

Introduction

An American Dilemma: Racial Disparities in Health – Past and Present

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.

Dr. W. E. B. Du Bois, 1899 [1]

Up until the late 1970s, Detroit, Michigan, was one of the great industrial American cities. It was the home of the “big three” American automakers (Ford, General Motors, and Chrysler) and many other businesses that supported the auto industry. Most of the residents (over 63 percent) were Black people.¹ Detroit had all the problems of any large American city, but the population was stable, and the city was “healthy.” Then things changed dramatically. The city’s population dwindled from about 1.2 million people in 1980 to just over 670,000 in 2019. About 75 percent of its current population are people who identify as Black [2]. The primary explanation of Detroit’s population loss was that people (particularly wealthier White residents) were leaving the city because of their fear of crime and the movement of jobs, including a significant number initiated by the automakers, to other places. Because of this exodus, the city’s tax base became smaller, the quality of the city’s public services declined, and even more people left.

These explanations for Detroit’s population decline are valid but incomplete. There is another critical reason why substantially fewer people lived in Detroit in 2019 than had lived there in the past. This other reason was identified by several physicians at Wayne State University (located in Detroit). These physicians were well aware of the health problems of Black Detroit residents and wondered whether health issues may have

¹ The terms “Black people” (or “Black Americans”) and “White people” (or “White Americans”) refer to whether a person’s ancestors primarily came from Africa or Europe. We use “Black” rather than “African American” because it is a more accurate and inclusive term for the Black population of the United States. Black and White are capitalized on the basis of the cultural and identity markers that have been placed on the groups over time. As discussed later in this chapter, these words have no biological or genetic meaning.

played some part in the city's loss of population. To answer this question, they gathered 19 years of data on mortality rates (i.e., deaths per 100,000 people) in the Detroit area and compared them to mortality rates in the rest of the state. More specifically, they computed something called "excess mortality," which is the number of people who die before they would normally be expected to die (i.e., at age 75).

The results were striking. The physicians found that large numbers of older Black men living in Detroit were "dying before their time." For example, the excess mortality rate among men of ages 40 to 49 and living in Detroit was almost twice as great as was the excess mortality rate for men in the same age group, who lived in the rest of Michigan. The mortality rate for Detroit men aged 50 to 59 was 122 percent higher than for men in the same age group in the rest of Michigan. If older Black men living in Detroit had simply died at the same rate as men in the rest of the state, 1,600 more of them would have been alive for each year of the study. Across the 19 years of the study, concluded well before the COVID-19 pandemic, the total excess mortality among Black men living in Detroit was over 16,000 lives. The physicians estimated that about 33 percent of Detroit's population loss over the 19 years was due to these premature deaths and the fact that there was no influx of people to replace them. Detroit was losing population not simply because people were moving away. Actually, many people – predominantly Black men – were staying in Detroit and dying before their time [3].

The phenomenon of Black people "dying before their time" is not limited to Detroit. It is a national problem. National mortality rates during the first two years of the COVID-19 pandemic revealed that Black people were disproportionately affected by the virus and died at a rate much higher than White people. Although this racial disparity in deaths declined from the beginning of 2020 to late 2022, even then Black people were still almost twice as likely to die of COVID-19 as were White people [4].

Dr. Nancy Krieger, professor of social epidemiology at Harvard University, and her colleagues further illuminated the nature of these racial disparities by comparing mortality rates during the first year of the pandemic among White people and Black people of the same age. At all ages, the mortality rate was greater for Black, Indigenous, and Other People of Color (BIPOC) than for White people, but this disparity was the greatest among younger Black Americans than White Americans. By December 2020, the death rate among Black people under 55 was 7 times greater than the death rate among White people of the same age [5]. Almost 87,000 years of potential life were lost to COVID-19 among Black people

under 55, compared to 61,000 years for White people. As in the pre-COVID study in Detroit, in 2020 Black people were much more likely than White people to “die before their time.” These huge COVID-19-related health disparities were put in a historical context by Dr. Anthony Fauci, director of the National Institute of Allergies and Infectious Diseases. Dr. Fauci noted that “health disparities have always existed for the African American community. . . . But here again, with the (COVID) crisis, now it’s shining a bright light on how unacceptable that is” [6].

In an interview for the television show, *60 Minutes*, Dr. David Williams, professor of public health at Harvard University and one of the leading authorities on racial health disparities, succinctly described the issue of excess mortality among Black Americans. He explained, “Imagine if every single day a jumbo jet loaded with 230 African Americans took off into the sky, reached a cruising altitude, and crashed to the ground killing all aboard . . . this is exactly the impact caused by racial health disparities in the United States” [7]. But, of course, this excess mortality is not due to plane crashes; it is because of the poor health of many Black Americans and inadequacies in the healthcare they receive. While we understand and acknowledge that many other racial and ethnic groups experience health disparities relative to White Americans, this book primarily focuses on the causes of many of the health and healthcare problems experienced by Black Americans. Where relevant, we also discuss health disparities that affect members of other BIPOC groups.²

Health Differences versus Health Disparities: An Important Distinction

The major causes of death in the United States are diseases, and the much higher mortality rates among Black Americans reflect the fact that a substantially larger percentage of Black Americans than White Americans suffer from the most common diseases. But, even when a Black person and a White person have the same disease, the Black person is much more likely to die from it. So, the simple and striking fact is that, on average, Black Americans are much less healthy than White Americans. There are two explanations of this fact. The first is that it represents a health

² The health disparities between Native Americans (Indigenous Peoples) and White Americans are about as great as the Black–White disparities. With respect to ethnicity, the disparities are smaller but still significant for Americans who identify as Hispanic. There are also substantial health problems among Americans whose ancestors came from many different countries in Asia.

difference – varying rates of deaths and illnesses between two groups because of some biological or genetic difference between them. The other is that it represents a health *disparity* – varying rates of deaths and illnesses between two groups that are the result of unfair economic, political, social, and psychological processes. The central thesis of this book is that much poorer health of Black Americans relative to White Americans represents a health disparity.

We believe that these racial health disparities are largely due to one insidious aspect of the current state of race relations in the United States – anti-Black racism – the idea that Black people are in some way different from and inferior to White people. Anti-Black racism also includes the notion of White supremacy, the belief that White people are superior and should control Black people. Anti-Black racism has a long history in the United States. The clearest example of it is the enslavement of Black people for about 250 years. There were, however, many social, cultural, and political forces that followed slavery that directly and intentionally disadvantaged Black Americans. Anti-Black racism is thus, an integral part of America's history, as well as of current race relations.³

Across this history, anti-Black racism has been responsible for laws, public and private policies, social customs, and individual beliefs and actions that directly or indirectly harm the health of Black Americans. These actions can be blatant, but often they are subtle. And it is not uncommon for people to engage in a racist action without consciously intending to do so. But whether blatant or subtle, conscious or nonconscious, anti-Black racism is dangerous because of the outcomes it produces.⁴ Anti-Black racism provides the motivation to and justification for a host of actions that directly or indirectly oppress Black people, putting their health at substantial risk. As Dr. Rodney G. Hood, a former president of the National Medical Association, wrote, “the poor health of African Americans is not a biological act of nature or an accident but can be directly attributed to the institutions of slavery and racism – circumstances under which African Americans have continuously suffered from for nearly four centuries” [8]. We agree that the inability to equitably

³ Two excellent books on the history of racism in the United States from the perspective of Black Americans are *How to Be an Antiracist* by Ibram X. Kendi and *How the Word Is Passed* by Clint Smith.

⁴ The word “nonconscious” means that race-related thoughts, feelings, or actions may occur without a person being fully aware of them. The word, “unconscious” is often used to describe the same thing in the research literature. We discuss nonconscious aspects of anti-Black racism at length in Chapters 1 and 6.

treat Black Americans is an “original sin” that has plagued America for over 400 years, and its impact on the health of Black Americans continues to this day. This inequitable treatment is almost entirely based on a misunderstanding of what the term “race” really represents.

Race: A Biological Myth, a Social Reality

At the core of anti-Black racism is some variant of the myth that a person’s apparent race reflects some important underlying biological attributes. For centuries, race has been used as a way to classify a person as being biologically Black or White. In fact, race is really a social construct that reflects how society identifies a person based on some easily observable physical characteristics, such as skin color, hair texture, and facial features. But, race has no biological or genetic foundation. People who are identified as Black or as White share over 99 percent of their genomes in common, and there is much more genetic variation within each group (that is, among people identified as Black and among people identified as White) than between them. Thus, there is almost a complete agreement among contemporary geneticists, biological scientists, and all major medical organizations that the notion of Black people and White people being from separate and distinct biological species or groups has no scientific merit.⁵ For example, in 2020, the American Medical Association (AMA) issued the following statement: “[The] AMA confirms race as a social construct. Race is a socially constructed way of grouping people, based on skin color and other apparent physical differences” [9]. Indeed, today, scientists who study the genetic origins of disease do not even include race as part of their explanations because it has no scientific value.

This does not mean that the nature of an individual’s genome is unimportant or that there is no variation in gene expression among humans with significant implications for their health. There are genetic diseases (e.g., cystic fibrosis, hemophilia, Huntington’s disease, sickle cell disease, Tay-Sachs disease). Further, there are a few diseases that seem to be more common among people whose ancestors are from Africa: sickle cell disease and prostate cancer, for example. But there are similar kinds of differences in a few genetic diseases among all population groups, and

⁵ Very accessible books that address this topic are: *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century* by Dorothy E. Roberts, and *The Gene: An Intimate History* by Dr. Siddhartha Mukherjee.

genetic diseases are a minute fraction of the illnesses that kill Black people in the United States.

Further, socially constructed race is about much more than how a person is identified by a society; it is also about power within that society. Identifying a group of people as belonging to a race that is different from the majority provides the basis for assigning that group a lower social and economic status. As author Ta-Nehisi Coates explains, “race is the child of racism, not the father. And the process of naming ‘the people’ has never been a matter of genealogy or physiognomy so much as one of hierarchy” [10].⁶

This is especially true in North America. The early European settlers were not the first to use the terms, White and Black, to describe people. But among them, the words took on special significance as a way of describing those who had power and those who did not [11]. The concept of race became a rationale for the subjugation of Black people. As Alveda King, niece of Dr. Martin Luther King Jr., explained in 2019: “Racism springs from the lie that certain human beings are less than fully human. It’s a self-centered falsehood that corrupts our minds into believing we are right to treat others as we would not want to be treated” [12]. Although it is the health of Black Americans that suffers the most because of anti-Black racism, all Americans pay a substantial price for racial health disparities.

The Cost of Racial Health Disparities

Research conducted in 2020 in Texas is an excellent case study of the economic impact of racial health disparities. In Texas such disparities created excess expenditures for healthcare amounting to \$1.73 billion. In addition, the cost of productivity lost due to diseases was about \$870 million, and the cost of lost contributions to the economy because of premature deaths was \$10.3 billion. Across these three domains, the excess costs of Black–White racial disparities in health in just one state in one year were almost \$13 billion [13].

Of course, Texas is a very large state with a conservative government and legislature. Thus, more may be spent overall for healthcare than smaller states, but proportionally less may be spent on healthcare for poor, minority patients than other states. But these estimates are in line with national estimates of the costs of health disparities. An article in the

⁶ Coates’ book, *Between the World and Me*, provides an insightful and personal discussion of race in America, which takes the form of a letter from a Black father to his son.

Harvard Business Review estimated that in 2015 the annual national costs of racial health disparities were \$245 billion [14].⁷ Dr. Paul Farmer, professor in the Department of Global Health and Social Medicine at Harvard Medical School and a long time advocate for healthcare equity, succinctly summarized this issue when he said that “it is very expensive to give mediocre medical care to poor or near-poor people living in a rich country” [15].

Not included in those estimates are the social, economic, and educational costs to the *individuals* who are the victims of racial disparities in healthcare. Serious medical problems almost invariably put a strain on personal and familial relationships. This may be especially true for women, who are much more likely to be abandoned by their partners after a serious medical problem [16]. For example, women with a brain tumor have ten times the risk of a divorce as do men with the same disease [17]. Serious diseases also very often prevent people from working and earning a living. This, in turn, prevents them or members of their families from obtaining an education that would increase their social and economic mobility. Thus, costs of healthcare disparities are intergenerational and grow, perhaps exponentially, over time.

Two Kinds of Anti-Black Racism

Social scientists and other scholars who study anti-Black racism usually talk about two different kinds of racism. They distinguish between racist thoughts and actions among individuals (*individual racism*) from racism that is embedded in the practices, policies, laws, and cultural values of a society (*systemic racism*). Both types of racism play critical roles in racial health disparities, but they do so in different ways.

Individual Racism

Individual racism involves negative thoughts (i.e., negative beliefs about Black people’s personal and physical traits) and negative feelings (i.e., racial bias) toward Black people. These thoughts are usually called “stereotypes,” a term first introduced in the 1920s by the famed journalist, Walter Lippmann. He described a stereotype as “a picture in our head” [18]. When applied to perceptions of social groups, a stereotype is the information people carry in their minds about the nature of people whom they

⁷ The costs of the same kinds of disparities for the Hispanic population in Texas, which is somewhat larger than the Black population, was almost \$14 billion.

believe share some characteristic in common. Together negative thoughts and feelings about Black people lead to unfair, discriminatory behaviors that harm individual Black people or Black people as a group. Many people thought that when Barack Obama was elected as president, America had become a “post-racial society” – that is, a place where a person’s race no longer mattered. Indeed, some people claim, “When I meet a person, I just don’t see their color or race.” They describe themselves as being “colorblind.”

There is, however, substantial research in social and cognitive psychology that disputes the accuracy of such claims. When people meet another person, they invariably see their race – immediately and automatically – and they use this information to categorize that person in certain ways. This process, known as “social categorization,” forms the foundation for individual racism. Once people are identified as a member of a particular social group, stereotypes about them and feelings toward them are more or less automatically activated.

Individual racism greatly influences the actions that White people take toward Black people in a variety of ways. Substantial media attention has been given to one way it affects people’s actions – when a White police officer badly mistreats or even kills a Black person who has been detained. However, the effects of individual racism are not confined to these dramatic and horrific examples of Black people being brutalized.

Individual racism also affects how White people make decisions about and act toward Black Americans in many different aspects of everyday life. This includes what businesses they patronize, what schools they send their children to, what political candidate they support, what movies or TV shows they watch, what friends they choose to have, and a host of other things in their day-to-day lives. In sum, individual racism in the form of anti-Black racism substantially determines how a White person or group of White people treat Black people.

Even more insidiously, individual racism can affect how a White person treats a Black person even when the White person does not want this to happen. For example, a White person who is racially biased against Black people may work hard not to show this bias, but their deeply held prejudice and negative stereotypes (sometimes held nonconsciously) often can “leak out” in actions that harm the Black person in some way. These behaviors could include unintentional “microaggressions” (e.g., expressing surprise at a Black person’s expertise or professional status or checking your wallet when a Black person passes by). Microaggressions also occur in conversations with Black people in the form of behaviors that signal

psychological discomfort, distancing, or lack of respect. Discomfort and distancing are manifested in making less eye contact, talking less, making more speech errors, maintaining greater physical distance, and adopting a closed body posture. Lack of regard can be seen in frequent interruptions and talk-overs, as well as looking away when a Black person speaks.

Irrespective of a person's intent to minimize their racist actions, individual racism can do great harm to the Black person who is its target. Often racist actions can have immediate material consequences, such as restricting someone's freedom or creating conditions that place them at a serious social, economic, and educational disadvantage. Further, as we discuss in Chapter 2, they can do great physical and psychological damage with direct implications for a person's health.

It may give us false comfort to think that individual racism is confined to a small number of Americans who, for a variety of reasons, espouse openly racist feelings. When we think of racists, the images that may come to mind are of armed "alt-right" White supremacist groups marching in the streets, carrying flags with swastikas on them and yelling racial epithets. But the reality is that most Americans harbor, sometimes nonconsciously, thoughts and feelings that are racist to some degree.

Individual racism is woven into the fabric of most Americans' thoughts and feelings, but this is particularly so for White Americans. Racial biases develop early in life, at least by the time a child is age five and possibly as early as age three [19]. In a country where individual racism's long legacy has made a person's race such a critical aspect of who they are, race is and will probably always be a very important part of how individual White people think about Black people and their personal characteristics. (In the next chapter we discuss the historical events and higher-order mental processes that have made individual racism so pervasive in America today.)

Whether individual racism is conscious or nonconscious, intentional or unintentional, the consequences for Black Americans are similar – fewer economic and social opportunities and a raft of disadvantages. Individual racism, thus, tips the scales, such that Black people are disadvantaged, and White people are advantaged. For example, discrimination in hiring is one very important area in which Black people were historically disadvantaged. The Civil Rights Act of 1964 made it illegal to discriminate against Black people in hiring decisions, but researchers have studied whether the law actually eliminated this kind of individual racial discrimination.

One way to answer this question is to conduct something called an audit study. In an audit study, two résumés that are identical with regard to an applicant's professional qualifications are sent out to potential employers.

However, one version contains information that clearly suggests that one applicant is White, and the other version that the applicant is Black (e.g., giving them stereotypically White or Black names). This is done to eliminate the possibility that one could justify any racial differences in responses to an applicant on the basis of their actual qualifications. One analysis combined the results of 28 separate audit studies conducted between 1989 and 2017.⁸ The researchers analyzed over 55,000 applications for over 22,000 jobs and found that White “applicants” received 36 percent more callbacks from the potential employers than did Black “applicants” [20]. Importantly, the size of this disparity did not change across the 28 years studied. Audit studies of racial discrimination in the renting and selling of housing show similar kinds of racial disparities. So, individual racism often persists even long after laws have been passed that prohibit it. It is also still present among healthcare professionals and creates racial disparities in the quality of healthcare patients receive. For example, over the last 15 or so years, almost every medical facility in the United States has implemented some kind of anti-bias training. Despite such programs, researchers find that physicians still consistently disparage their Black patients in the notes they make about their cases [21] (see Chapter 6).

Systemic Racism

Systemic racism encompasses a broad range of societal standards and cultural values, as well as formal practices, policies, and laws that systematically disadvantage Black Americans relative to White Americans. These practices can occur in large and small institutions in both the public and private sectors (which is sometimes termed “institutional racism”). It represents a social, economic, political, and legal system that essentially legitimizes racism and inequity by making it a “normal” part of everyday life. The fact that this kind of racism permeates all essential facets of Black American’s lives has led some researchers to characterize it as “atmospheric racism” [22]. Its effects can be seen in the vast racial disparities in the income and wealth of Black Americans versus White Americans, and a similar kind of disparity in political power. These things, along with a host of other consequences of systemic racism, endanger the health of Black Americans.

⁸ This kind of study is called a meta-analysis. The results of many different studies are statistically combined to produce an estimate of the consistency and strength of some finding or relationship between two variables. Meta-analyses are widely used in studies of racial health disparities.

Historically, the most obvious and dramatic example of systemic racism in the United States was the legalization of slavery. The notion that enslaved people had no legal rights and could be “owned” by another person was written into laws at all three levels of government (i.e., local, state, and federal) and reinforced by numerous court decisions, including those made by the US Supreme Court before slavery was finally ended by the 13th Amendment. However, formal laws and informal customs and practices have resulted in the continued social dominance of White Americans over Black Americans.

For example, after the Civil War ended, as part of a desire to resolve some of the enormous racial inequities of slavery, the US Congress passed the Reconstruction Act of 1867. It established a list of things southern states needed to do to be readmitted to the Union. These involved endorsing the constitutional amendments that gave Black residents of these states the same set of political and economic rights as the White residents. Federal troops were sent into many of these states to ensure that promised changes were translated into actual changes in the economic and political structure of states in the former Confederacy. These efforts should have given formerly enslaved Black people more political power and control, as well as many more personal rights, but there was massive political resistance to the Reconstruction Act and the political, economic, and social rights it gave to Black Americans. Thus, Reconstruction was short-lived; it ended 10 years after Congress had enacted it.

Shortly after Reconstruction ended, all the states that had been part of the Confederacy passed a number of laws that collectively came to be known as “Jim Crow” laws [23]. Similar laws were later enacted by some states outside the former Confederacy. These laws legalized racial segregation and ensured that the legal and social status of Black residents remained significantly lower than that of White residents.⁹ Many states incorporated biology, such as the “one-drop rule,” into their Jim Crow laws. These laws proclaimed that a person with any Black ancestry (just one drop of “Black blood”) was legally Black. That is, if it could be found that even a very distant ancestor of a person was Black, then that person was also Black. Some examples of Jim Crow laws were that Black people could not own property, vote, or serve on juries; they had to attend segregated

⁹ Laws that specifically target Black people or other groups and deprive them of certain rights and privileges are examples of “structural racism.” They often provide a legal basis for certain aspects of systemic racism. Because these laws place Black people and many other groups at a fundamental disadvantage, their impact continues long after the laws are repealed.

schools that received substantially fewer resources than White schools in the same area; they could not live in certain neighborhoods, shop in certain stores, or use the same public facilities as White people; and if they could find medical care, it was segregated and far inferior to the medical care available to White people. The overall consequence of Jim Crow laws was described by the psychologist Dr. John Dollard, who extensively studied their effects in the 1930s by going to southern towns. He concluded that “the Negro must haul down his social expectations and resign himself to relative immobility” [24]. The Jim Crow laws rendered the Black people who lived under them virtually powerless.

These racist laws covered every aspect of a Black person’s life. For example, in Alabama it was unlawful “for a negro and white person to play together or in company with each other at any game of pool or billiards.” They even reached into people’s bedrooms in the form of anti-miscegenation laws, which made it illegal for people identified as Black and as White to marry or have any sort of sexual relations. As another example, in Florida, the anti-miscegenation law read, “All marriages between a white person and a negro, or between a white person and a person of negro descent to the fourth generation inclusive, are hereby forever prohibited.”¹⁰

And, there were many Jim Crow laws that even tried to control what people said or wrote about the rights of Black Americans. The state of Mississippi actually banned people from promoting equality between its Black residents and White residents: “Promotion of Equality—Any person. . . who shall be guilty of printing, publishing, or circulating printed, typewritten or written matter urging or presenting for public acceptance or general information, arguments or suggestions in favor of social equality or of intermarriage between whites and negroes, shall be guilty of a misdemeanor and subject to fine or not exceeding five hundred (\$500.00) dollars or imprisonment not exceeding six (6) months or both” [25]. And, of course, Jim Crow laws rigidly segregated medical care in the southern United States until 1964. Because of this, there was little adequate medical care for Black people in these states.

¹⁰ It was not until 1967 that the US Supreme Court ruled that the right to an interracial marriage was protected by the “Equal Protection and Due Process” clauses of the 14th Amendment to the US Constitution. It made the same ruling about same-sex marriage in 2015. In 2022, the US Congress passed the “Respect for Marriage Act,” which guaranteed the legal validity of both interracial and same-sex marriages. They did this after the Court ruled that the same clauses in the 14th Amendment did not guarantee a woman’s right to an abortion.

Systemic racism has been used to maintain White dominance throughout the US history. It has caused harm to every racial or ethnic minority group in the United States. From the sixteenth to the nineteenth century, large numbers of Indigenous Peoples were enslaved in the American Southwest [26]. In addition, laws that restricted a host of their rights resulted in enormous damage to the lives and traditions of Indigenous Peoples that affect them to this day. Their land was taken, they were forced to move from their original homeland to distant locations, denied basic rights of self-governance, and their children were forced to attend residential schools, where the curricula deprived them from knowing about their cultural heritage [27]. A visit to most contemporary “Indian” reservations will show the long-lasting and devastating effects of the racism directed at them. (“Indian” is the term used by the Federal Agency responsible for these reservations.) At one time, people of Chinese ancestry who had lived in America for many decades were denied the right to become US citizens because they were not considered to be “White.” During World War II, laws were passed that put over 100,000 people of Japanese descent, the majority of whom were US citizens, in internment camps [28]. Many states still have anti-immigration laws that almost exclusively target Hispanic immigrants. (“Hispanic” is a U. S. government demographic designation. Some individuals prefer “Latino/a” or “Latinx” in place of Hispanic.)

Racism in the Civil Rights Era

It was not until the 1950s and 1960s that actions in the courts and Congress began to dismantle some of the laws that were part of systemic racism. For example, in 1954, the Supreme Court ruled that segregating people by race in “separate but equal” public schools (and other facilities) was unconstitutional. In 1964, Congress passed the Civil Rights Act that, in addition to prohibiting racial discrimination in employment, banned racial discrimination in restaurants, hotels, and public facilities, such as bathrooms and service stations. But, there was an important qualifier to this law. The law only applied to entities that engaged in interstate commerce or received federal funds. This left plenty of room for racial exclusion to continue. Private medical facilities that did not receive funds from the US government continued to exclude Black patients for several more years.

Because of the 1964 Civil Rights Act and subsequent acts passed in 1968 and 1988 that prohibited racial discrimination in housing and numerous court decisions upholding these laws, there are no longer any statutes in the United States that *explicitly* target the rights of people of

color. But, the spirit of the structural or legal part of systemic racism is not gone. In the 2020s, laws were passed in several states that were clearly intended to restrict the voting rights of Black and other minority voters. Once again, there were laws on the books that were intended to deprive Black Americans of their basic rights.

One major problem in addressing contemporary systemic racism and its consequences for the health of Black Americans is that it is not as blatant and obvious today as it was in the past. Further, it is so ingrained in American society that it may not stand out. As Kareem Abdul-Jabbar, an author and Hall of Fame basketball player, noted, “Racism in America is like dust in the air. It seems invisible – until you let the sun in. Then you see it’s everywhere” [29]. But not everyone sees it. As a result, a substantial portion of White Americans think of racism primarily as a relic of the past, when laws formally restricted the freedom of Black people in almost every aspect of their lives. Indeed, a large number of politicians and their followers have vigorously disputed the notion that systemic racism is real and still a major social problem. They want, for example, to ban classes that taught about racism as it existed in the past and exists today. As of 2023, a total of twenty-three states have passed or are in the process of passing laws that would at least severely restrict the way public schools teach students about racism and/or the history of racism in the United States.

Thus, systemic racism is just as real as it was in our past, but it is often cloaked in socially acceptable forms that do not appear to systematically disadvantage Black people until we pull the curtain back a bit. We offer a few recent examples. The National Football League (NFL) provides us with a clear instance of systemic racism in a large organization. It involves how retired players are compensated for the brain injuries they suffered while they were playing. In 2013, the NFL signed a \$1 billion settlement to compensate players who had suffered brain trauma during their careers in professional football. To determine the level of brain trauma that merited compensation, the NFL used a supposedly race-neutral, “objective” criterion of the amount of decline in a player’s cognitive functioning. But, this objective criterion was different for Black and for White ex-players. The NFL justified this by using a practice called “race norming.” Race norming simply means that separate norms or averages for performance on some tests are created for Black people and White people; in race norming, an individual’s score is only compared to other people of the same race. This was originally done on tests of things such as job skills or intellectual ability because it was believed that socioeconomic hardships or

bias in the test itself could put Black test-takers at an unfair disadvantage. Race norming would correct this.

Even critics agreed that this norming in that context was a well-intentioned idea. But, the NFL used it in a way that made it more difficult for Black, relative to White, ex-football players to receive compensation for their injuries. The criteria for cognitive decline were based on a player's current level of cognitive function compared to cognitive functioning for someone with mild or moderate dementia. But, this left open the question of mild or moderate dementia among which group of people? The NFL used different norms for dementia in Black people and White people, with the assumption that all Black people with dementia would show a substantially lower level of cognitive functioning to be classified as having dementia compared to White people. This virtually assured that the difference between an ex-player's level of cognitive functioning and the norm for their race would be much smaller for Black than White ex-players. As a result, the percentage of Black ex-players' claims that were denied by the NFL was much higher than the percentage for White ex-players. In 2022, after numerous legal challenges, the NFL finally agreed that there was no scientific basis for using such race-based norms and said that it would stop this way of deciding who was eligible for compensation [30]. (We do not know, however, if this agreement will compensate the families of Black ex-players who died of brain injuries before it was reached.) This case illustrates how large institutions may engage in practices that are presented as "fair" and "free of racial bias" but, in fact, are grossly unfair in their consequences for Black people.

Systemic racism also pervades health and healthcare in the United States, but sometimes it is quite subtle and not obviously racist. Consider how a community might decide where to put vaccination centers for COVID-19. In 2020, a National Public Radio (NPR) investigation revealed that, in Dallas, Texas, there were three times as many COVID testing sites in the neighborhoods where the residents were predominantly wealthy and White than in the neighborhoods where the residents were predominantly poor and Black [31]. As the result of this disparity in testing, it appeared that the COVID-19 problem was greater in the wealthy White neighborhoods than in the poor Black neighborhoods, which would very reasonably influence where resources were placed to fight the virus, especially the distribution of vaccines.

While one cannot totally discount some intentionally racist actions being responsible for this kind of health disparity, the NPR investigation concluded that there is no evidence that any city official had intentionally

decided to put fewer testing sites in certain neighborhoods because the residents were Black. Rather, the immediate causes were disparities in socioeconomic status (usually called SES) between the neighborhoods. Usually, wealthy White people can demand and support many more medical services than can poor Black people. Thus, facilities housing these services in the rich, predominantly White neighborhoods quickly became COVID testing sites. As a consequence, there were many more places to test for the coronavirus and thus more reported cases of infections.

However, the situation in Dallas begs the question of *why* the disparity in wealth and power existed in the first place. It is not much of a stretch to tie these things back to the Jim Crow laws that existed in Texas up until 60 years ago and to the institution of slavery in this region before that. So, again, we see that one of the particularly insidious aspects of systemic racism is that there is often no obvious “villain” directly responsible for some current social injustice.

“To the Full Extent of the Law”: Individual and Systemic Racism Intertwined
Although individual and systemic racism are conceptually distinct concepts, in practice, they often operate in consort. One example is the enforcement of laws regarding the questioning and detention of private citizens. The US Constitution says that law enforcement officers can only detain a person if they have reason to believe the person has or is about to commit a crime. But, all 50 states have had some version of stop and frisk laws that permit a police officer to stop and frisk a person without stating a reason. For many of the laws, all that is needed to do this is “reasonable suspicion,” which can be based on the person *looking* suspicious to a police officer. These laws as originally proposed appeared to be a race-neutral way to reduce crime. But, the racial disparities in the actual enforcement of these laws are glaring. Between 2004 and 2012 in New York City, 4.4 million people were detained under this law. Although the Black and Latinx residents of New York City comprised slightly over half of the city’s population, they comprised 83 percent of the people stopped [32]. Because of successful legal challenges to the stop and frisk law in New York City, the number of these actions by the police declined dramatically. By 2017, it was only a fraction of what it had been earlier, but 90 percent of the people stopped were still Black residents of New York City. These patterns are replicated in most other major American cities, such as Boston and Chicago [33, 34].

A multitude of other studies show the impact of a person’s race on how they are treated by the police [35]. Consider traffic stops. Black drivers are

more likely to be stopped than White drivers, but the biggest difference occurs during the daytime when a driver's race can be easily identified; this difference largely disappears at night when it is more difficult to identify the race of a driver [36]. In Florida, Black drivers are twice as likely as White drivers to be pulled over for seat belt violations. In one large Florida city, Black citizens were three times more likely to get tickets for jaywalking. Black suspects stopped by the police are three times more likely to be searched. This occurs even though police are more likely to find drugs on White than Black suspects. Finally, although there is no racial difference in marijuana usage, in 2018, Black people were four times more likely to be arrested for possession of marijuana.

While some of these examples of individual and systemic racism have not directly involved health disparities, they serve to illustrate the pervasive and oppressive nature of both kinds of racism in the United States. Understanding both kinds of racism is critical to an understanding of the large racial disparities in health that exist today.

Racial Health Disparities Today: A Massive Racial Injustice

In this book, we specifically focus on the disparities between the health of groups of people in America who are socially assigned the racial designation of "Black" and people who are socially assigned the racial designation of "White." Thus, we talk about disparities between these two quite large groups, and we use statistics that provide information on *average* disparities in the current frequency (or "incidence") of some disease or the rate at which people die. But, neither Black Americans nor White Americans are a homogenous group; we acknowledge that there is enormous variability among people within either of these groups.

There is a widespread acknowledgment that White Americans represent a "melting pot" of family backgrounds, but it is less widely acknowledged that there is comparable heterogeneity among Americans who are identified as Black. Some Black Americans are the descendants of the enslaved people brought to America centuries ago; others are much more recent immigrants from different countries. These differences are not only in their nativity, heritage, and family histories but also in their particular circumstances, personal experiences, and a variety of other important ways. Thus, when we discuss some racial health disparity, we are not suggesting that all Black Americans are basically the same or are more homogenous than White Americans. To do so would be an echo of past and present racist tropes about Black Americans being indistinguishable. But, despite

this substantial variability, Black Americans do share the same racial designation and the lived experiences associated with this designation. Consequently, as a group, they may experience social, economic, and political circumstances and interpersonal experiences that are different from White Americans as a group. These differences cause racial health disparities [37].

It is generally acknowledged by the Centers for Disease Control and Prevention (CDC) and other government health agencies that racial disparities in health represent a massive public health problem. It exacts an enormous physical, emotional, and social toll on all Americans, but especially Black Americans. Moreover, racial health disparities differ from other public health problems, such as salmonella in the food supply or the outbreak of certain diseases after some natural disaster pollutes the water supply. Unlike these other problems, racial health disparities are a racial injustice that threatens the fundamental right of a healthy and long life for a significant portion of the US population – Black Americans. We label it as a racial injustice because it is caused by anti-Black racism. To be more precise, anti-Black racism leads to three characteristics of modern America that endanger the health of Black Americans. They are (1) widespread racial discrimination that causes physiological and psychological responses that threaten a person's health; (2) racial housing segregation that creates neighborhoods whose residents are predominantly economically disadvantaged Black people; these neighborhoods are under-resourced in terms of the housing and economic opportunities, have a lower quality of life for the residents, and contain numerous threats to the residents' health, including substantial difficulties in the access to and quality of healthcare; and (3) great inequities in the quality of healthcare that is available to and used by Black patients and White patients that create threats to the health of Black people who require medical care.

Healthcare in Black and White

Perhaps the most clearly identifiable examples of racial health disparities are the ways in which Black patients are treated when they seek healthcare. Thus, we begin by presenting some of the experiences of Black people seeking healthcare. Our first informant is Voncile Brown Miller, a Black longtime resident of Detroit, Michigan. She has a long history of involvement in healthcare disparities as a social activist and later as part of a research team that studies racial disparities in the treatment of Black

patients and White patients with cancer. But, she has also encountered some of these disparities firsthand.

In a 2016 interview with a local magazine, she described one of her first experiences with such disparities. In 2008, her brother was hit by a car and was taken to an emergency room. Ms. Miller was there to meet him. The attending physician did not give her brother anything for his pain and did not even bother to clean the wound. Ms. Miller asked the physician why, and the physician replied, "Well, um, he's so drunk right now that he wouldn't even know I'll be doing this." She told the physician that she "worked on health disparities and this is something we address, and I just need to let you know that this is what I am seeing right now. I need you to do your best . . . you can give him a stitch that won't even show a scar. That's what I want you to do." The physician apologized and said that he had been having a "bad day." Ms. Miller doubts that such things would have happened this way had her brother been White. But, this was not the last disturbing encounter with the healthcare system that she had.

In another interview we conducted with her, Ms. Miller told us a different but equally chilling story about a relative who needed heart surgery. The relative was a middle-aged married Black woman. Her primary care physician brought in a prominent heart surgeon to perform the needed surgery. When the surgeon looked at the woman's medical history, he saw that many years earlier she had been an intravenous drug user, a problem she had long since overcome. But, the surgeon told her that he was not going to do the surgery because she had brought her heart problem on herself. He said that he "didn't want to waste his talent" on someone like her. Her physician pleaded with the surgeon to reconsider, and the surgeon reluctantly agreed to perform the operation. However, in the pre-operative consultation, he told the patient, "OK, I'm going to do this, but *you* better not mess this up." The surgery was a success, but the woman's family has never been able to forget the degrading way the surgeon had treated her.

Of course, we do not know for sure whether the uncaring attitude of the emergency room physician in the first example or the surgeon's atrocious behavior in the second one was solely because their patients were Black people. It is possible these physicians would have behaved in the same way even if the patient was White. But, other stories of Black patients' encounters with the healthcare system can make the role of racism in medical treatment clearer.

One of these stories requires that we talk about two racial stereotypes that exist among many healthcare providers. The first is that Black people

feel less pain than White people. This is a myth that most likely has its origins in old racist theories about innate biological differences between Black people and White people that has permeated American medicine for at least 400 years. It was often used by slaveholders as a justification for the physical abuse they inflicted on enslaved Black people. Despite there being no scientific basis for this belief, it persists in modern medicine. As recently as 2016, a group of researchers at the University of Virginia found that about half of the medical students in their study believed that Black people had a greater tolerance for pain than do White people [38].

The second commonly held stereotype among healthcare providers is that Black patients are much more likely to abuse narcotic pain killers than White patients. Thus, healthcare providers generally are less likely to prescribe these drugs to Black patients than White patients; this is true even when the Black patients are children [39]. These two racial stereotypes came together to dramatically affect the life of Lisa Craig [40].

Ms. Craig is a middle-aged Black woman who suffers from sickle cell disease. Sickle cell disease is much more common among Black Americans than White Americans. It is caused by a mutation in a single gene that results in a person's blood cells being shaped like a sickle rather than being round. This makes it more difficult for the sickle cell to carry blood through the body, and this causes severe chronic pain. Over the years, Ms. Craig's attempts to find relief from her debilitating pain have exposed her to both of the racist stereotypes.

On numerous occasions Ms. Craig has gone to emergency rooms because her pain has become unbearable. When she arrives, however, she is very often told that her pain cannot really be that bad, and she is sent home without any pain killers. Why would the emergency room staff do that? There are no objective ways to measure pain. Thus, the only information a staff member has is what a patient tells them, and they have to evaluate that information. In Ms. Craig's case, it appears they believed that the pain or at least the discomfort it was causing was much less than Ms. Craig said it was. It seems quite possible that the emergency room staff relied, perhaps even nonconsciously, on the racial stereotype about Black people's greater tolerance for pain.

Ms. Craig had never abused narcotic pain killers but, when the opioid crisis hit, the second racial stereotype seemed to have kicked in.¹¹ Her physicians became suspicious of her many requests for pain killers and

¹¹ The opioid crisis began in the 1990s when, with the considerable support and encouragement of large pharmaceutical companies, many physicians began to seriously over-prescribe narcotic opioid

usually denied them. As one physician said to Ms. Craig, “So really I don’t have any justification why you should have pain”; he refused to provide any narcotic pain killers. He justified his actions by saying he might be “red-flagged” and asked by authorities to justify prescribing these drugs, when he only had Ms. Craig’s report to go on. This is a remarkable statement because, as we just noted, there is really no way to assess a patient’s pain other than the patient’s self-report. But, he claimed to be worried that drug enforcement officials might think that he was just helping an addict get some drugs. Ms. Craig replied, “You don’t understand [my pain] because you don’t have the disease. And, you’re not one that they look at and go, ‘Oh she’s just exaggerating her pain,’ when I want to saw my own freaking legs off.” Her pain from sickle cell disease has never been effectively treated.

These kinds of stories serve to illustrate the types of medical inequities many Black patients and their families continue to confront. But, they are only part of the much broader problem of racial health disparities.

A Portrait of Health in Americas: Separate and Unequal

The system for gathering statistics on the overall health of Americans is pretty simple and straightforward. Health departments in cities, counties, or other geographic areas gather data on the incidence of diseases and mortality from the local healthcare systems and other sources (e.g., county coroners) in their areas. They compile these data and send to “reporting jurisdictions” who collate these data and send them on to the CDC. The CDC collects these various reports and provides weekly summaries of the incidences of “morbidity” (i.e., diseases) and “mortality” (i.e., deaths) and annual summaries of these and various other aspects of Americans’ health. The National Vital Statistics Center of the CDC has been keeping such health records since 1915. It and other similar public health records document the significant health disparities between Black Americans and White Americans for at least the last 100 years.

The most direct way to illustrate the extent of these health disparities between Black Americans and White Americans is to use the data in these health reports to compute ratios that reflect these disparities. One such

pain killers to their patients. In many instances, there was no medical reason for giving a patient these drugs, but many physicians and especially the companies became very rich from the illicit provision of them to basically any patient who requested them. As a result, many people died of opioid overdoses. An excellent book on this is *Dopesick: Dealers, Doctors, and the Drug Company That Addicted America* by Beth Macy.

ratio compares the “incidence rate” of an outcome (or condition or disease) for the two groups. An incidence rate represents the number of people per some number (e.g., 100,000) who have a certain disease at some specified point in time (e.g., the number of people per 100,000 who had a COVID-19 infection in 2022). The disparity ratio is usually computed by dividing the rate for Black Americans by the rate for White Americans. A ratio of 1.0 would indicate that the health problem occurs at the same rate for Black Americans compared to White Americans. A ratio of 2.0 would show that the condition occurs much more frequently for Black Americans – specifically, it occurs twice as often for Black Americans compared to White Americans. The same kind of ratio can also be computed for mortality rates – the number of people per 100,000 who die from any cause within some specified period of time. We use these ratios as we discuss contemporary health disparities.

Specific Health Disparities

The United States has a higher infant mortality rate (the number of children born during a specific year who die before they reach the age of one) than 33 other industrialized countries. Embedded in this disturbing statistic are large racial health disparities [41, 42]. From the moment they are born, Black children are at a greater risk of dying than White children. Their mortality rate is over twice as high. This disparity exists for neonates (less than 28 days) and for babies between the ages of 28 days after birth and one year. Remarkably, although health statistics show that infant mortality rates have declined quite dramatically in the last 100 years, this disparity in mortality rates (2.0) is actually the same as it was 1915. This disparity is actually greater than was the disparity in infant mortality rates that existed between Black women who were enslaved and White women over 160 years ago (1.6). Currently, Black mothers are also twice as likely as White mothers to have a “stillbirth,” a fetus dying while still in the womb.

The risks during childbirth are not only greater for Black children than for White children but also for their birthing parents. In 2020, Black women were about three times more likely to die during childbirth than were White women [43]. This likely contributes to the fact that the United States has a higher maternal mortality rate than 11 other of the most developed countries [44].

The role of long-term exposure to systemic racism in these disparities is suggested by another study. Dr. Tiffany Green, professor of population health sciences and obstetrics and gynecology at the University of

Wisconsin–Madison, and Dr. Tod Hamilton, professor of sociology at Princeton University, compared infant mortality rates for Black women born in the United States with Black women who were recent immigrants to the country [45]. The infant mortality rate was 1.5 times greater among the native-born Black women. This disparity was greatest among the women who had the lowest levels of education. It may reflect the cumulative effects of being disadvantaged in the United States.

Disparities in how long White people and Black people live on average represent another example of racial health disparities. But, because of the COVID-19 pandemic and a sudden increase in mortality rates, a discussion of past and present racial disparities in Americans' life expectancies and mortality rates becomes a bit more complicated. Before 2020, the health trends for all Americans across the years were quite constant. If one wanted to compare disparities in Black Americans' and White Americans' life expectancies from, say, 1900 to "now," it really did not make much difference if they used data from 2017, 2018, or 2019 as "now." But, in 2020, there was a quantum shift in life expectancy and mortality rates from these previous years. The CDC data from 2020 showed that the trend of 100 years of longer life expectancies and lower mortality rates for all Americans abruptly stopped in 2020. So, we separately discuss racial disparities before 2020 and what we know about these disparities that year and after.¹²

Before 2020 (the first full year of the COVID-19 pandemic), the average American's life expectancy at the time of birth was almost twice as long as it was in 1900. This reflects the improvements in medical care and the development of new drugs to treat many diseases that occurred during this time period. Racial disparities in life expectancy have also declined dramatically from the early twentieth century, when Black Americans' life expectancy was almost 15 years less than the life expectancy for White Americans. The disparity has significantly closed over the years, but it has never gone away. In 2018, Black Americans' life expectancy at birth was still about 3.5 years less than that of White Americans. This disparity was a bit more for men (4.2 years) than for women (2.8 years). Also, the size of the disparity became somewhat smaller as people get older. For example, at age 65, the racial disparity in life expectancy was 1.6 years for men and just less than one year for women [46].

¹² The CDC's final reports on the nation's health usually present data from one to two years before the date of the report. Throughout the book, we discuss the most recent data we can locate. Usually this is for 2020 or 2021.

COVID-19 reduced the life expectancies of all Americans over the first two years of the pandemic. The COVID-19 pandemic also significantly increased the racial disparities in life expectancies. From 2019 to 2021, the overall average life expectancy for White Americans declined by slightly more than one year. Among Black Americans, the average life expectancy was about 4.0 years shorter, and Black people's life expectancy was the lowest it had been since 2000. Most public health officials believe this increased racial disparity in life expectancy will continue well after 2021 [47].

Closely related to disparities in life expectancies are disparities in mortality rates. The mortality rate is the number of people per 100,000 in the United States who die in a given year from any cause. The vast majority of deaths in the United States are due to diseases. Before the pandemic, the annual mortality rate in the United States due to diseases was roughly half of what it was in 1950. But, of course, our interest is in racial health disparities. Despite the dramatic decline in the mortality rates for both Black Americans and White Americans, disparities in the mortality rate between them have not changed much over time. The racial disparity ratio in mortality 70 years ago was 1.22 (or 22 percent higher for Black Americans than for White Americans). In 2019, the year before the pandemic, the disparity ratio was about 1.20, a trivial decline from 70 years earlier. The racial disparity ratio in mortality was greatest among Black Americans and White Americans between 35 and 49 years of age (1.41 or 40 percent higher for Black Americans than for White Americans). So, again, we see that there are more years of potential life lost among Black Americans than White Americans [48]. Data for the first 11 months of 2020, the first year of the COVID-19 pandemic, indicated that the overall increase in mortality rates across all races and ethnicities was about 16 percent. The racial disparity in mortality rates increased from the previous year to 1.33 – the mortality rate among Black Americans was 33 percent higher than among White Americans [49].

Disease and Mortality

Looking for historical trends in disparities in the incidence of diseases other than COVID-19 is also difficult, but for different reasons than life expectancy or mortality rates. The kinds of diseases that killed people in the past are very different from those of the present. Seventy years ago, before the existence of flu vaccines and the widespread usage (perhaps over-usage) of antibiotics, influenza and pneumonia were among the four

leading causes of people's death. Today, they are not even among the top eight.

Heart disease, cancer, cardiovascular diseases (e.g., strokes), diabetes, and asthma are among the most common causes of death in the United States today. Black Americans are more likely than White Americans to die from all of these diseases. The disparity in mortality rates ranges from 1.10 for cancer to about 3.0 for asthma [50]. The only two main exceptions to this pattern of health disparities are with respiratory diseases (i.e., diseases of the lungs) and Alzheimer's disease; White Americans are more likely to die than Black Americans from these diseases. The complete data on the direct effects of COVID-19 on mortality rates will likely not be available before this book is published. But, as noted earlier, from the beginning of the pandemic until August 2022, twice as many Black Americans had died from COVID-19 infections as did White Americans [51].

Are these kinds of disparities in mortality primarily because Black Americans are more likely to have these life-threatening diseases than White Americans? Data on racial disparities in cancer incidence rates versus mortality rates suggest that this usually is not the reason. Cancer is the second leading disease-related cause of death in the United States, ranking just behind heart disease. It is expected that about 600,000 Americans will die from cancer each year [52]. There is no single type of cancer. Rather, cancers are presently classified by the part of the body they primarily attack, such as pancreatic cancer, prostate cancer, or lung cancer. One of the most common cancers is breast cancer. It is, by far, the leading cause of cancer-related deaths among women in the United States.

The incidence rate for breast cancer among Black women is actually slightly lower than among White women, although that gap appears to have narrowed in recent years. Our interest here, however, is in how these racial disparities in incidence rates compare to racial disparities in mortality rates from breast cancer. According to the 2022 report from the American Cancer Society, despite the lower incidence rate, the mortality rate among Black women is almost 40 percent higher than the mortality rate among White women (28 deaths per 100,00 versus 20 deaths per 100,000) [52]. That is, even though Black women are less likely than White women to develop breast cancer, they are much more likely than White women to die from it. The disparities in mortality rates also far exceed the difference in incidence rates for other diseases that are major causes of mortality (e.g., strokes, diabetes, and asthma). This kind of disparity exists for heart disease, too, but it is a much smaller disparity compared to these other diseases [53, 54].

Explanations for Racial Disparities in Health

We have described *what* the problem is – widespread racial health disparities between Black Americans and White Americans that have persisted across the history of the country. Our core thesis is that anti-Black racism creates the conditions that lead to these disparities. But, other explanations have been offered as well.

Socioeconomic Disparities and Health

One explanation of racial health disparities that enjoys considerable support in lay and academic circles proposes that racial health disparities are primarily due to racial disparities in socioeconomic status (SES) rather than individual or systemic anti-Black racism.¹³

To be sure, SES, and especially income, is strongly associated with a person's health: The higher a person's SES, the healthier the individual tends to be. The average SES of Black Americans is substantially lower than that of White Americans. The median annual family income for Black Americans is about \$30,000 less than that for White Americans; the average net worth of a Black family is about 10 percent of what it is for a White family (about \$17,000 versus \$170,000) [55]. The average level of educational achievement is also lower for Black Americans than for White Americans [56]. For example, the percentage of Black Americans who complete high school is about 10 percent less than for White Americans.

At first glance, disparities in SES present themselves as a reasonable alternative to anti-Black racism as an explanation of racial health disparities. One strategy to test this idea and separate SES from race as a cause of health disparities is to statistically divide people into different levels of SES. Then, the health of Black people and White people within the same level of SES is compared. The logic of such comparisons is this: If a racial health disparity disappears when one compares the health of Black people and White people who are equal in their SES, then SES rather than anti-Black racism, *per se*, provides a better explanation of that racial health disparity. But, if the health disparity is still present, people's racial identity plays a significant role in it.

Studies that examine racial disparities while statistically controlling for SES generally find that the magnitude of racial health disparities within a given level of SES becomes smaller; however, racial health disparities still

¹³ A person's SES is generally based on three factors: their income, the highest level of education they completed, and the status of their occupation.

remain. Also, there are some health disparities that do not get smaller even after controlling for SES. Thus, there is something causing racial health disparities beyond a person's SES. We can see evidence of this in what Americans tell us about their health. In their annual assessments of Americans' health, governmental agencies, like the CDC, conduct interviews with a randomly selected number of US households. Among the questions they ask is, "Would you say your health is excellent, good, or fair, or poor?" We are going to focus on the "fair or poor" category. In the CDC's report, "Health United States 2020-2021" (the most recent report available at the time this book was being written), about 10 percent of the Americans interviewed answered that their health was only fair or poor [48]. People's SES clearly affected how they felt about their health. Whereas 25 percent of the people whose annual income fell below the federal poverty level said their health was fair or poor; only five percent of people whose income was 400 percent greater than this level gave this response. Race had a similar effect; whereas about 16 percent of Black Americans said they were in fair or poor health, only about 10 percent of White Americans gave this answer.

But, our interest here, again, is in disparities between the responses of Black people and White people who earned roughly the same amount of money. These are presented in Figure I.1. It shows the percentage of Black people and White people at different levels of family annual income who reported their health was only "fair or poor." Black people whose income was between 100 percent and 199 percent of the poverty level were slightly less likely to report their health was fair or poor than White people at this income level. However, at all the other income levels Black people reported poorer health than White people. For people whose annual income was below the poverty level (far left side of the figure), the percentage was about 28 percent for Black people versus about 24 percent for White people – a racial *disparity* of 16 percent. But, now look at the far-right side of the figure; it shows the racial disparity in self-reports of health among people whose income was at least 400 times greater than those at the poverty level. The percentage of Black people who reported poor or fair health was 7.5 percent, much smaller than for poorer Black people, but it was almost one and a half times high as the 5.0 percent for the White people at this same income level. The racial disparity in people's reports about their health was much greater among the wealthiest people than among the poorest people.

More evidence that being well-off financially not only fails to eliminate but also can magnify racial disparities in health comes from a study with

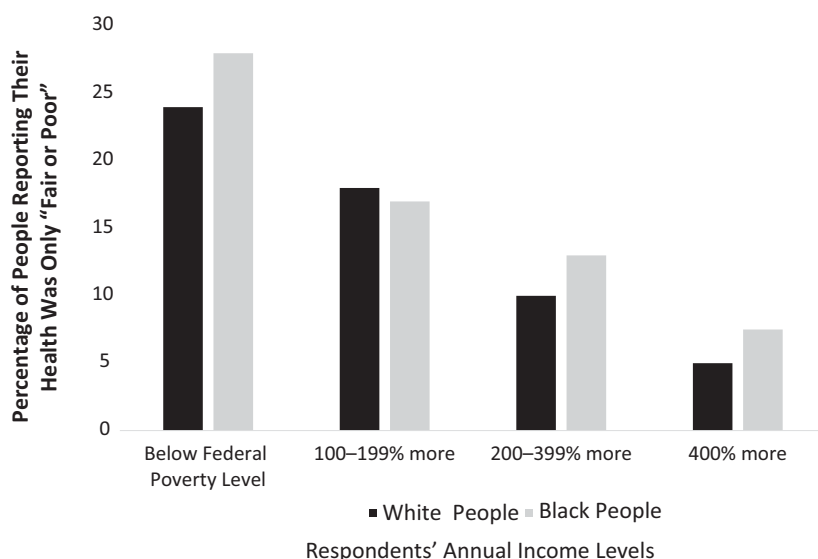


Figure I.1 Income and health status: The percentage of Black people and White people at four annual income levels who report their health to be only “fair or poor.” For both groups, higher income is associated with better health status, but substantial racial health disparities remain even at the highest income levels.

Source: CDC Health United States 2020-2021 www.cdc.gov/nchs/data/hsu/2020-2021/Hstat.pdf

some atypical participants. This study compared the health of a sample of very high-income Black Americans and White Americans. These were people who made over \$175,000 per year, or about three times what the typical American makes. In a survey, they were asked whether they had been diagnosed by a physician as having hypertension (i.e., high blood pressure), diabetes, or high cholesterol, and about their overall physical and mental health. The high-income Black people were much more likely than the high-income White people to report that they had all three diseases and to describe their overall health as poor [57]. Thus, even among people who have the financial means to get the best health insurance and health-care, there is still evidence of the pervasive disparities in the health of Black Americans and White Americans.

Another component of SES that has been theorized to impact people’s health is education. And, like overall SES, educational level predicts certain health-related outcomes. One example of this is infant mortality rates. The better educated a mother is, the less likely her infant will die during the first year after birth. This may suggest that education serves as a

“protector” against losing an infant in the first year of life. This is, in part, because more educated mothers may start prenatal care earlier and engage in fewer behaviors that would jeopardize the health of the fetus (smoking, for example) than less educated mothers. But, there is also a racial health disparity hiding in this relationship.

In the same study we presented earlier, Dr. Tiffany Green and Dr. Tod Hamilton used data from the National Center for Health Statistics to also look at the impact of education on infant mortality among children who survived more than 28 days after birth (post-neonatal) [40]. They examined data from 13 million Black mothers and White mothers. Among White mothers, their level of education had a strong impact on infant mortality; the mortality rate per live 100,000 births for White mothers who did not complete high school was almost five times as great as among White mothers who had a college degree. There was also an association between education and infant mortality among Black mothers, but it was not nearly as strong. The disparity ratio for infant mortality between the least and most educated Black mothers was less than three, or about half of what it was for White mothers. Perhaps most strikingly, the infant mortality among Black mothers with a college degree was greater than among White mothers who did not finish high school. In sum, a mother’s education is a much weaker “protector” of Black infants than of White infants. The conclusion from this and other studies is that higher SES often does not produce the same health-protective benefits for Black Americans as it does for White Americans.

Still, it is true that the studies that statistically equate SES of Black people and White people do show a reduction in health disparities; SES disparities thus cannot be ignored in discussions of racial health disparities. But, studies that statistically equate Black people and White people on things like income must be put in context. A study that statistically places Black people and White people at the same SES levels has created an artificial world that does not exist. As already discussed, in the real world, Black Americans’ SES is substantially lower than the SES of White Americans. So, dismissing racial health disparities as simply due to the effects of SES disparities is really ignoring the harsh realities of how the racial SES disparities that actually exist create substantial health disparities.

Further, attributing some portion of racial health disparities to disparities in the components of SES misses a larger point. Racial disparities in economic status, educational level, and occupational status did not just

happen. Anti-Black racism created and then sustained these large societal inequities. To be sure, many of the formal and legal barriers to social and economic mobility for Black Americans that once existed are gone. But, their legacies and contemporary individual and systemic racism still lead to substantial economic challenges for Black Americans. We discuss this legacy of past racism in more detail in Chapter 3. In sum, SES is one consequence of anti-Black racism that serves as a proximal cause of racial health disparities. This book reviews this and the other pathways from anti-Black racism to racial health disparities.

Putting It All Together

The dramatic racial disparities in infection and mortality rates over the course of the COVID-19 pandemic are really only the latest chapter in a very long story of large racial disparities in the health of Americans. Poorer health among Black people (and many other racial/ethnic minorities) predates the founding of the United States and, despite the dramatic improvements in the health of all Americans over the last century, this racial health disparity is still glaringly present.

For far too long a time, the most influential explanation of the disparities in the health of Black people versus White people posited that Black people are more likely to get sick and to die simply because of inherited biological and genetic defects. That is, the Black “race” was inferior to the White “race.” We acknowledge that there, of course, are biological and genetic causes of health problems. However, race is a social construct used to identify groups of people and has no biological foundation or meaning. The actual genetic differences between people identified as Black or White are miniscule. Like all intergroup disparities that place minorities at disadvantage, health disparities are primarily due to political, economic, and social factors.

It would be far beyond foolish to propose a simple, unitary cause for all racial health disparities, but the evidence for individual and systemic racism as two of the most powerful causes is overwhelming. Anti-Black racism offers a far better explanation of why Black Americans are so much less healthy than White Americans than any pseudo-scientific genetic explanations or overly simplistic ones based solely on SES disparities between Black Americans and White Americans. Our task in this book is to present the empirical evidence that supports our position and describe the different ways in which anti-Black racism endangers the health of Black Americans.

What Lies Ahead: An Overview of the Chapters That Follow

In the remaining seven chapters in this book, we describe the current state of scientific knowledge and theories relevant to racial disparities in health and healthcare. In Chapter 1, we discuss the reasons for the persistent presence of anti-Black racism. The first part of discussion is about the historical roots of racism within the United States and its impact on current social and economic racial inequities and the content of many of today's racial stereotypes. The chapter then considers how the intellectual capabilities of human beings make it quite likely that they will develop negative thoughts and feelings about people who look, think, or act differently from them. Later chapters show that anti-Black thoughts, feelings, and actions are directly and indirectly responsible for the pervasive and substantial racial disparities in health and healthcare.

In Chapter 2, we describe the deleterious health effects of exposure to racial discrimination. We discuss the pervasive nature of racial discrimination in the United States and the extent to which it intrudes on the day-to-day lives of Black Americans. We then present evidence of a causal link between experiencing racial discrimination and the health problems experienced by many Black Americans. In this causal process, consistent exposure to racial discrimination produces high levels of chronic stress in Black people in the United States. This stress, in turn, has physical and psychological effects that put Black people at dramatically increased risk for a wide variety of diseases and even premature mortality.

In Chapter 3, we consider the health consequences of residential racial segregation. We first examine the ways in which systemic racism produced public and private policies and practices that dictated where Black Americans could and could not live. Usually, the places where they could live were undesirable locations with few natural resources and isolated from surrounding communities. Then, we discuss the current health dangers contained in these neighborhoods. They range from high levels of environmental toxins to the inadequate amount of healthcare available in many of America's under-resourced, Black neighborhoods.

In Chapter 4, we review the long and shameful history of anti-Black racism in the practice of medicine in the United States. This includes the formal and informal policies that greatly restricted Black people's access to medical care and the horrific medical experiments conducted on Black people as subjects through coercion and/or deception. Other policies enacted by professional organizations greatly reduced the number of Black people in healthcare professions. This racist past in medicine

continues to affect how non-Black physicians and their Black patients feel about and act toward one another.¹⁴

In Chapter 5, we discuss contemporary racial disparities in the quality of healthcare received by Black patients and White patients. Chapter 5 concerns the way healthcare is financed and structured in the United States, which causes large racial disparities in the quality of healthcare patients receive. Because healthcare in America is not a single-payer system that covers the medical expenses of all citizens, the quality of healthcare provided to Black Americans is directly affected by the broad political, economic, and social inequities created by systemic racism. Systemic racism within the healthcare system also creates policies and practices that further disadvantage Black patients. These include educational and institutional practices that result in a dearth of Black physicians and the widespread use of supposedly race-neutral diagnostic algorithms that, in fact, disadvantage Black patients.

In Chapter 6, we first document the pervasive disparities in the medical treatments received by Black patients and White patients who have the same diseases. Then, we discuss how race relations in the United States and the race-related thoughts, feelings, and actions of healthcare professionals and their patients may contribute to these kinds of racial disparities in healthcare. The discussion includes the impact of racial bias among non-Black physicians on how they interact with their Black patients and the patients' responses to this. In addition, we consider how past and present racial disparities in healthcare create mistrust among Black patients, with implications for the kind of healthcare they receive.

In Chapter 7, we present a number of interventions that might significantly reduce racial health disparities. These proposals largely parallel the causes of the disparities presented in the earlier chapters. Some of them involve significant changes and innovations in broad public policies that could reduce the breadth and depth of some racial disparities. Others focus on specific changes directed at the healthcare system and healthcare

¹⁴ We use the term "non-Black" to describe physicians who do not identify as Black or African American because a significant minority of the physicians in the United States may be Asian (especially South Asia) or Middle Eastern. Thus far, research has not found that such racial and ethnic differences among non-Black physicians produce differences in how they treat their Black patients or how the patients react to them. However, it is possible that subsequent research could identify such differences.

professionals that could eventually mitigate differences in the quality of care that Black Americans and White Americans receive. We harbor no illusions about the potential difficulties of implementing the changes we propose. Nevertheless, there is a moral imperative that we try to address these unfair and pernicious racial health disparities.

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