Announcer (00:05):

Welcome to Hospitals In Focus, from the Federation of American Hospitals. Here's your host Chip Kahn.

Chip Kahn (00:14):

We continue our conversation on the social determinants of health today, focusing on the ways in which they have affected our nation's communities of color, and offering approaches to mitigate disparities generally, and during the COVID-19 pandemic.

It is a distinct pleasure to welcome our guest. He has had a defining academic career in public health and health equity, especially when it comes to the ethnic and racial disparities that affect the health and medical care of millions of Americans. He is also the Dean at the Tulane University School of Public Health and Tropical Medicine, from which I received my MPH, I'm embarrassed to say, 40 years ago.

As a proud alum, I am particularly appreciative of the health policy focus he brings to the school and his innovative and forward-looking leadership at the oldest school of public health in the United States. I am confident we will all have many takeaways from the interview today, Dr. Thomas LaVeist, thank you for joining me today.

Dr. Thomas LaVeist (01:15):

Well, thank you for having me, Chip.

Chip Kahn (01:17):

Tom, just to get started, can you tell us a bit about yourself?

Dr. Thomas LaVeist (01:22):

Sure, so I come to this, my new position ... Well, I guess it's relatively new. It's been two years now, as Dean of the School of Public Health and Tropical Medicine at Tulane after spending 25 years at Johns Hopkins, at the School of Public Health there, and two years at George Washington University School of Public Health. I'm a medical sociologist and my work has focused on racial disparities in health with a particular emphasis on policy as a tool for impacting the health of populations.

Chip Kahn (01:56):

Tom, historic racism in our nation's medical care and research has fostered distrust of American medicine in the black community. How successful have we been at moving beyond the effects of systemic racism in recent years?

Dr. Thomas LaVeist (02:13):

Well, certainly, I think it would be accurate to say that we've moved beyond many of the most [inaudible 00:02:19] practices in healthcare that we had in the past, such as racially segregated wards, racially segregated blood supplies even, a lot of that sort of thing we've moved away from. We certainly have made tremendous improvements there, but we still have a ways to go. There's still problems in the healthcare system. When you look at the number of African-Americans going into the health professions, not just as physicians, but in all areas, they still are dramatically underrepresented and we haven't made much progress even in the last 50 years in that area. I'd say it's a mixed, mixed a record. We've made some improvement, but I think we still have a ways to go.

Chip Kahn (03:05):

What you're describing is so apparent with COVID-19, even where we have been able to move beyond bias in the care. There's still that residual distrust, which is as you point out really often justified. How can healthcare providers assist in dispelling these concerns or work to mitigate these concerns for the most vulnerable in our communities?

Dr. Thomas LaVeist (03:33):

The issue of trust, and this is just human nature. It takes a long time to build trust. It doesn't take very much at all to destroy that trust. I think it's building the trust in the African-American community among the healthcare industry. I think that's a journey. That's something that's going to take time. There certainly has been a long history of untrustworthy behavior, many, many cases, things that have happened that generated the distrust. I think it's just a matter of time. Time, and also consistently being trustworthy in the things that we do.

Chip Kahn (04:11):

Tom, you have developed an innovative approach to address the distrust factor and other adverse effects of disparities. Would you tell us a bit about your program, The Skin You're In?

Dr. Thomas LaVeist (04:23):

The Skin You're In, it's a multimedia health education project that began first ... It began as a book that I wanted to write, and the idea was to write a book that would take all of that great information that's been generated on racial disparities in health, but is locked away in the university library in academic journals that most people can't access. I wanted to take that content and put it into digestible format where people could understand it. A friend suggested that more than a book was needed, but rather maybe a film would be a better way to go. I decided that I would make a documentary film on this topic and under the name, The Skin You're In, and then ultimately, the film project kind of morphed into a series because there actually was too much content to fit into one film. Now, it's become this multimedia project, which is a book, documentary film, website, social media, where we try to put out authoritative and accurate information targeting African-Americans with accurate information. Now, we've been focusing almost exclusively on COVID for this year.

Chip Kahn (05:41):

That's great. Could I ask real quickly, how can people find you on the internet or on social media?

Dr. Thomas LaVeist (05:46):

In social media, we do have the handle TSYI, which is the initials for The Skin You're In. If you search for TSYI on Facebook, Twitter, or Instagram, you'll get us.

Chip Kahn (05:59):

Great. Thanks. I'm sure you were not surprised by what happened with COVID. This issue of racial disparities goes all the way from susceptibility to illness through the entire continuum of care for disease. Why did we not see this coming?

Dr. Thomas LaVeist (06:17):

I think it was predictable and I saw it coming, but what I didn't see coming was the magnitude of the disparities. The disparity is actually bigger, in terms of the death rate, is actually bigger than I thought it would be. I think that might be a surprise to others as well. When you think about an infectious disease like this, it spreads on the basis of physical proximity and that's really it. If you're close to someone who was infected, your odds of being infected increases, right? It's that simple. The country is segregated on race. Who are you interacting with most commonly? You're interacting with people of your same racial ethnic group. That goes for every ethnic group in the United States because of racial segregation. Then when you look at the occupations that African-Americans are more likely to be in, they're occupations that we've now come to call essential workers.

They're the people that do the jobs that allow others to work at home on Zoom and not have to go out and be at risk. It's the people that are bringing food on Uber Eats. It's the people who work at the supermarket. It's the people who have the jobs that require them to go out. Those are the people that are going to be disproportionately infected. Then once you're infected, you're going home to your neighborhoods, which tend to be racially segregated. The people that are at risk of being infected by you are going to be people of your same racial ethnic group. I think that's the genesis of the disparity.

Chip Kahn (07:56):

You implied or alluded here to a really shocking statistic, that one in 1,000 black Americans have died from COVID. Black Americans are much more likely to be hospitalized for COVID and clearly suffer worse outcomes. How can we do a better job for black Americans?

Dr. Thomas LaVeist (08:19):

No, I think it's a key question. I wish I had a simple and easy answer. I mean, early on in the pandemic, one of the things that we faced, especially on social media was false information. Information that was being targeted to African-Americans. One of the early myths that came around was that African-Americans were immune. They were immune to COVID-19, which to me was just absolutely bizarre. How can any human being be immune by just because of their skin color? That sort of thing may have slowed reaction in the black community and maybe some of the early infections occurred there. We also had some ... I think we've had a lot of bad health communication coming from the federal government. I mean, terminology like social distancing. Social distance is just a horrible health communications term and Chip, as one of our MPH alumnus, I hope that you would know to do better in our communications, but we're not asking people to be socially distant.

We don't want anybody to be. In fact, we need people to be socially connected if we're going to maintain civil society. What we want is for people to be physically distant. Social distancing, it's not even an accurate term to describe what we want and it actually describes the opposite of what we want. This is just one example, Operation Warp Speed, horrible terminology. Operation Warp Speed is the government's program. Well, it's a public private partnership to accelerate the development of a vaccine. Well, the last thing you want to do for a society that is already skeptical of vaccines, is to emphasize the speed at which you are creating this vaccine, but you call it Operation Warp Speed. I could go on with other examples of kind of really bad communication. In some cases, communication that targeted African-Americans. The Surgeon General early on was warning people not to purchase masks, not to use masks, which is of course, the complete opposite of what we should have been telling people.

Then when we started to learn about the disparities, he started saying that the disparities existed because of underlying health conditions in African-Americans, the high rates of obesity, hypertension, and diabetes. If African-Americans just did a better job of taking care of themselves, they

wouldn't have this problem. Of course, that doesn't make any sense because down here in Louisiana where I live, whites have very high rates of obesity, hypertension, and diabetes also. The disparity, the racial disparity in those conditions is not nearly big enough to explain the COVID disparity, right? Clearly, it couldn't possibly have been the underlying health conditions, but yet that myth continues to circulate. You still see that out there. I think that the start to how we do better with African-Americans as we start with being more thoughtful about the health communications, what we're communicating to African-Americans and really to all Americans and what language we use in that communications.

Chip Kahn (11:36):

I guess, beyond failing public health 101, as you just described, what are the key issues that you think have emerged for communities of color from this pandemic that need to be addressed by governmental action by public policy?

Dr. Thomas LaVeist (11:54):

I talked about occupations, right? People in different occupations are at different levels of risk and African-Americans are more likely to be in those occupations that are at risk, but it's not only occupation. There's also housing and housing density. African-Americans are more likely to live in urban environments and more highly dense population-dense communities, which also accelerate the spread of this virus. When you look at these structural factors, I made a comment the other day in another news report that this disparity is a function of sociology and economics, not biology and genetics. If it's a sociological or an economic problem, it can be addressed with public policy, right? That's the way we affect public policy. We could work on increasing access to healthcare. You look at many of the states here in the south, Louisiana being an exception, but many of the states here in the south have refused to expand Medicaid.

Well, these are also the states with the largest black population. African-Americans are disproportionately impacted by states that have refused to expand Medicaid. You don't expand Medicaid, you have fewer people with access to healthcare than you otherwise would have, and you're in the middle of a pandemic and people are going to get sick. They're going to show up in your emergency room anyway, whether they're insured or not. I think just universal access to healthcare. I'm not saying that from the standpoint of arguing for a single payer or any particular approach to getting there, but I think getting there is what's key. I think that would help all populations, including African-Americans.

Chip Kahn (13:46):

Also, you brought up Warp Speed. Hopefully there will be success in the near future with a vaccine, but considering the unfortunate historical precedent, we must be concerned that our black community may not be treated equally when it comes to the vaccine. How can we make sure that the vaccine is accepted by the black community who have been so hard hit by the pandemic and make sure at the same time that the vaccine is fairly allocated, once it arrives?

Dr. Thomas LaVeist (14:18):

This is a really difficult nut to crack. I'm involved in several projects where we're trying to work on this issue. I mean, one of the things that I do is I'm the co-chair of the Louisiana governance task force on health equity, and COVID-19. One of the things we're looking at is very useful. You're talking about the African-American community, the distrust of vaccines in general, the distrust healthcare. The fact that when we began to have testing capability, African-American communities was not first in line to get

testing. Now, there are many who are arguing that now that we're developing a vaccine, they should be first in line to get the vaccine. Many African-Americans feel that that's because they want to test the vaccine and make sure once they deploy it in a large population of people, they want to make sure that it's safe.

This is a huge, huge problem. I think the way that we're going to address this issue in time is through trusted messengers who can speak to the black community and convince the community that it is important that African-Americans be involved in the phase three clinical trials, because you want to have a representative population of people in the trial. A population that represents the people who will actually be using the vaccine. You'll need trusted messengers to communicate to African-Americans that once the phase three trial is completed, that the trial was done correctly and that it's safe and effective. Again, we're really not doing a great job there because the potential trusted communicators for the black community are not really able to access Operation Warp Speed because so much of what's happening there is being done in silos and in secret. I think it's going to have to be getting trusted communicators to be willing to put their credibility on the line, to communicate to African-Americans and convince them that they are to use this vaccine. That only happens if you can gain the trust of those trusted communicators.

Chip Kahn (16:31):

You mentioned that you're co-chair of the Louisiana governors task force on COVID and health equity, we just talked about the vaccine. Beyond that, what are the major features of the task force's agenda and how responsive has the public and the state government been to that agenda as you've moved along?

Dr. Thomas LaVeist (16:50):

The task force has I think quite a broad agenda. We've been given a very broad charge and we have a set of sub committees that are looking into a wide variety of things. We're looking at prisons, nursing homes, other congregate living situations. We're looking at issues of healthcare resource distribution, testing, making sure that the testing is adequate in all communities, particularly in the rural communities here in Louisiana. It's just a comprehensive set of things. We're looking at economic impact of the pandemic. To this point, we have made a set of recommendations to the governor. I know that the governor is looking at those recommendations. He has communicated that back to us. We met earlier this week with representatives from the health department, they are responding to our recommendations. Over the next week or so, I think we'll start to hear more about how the governor is going to respond, but to this point, I would say that they have been responsive to what we've been providing them.

Chip Kahn (18:01):

That's real encouraging. Let me touch on this sort of state local issue and just ask you, Tom, and this'll be our concluding question. As a public health policy expert, and we have heard some interviews a few moments ago on communication at least, do you think we need a clearer national strategy overall against COVID? If we did that, what role do you think, and I know you've done a lot of thinking about this, should the states play? What should this sort of federal state mix be if frankly, our leaders had taken a public health 101?

Dr. Thomas LaVeist (18:37):

Well, I'll give you my off-the-cuff [inaudible 00:18:40] answer first, and then I'll give you a more thoughtful answer. Imagine if December 7th, 1941, the Japanese military attacked Pearl Harbor in Hawaii, and the president said, "It's the responsibility of the governor of Hawaii to address this attack." This is a national, international, global tragedy that requires a global response, not just a national response. We have pulled out of the World Health Organization. An organization that was set up to respond to global health pandemics, to which the United States is one of the founding members. That's the short answer. The longer answer is, I was on NPR back in probably March, and they were asking about a national response. My comment was, "Look, if we continue to do this on a state-by-state basis, we're going to play a McCobb game of whack-a-mole."

"We're going to have an outbreak in one state, and once that state is able to get that outbreak under control, it's going to flare up in the next state. Then once that state is under control, then it's going to come back to the previous state." That is precisely what has happened and what we're doing, because we don't have a coordinated national response. This pandemic is going to be prolonged. It's going to be more difficult to get under control. There's just going to be more carnage and more loss of life that could be avoidable if we were coordinated in the way that we're responding.

Chip Kahn (20:24):

Tom, thank you so much for joining us today. We deeply appreciate your insights. We appreciate all you're doing. I know our audience will want to learn more about The Skin You're In. To learn more about The Skin You're In, visit tsyi.org, or @TSYIBLKHealth on Twitter. Hopefully in the future, the country is going to do a little better. We really need your guidance and the guidance of other leaders in the public health community across the country. I, again want to just express my deep appreciation as a Tulane alum from the School of Public Health, for all you've done to improve the school. With that, look forward to working with you and talking with you in the future about these kinds of issues.

Dr. Thomas LaVeist (21:18):

Well, thank you. It's always a pleasure. Good to talk to you again, Chip.

Announcer (21:26):

Thanks for listening to Hospitals and Focus, from the Federation of American Hospitals. Learn more at fah.org. Follow the Federation on social media at @FAHHospitals, and follow Chip @ChipKahn. Please rate, review, and subscribe to Hospitals and Focus. Join us next time for more in-depth conversations with healthcare leaders.