Countering the Opioid Crisis: Time to Act Podcast
Episode 3: Racism and the American Opioid Epidemic
Guests: Helena Hansen and Joy Rucker
Host: Ruth Katz

Narrator: Welcome to *Countering the Opioid Crisis: Time to Act*, from the National Academy of Medicine and the Aspen Institute. This podcast explores the most critical drivers of the opioid epidemic and key strategies to stem the crisis. Host Ruth Katz leads the Aspen Institute's Health Medicine and Society Program and co-chairs the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. Here's Ruth.

Ruth Katz: The opioid epidemic sits at the intersection of systemic racism, policy, and healthcare, Black and brown communities face higher overdose and fatality rates than their White peers, very often receive inferior care, and have fewer Black clinicians to treat and understand their care needs. Undoubtedly, the already severe health disparities for Black and brown communities have been exacerbated by the COVID pandemic. In 2020, the U.S. experienced the largest annual increase in drug-related deaths in 50 years and nearly 30% increase compared to 2019. That measure translates to 93,000 people who lost their lives to drug overdoses last year. The disproportionate risk minorities face in this epidemic is not new. The rates of fatal overdose among Black African-American, LatinX and American Indian, Alaska Native people have been rapidly rising since 2013. Today we'll look at the opioid crisis and its impacts through the lens of structural racism and consider ways to redesign systems and policies to ensure appropriate and equitable care for opiate use disorder for all. With us is the University of California at Los Angeles, social science and health equity, professor Helena Hansen and Joy Rucker, former executive director of the Texas Harm Reduction Alliance. Helen, Joy, welcome.

It's great to have you here.

Helena: Thank you

Joy: Thank you

Ruth: To start us off, help me, actually help all of us listening in here, to understand exactly what is meant by the concept or the term structural racism.

Joy: The more I think about the term structural racism, I think it's more systematic than structural because if we look at the structure in its purity, like educational, medical, structure and its purity, there aren't any biases in there. And then what happens is we create, uh, and make policies and vote on systems that create inequity. If we look at voting in its purest form is you have the right to vote. And now we have states that are now creating systems that are making it harder for people to vote. So, I'm starting to look at the difference between the structure and the systems that we create within the structure that create inequities

Helena: That's really thought-provoking. In my world of studying structural determinants of health, I use the term systemic and structural racism interchangeably. I do that because it's only possible for systems to persist because of the ways that they're structured into our institutions and our policies. And so I'd

have to think a little bit more Joy about that really, um, a provocative question about what this what's the difference between structure and system, but certainly in this country, we have had centuries of institutions and policies that are specifically designed to preserve the racial hierarchy. Of course, that goes back to slavery, but, more recently, we're all pretty familiar with the fact that the U.S. is incredibly racially segregated in terms of its housing, where people live, school systems as a result of that. And therefore the education people have access to since schools are funded by residential tax basis, rich and poor districts have rich and poor schools. And our health care system, that's a very obvious place where we have persistent and serious segregation, by race and by class.

We definitely have at least two different tracks of health care, uh, the public safety net system, the place where people who are publicly insured, Medicaid, Medicare, or uninsured, end up. Versus the private healthcare system, people with private insurance or the ability to pay out of pocket, you get two vastly different worlds of care and response. And then as we'll get into it a little bit, of course, there's the very idea embedded into drug policy that certain people who use drugs should be treated medically and other people who use drugs should be treated as criminals within the criminal legal system and that largely plays out along racial lines. It's actually intentionally built into our drug policies based on racial stereotypes about who uses the most dangerous drugs and who are the most dangerous drug users. And who is morally culpable and who's more biologically prone. There are just so many ways that the public policies and the institutions that I think of as structures, they mediate systemic discrimination because they're actually designed with that purpose in mind. I, I, you know, I don't, I think we're in a moment in U.S. history where we can just acknowledge that, that there is racial intent to the way that our policies are put together and our institutions are crafted.

Ruth: There's another concept that we're hearing a lot about these days and that's the concept of health inequity as opposed to structural racism. And again, I want to focus how these concepts play out in the world of health and health care.

Let me, give you three examples, and you guys may have better ones than I've come up with, that I hope can illustrate the difference between the two. Um, I suspect that many of our listeners are familiar with the Tuskegee syphilis study on Black males that took place between 1932 and 1972, and was actually sponsored by the U.S. government.

The study, as I understand, it was intended to observe the natural history of untreated syphilis. And as part of the study, researchers did not collect informed consent from participants and they didn't offer treatment even after treatment was widely available.

Now, the other well-known case involves Henrietta lacks, a Black woman whose cancer cells have been the source of invaluable medical data for some 70 years. Now, back in 1951, as you both know, Lacks was the unwitting source of these cells from a tumor biopsy during treatment for her own cervical cancer at Johns Hopkins Hospital. And these cells were then cultured to create a cell line, a cancer cell line that is used today for medical research. As you also know, as was the practice, then no consent was required to culture. The cells obtained from Lacks as treatment and neither Henrietta nor her family was compensated for the cells extraction or use.

Those two cases are well-known. Let me give you one more: when residents that is doctors who were in training present their cases to supervising physicians or to their fellows and to their fellow residents. It's

been the practice to describe the patients they're gonna see, by race, as well as by sex, age, and diagnosis. And that tradition in medicine seems to have set up certain biases among residents and training before they even have the opportunity to examine the patient.

Help us understand the difference between structural racism and health equity. Again, focused on health care in particular.

Helena:
So this is a unique moment in time because on the heels of a year of attention to racial inequalities in COVID testing treatment and outcomes, as well as the murder of George Floyd and all of the protests that unfolded after that, um, all of a sudden we're seeing structural racism and systemic racism, those terms pop up in places where we'd never heard them before.

Prior to that, we spoke much more indirectly and passively about health inequalities about, um, health disparities in a kind of passive manner.

You know, we spoke about underserved patients, um, who lack access to care without really identifying well, why do they lack access to care? Like why are they underserved? So there was this kind of unspoken void when it came to the explanatory model. Somehow certain groups of people were just lacking. Um, and I think all of a sudden this year, we're speaking much more openly in academic medicine about the fact that there are active processes that create these kinds of inequalities.

So that's what I'm referring to when I talk about structural racism. And I want to point out that the reason for the emphasis on structure or even systems and Joy, I don't want to dismiss the distinction you're making, because I think that's a really important point. But in my mind when I use either the term structural or systemic, what I'm trying to do is call attention to the ways that racism and healthcare work at a level that isn't confined to the individual practitioner, because so much of what I was taught about racism as a source of inequalities in health and health care as a medical student revolved around, well, what are the attitudes of the individual doctor, right?

But if we think about these systems, if I'm a doctor practicing in a safety net setting, like a federally qualified health center, or, um, really underfunded public hospital in a low-income Black or brown neighborhood, I may have all the best intentions in the world for my individual patient, but I'm totally constrained by the policies of the institution, the policies at the state and federal levels that determine what gets paid for what doesn't get paid for. What's even possible for me to do in the exam room or in the operating room. That's what I'm talking about. But these things have had a momentum that goes well beyond the intentions of the individual practitioner.

That's what I mean by structural or systemic racism that, um, even though public policies and institutional practices are set they're, they're influenced by popular opinion particularly powerful groups like middle-class White voters. So their impressions of who's addicted, who's responsible for drug-related crime, who deserves treatment, those kinds of attitudes, for sure, at a group level, do support policies and institutional practices deriving from them that force individual practitioners into a certain predicament.

So I'm not saying that individual attitudes of practitioners aren't important, but I'm saying that if we really want to address the source of these inequalities, we have to look at a level above the individual practitioner. We have to ask ourselves, what can we do to intervene at that level at the level of public policies and the ways that institutions are structured.

And then very quickly to get to the points about Tuskegee, the Tuskegee experiment and the example of Henrietta Lacks. Um, I think that those are excellent examples of how biomedical research is based on a racial hierarchy. This is a really good example of structural racism at play because, in the era of both Henrietta Lacks and the Tuskegee experiments, it was actually very, very well widely known and accepted that poor Black and brown people served as experimental subjects.

Affluent middle-class White people were the intended consumers of the medical knowledge that was generated from those experiments. Okay. So we're talking about a racial system within biomedical research that was widely acknowledged. And after these, these two events in the midst of civil rights activism, Black power activism, you know, I just want to put in historical perspective that these things were not scandals in their own, right. They were perfectly consistent with the racial hierarchy that White Americans and especially, um, middle-class and affluent White Americans had already agreed upon, right? That it was fundamental our system of biomedical research, this racial hierarchy who would serve as subjects who would serve as consumers of the knowledge, but then in the midst of civil rights activism, which actually started to have a real toehold in the late sixties to early seventies, it was only then that these practices became scandalized, became the grounds for reforms, IRB protections, et cetera. And at least some, um, some facade or some, uh, attempt to look as though we're working towards equity in terms of who gets to serve as research subjects and who benefits from that knowledge.

But to this day, if we really look carefully at who serves as research subjects and who serves us when it comes to dangerous research and who serves as consumers of the knowledge we're seeing in the country, still a racial hierarchy, biomedical research centers that have a lot of clinical trials going, tend to be located in poor Black and brown neighborhoods. A very, very significant trend. Also, now that we're in a global moment of pharmaceutical industry and biotech, it's the low-income Black, brown, and Asian countries that often provide the experiment experimental subjects, so we still have a racial hierarchy. It's just a little more hidden and there are a few more institutional protections designed to try to rectify them.

Ruth: How has structural racism impacted our health policy approaches to drug use. And what has been the resulting health inequities within Black, brown, and other minority communities let's say in terms of, of overdose rates? Joy?

Joy: When the crack epidemic was happening, there was not the kind of attention focus, funding research in the African-American community, as there is now as it's related to opiate overdoses. And that's because the face of the overdose or the face of, uh, the drug issue has changed. As soon as it became young White Americans, there there's a crisis. Following Helena's point that in this country, we built a structure, a system that supports that people of color have never, never, never been treated equally. And so, we're now at this point as a result of George Floyd's death and all the other protests that are coming to light in this country of now looking at structural racism and how it impacts every level

of people's lives.

It's always been there, but it's only the result of George Floyd's death and the number of protests and the issues, the worldwide attention to this. It's like all of a sudden, we, as people of color have always known that, you know, if, if you're a person of color, you're going to be impacted on where you can buy a house, where you can get a loan. And as a result of that, that's going to indicate what kind of health care you get, what kind of education your kids are going to get, what kind of neighborhood you're going to be able to live in. Now we're looking at, oh, this is a much larger issue than the physician's attitude toward the patient. Racism just does not rear its ugly head, it's voted on.

And, you know, that's what Helena was saying in terms of the structure. And then we have the systems that, oh, now this is, this is an epidemic. So now we have to address it. And what, how did it become an epidemic? What, what made it an epidemic? Overdoses have been happening for years in Black and brown communities, but there has never been the documentation of it or the attention that is now focused on it. It just continues to play out the systematic racism that we're, that we live in.

Ruth: Now that we have the attention of the public in a way that we did not before, now that we have the attention of policymakers, I would suggest in a way that we have not had before, you both have spoke to very troubling outcomes, very, very troubling, rates among minority communities.

What do we do in terms of systems and services to begin to reverse these very troubling outcomes that we're seeing beyond just the opioid epidemic, drugs across the board? What do we do?

Helena: So, one thing that Joy was describing was that the very way that we frame something as a health crisis. as opposed to, for example, a crisis of crime in the inner cities, which is the way that the heroin problem and overdose problem in Black and brown inner cities facing very high unemployment in the sixties to eighties, that was the way it was framed, as a crime epidemic, not a public health epidemic. And it led to further White flight from urban U.S. and disinvestment of public resources from the very cities that were already suffering from disinvestment. Um, and now all of a sudden we have a health crisis. And so I think what Joy was flagging was there is structural racism built into even how we identify a crisis, um, and it has to do with who's affected, right. And what they're supposed to role is in society.

Based on the White identity of the intended markets of Oxycontin and sister products in the nineties, because the White middle-class consumers, for which these products were geared, were not thought of as a high risk for addiction, right? And so there weren't a lot of, there was not a lot of, um, skepticism or regulatory impulse there. And then once it became a very obvious problem in terms of rising overdoses, there was a need for a separate track from the drug war track, that had been structured for Black and brown Americans, of criminalization. There was a need for something even right, more, um, biomedical than methadone, which had it because it was introduced really to address a growing Black and brown, as well as Vietnam veteran-centered heroin problem. And then the sixties always carried this slightly kind of criminalized tone and was very, very highly regulated directly by the DEA. There was a need for something other, something it'd be quote, unquote appropriate. And here I'm taking from the congressional records, um, where buprenorphine legalization of office space, buprenorphine was being debated.

There was a need for a more appropriate intervention for Whites, well, suburban, youth, they used coded language like suburban youth that were being affected. this is where addiction medicine as a field got a huge boost. This is where 80 years of prohibition of private office-based maintenance treatment for opioid dependence with opioids. Eighty years of that kind of prohibition was reversed and it was, it became legal for medications like buprenorphine and opioids to be used in office settings because methadone and criminalizing approaches were not seen as appropriate for this quote-unquote new category of users.

Ruth: Let me just send her up for a second here. Suboxone, buprenorphine and methadone, all three are medications that are used to treat opioid use disorders. That, right?

Joy: Exactly.

Helena: Yes. And so not only did, um, addiction medicine get abused, but the very concept of addiction as a brain disease. So the national discourse began to swing from addiction as a moral scorge. We need not look any further than the nineties during the crack epidemic that Joy was mentioning, to see how incredibly stigmatizing and punitive and racialized the language about crack addiction was at that time.

We're swaying from that to a really prominent, discourse of addiction as a brain disease requiring biomedical intervention. So what we have right now is a set of federal and also state and local policies that support buprenorphine and a biomedical approach to addiction, but it's largely because of systemic racism playing out, for access for a White middle-class clientele, because it is private office-based within a health care system in which essentially White and largely middle-class consumers are the ones with primary care doctors, people that can prescribe people who would get certified to prescribe buprenorphine. And that's well-documented that that's, who's getting access to buprenorphine. So we have a two-tier system right now where there's a biomedical track that was created in response to the middle-class White opioid overdose problem, largely embodied in buprenorphine. And, uh, we continue to have a criminalizing track that is still concentrated in Black and brown neighborhoods and also poor White neighborhoods, a more complex story there, but in largely White states and White areas, like the Appalachian states, poor White people, essentially are being subject to drug war-style interventions. There's almost a racialized discourse around poor White people. You know, they're kind of standing in for Black and brown people in predominantly White states.

So we have these two tracks, a medicalized track, and then a criminalized track still. And my issue with the brain disease model, it sounds good to be promoting a biomedical approach, seemingly a nonjudgmental approach to addiction. But first, we have to look at well, how is it playing out? First of all, it's restricted to certain segments of society. Second, what does it leave out? It leaves out the social determinants of health. And most importantly, the structural drivers, like the system, the structural and systemic forms of racism that Joy and I have been describing. Instead of confining ourselves to brain disease model and investing a lot of money into finding the new molecule, the new biotechnology or the next new pharmaceutical, we should instead be investing in addressing the root causes of social determinants and structural drivers.

Ruth: What are your ideas, Joy's ideas as well, as to what we would have to do to change our services, change our systems. Again, I recognize this is over a long period of time to really get at the root problem here.

Joy: My understanding is that medical professions only have eight hours, 10 hours of education around addiction and yet and still, they are a gatekeeper for people that need services a lot of times. So I would expand that, in the same way, that their medical students have to have more, more education around addiction and working with people that use drugs than they currently do now. And the other is that you know, this is to make, um, medicated assisted treatment readily available for anyone that needs it. And that does not mean just in an office setting. You know, like Helena was saying how we have this structure around methadone that is really, punitive, but we have this medicated assisted treatment where, you know, you could go to the pharmacy and pick up your own, um, medicated assisted treatment and take it home.

Ruth: That's what we have or that's what we should have.

Joy: Well, we do, we have, we have both. And, and what I'm saying is that we should move away from, the punitive and move toward the medicated assisted model because that's, what's humane. If you look at the structure around methadone, like I have to be there at five o'clock in the morning, I have a few hours that I have to dose between. And then I have to have these behaviors that indicate that I can have take home. If I'm on Suboxone, all I have to do is go to the pharmacy and get a prescription. What, why is there a difference if we're going to say that, oh, this is a brain disease, then what makes the distinction that this should be treated differently?

Helena: That is such a good point. That it's the way even that these medications are dispensed, the settings in which they're dispensed, what goes along with that, that makes all the difference. And, um, as a counterexample to the private office-based model that we have, I mean, I just want to point out that when it comes to buprenorphine, our most recent nationally representative data is that White Americans are three to four times as likely as Black Americans with opioid use disorder to get buprenorphine that the most common payment method by far is out of pocket for a very expensive drug. The next payment, most common payment method is private insurance. And very far down on that list is Medicaid. So that tells you the race and class background of the people getting buprenorphine. And that's by design. I mean, buprenorphine was legislated, um, you know, approved legally approved and marketed for that clientele. It's the system that we live in.

If we look to other countries that have done a much better job in terms of disseminating evidence-based medications, I'll take France, which a lot of buprenorphine advocates in the U.S. like to point to because it was introduced early in 1996, it was, um, dispensed by general practitioners without a certification requirement, just taken for granted as a part of the armamentarium that any physician should have and went along with-an 80% decline in overdose rates in the first, first five years.

Sounds terrific. But what we don't learn in this country is everything that went along with that buprenorphine. So it's not only that buprenorphine was disseminated by general practitioners. It was that France has a universal health care system, France engaged people who use drugs, people with lived experience in designing a system of community-based centers where people can go not only for buprenorphine and increasingly for methadone, they have a choice of medical treatments. They also go for comprehensive health care, social services, including housing placement, employment placement, harm reduction.

I'm a buprenorphine certified provider, I worked in a methadone clinic. So I believe in these medications, however, I also can see that people get on medications and they go on them, go off of them. They need a lot of support. They need harm reduction at many critical junctures. So offering syringes, offering safe injection facilities, which are legal in France alongside the medication, so that you can meet people where they are, and having peer support, peer workers on site, all of those things were combined in France.

So there's such a wraparound in France that we're entirely lacking in this country. And that's where we can really learn a lot. Just that one example of how do you successfully use these medications, even that it points to you have to build around the medication, an institutional system and a set of policies that provide social supports, social services for the many needs that people have that you have to meet in order to support their recovery. Also a way to engage people who use drugs in their own futures. So the activism and the advocacy and the peer support, that's all really critical. So just in that one example, I think is embedded the things that we would need to build in besides simply marketing new pharmaceuticals.

Ruth: If HHS Secretary Becerra is listening in, and I hope he is because this has been a terrific conversation, what is the one thing each of you would advise him to do right now, to turn the tide of the opioid epidemic, especially with regard to minority communities who have been hit so terribly hard?

Joy: Well, I would say, um, support, harm reduction, the entire continuum of harm reduction. Since I can answer more than one, one suggestion. And so whatever is on that continuum and have a base in communities where people can access them.

Ruth: Have them available and make them easily accessible.

Joy: Exactly

Helena: I totally endorsed with Joy is saying, and I do have a suggestion for how to go about it. So taking our lessons from the aids pandemic. I would say let's really look carefully at the Ryan White Care Act and the way that it mandated community-based councils' decision-making bodies.

Ruth: The Ryan care act was enacted by Congress. Ooh, I'm going to say about 30 years ago, which provided community-based services for individuals with HIV AIDs. It was named after Ryan White, a young boy who died of AIDs.

Helena: The thing that really interests me about Ryan White Care Act is that the way that they made decisions about how many will be spent is handled, people, it mandates that people who are HIV positive, directly affected by HIV participate on decision local decision-making councils that allot the funding and what these councils have ended up doing has really, um, supported a lot of innovation. For example, peer support funding, peer support as a part of treatment funding, housing as a part of treatment. So basically when you take people who are directly affected, not only are you enhancing the democracy of our country, and, um, that's very necessary for addressing racial inequalities because what we're seeing is a lack of democratic voice when it comes to communities of color. So you're addressing

people, having a voice in their own health care number one, but what you actually see from that of innovations that are directly responsive, responsive to the experiences of people on the ground, which have a lot to do with social needs and structural drivers. So what's happened in the hands of Ryan White Care Act bodies is that they've introduced all these really interesting innovations that probably apply equally well to opioid use disorders and preventing overdose. So addressing housing and basic social needs, addressing social support, building that in as a line item financially using healthcare dollars as a part of that, to get actually savings on the other end through better outcomes. So that's, that's what I would propose looking very carefully at how something like that could be adapted to the overdose crisis.

Ruth: Well, this has really been a terrific and very insightful discussion. I'm sure we've given our listeners a ton of stuff to look at as we consider how to create equitable and actionable solutions to combat the opioid crisis. Helena, Joy. Thank you so much for joining us for a very terrific conversation.

Helena: Thank you.

Joy: Thank you

Ruth: Helen, Dr. Helena Hansen is a professor and the chair of the research theme in translational social science and health equity at the University of California, Los Angeles, and Joy Rucker is the former executive director of the Texas harm reduction Alliance. Both are also participants in the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic.

In our upcoming episode of *Countering the Opioid Crisis: Time to Act*, we'll review the latest overdose statistics from the Centers for Disease Control and Prevention, especially as those numbers relate to the opioid epidemic. So be sure to follow us in your favorite podcast app and make it easier for others to find this podcast by giving us a rating in Apple podcast. I'm your host, Ruth Katz be well and stay safe.

Narrator: Ruth Katz is Vice President and the Executive Director of the Aspen Institute's Health Medicine and Society Program. She Co-Chairs the National Academy of Medicine's Action Collaborative Countering the U.S. Opioid Epidemic.

The conversations in this podcast build on the ongoing work of the NAM Action Collaborative. The Action Collaborative is committed to developing, curating, and disseminating multi-sector solutions designed to reduce opioid misuse and improve outcomes for all who are impacted by the opioid crisis. To learn more about the Action Collaborative, please visit nam.edu/opioidcollaborative

Our theme song was composed by Benjamin Learner and Joshua Sherman and recorded at Old Mill Road Recording in East Arlington, Vermont. The Aspen Institute's Pearl Mak created our logo. Our podcast editor and producer is Shanna Lewis. Special thanks to the Aspen Institute and The National Academy of Medicine.