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MINNESOTA PUBLIC HEALTH ASSOCIATION
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Testimony to Committee on Racial Justice
Recommendations
October 13, 2020

Madam Chair, my name is Jaime Martínez and I am representing the Minnesota Public Health Association (MPHA), a professional association comprised of over 400 members that include public health workers, health care providers, advocates and students dedicated to the health of all people who live in Minnesota. We are an affiliate of the American Public Health Association and have worked with Camara Phyllis Jones, M.D., M.P.H., Ph.D. who has previously testified on this committee.

According to data from the United Health Foundation, Minnesota has ranked in the top 10 healthiest states in the nation for the past three decades. But this ranking does not tell the whole story. Too many people in Minnesota are not as healthy as they could and should be, and the health disparities that exist are significant, persistent and cannot be explained by genetic factors.

MPHA is acutely aware of the significant and longstanding disparities in health outcomes among African Americans, American Indians and other populations of color in Minnesota and elsewhere. These disparities are an indication of deep systemic inequities that exist to prevent some communities from thriving and achieving optimal health.

The landmark report from the Minnesota Department of Health *Advancing Health Equity in Minnesota*[1] identified the social determinants of health (e.g. poverty, income, and housing) as well as systemic issues such as structural racism, discrimination, and conscious and unconscious racism that are deeply engrained in all of our systems and benefit some populations, while having an adverse impact on others.

1 Advancing Health Equity in Minnesota. https://www.health.state.mn.us/communities/equity/reports/aheexecutivesummary.pdf

Racism manifests itself in institutional and structural ways (e.g. laws, institutions, schools, justice system, media and culture) that deeply harm the health and well-being of our communities. In Minnesota, African Americans, American Indians and other populations of color, particularly African Americans and Indigenous populations, experience higher rates of nearly every adverse measure of population health.

A multitude of studies connect racism to inequitable health outcomes for African American, American Indians, and People of Color, including cancer, coronary heart disease, diabetes, hypertension, high infant and maternal mortality rates demonstrating that racism is a root cause of social determinants of health.[2] [3] [4] [5]

MPHA recognizes the severe impact of racism on the well-being of Minnesotans and we all need to engage in racial equity in order to name, reverse, and repair that harm done to American Indian and People of Color in Minnesota.

The Minnesota Public Health Association believes that the Minnesota state government has a significant role to play in addressing racism and recommends the following:

1. Adopt a formal statement condemning racism, in all its forms;
2. Acknowledge and adopt a statement that Minnesota is on the ancestral lands of the Dakota and Anishinaabe.
3. Undertake system-wide reviews of regulations, policies, processes and practices to identify and remove any racist systems and approaches (this includes policing in communities);
4. Implement assessment methodologies to identify and remove racist laws, regulations, procedures, practices and equity impact assessments for new legislation;
5. Provide mandatory, rigorous and system-wide anti-racism and anti-oppression training for all staff and legislators;

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2 Phelan, Jo C, & Link, Bruce G. (2015). Is Racism a Fundamental Cause of Inequalities in Health? Annual Review of Sociology, 41(1), 311-330.

3 Institute of Medicine. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. https://www.nap.edu/read/10260/chapter/2#7. Accessed August 9, 2020.

4 Minnesota Department of Health. Advancing Health Equity Executive Summary. https://www.health.state.mn.us/communities/equity/reports/aheexecutivesummary.pdf. Accessed August 9, 2020.

5 Link BG, Phelan JC. Understanding sociodemographic differences in health--the role of fundamental social causes. Am J Public Health. 1996 Apr;86(4):471–473.

6. Enhance public health surveillance systems by collecting and analyzing race and ethnicity data in an appropriate and sensitive manner and disaggregate data for smaller communities;
7. State departments should realign their grant making process to fund community-based organizations that are part of specific communities most disproportionately impacted to improve health outcomes;
8. Appropriate funds to establish full scholarships at Minnesota public health schools to develop/graduate public health leaders from American Indian, African American and communities of color—commit to this effort for at least a ten year period. This is an upstream strategy to build statewide capacity to advance health equity; and
9. Continue to support and create state citizen advisory committees/boards representative of American Indians and communities of color that have power to realign state strategies in addressing health and racial equity.
10. Our education system is intended to uphold equal opportunity, but too often it also entrenches racial disparities by its design. Education must engage educators, students and allies to foster real dialogue around issues of racial justice in education, to examine policies and practices in our school systems and our communities, and to mobilize and take action for education justice.[6]

6 National Education Association. https://neaedjustice.org/racial-justice-is-education-justice/