity, advancing, justice and equity work, how do you define redistributive justice work? What does that look like in the context of health care and medicine?

Dr. Richardson: Thanks. So the way I understand it, and I've learned from plenty of people that have come before me, so truly standing on the shoulders of giants when it comes to understanding what oppression looks like because I'm on the side of the oppressing but redistributive justice to me means simply just understanding that, if we take our country for example, that this country was built on systems of oppression and extraction that didn't just end with Emancipation Proclamations. They continued into Jim Crow and redlining and lethal policing and unfair credit markets and all of that. And so, there is a system that distributes resources such that people of color are disadvantaged on many material fronts and then this manifests as health inequities. And so redistributive justice is actually realizing this history and working towards fairer distribution, not only for material equity, but for health equity.

Dr. Maybank: Thank you. Dr. Darity?

Dr. Darity, Jr.: So, we've been engaged in the project here at Duke at the Cook Center funded and supported by the Robert Wood Johnson Foundation to look at the relationship between wealth and health. And I'd like to distinguish wealth from income, where income is a flow concept of resources that people receive in a fixed amount of time, usually associated with their earnings in contrast with wealth, which is a stock of resources that individuals can carry with them through time. What we usually think of as the difference between what you own and what you owe or the difference between your assets and your liabilities, or the net value of your property. And we've been arguing that while people conventionally look at socioeconomic status as an element of structural racism that produces health disparities. When they do that, they frequently look at income, education or occupational status, and they don't pay close attention to wealth.

And so, we've been trying to explore the relationship between wealth disparities and health disparities. And that relationship actually appears to be quite strong. I think that the most substantive body of work that's been done recently on the topic is by Courtney Boen and her colleagues and a team of researchers that demonstrate how powerful the effect of wealth disparities is on health differences, particularly by race in the United States. And so, the last thing I'd like to mention in these opening remarks is that we should pay close attention to the magnitude of this wealth differential by race. The Black-white gap in wealth in the United States is about \$845,000 per household. And that translates into a difference of about \$350,000 per person. And this has staggering effects on not only health outcomes but disparities in other arenas.

Dr. Maybank: Thank you for that. So Ivelyse, I'm going to come to you now and I'm going to probably get two questions at this time because what Dr. Darity mentions is very much kind of a lot of the roots of what the work that you do. In terms of you're in the space of innovation. We know innovation is extremely exclusive, right? Extremely important in terms of the ability to build wealth and has been kind of the value of building wealth when we think about technology within this country. However, it's a very exclusive space, the realities of it. It's really predominantly white men who have the ability to have access to capital whose ideas are valued in order for products to be designed. And so, can you just

speak to that connection and kind of what Dr. Darity just mentioned, the work that you do? And then I'm going to ask you and you your terms, what is redistributive justice for you and how does that look like?

Andino: Well, I just want to echo, and really love what my co-panelists have said around the idea of wealth and how that contributes to some of the gaps that we see. What we're talking about there too, is the ability to create. The ability to see a problem, live with a problem and create. And in many ways for myself, my experience has been that I've lived through the structural and social determinants of health. I didn't know what they were, I didn't have the clinical words for them but I knew what the problem was and felt like I could create solutions to address that, to address the inequities that we see in health.

But when I went to do that with my company, to your point Dr. Maybank, I couldn't get any capital to create the solutions that I knew would work and that would really build with my community. In many ways that access and holding of power and the economic resources really is a huge detriment to advancing solutions. And new technologies, new innovations, new solutions and whether those contain technology or not, it's blocked off, it's not accessible.

And for folks who I think are really well suited to address these issues, we don't have a chance. We don't have the ability to create, let alone pass down additional options for folks who come after us. And I think to answer your second question of what is redistributive justice, I think the way I look at this at Radical Health is there is absolutely the economic components that we want to share, that we want to make sure that folks have access to the capital, to the wealth. But I also think it also comes down to social capital and informational capital. Social capital, we spend a lot of time. And what happens in a lot of these networks that are predominantly exclusively white men, all of that capital, all the information kind of gets shared there. And for me, it took me a really long time to break in, to find the networks that could support this work.

And the same is true with information, especially in medicine, especially in health. I often say that there's a paywall and for all of the physicians here, you either pay with your dollars and the hundreds of thousands of dollars in debt to get into med school and build that, or you're paying with your time and your network, and that's not accessible for most folks. And so when we start to think about what it looks like for the future, when we start to think about solutions that are equitable, I think it really boils down to the three kind of distributions of power: the economic, the wealth, the social capital and as well as the information.

Dr. Maybank: Fantastic. Thank you for that. So going to Gene and Sandy, to build a little bit on that, I had the honor and privilege to be asked to participate. Dr. Mary Bassett, I think referred me, we are all very familiar with, to the Lancet Commission on Reparations and Redistributive Justice. And so Gene, you published ... well, there was a paper that was published that we collaboratively did, really looking and talking about in highlighting, reparations for Black Americans in this context of COVID. And I would love for you to just share how racial justice and interventions such as wealth distribution can prevent or exacerbate physical, mental, emotional, spiritual harm that continues within Black and Brown communities, especially as it relates to COVID.

Dr. Richardson: Thanks so much. And thanks to Ivelyse for outlining what to me sounded like technological redlining in a way.

Dr. Maybank: There you go.

Dr. Richardson: My colleagues find it hard to understand, "Oh, that redlining and all that stuff is in the past. Can't we just move on?"

Dr. Maybank: That's right.

Dr. Richardson: It's like, here's a perfect example of what is meant by contemporary, continuing harms and what they look like. As far as the paper we did together on COVID and reparations, we essentially used data from Louisiana and did some modeling and demonstrated that if the monetary payments had been made as part of a reparations package to eradicate the wealth gap that Dr. Darity described, that we could have in this

country seen 30 to 60% less across the board of a COVID outbreak. And the reason for this, it mainly just boiled down to the ability to have safe space to social distance.

So, we use data showing that there is significant overcrowding in Black households compared to white households. And so, it's not too farfetched to think that higher wealth or eradicating the wealth gap would lead to a situation of parity where people in Black households could actually achieve less overcrowding. And also, they wouldn't be forced in the frontline work as much. People are asked, why so many people of color first in frontline work? And it's because we're forced into it. Because there is no wealth to fall back on. So just those two things: being able to mitigate overcrowding in housing and participation in frontline work was enough to reduce COVID incidents in the highest risk group, which are people of color. And the way infectious disease transmission dynamics work is that when the transmission is reduced in the highest risk group, there's benefits for the population at large.

And what was most interesting to me is not these findings, they seem pretty obvious and pretty logical but the paper itself was rejected at many places. And most of the editors, all of which but one were white said that, "The modeling's great but you know, this is kind of farfetched." To think, I think what they were saying is farfetched to think that reparations would ever be paid. And so, this is what I work on when I say that global health and public health science contributes to white supremacy is that a lot of these times when people are doing modeling, they really narrow our social imaginary to just continuing these status quo relations of inequity. They never expand it to include racial injustice interventions or structural risk interventions. And by doing that, they're doing racist work.

They're doing racist analyses because they're perpetuating the inequities. And so, this was an attempt at what doing what anti-racist modeling might look like. And I was surprised to find that it was one of the first attempts. And I guess, I shouldn't have been surprised because that's how the system works. And then it was published and it got out in CNN and then you all saw, we received hate mail and threats. And so, I got my first real dose of culture wars in really trying to do work that extended current modeling practice, current public health practice into what would it like to actually build in anti-racist interventions.

Dr. Maybank: Thank you for that. And thank you for mentioning also the experience of it too, of doing this work because that's sitting with a lot of us lately, especially me lately in terms of just, what is it like to lead with these conversations? And not only just the conversations, the work of it, the actions of it of anti-racism work and how is it accepted or not accepted. And Dr. Darity, you've been at this for a while. And so, Gene you said, well, I don't know how well reparations is going to be accepted. And clearly, we still have lots of resistance to just not even the it of it and what it is but just even the language around it and using it and talking about it. And so, Dr. Darity, just want to have a sense from a long view and more of a historical view, where are we now in this movement and work of really calling out the importance of reparations, and do you see the possibility of it?

Dr. Darity, Jr.: I don't see a realistic possibility of reparations being something that is enacted by the current Congress and United States, not a comprehensive reparations plan. But that simply just gives us another reason why Congress needs to be changed or who is in Congress needs to be changed. And that's a project for an effective social movement. But I would like to say that I think it's critical that we analyze the wealth gap and the health gap in the context of what we now are referring to as structural racism. And I'm inclined to define structural racism as the institutional and policy regime that supports white supremacy in the process of shaping American race relations. And there's a great definition from Zinzi Bailey and her co-authors where they define structural racism as the totality of ways in which society's foster racial discrimination via mutually reinforcing inequitable systems.

For example, in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, that in turn reinforce discriminatory beliefs, values and distribution of resources. And I'd like to summarize that by saying that essentially what structural racism does, it sets systemic conditions as the root source of racial inequality rather than group-based differences and culture or behavior. So, that's an important pivot. And in that context, it also points us towards recognizing that the racial wealth gap is a consequence of a historical array of policies that have been conducted by the federal government. I

would begin with the period immediately after slavery ends, where the formerly enslaved were promised 40-acre land grants as restitution for their years of bondage and that was a promise that was not met. At the same time, the federal government was allocating 160-acre land grants in the Western territories. As it completed its colonial settler project in America, 160-acre land grants to one and a half million white families. That translates into a situation where there are 45 million living white Americans who are beneficiaries of the Homestead Act patents.

And then in the interval between the end of the Civil War and the beginning of World War II, there were upwards of a hundred massacres that took place across the United States. White massacres, where not only were Black lives taken, but also Black property was seized and appropriated by the white terrorists, which was another mechanism for building the accumulation of white wealth to the detriment of Black wealth. And then in the 20th century, the federal government shifts from promoting asset accumulation via land allocation to home ownership. And then when it does that, it does it in a discriminatory fashion. So, including the original version of redlining, as well as the discriminatory application of the GI bill, particularly the provisions of the GI bill for returning veterans from World War II that involved home buying as well as business development. So, the federal government is deeply implicated in the process of creating the racial wealth gap.

And this means in turn that the federal government has the obligation and responsibility for reversing and ending or eliminating the racial wealth gap. And that's something that must be done via a program of direct payments to eligible recipients in the Black community. One final comment, there actually has been real change in American attitudes towards reparations. And so, while we still have a minority of white Americans who would endorse monetary payments to Black Americans for reparations, that percentage is vastly different than it was at the beginning of the 21st century. At the start of the 21st century, only about 4% of white Americans endorsed reparations for Black Americans in the form of monetary payments. By the year 2014, that percentage was closer to 16. In 2020, that percentage had risen to about 30%. And today, it seems to be in the vicinity of 38%. So still not a majority but certainly vastly different from the percentage at the beginning of this century.

Dr. Maybank: Thank you. Ivelyse, I want to give you some space to respond or elevate something that may have come to mind for you.

Andino: I just think, thank you Dr. Darity for pulling that together. And even as you were chatting, this idea of white wealth being centered and enhanced over Black wealth. You talked a little bit earlier about this technological redlining but it's the same thing in terms of how we look at how health care is delivered. It's specifically again in this niche of technology, innovation, health care and equity, where our entire health care system based, created, generated specifically for white populations.

And now when we think about the tech, the access, even post pandemic ... well definitely not post pandemic, let me not even say that. But in the middle of this pandemic, the telehealth solutions, the access, what's being created. I'm part of the 0.01% of Black Latina CEOs in health care. There are not many like me. I'm so underrepresented and when you see that contrast between the C-suite, the folks who make decisions versus the folks who are out there doing the actual work, it really is stark. And I think we just see that play over and over again. And just wanted to add emphasis to that, that it's what we're working with. And even how I get care, how we all get care, it's really deep in that.

Dr. Maybank: And then where I want to go now is, I'm trying to also just make it now for the context of the audience and what does the audience do that primarily probably physicians or health professionals, where do they land? Because oftentimes when the feedback I get when we're having conversations on whether it's anti-racism, redistributive justice which most folks haven't heard too much of, reparations which folks have heard of but not really fully sure what it is, they're not really clear on what their place is in it.

Especially as health care providers, professionals, other leaders of health institutions, how should they be showing up? What are your recommendations in terms of being able to engage in this kind of work within their institution? I know Brigham's, I think it's at Brigham's has done some work. I know Michelle Morse and Bram wrote a really profound paper that was published in The Boston about some of the work, in Boston Review rather,

about some of the work around redistributive justice. And so, I just want to have a sense from you and I'll start with you Gene, of how is it that health professionals should be showing up in this space? What should they be talking about? What should they be learning?

Dr. Richardson: Thanks. I think part of it is to realize that even though you're doing the good work of caring for patients or working out in the community, that you can actually be part of a system that's reproducing these inequalities. And so, I'll use the example of the Institute for Health Metrics and Evaluation at the University of Washington. They've become kind of the premier describer of the COVID pandemic. They're used by the White House; they're used by WHO to do global burden of disease studies. And as I talked about earlier, when you look at the modeling, say they've done for COVID early on, it was wrong most of the time but they also had these plunging projections that were used by Trump to say that he was doing a good job. So, they were easily co-opted for ideological purposes.

But in the end, I think they did a lot of racist work too, because they came to dominate how we were understanding epidemic dynamics, yet they weren't doing anything about risk structure, racial injustices, why Black people were dying at two to three times the rate. And so, in their gathering of our social imaginary, they were bringing us to a place where racial inequity continued. Maybe there was less COVID but there was still the status quo racial inequity. And to me, that is how in your public health work, you can continue to reproduce a racist system. So, it's part of the reason why we took on this anti-racist modeling project to show what broadening the social imaginary might look like as far as our analyses of what affects us health wise. But I think if we also fall back on that dictum that politics is just medicine writ large, is realizing that you can't just practice and see your patients or do the health care work in a bubble. You do need to be involved politically.

So, if it's like Dr. Darity talked about electing a Congress that supports reparations, or reparative justice, or it means voting for people that support universal health care, or it means supporting Black Lives Matter movements at their grassroots level, it means stepping out of the workspace and understanding that you are a political entity, and that a lot of what we're talking about is not going to happen without the political organizing.

And so oftentimes health care workers are in these privileged positions to understand health impacts on the people they care for. And so, they need to speak out beyond the hospital and get involved politically any way they can. For me, I think of things because I do more global health. So, I'm really interested in debt cancellation because that is another system by how transnational instead of intra-national inequities are continued. So, finding a niche that speaks to you but that is political in nature so that you can be part of the organizing that beyond the hospital, beyond the clinic, that that can help combat these inequities.

Dr. Maybank: Thank you Gene. Dr. Darity?

Dr. Darity, Jr.: I was thinking that what we need is a federally funded program of reparations, a comprehensive program that would provide the resources that would eliminate this racial wealth gap that I'm talking about. And if it's about \$350,000 per person, it would require an expenditure of at least \$14 trillion to eliminate the disparity. That would be the size of the project. It could be conducted over the course of a decade, although I would hope it wouldn't be done longer than that. But I would say that if there are folks who are truly committed to the question of elimination, of structural racism and its effects in this society, then they could become advocates for a federal program of reparations. And it would be fantastic if physicians and their associated or allied medical organizations made a commitment to be part of a coalition to support a comprehensive reparations program across the United States. I must say it has to be federally funded because states and localities don't have the capacity to meet the bill. Their total budgets are about \$3.1 trillion.

And that's a great shortfall beneath the \$14 trillion that's required. And then the other thing I would mention is just to echo Gene's comment, which is that it's important to get your own house in order. That you need to make sure that the types of activities that you're engaged in professionally and that your colleagues are engaged in professionally are not promoting the types of inequities that we've experienced. I know that one of the central findings that has emerged in thinking about physician practices and the medical system is

the observation that a significant number of physicians actually believe that Black patients have a lower pain threshold. I'm sorry, have a higher pain threshold, and don't feel pain to the same degree. And I think that, that's just indicative of some of the stereotypical beliefs that poison medical practice. And that's an important phase of what needs to be done because closing the wealth gap will not in its entirety close the health gap.

Dr. Maybank: Thank you for that. And Ivelyse, to close it out?

Andino: Yeah. So, I love again what Dr. Darity and Gene both said, and there was a lot of kind of just solutions there focused on coalitions and getting together. And I think it's really timely to quote Bell Hooks, where she says, "Rarely if ever any of us are healed in isolation, healing is an act of communion." And want to echo that for the day to day. How is it that when you witness one of the acts of injustice, when you witness an act of racism and so maybe it's someone not getting their labs that were requested or you feel that, you see that, that you talk with someone else that you share that in communion and you both can agree and come together and start to organize there. And the same thing, I think it's true for those of you in patient care or community care.

When we see a patient who has an experience that we know is not isolated. So, whether it's people who are birthing or care and prescription access, how can we connect them as well? And my theory is always around, how do we redistribute social capital? How do we share build connections? We know that all movements and all change are never ever isolated, but again, happen through organizing through togetherness. And so, I think it's always great to take action where you can take action individually but as often as you can share your power, your access to connections through introductions, as well as your access, to information. So as simply as we can describe it, as much as we can make that accessible and as much as we can build together, I think is where we start to see some of those smaller shifts that then become the big waterfall.

Dr. Maybank: Fantastic. Thank you all. I heard in terms of suggestions of political engagement, clearly at large advocacy, whether it's state, federal levels. But then there's within their own houses and right in getting our own houses in order and advocacy within our own house. And how do we advocate for ourselves, for our patients, our colleagues and coworkers? I will not forget, closing the wealth gap will not close the health gap for sure. And sharing and building connections to the point of where we're getting to healing. Thank you for naming Bell Hooks. At the time of recording, she passed yesterday and has meant a lot to many of us in this space of justice and really has rooted and has really elevated for us in the space of justice, the importance and the memory of love. And last year, I actually gifted my team, "All About Love."

And I thought it was really critical because what was happening was this over-intellectualization of harm and of exclusion. And I get, and all of us very well get, the importance of our data and our evidence and analysis and all of that. But sometimes and many times, folks use that as a cover and a guard to not really realize that the reason why we're naming racism and injustice is because of love and love for ourselves love for our family, love for our communities. And so, I just think it's always important to center that in this work more so than I've ever felt before. And it's not common to bring up the context of love but I'm going to be doing it more and more as we go forward. So, I really thank all of you for spending the time with me today. Thank you for all your leadership in all the many spaces that you are and the people that you communicate with. And thank you all for tuning in to this series, this episode of Prioritizing Equity. Take care.

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