

“Enough Is Enough.” An Historical Perspective:

Long Lasting Health Disparities in the African American Population in the Midst of the COVID-19 and the George Floyd Incident

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Introduction

The disproportionate health disparities seen in the African American population today resemble the health inequalities that existed in the population during enslavement and up to the Civil Rights period when the group’s health status began to improve in the 1940s. Using life expectancy data, national health statistics show the difference in life expectancy of Black and White men decreased from a differential of approximately 11 years in 1940 to a 6-year difference in 1960. Despite this improvement, currently, African Americans are more likely to live close to polluted areas, have incomes below the poverty line, and live in substandard housing. Having connected presented day health inequality so apparent in the African American population today to structural racism dating back to pre-emancipation, Noonan, Velasco-Mondragon and Wagner have concluded that “The history of slavery and the current racial discrimination this group continues to suffer clearly underlie the inexcusable poor health status of African Americans as a whole.”

Using an historical-ecological perspective, this article will link present day health inequities in the African American population to the antebellum period (1861-1865). At first, African Americans were Christian indentured servants and no negative distinction based on ethnicity or color was attached to them. Then, around mid-1700, they became enslaved chattel and by law were ascribed slave status by virtue of color. The group’s caste status in American society by virtue of color and ethnicity prevails today. As Gunnar Myrdal noted in his study of race in the United States, in 1944,

[T]he caste or, as it is more popularly known, the color line – is not only an expression of caste differences and caste conflict, but it has come itself to be a catalyst to wide differences and engender conflicts. To maintain the color line has, to the ordinary White man, the “function” of upholding the caste system itself, of keeping the “Negro in his place.”¹

Accepting that health disparities in the Black population is a public health crisis, this article will utilize selective historical moments in Black history and public health as reference points for linking the county’s public health response to Black health disparities.

The reprehensible murder of Mr. George Floyd at the hands of a police officer while unarmed and handcuffed, coupled with African Americans having the highest rates of infections, hospitalizations and deaths due to COVID-19, has generated the outcry, “Enough is Enough.” Millions of African Americans, along with their fellow Whites, Hispanics, and Asians; and young citizens from all age groups, all over the United States, are marching and demanding

justice. Specifically, the demand is for justice from the courts that should hold police officers accountable for the deaths of Black men and women. These grassroots and professional advocates are also demanding social justice for African American citizens who are currently living under the burden of structural racism. The harmony among diverse individuals representing multiple ethnic groups and every socio-economic class is awe-inspiring. In fact, the hundreds of demonstrations, Zoom meetings, and interracial group discussions involving police officers, mayors, governors, ministers and former U. S. Presidents, highlight what appears to be an unprecedented, and genuine awakening to structural racism and its burden on the Black community, manifested as ongoing police brutality and in the high, differential impact of COVID-19 in the African American population.

In-depth examination of racism and health began receiving serious attention in the literature in 1991. An important consequence of this historical moment of outcry is that it is prompting public health experts to look more closely at the efforts and impact of America's public health system relative to reducing the on-going and sustained health disparities in the Black population. But, of course, thinking in this manner means that the public health workforce - physicians, epidemiologists, researchers, academics, social workers, nurses and others - must honestly discuss how the field has historically responded to persistent race-based inequities within the context of and with a clean acknowledgement of structural racism.

Historical Context for Social Justice

In 1928, Louis Israel Dublin wrote,

An improvement in Negro health, to the point where it would compare favorably with that of the White race, would at one stroke wipe out many disabilities from which the race suffers, improve its economic status and stimulate its native abilities as would no other single improvement.

Dublin's analysis is applicable to discussions that connects current health disparities in the Black population to the group's health status in the past. His statement brings attention to the fact that to be Black and of African descent in the U.S. in 1928 was a risk factor and one that impacted Black lives over the life span in many ways, including health. In 1920, the life expectancy of African American men was 47.6 years, compared to 59.1 for White males. For African American women, the life expectancy was 46.9, compared to 58.9 for White counterparts. There is no need to argue that if one stroke [of the opportunity wand] eliminated all barriers to optimal health, Black Americans would have boldly waved the wand. However, the opportunity wand has never been in the possession of African Americans, and they have never had the power to obtain or control it.

Public Health as Social Justice

A review of the literature did not yield any definitions of public health that did not highlight and discuss social justice as its core value. For example, Turnock stated, "Social justice is said to be the foundation of public health."² Krieger and Birn discussed public health as social justice by precisely linking it to other movements, like anti-lynching, which emerged at the same time and were similarly grounded on the philosophical tenets of social justice.³

For the purposes of this article, Rawls' definition of social justice provides a fitting foundation for measuring a public health response to health disparities in the Black population throughout history.⁴ His definition states that a society's resources must be distributed in a way that benefits the least advantaged. His philosophy allows just societies to have a wealth/asset hierarchy where some members can have greater economic means than others.

Rawls' definition, then, does not eliminate the opportunity for America to be a just society because of a class structure that ranks individuals according to their economic resources. However, Rawls' theory does stipulate that the differences in such a hierarchy are acceptable only if those who are the less well-off benefit.

A second premise of this article is that Rawls' conception of social justice provides a rationale for a special approach to addressing health inequalities among African Americans henceforward referred to as "societal redress." This concept refers to an accepted obligation on the part of society to compensate African Americans for the impact of enslavement and discrimination from 1619 to the present by providing comprehensive public health services and programs that will eliminate health disparities in the African American population. This application of social justice also accepts that having originated from structural racism, racial health inequalities impacting the lives of African Americans must be regarded as a social determinant of health. Indeed, a growing body of literature has revealed that racism is associated with poor physical and mental health. This concept maintains that racism has been and continues to be an environmental factor that is an impediment to optimal health. Equally important is the perennial situation where structural racism has and continues to be beyond the control of the African Americans to the extent of having the power to eliminate it as an obstacle to good health.

Under this conception, social justice as a conduit for "societal redress" further accepts that the tools of structural racism that were employed by all of this society's institutions, including public health, created significant economic benefits to American society as a whole social advantage to all White citizens (poor and wealthy) specifically in terms of superior social status and white privilege. In his article written for the New York Times' 1619 Project, Mathew Desmond wrote "By the eve of the Civil War cotton cultivated by enslaved Africans was the nation's most valuable export." Respected historians Johnson and Smith have written,

By the mid-nineteenth century, slavery was the way American breathed.⁵

Indeed, there may have been no America without it. It was an institution with thick, tangle roots, one that even touched the lives of those who had never owned slaves.

Translating social justice as the tool by which society pays the debt the society owes to African Americans should not be interpreted as indifference to or a devaluation of the labor of other ethnic groups who contributed to America's status as the dominant, global economic power. Nevertheless, the African American experience is unique because of constitutionally sanctioned and governmentally enforced slavery and its legacy. Perhaps placing "societal redress" next to an explanation of the rewards America derived from Black subordination clarifies the "societal redress" relationship to public health as social justice:

Finkenstaedt wrote:

The Black has, in effect, been responsible for the material success of America. His relegation to outcast status was how the nation

reunited, centralized its territory and economy, consolidated a heterogeneous work force and burst on the international scene in two world wars as a productive giant.⁶

The belief that society is obligated to protect and promote the health of citizens (except to respond to uncontrollable circumstances, e.g., hurricane) totally deviates from principles and values associated with individualism, the Protestant work ethic and obtaining society's benefits (and largess) through merit rather than personal need. Regarding this matter, Turnock notes, social justice rests on the notion that "significant factors within the society impede fair distribution of benefits and burdens."² In the case of African Americans, structural racism is not only a social determinant for health disparities but, in addition, explains the occasions when public health abandoned its social justice mandate. Such historical moments resulted in uneven delivery of public health services, unethical conduct by physicians, social workers and researchers and patient abuse.

Social Justice within the Context of Public Health

A third premise of this article is that social justice and public health should not be viewed as separate and mutually exclusive. Rather, combining Turnock's and Rawls' conceptions of social justice with "societal redress" considers public health an institutional means by which to ameliorate race as a social determinate of health disparities among Black Americans. The food deserts that characterize poor African American communities and pollution that is killing African Americans living in overburdened communities are examples of structural equality manifestations which include environmental racism, reinforced by redlining and gentrification. "Societal redress" through public health is an approach to mediate the problems of disparities in this population.

This line of thinking is supported by the Institute of Medicine's (IOM) conception of public health as social justice. In their 1988 report, *The Future of Public Health*, they stated the following:

As a part of the assurance function, in the interest of justice public health agencies should guarantee certain health services. Such a guarantee expresses a measurable public commitment to each member of society. In operational terms, this implies guaranteeing both that the services are available (present somewhere in the community) and, in the case of services to individuals, that the costs will be borne by the government for those unable to afford them. When these services are not and cannot be present in the larger community, it is the public health agency's responsibility to provide them directly.⁷

The objective of the discussion up to this point is to provide an historical and conceptual framework for comprehending present-day health inequities in the African American population as problems that are directly connected to the group's caste status established when Africans were brought to the country as enslaved chattel over 400 years ago. This position has been inescapable. Therefore, the health disparities seen, for example, in the disproportionate high levels of COVID-19, as well as the belated responses on the part of public health profession to the crisis reflects a longstanding reluctance on the part of the public profession to: (1)

acknowledge historical racism as an explanatory variable for the disturbingly high level of poor health in the Black population and (2) to consequently develop and advocate for policies and programs that frame public health services to African American communities within the context of public health for the purpose of social justice.

The next section of the discussion that follows provides examples of structural racism in public health and the outcomes for African American during selected historical periods.

Planting the Permanent Seeds for Persistent Racial Disparities in the African American Population: Antebellum to 1860

Diseases like smallpox, diphtheria, yellow fever and tuberculosis created massive illness and death for the White settlers in the New World and for Europeans who became city dwellers during the early processes of urbanization and industrialization. During the seventeenth and eighteenth centuries, attitudes toward the cause of disease changed, and methods of containing disease and public responsibility for assuring optimal health for all citizens evolved from isolation of the ill and quarantining of the exposed, to the establishment of voluntary hospitals and sanitation boards, to acceptance of public responsibility for the establishment of the first public agency for health. The New York City Health Department began in 1866.

However, the perspective that public health should assure good health for all of society's inhabitants did not apply to enslaved Africans after they arrived in the colonies.

Interceding to ease the conditions under which enslaved Africans lived and worked was not compatible with the profit motives of plantation owners. Indeed, "the planters had reckoned that it was cheaper to lose and replace slaves than it was to feed them, treat their illnesses, punish them humanely, and keep them alive." Though some plantation owners provided medical attention, an owner's decision to dispense medical attention or authorize treatment by a physician was often determined by whether it was believed his human property was malingering.

Under this mindset enslaved Blacks labored from dawn to dusk, doing continuous back breaking work. Work included picking cotton, digging ditches, and cutting and hauling wood. Their diets were nutritionally inadequate and insufficient to maintain the level of health and stamina their workload demanded. They lived in rudimentary quarters that exposed them to extreme heat and cold.

The most dangerous work was cultivating rice. America's Black unpaid workforce had to stand in water for hours at a time in the blistering sun. Although malaria was widespread in colonial America, life in a climate that contained malaria had given many West Africans (through the sickle-cell trait) a partial resistance to the disease. Living under such conditions created susceptibility to respiratory illnesses like pneumonia, tuberculosis, and infections caused by parasites. Working conditions were similarly inhumane for those working the tobacco, cotton and sugar cane fields where the enslaved Africans were expected to work from sun up to sundown regardless of the weather.

Although the Public Health Act was passed in 1848, a social justice mandate was not used as leverage to stop either plantation doctors or the medical profession from routinely using African Americans for medical research without consent. This was an example of systemic racism within the medical profession, scientific research community and the health care system. Harriet Marineau, often identified as the first woman sociologist, once commented "[t]he bodies of the

coloured are exclusively taken for dissection ‘because the Whites do not like it and the coloured people cannot resist.’ Between 1845 and 1849, Dr. Mirian J. Sims, the father of modern gynecology, completed 30 operations on three Black women without anesthesia to develop a procedure for White women suffering from a condition that resulted in the leakage of urine through the vagina. Ignoring the Hippocratic Oath, “First do no harm” corresponded to the scientific racism of the period. Bogus research was the basis for describing Blacks as inferior, subhuman and possessing a physique that made them perfect for medical experimentation. After the procedure to treat was perfected, he used anesthesia when performing surgery on White women.

Some have said that Sims’s abuse of African American women resolved a medical problem many women suffered. However, there is no ignoring that Sims’ grave injustice against African American women was among previous and future grave misjustices in medical health that created a situation where no group mistrusts the American medical system, particularly medical research, more than present-day African Americans.

Racial Disparities: Civil War and Reconstruction 1861-1900

Although they were without civil rights, 186,000 formerly enslaved and free African Americans enlisted in the Union Army. The health status of Black soldiers during the Civil War revealed that disease and sickness had a more catastrophic impact for ex-enslaved men, compared to White soldiers. In 1864 in Camp Kentucky, hundreds of freed slaves died of malnutrition and exposure, while White soldiers in the same camps did not. The War Department also did not assign doctors to the Black encampments.

This historical moment provides further evidence for a historical perspective that supports connecting longstanding health disparities in the Black population to structural racism that prevailed during this period. This reality stings even more with the realization that the measures used to improve the sanitary conditions in military camps with the intention of returning White soldiers to their families alive led to creating America’s organized public health system. This historical moment also highlights how neglecting the health needs of the African American population led to practices in public health that significantly benefits the country’s White population but were not equally applied to African Americans.

Byrd and Clayton describe Reconstruction as the “nadir of Black health status.”⁸ Following the Emancipation Proclamation, four million Africans transitioned from penniless chattel to helpless paupers beset with problems that included epidemics, poverty, poor housing, poor sanitation, and unequal access to formal healthcare and epidemics, all of which can be linked to structural racism. The Bureau of Refugees, Freedman, and Abandoned Lands, created in 1865, was designed to provide aid to formerly enslaved Black people. In their history of the Bureau, Franklin and Moss report that the organization provided public type services that yielded positive outcomes.⁹ For example, the death rate among formerly enslaved Blacks was reduced and sanitation conditions improved. This was accomplished before the advent of medical insurance.

Bowing to pressure from White politicians who viewed the Bureau as an encroachment on state’s rights, it was disbanded after a short seven years in 1872. After being enslaved for 250 years, seven years was certainly not sufficient to address the cumulative effects of disease and illness on African Americans. The continuing condition of ill health and disease would be apparent in the population as they settled in rural areas and cities.

Racial Disparities: Early Twentieth Century 1901-1929

In his classic study, the Philadelphia Negro, DuBois uncovered disparate health outcomes in the Seventh Ward, an area where Blacks were concentrated.¹⁰ Health disparities were apparent in death rates attributable to illnesses involving the urinary system, pneumonia, diarrheal diseases, cancer and tumor. For example, the mortality rate for Blacks due to pneumonia was 356.67 per 10,000 people, compared to 180.31 for Whites. His study uncovered tuberculosis as the leading cause of death among African Americans, noting “Bad ventilation, lack of outdoor life for women and children, poor protection against dampness and cold are undoubtedly the chief causes of this excessive death rate.” Consistent with DuBois’ reputation of holding the Black community accountable for some of their problems as well as their uplift, he also stated,

The most difficult social problem in the matter of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have, for instance, been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference.

Racial Disparities: The Great Depression to World War II (1929-1945)

The consequences of the Great Depression in the areas of health were devastating for White and Black Americans. Poverty, among other things, created homelessness and unemployment. This situation meant that people were not living in the most sanitary environments, regularly eating healthy foods, or maintaining sanitary habits. But, while the depth of poverty, hunger, sickness and mortality was severe for everyone, it was greater for African Americans. In 1929, the first year for which national figures are available, White life expectancy at birth was 58.6 years, and Black life expectancy was 46.7 years for men and women combined.

By approving and carrying out the Tuskegee Experiment, public health earned a permanent stain on its reputation as an agency that contradicted its mission to prevent disease especially in a disadvantaged, underprivileged populations. Sponsored by the U. S. Public Service in Macon County, Alabama, this research followed the progression of untreated syphilis in more than 400 poor African American men, most of whom were sharecroppers or day laborers. The study was conducted from 1932 to 1972. Later research showed that there was, “no evidence that informed consent was secured from human participants in the study.” It was only after the study was reported by the Associated Press in 1972 that it was ended.¹¹

Racial Disparities: Civil Rights Period - Pre-COVID-19 (1960s-2020)

The Civil Rights Era expanded the African American population’s pathway to health outcomes that are equal to those of White Americans. By doing so, the period demonstrated how civil rights laws and their enforcement added leverage to public health as an instrument for social justice. Literature not only links enforcement of civil rights laws to better health outcomes for African Americans, but also designates civil rights as a social determinant of health. For example, until the start of the Civil Rights Movement, hospitals in the North and the South either denied admission to African Americans or restricted their in-patient care to segregated wards, frequently situated in cold attics or damp basements. The 1963 decision in *Simkins v. Moses H. Cone Memorial Hospital* found that the separate-but-equal clause of the 1946 Hill-Burton Act, which provided federal monies for hospital construction, was unconstitutional. The ruling ended

segregation in hospitals. Subsequent Medicare and Medicaid legislation in 1965 mandated the integration of hospitals; thereby, giving the African American population access to “decent,” mainstream health care after 300 years of indecent healthcare.

Hahn, Truman and Williams concluded that civil rights break down barriers to access to care and, in addition, reduce health disparities in the African American population.¹² For example, following enforcement of Title VI of the Civil Rights Act, data showed that in hospitals that were previously segregated (most were in the South) between 1965 and 1971, the infant mortality rate among non-Whites (approximately 99% of whom were Black) fell by 40% from 40 to 28 per 1,000 live births, while the rate among Whites changed little. Overall, it is estimated that between 1965 and 2002, approximately 38,600 Black infant deaths were prevented by implementation of Title VI of the Civil Rights Act.

The Heckler Report, published in 1985 and authorized by then Secretary of Health, Education and Human Services, Margaret Heckler, produced the first complete examination of the burden of health disparities carried by African Americans and other people of color. She described health inequalities among disadvantaged African Americans and other minorities “as an affront both to our ideals and to the on-going genius of American medicine.” At the end of the Great Depression, the age-adjusted mortality rate for Black men was 53 percent greater than that for White men. By 1984, it was 46 percent greater. A National Center for Health Statistics Report published in 1985 indicated that African American children were twice as likely as White children to die before reaching one year of age.

Eighteen years later in 2003, the Institute of Medicine (IOM) would publish an incisive report that would also link health inequities in the Black population to structural racism.¹³ In its discussion of health disparities in the Black population the IOM’s review of the problem, said,

Despite steady improvement in the overall health of the U.S. population, racial and ethnic minorities, with few exceptions, experience higher rates of morbidity and mortality than non-minorities. African Americans, for example, experience the highest rates of mortality from heart disease, cancer, cerebrovascular disease, and HIV/AIDS than any other U.S. racial or ethnic group.

The report also noted that when socioeconomic factors are equal among Whites and Blacks, inequality in quality of health care is still present and thus is a reason for concern.

Mr. George Floyd and Others: Police Violence as a Public Health Crisis:

Including the deaths of African Americans at the hands of police officers in a discussion about race and health disparities and race and public health might seem out of place until the American Public Health Association’s (APHA) policy statement declaring police violence a public health crisis is considered. The statement, in part, states, “Physical and psychological violence that is structurally mediated by the system of law enforcement results in deaths, injuries, trauma, and stress that disproportionately affect marginalized populations...”¹⁴

With respect to African Americans, the salient literature includes research that shows that Black men in America are 3.5 times more likely to be killed by police, compared to their White counterparts. For Black women, the rate is 1.4 times more likely. In fact, other important studies

reveal that the impact of police brutality goes beyond physical death and physical harm. That inequities in terms of the negative outcomes also include negative psychological consequences. For instance, two large studies revealed that African Americans were more likely than White respondents to report stress as a consequence of interactions with police.

The APHA's response is particularly instructive in the way it not only connects police brutality to structural racism but, in facilitating viewing the crisis through a historical lens. Accordingly, the association offers the ecosocial theory of disease distribution as a conceptual framework for such an approach, noting that the concept "holds that to meaningfully analyze and interpret the population distribution of health exposure, a grounding in historical context from which the exposure emerged is necessary. Having applied the theory to the status of Blacks before and after emancipation, the APHA maintained that

"U. S. policing was historically deployed for the social control of communities deemed socially marginal (i.e., in the 19th century, it evolved from ruling-class efforts to control the immigrant working class in the North and the slave patrols in the South."

Myrdal made this point in his classic study, *An American Dilemma*, in which he concluded, "In the policeman's relation to the Negro population in the South...he stands not only for civic order...but for white supremacy."¹

Thus, the police brutality seen in African American communities is not a recent phenomenon but rather represents part of a legal institution with interlocking policies and procedures that support a system of discriminatory policing that creates and maintains a disproportionately high burden of health disparities in the form of death, physical injury and psychological trauma and other form of mental disorders in the African American population. Furthermore, this situation is not a recent phenomenon. Its origin can be traced to periods before the Civil War, from 1619 to the Civil War, and after African Americans' emancipation from enslavement in 1865. This ascribed position immediately translated into inequities in the areas of health and law enforcement that are long standing and have pointed the eyes of public, public health professional and the health care system, in general to an even deeper look toward history as a conveyor to the present day health disparities so readily apparent in the African American population

Conclusion and Recommendations

The past really does inform the present. Accordingly, this paper supported the point of view that the "Enough Is Enough" protests that erupted across America following the death of George Floyd, and the longstanding health inequities the COVID-19 pandemic brought front and center for many Americans can be traced back to the 17th century. During the mid-1600s the ancestors of present-day African Americans were relegated to the lowest rung of American society legally and in terms of social status. The rationalizations for the rulings and subjective judgements that placed this population in a caste position were based on race, color, scientific racism, and, the need for a free labor force that was the life line for the economic future of the colonies. The laws that held enslaved Africans and maintained their descendants in an unequal status did so not because they were poor, or because they were vagrant or because they were guilty of committing crimes, "but simply because they were African" and of African descent. Their ancestry and ethnicity became the maker for indelible subordination and inequality. This situation, in turn, directly contributed to health inequities that have persisted up to present day. Thus, the outcomes

have been cumulative and have negatively impacted the health status of millions of African Americans.

Herein lies the essence of this article. Namely, the “caste status” to which African Americans were assigned during the country’s formation created immediate and on-going inequities in health outcomes that are continual and diffuse in today’s African American population. The article emphasizes that the differentials in health status are manifestations of structural racism that have impacted generations of Black people. Moreover, not just the public health profession, but the health care system, as a whole, has been complicit in the persistence of health disparities we are witnessing. In other words, structural forces and interconnected systems including, but not limited to, discrimination, segregation and police violence combined to create long-standing structural racism as a factor that explains the situation where African Americans were and remain less healthy physically and psychologically, compared to their White counterparts. Therefore, this article maintains that structural racism should be included in the social determinants of health.

Unless the public health profession declares the elimination of health inequality in the African American population as its top priority, the health disparities among African Americans will remain a major healthcare problem for health care professionals, medical researchers and policy makers. Furthermore, this article has demonstrated that including history as a variable in the analysis of the morbidity and mortality gaps between Black and White Americans certainly provides a basis for framing public health as a medium for social justice. That is, redressing deliberate public health and health care policies, the results of which include health disparities, that created cumulative health outcomes since the 1700s that are readily apparent in the health disparities that exist today.

A historical context gives credence to specific recommendations that can lead to equity in health outcomes for African Americans:

1. Public health for social justice should be grounded on an historical understanding of the manner by race and related structures, processes, ideologies, and connected institutions (e.g., healthcare, law enforcement) influence present day health outcomes for African Americans. Although there is research that suggests that past events have substantial impacts for future generations, few studies focus on health outcomes or health inequities.
2. Public health organizations should frame necessary policies, programs and services to African Americans as a form of material restitution for enslavement and the burden it exacted on African Americans for 400 years.
3. Public health organizations and the medical profession in general should address the widespread mistrust among African Americans toward medical research. Such acknowledgement should begin by acknowledging the notorious ethical misconduct by public health officials and practicing physicians that occurred and the group’s understandable reluctance to participate in medical research. The *mea culpa* should be followed by research universities, medical institutions and research agencies giving African Americans clear explanations regarding need for participation in medical research on the part of African Americans. African Americans desperately need the medical advantages and revelations that only ethical, essentially therapeutic research initiatives can give them.¹⁵

4. The health profession should expand the number of community-based health and public health programs that include a required community-engagement component. Membership on advisory and research boards must include ordinary people who can offer workable and effective ways to: (1) obtain community buy-in to research and (2) offer the kind of knowledge, insights and creative solutions based on lived experiences that cannot be provided by mainstream-oriented professionals who do not reside in the communities most beset by health inequities. Such programs involve grassroots residents in every step of the research process including identifying the problem, selecting methodology, collecting and analyzing data, and disseminating and advocating for policies and programs to legislators, governors, and other constituents. The DE-CTR ACCEL and Citizen Science offer concrete examples of participation in research with satisfactory results for both scientists and citizen participants.
5. Structural racism should be included in the social determinants of health; that is a condition in which people function that impacts quality of life. Structural racism - historical and contemporary - as an impediment to access to health care and as an explanation for health disparities among African Americans that have passed from generation to generation is a social determinant of health. However, obtaining healthcare does not necessarily lead to reducing health inequities. Mathew, Reeves and Rodrique report health care alone accounts for only approximately 10 percent of health impacts, where social and environmental factors account for 20 percent, genetics, 30 percent and behavior 40 percent.¹⁶ They also note that closing the gap in health outcomes for Blacks and Whites means addressing inequity in upstream social and environmental factors that impact health.
6. Public health professionals should more frequently employ ethnographic research models that provide contextual data in the areas of behavior, culture, physical, psychological status and history that cannot be gleaned solely from quantitative data.
7. Undertake recruitment efforts that aim to increase African American health professionals. Health inequities are connected to cultural and psychosocial factors related to patient views of health, health status, and the health care system, all of which determine health care-seeking behavior and are influenced by structural characteristics of our health care system. A Stanford study revealed that, when patients and doctors had an opportunity to meet face to face, patients assigned to an African American doctor increased their request for preventive measures, even invasive procedures.
8. Increase funding to Historical Black Colleges and Universities to develop training centers for African American public health professionals. In 2018, figures published by the American Medical Association reported that among practicing doctors, 56.2 percent self-identified as White, 17.1 percent Asian, 5.8 percent Hispanic and 5.0 percent Black or African American.¹⁷ Of the top ten undergraduate feeder institutions applying to medical schools, three HBCUs- Spellman, Howard and Xavier (LA)- are the top producers of individuals who plan to become doctors.

9. Increase funding to support universal public health system that has the capacity to assure equal access and quality and non-disparate outcomes.

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Additional Resources

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