Before I start, I would like to give my sincere thanks to Deputy Mayor Palacio, Dean Fried, the selection committee and the family of Frank Calderone, particularly Francesca Calderone Steichen and Ariana Calderone Stahmer.

To be the recipient of this award is not just an honor for me, it is a testament to the incredible team I lead at the Health Department. I am grateful to Mayor Bill de Blasio, who appointed me now nearly three years ago, and gave me the opportunity to serve the people of New York City as health commissioner. This award is also a testament to the strategy and the sacrifices of the racial justice movement. I do my best to be a worthy representative – and it is especially moving to be given the Calderone award for this reason, for the work I do builds on a path that Dr. Calderone helped pioneer to improve the public’s health, with an eye on health equity.

After I read that Frank Calderone worked at the NYC health department, my team and I did a little research. We learned that after Frank received his master’s degree in public health from Johns Hopkins in 1937, he returned to New York City to become a District Health Officer for the Lower East Side. In this role, he was responsible for starting the new Health and Teaching Center. For the curious, we tracked down this building – still standing on 1st Avenue and East 25th Street – and today it is serving a similar role, albeit for the NYU School of Medicine.

At this point in history, District Health Centers were still a new concept for the Health Department and were opening up slowly, neighborhood by neighborhood. When Frank opened the Lower East Side Center, we can imagine with reasonable certainty that his job was to coordinate the variety of services and resources available at the District Office. We also know from a report authored by Herbert Kaufman in 1958 that the entire period Frank worked at the Health Department was characterized by a broader tension about the authority between District Health Officers, like himself, and the overseers at the agency headquarters.[[1]](#endnote-1) I imagine that Frank was an advocate during this time, like his peer District Health Officers, and argued that his role should be broader, with more control to respond more swiftly to local concerns.

Some of you may know that the District Health Center program did not survive the ensuing decades, and many of these buildings went underutilized for years. In a fateful serendipity only possible at an event like this, I was the person who originally advocated for reopening three District Public Health Offices over a decade ago when I was Deputy Commissioner at the Health Department. As Commissioner, I am going further and returning more of these buildings to community service. Today is a different day and we need hipper branding, so they’re called Neighborhood Health Action Centers. But the essence of Frank’s great contribution to the City is unchanged.

In the coming year, and with support from Mayor de Blasio, we are launching several Neighborhood Health Action Centers, which open up underutilized Health Department buildings to needed community services and programming. In that model, we bring a number of services together – for example, a Federally-Qualified Health Center on the first floor, a Women’s Health Suite, a community teaching kitchen and food pantry, a multipurpose room, and more all in one building, and use our staff to bind them all together as a space fully coordinated to meet the needs of whoever walks through the door. In the coming year when these buildings come online, they will also play a crucial role in convening and supporting neighborhood planning activities across East Harlem, East and Central Brooklyn, and the South Bronx. It is my hope that we can extend this model to parts of Queens and Staten Island.

Why did we pick these neighborhoods as our initial focal point? Because during my tenure as Health Commissioner, we are prioritizing racial equity in health. You will recognize these communities as poor neighborhoods, ones that have an excess disease burden. They are also overwhelmingly Black and Latino communities. We see a focus on racial equity as crucial, and do so with the understanding that racial equity presumes – but cannot be reduced to – an issue solely of economic justice. Instead, we have to deal with the ongoing realities of how racism corrodes our society, affecting every institution and every body, literally – including the state of our physical and mental health.

Let’s step back and think about what this priority means.

Where better to start than reflecting on this election now just days away? I can safely assume this topic is on everyone’s mind, and as a result of our unrelenting media coverage, our very public candidates, and the lengthy election cycle, nearly everything that could be said, has been said. In that spirit, I want to invite you to take a step back even further with me. Before Hillary secured the nomination, before many “felt the Bern,” and indeed, even before there was change we could believe in, there was a presidential candidate of several firsts running to represent a major party ticket who broke the mold in more ways than many could comprehend, let alone support. I am speaking of Shirley Chisholm.

There’s so much to learn from her, but what I want to focus on today is her bold, unapologetic, and explicit commitment to naming racism. In her memoirs, she wrote: “Racism is so universal in this country, so widespread, and deep-seated, that it is invisible because it is so normal.”[[2]](#endnote-2) If you think the conversation on race in our country is just getting legs now, can you imagine a presidential candidate saying this in 1972? And still, nearly 45 years later, her analysis stands.

Congresswoman Chisholm has us consider how we lose sight of what’s right in front of us.

This is a consideration that has woven its way throughout my working life. A little over 30 years ago, Nancy Krieger and I published an article in the *Monthly Review* titled “The Health of Black Folk.” In it, we wrote about the normalization of poor health among black people – how the status quo of poorer health and shorter lives comes to pass as one the “facts of being black.” The following passage begins this essay:

What is it about being black that causes such miserable odds? One answer is the patently racist view that blacks are inherently more susceptible to disease, the genetic model. In contrast, environmental models depict blacks as victims of factors ranging from poor nutrition and germs to lack of education and crowded housing. Instead of blaming the victims' genes, both liberals and conservatives blame black lifestyle choices as the source of the racial gap in health.

The “facts of being black” are not, as these models suggest, a genetically determined shade of skin color, or individual deprived living conditions, or ill-informed lifestyle choices. The facts of being black derive from the joint social relations of race and class: racism disproportionately concentrates blacks into the lower strata of the working class and further causes blacks in all class strata to be racially oppressed.[[3]](#endnote-3)

I believe we’ve come a long way since the 1980s, but I’m not sure that our analysis of racism and health, or social justice and health, has grown more sophisticated, drawn more practitioners, or explicitly influenced much policy. I can say that because I continue to find myself explaining the very same concepts I wrote about in the 80s in 2015 and 2016, most recently in an interview with Big Think[[4]](#endnote-4) and in a piece for the New England Journal of Medicine about the importance of #BlackLivesMatter.[[5]](#endnote-5)

All of this is true even when there has never been more attention given to concepts like the social determinants of health and health equity. Representative Chisholm’s insight becomes prescient in this respect, for today our analysis of equity and social determinants is ironically myopic, a limitation that keeps us from fully realizing their potential as frameworks.

Today, we can speak of health equity without invoking race at all. Those who do speak of race seldom explicitly name racism, and even in those few forays into racism, there is hardly mention of the history and the contemporary of racial oppression, or the staying power of white supremacy. This troubles me, because it doesn’t take much for invisibility – what we don’t see – to become blindness – what we can no longer see.

My goal is to convince you all that we must explicitly and unapologetically name racism in our work to protect and promote health – this requires seeing the ideology of neutral public health science for what it is and what it does. We must deepen our analysis of racial oppression, which means remembering some uncomfortable truths about our shared history. And we must act with solidarity to heal a national pathology from which none of us – not you and not me – is immune.

There are many well-meaning and well-trained public health practitioners who disagree from the outset that we must name racism. That argument will sometimes claim that the very essence of public health is about helping people, pointing to increased lifespans and decreased infectious disease outbreaks over time. Their argument will at other times claim that we don’t want to muddy the clear waters of public health with the messy politics of race, that this sort of a topic is best left to protesters, opinion editorials and campaign stump speeches. I have also heard the claim that identifying racism opens this Pandora’s Box of problems that our modest field cannot hope to address comprehensively – that identifying racism hoists too heavy a burden. Last, there are those who say that racism is not the core issue, but instead poverty. We cannot fix racism, but we can fix poverty.

Of these, I believe the most dangerous claim is the first, that our technical expertise is enough to meet the challenges of poor health, wherever they are. This mindset presumes a neutrality of public health that has never been true – it ignores the fact that public health both operates in a political context and is itself, like any science, permeated by ideology.

Much is conflated when medicine and public health attempt to fly below the radar of politics by donning the armor of scientific objectivity – guarding the faith by positing the cold logic of the scientific method. Let me start by saying that science is not all methodology – one simply cannot judge the prudence of a whole ecology of funders, research proposals, theory-building, conferences, journals, institutes, and applications by reducing all of that to the scientific method. Each of these facets is fully penetrated by the biases of human behavior, by the ideologies of our time.

Consider two examples: funding priorities of the National Institutes of Health (NIH) and the public health, medical, and criminal justice response to the current opioid crisis.

In the case of the NIH, see its most recent 2012-2013 biennial report to Congress: as my colleague Nancy Krieger has pointed out, not only did it allocate only 9 of its 441 pages to “Minority Health and Health Disparities,” but within these 441 pages, the terms “genome,” “genomic,” “genetic,” and “gene” appeared 457 times, whereas “social determinants of health” occurred only once, “discrimination” and “poverty” twice, “socioeconomic” 12 times, and “racism” not at all.[[6]](#endnote-6)

Or, with regard to the current opioid crisis – and its appropriate reframing as a public health and not criminal justice issue – how differently it would have been had the same framing been used when Nixon declared his “War on Drugs!” But of course he did not. Today, the opioid crisis is perceived as primarily affecting white populations, people who need help. No such frame of deserving victims was used, however, by Nixon. Instead, as shown in Ava DuVernay’s extraordinary new film “13th” that was a “war” that aimed to criminalize the black population and reverse the gains of the Civil Rights Movement and the War on Poverty.

We must remember that objectivity is not a synonym for neutrality. Objectivity refers to the idea that independent researchers can independently seek to test the same hypothesis and, if the hypothesized causal processes are indeed going on, they should come up with the same results if they use the same methods. However, what researchers choose to study and how they frame hypotheses determines the context in which objectivity is deployed. I urge you to consider, for example, that a great deal of unacceptable actions have taken place when objective methodology is utilized without regard for the role of science in oppression: eugenics, forced sterilization, the Tuskegee study. Often these are dismissed as bad science, or unethical science, when they too, in fact, are science.

Knowing this, we must name racism in our research proposals, in our theories, in our oral presentations and conference tracks, and even in our hypotheses. The essence of naming racism is this – how we frame a problem is inextricable from how we solve it.

This is also why it is important to name racism as something more than poverty concentrated in communities of color. Not only does poverty not explain why several disparities cut across classes of Black and Latino peoples, but starting our analysis of poverty through the lens of racism changes how we think and act with respect to poverty.

An anti-poverty lens might look at the higher rates of obesity and diabetes among populations of color and conclude that the problem to address is the prohibitively high cost of good food. There’s truth to that analysis. It is more expensive to eat a healthy diet and avoid diet-related illnesses. The solution to this problem, understood in this fashion, would be to subsidize fruits and vegetables or reduce prices somehow to facilitate their purchase. We do have programs that do this – our Health Bucks, for example, act like a coupon that allows a person to buy more fruits and vegetables at the local farmers market. Now I like this program, which started under my leadership as a Deputy. Adopt a racial justice lens, though, and you see that Health Bucks, by themselves, are not enough.

Because of the legacy of redlining and neighborhood divestment, farmers markets (not to mention, full service grocery stores) are far less likely to open in low-income communities of color, and if they do, they tend to cater toward new residents who reflect a wave of gentrification. The answer here requires further action, we need to address what some are beginning to call “food apartheid” in rapidly gentrifying neighborhoods like Brownsville or East Flatbush, the South Bronx, and East Harlem. An anti-racist lens, in contrast, doesn’t just see the factors associated with poverty, but the entire historical dossier of policies, norms, and actions – what Nancy and I called the joint social relations of race and class.

Hearing this, you may be reminded of the last rebuttal of naming racism I listed, this anxiety that a focus on racism opens a Pandora’s Box and asks us to do too much when we aren’t equipped to change society or upend the prison industrial complex, for example.

I’m here to tell you otherwise. The conditions of our society – for starters – are not the outcome of some vague social physics impenetrable to change, they’re the product of decisions made at every level of power. In that respect, each of us has real power to make different choices. More important, many in the field of public health are tied to institutions, such as government, academia, and hospitals that are immensely impactful in communities of color.

For the students of history in the room, you know how much the US was transformed during the relatively brief and unfinished periods of Reconstruction and the War on Poverty. It is clear to me how much can change when there’s will and resources. That brings me back to the parable of Pandora’s Box, which seems to be relayed only partially when invoked in speeches like these. Does anyone know how the story ends? When Pandora opens the box, out flies all manner of evils into the world. But sitting there at the bottom of the box is its only remaining item, hope.

I hope I have done my part to show you why it is crucial that we name racism, but I want to be clear that naming racism is only the starting point for the work that we must do.

It is just as critical that we deepen our analysis of racial oppression to account for the sobering history of American racism and its counterpart, white supremacy. The history we’re taught about racism in the United States is not just inadequate, it’s dangerously misleading. Among the many topics and events that form the bedrock of seeing racism in its full context, I now want to take some time to talk about one topic I believe is most frequently avoided or misunderstood: white supremacy.

Let me start by reading some quotes selected from a report:

What white Americans have never fully understood—but what the Negro can never forget—is that white society is deeply implicated in the ghetto. White institutions created it, white institutions maintain it, and white society condones it.

The press has too long basked in a white world, looking out of it, if at all, with white men's eyes and white perspective.

Our nation is moving toward two societies, one black, one white — separate and unequal.

These words are taken from the final report released by the Kerner Commission in 1968.[[7]](#endnote-7) President Johnson commissioned the report in response to race riots in Los Angeles, Chicago, and Newark that happened between 1965 and 1967. He wanted answers to the questions: “What happened? Why did it happen? What can be done to prevent it from happening again and again?” Martin Luther King Jr. read the report as a "physician's warning of approaching death, with a prescription for life." His vision, of course, was fulfilled too soon. Johnson rejected the report and its recommendations, Dr. King was assassinated a month later, and within one month of the report being released, riots broke out in more than 100 cities.

What the Kerner Commission highlighted is remarkable, and something that hasn’t been articulated by government since. After reviewing the evidence and holding discussions, a panel composed mainly of white men responded with President Johnson’s questions with a reflection on whiteness. I’ll let you think about that for a moment.

Speaking about whiteness and white supremacy is not something that comes naturally to most white people. Just broaching the topic is the cause of great anxiety and paranoia, sometimes resistance and anger. Those who have come to be known as white will tell you they didn’t choose that label or their history any more than black people did. Still worse, some may say it’s divisive to speak so much of whiteness and blackness that we should all just get over our races already. The elusiveness of that goal, I think, takes us back to the inception of whiteness.

When Europeans arrived in the Northeast, they quickly assessed a need for laborers to work the land they identified as theirs. These lands, of course, were expropriated from the Indigenous peoples already living here, whom the Europeans found they could not enslave. The resulting warfare following European incursion, including deliberate genocidal campaigns, has marked the U.S. polity to this day and continues to be seen in the terrible health statistics of American Indians. Native peoples defiantly have continued not only to survive, but even now are organizing to ensure the survival of this planet, as seen in the protests against the Dakota Pipeline.

The first solution to the inadequate colonial workforce was found in Irish bond labor, and so Irishmen worked the plantations until the English desired more labor to maximize the gains of more land. This is where the Atlantic Slave Trade was born. For an early period, some workers of African descent also worked as bond laborers, freed just like the Irish following the period of their indenture.

This period came to an end when the settlers decided they were releasing too many bond servants into freedom to make full use of their land. At the same time, a growing lower class of peasants would occasionally rise up in rebellion against large plantation owners, light-skinned and dark-skinned fighting side by side against the tyrannies of the wealthy.

The elite and lawmakers in Virginia found the most effective answer to this problem, an answer that is still with us today. In the 1680s, Virginia created a new category of people: whites. White people were afforded rights that were subsequently denied to non-whites. By the 1700s, whites could not be held in slavery into perpetuity and black slaves could not gain their freedom through work. Poor whites were instructed that God made non-whites inferior, in much the same way that the propertied were superior to the poor. What’s crucial here is that poor whites were not given the right to vote, and they certainly weren’t given a way out of poverty. What they were given were financial incentives to turn on their former allies – bounties for runaway enslaved Africans and plantation jobs for policing enslaved laborers.

But superiority was enough – the Virginia solution forever created a fissure between poor whites and blacks that the wealthy and powerful have taken full advantage of ever since. The rest of the story, I think, many of you know.

Knowing the origin of whiteness, and seeing whiteness as a social construct with a particular history – these are crucial to racial justice. The creation of white peoples and the data collected since demonstrate roundly that white supremacy without a doubt privileges whites in relation to people of color, but it still limits the potential gains of our collective liberation, whites included.

One the most telling studies in this respect – I turn again to my colleague Nancy Krieger – looks at the relationship between Jim Crow laws and infant death rates. The graph she assembled compares infant mortality for whites and blacks who lived under Jim Crow to those who did not, before and after the Civil Rights Act of 1965. You might guess that the disparity between blacks living under Jim Crow and blacks not living under Jim Crow was erased. But what is striking to me is that whites living under Jim Crow had higher infant death rates before the Civil Rights Act compared to whites not living under Jim Crow. This disparity too was wiped out following the passage of civil rights legislation.

Yet, dog-whistle politics have harmed whites by racializing the safety nets of our social contract. Since the 1970s, as with Nixon’s “Southern Strategy,” conservative elites in power have linked nearly every public institution to unworthy people of color, hoping that poor whites would take the hint that they’re the better, hard-working race. By tying government institutions to an undeserving non-white underclass, we saw growing populist support to defund the War on Poverty, the Great Society, public schools, public hospitals, all while increasing penalties on drug possession and use. Today – particularly the last several years in which whites have been railing against the War on Drugs – all of these shortchanges have served to harm both non-elite whites and all blacks. The President of Demos, Heather McGhee, talks about the harms of racism on white people like this: “we prefer to drain the public swimming pool of economic opportunity rather than let people of color swim, too.”[[8]](#endnote-8)

All that said, my hope is that white supremacy does not make you anxious or uncomfortable. It should make you mad. Understand that anti-racism is not a witch hunt, but a collective healing, without which our nation will remain painfully and inequitably divided, corroding opportunity, spirits, and bodies alike.

Over time, the explicit bias of white supremacy has turned into an implicit bias, something measured deftly by the Harvard Implicit Association Test – I encourage you all to go online and take it.[[9]](#endnote-9) What it has shown is that implicit bias against blacks, as well as other identities, is pervasive, including among people of color. The socialization we all go through in this country, because it is so thoroughly imbued with anti-black messaging and imagery, creates a bias most of us most exact active effort to counterbalance. So you can see the power of explicitly naming racism and taking stock of white supremacy.

The question arises – how do we act in solidarity? What does this all mean for our practice?

Naming racism, keeping it at the forefront of our consciousness and in our dialogues, is really important. Talking about racism, I hope, will encourage you to read and study more about some of the topics I’ve discussed, and the many more that I have not. If your study leads to critical self-reflection, I say that’s a good thing if you truly believe that racism hurts everybody. I do caution you, if you are a white person, to avoid placing too much of a burden on people of color to explain their racial oppression to you.

If acknowledging racism and white supremacy is the minimum, there’s room for much more. I wrote in the New England Journal of Medicine that we must use our tools in public health to carry out more critical research on racism to help us identify and act on longstanding barriers to health equity. This is why, in part, we are emphasizing the revitalized Neighborhood Health Action Centers I described at the beginning of this talk, and are placing them in neighborhoods long deprived of societal resources that should be theirs.

Further still, we can look inward toward the makeup and conduct of our own institutions. When I started as Commissioner almost three years ago, I put resources toward a group of staff to lead what we call “internal reform” at the health department. With the goal of becoming an anti-racist institution, the agency is acting on recommendations made by staff to reform our budgeting and contracting practices, our recruitment and hiring procedures, our community engagement behaviors, our training protocols, and our communications frameworks. It takes a sustained commitment to realize the full promise of these reforms, but we are laying the groundwork with urgency.

Last, I think one of the most important things we can do to stand in solidarity is lend our voice to advocacy for racial justice, unto itself and fully cognizant of the many other struggles for justice in which the work for racial justice is entwined. Those of us who work in public health have been afforded great privileges, tremendous credibility. The best use of that is to be a voice for the voiceless – and to amplify the voices of those who are speaking up, especially those of the youth who have the energy to drive us forward.

In time, more will see, as I do, that racial justice is not just a *value* for public health work, but a necessary commitment if we are to do our jobs competently. The mission of the New York City Department of Health is to protect and promote the health of all New Yorkers. I don’t believe that mission can be accomplished without regard for the pervasive reality of racial injustice. As New York often leads the nation in innovating responses to advance health promotion and disease prevention, so too should we see an anti-racist approach to public health in the same light.

We have a real moment to make change, one that has been paid for in blood. There are many who resist, many who are unsure, but I really believe that the tide is turning. Do not forget that hope is the gift from Pandora’s box that enables us not only to survive, but also to imagine how we all – everyone one of us – can thrive. I believe here that another one of Shirley Chisholm’s reflections is apt: “I don’t measure America by its achievement, but by its potential.”[[10]](#endnote-10)

Thank you.

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