



Remarks of Dave A. Chokshi, MD, MSc, Commissioner, Before the New York City Board of Health on a Resolution Declaring Racism a Public Health Crisis

October 18, 2021

My fellow Board members, as your Chair, it is my privilege to introduce our next agenda item—our Resolution on Racism as a Public Health Crisis.

I wish to start by invoking the history of the New York City Board of Health. As many of you know, the Board was originally forged in the crucible of epidemic response: yellow fever, cholera, and smallpox. The scientific links between the environment and public health became irrefutable, and advances in sanitation saved countless lives, particularly those of poor and immigrant New Yorkers.

Now we are in another crucible—another pandemic in which suffering is not borne equally. We recently marked 700,000 deaths from COVID-19 in the United States, but even that devastating overall toll belies that Black, Indigenous, and people of color are all [at least twice as likely to die](#) compared to White people. And focusing solely on mortality obscures other, reverberating effects on public health. A Health Department [analysis](#) found that, last year, Black and Latino New Yorkers were 1.3 to 2 times more likely than White New Yorkers to report being unable to pay rent, phone or Internet bills, and afford groceries. These numbers demonstrate the catastrophic combustibility of historical patterns of injustice, particularly structural racism, intersecting with disease.

As the saying goes, “History doesn’t repeat itself, but it often rhymes.” In 1865, our forebears on the Board of Health [wrote](#): “We believe that housing, politics, morals and health are all intertwined.” They are indeed, and the data bears this out. Just as our predecessors moved beyond a superficial understanding of the links between the *physical* environment and health—like the miasma theory of disease—we must further confront how the *social* environment shapes health and illness.

For instance, to elucidate the root causes of racial inequities during COVID-19, [we must ask ourselves](#) a succession of “Why?” questions. Why do some non-White populations develop severe disease and die from COVID-19 at higher rates than Whites? Underlying health conditions undoubtedly play a role. But why are there higher rates of hypertension, diabetes, and obesity in communities of color? The answer does not lie in biology. Structural and environmental factors such as disinvestment, discrimination, and disinformation underlie a greater burden of these diseases in communities of color. The most significant “why?” may be: why are these widespread inequities allowed to persist? We must keep in mind that inequities are disparities that are avoidable, unjust, and unfair.

Racism, as my colleagues will describe further, negatively affects the mental and physical health of our family members, neighbors, and colleagues. Importantly, racism exacts a health and economic cost on *all* of society, what the scholar Heather McGhee [encapsulates as](#): “We are greater than, and *greater for*, the sum of us.”

We are therefore at a pivotal moment in taking on racism as a public health crisis—and the COVID-19 pandemic must render unacceptable that which has been condoned for generations. We have chosen our words carefully, in presenting this to you as a *resolution*, rather than just a declaration. Because we must be *resolute*—because we must *resolve* to take action, beyond our recognition of the problem. With that prelude, I am pleased to turn the floor over to Dr. Torian Easterling, First Deputy Commissioner and Chief Equity Officer of DOHMH, and Dr. Michelle Morse, Deputy Commissioner and Chief Medical Officer.