

The Past, Present, and Future of Racial Health Disparities in the United States: A Report

Michael Esposito, University of Minnesota; Washington University in St. Louis

Nick Graetz, Princeton University

Margaret Hicken, University of Michigan

Hedwig Lee, Duke University; Washington University in St. Louis

Uncovering Inequality, the Ira A. Lipman Center for Journalism and Civil and Human Rights

December 2022

Section 1: Introduction

Throughout the devastation of the COVID-19 pandemic, Black Americans have suffered more than white Americans. They have been more likely to sicken, more likely to die ([Hooper et al. 2020](#)).

But this is only the latest chapter in the long, long story of unequal risk to premature death and disease in the United States.

Black-white inequality in nearly every form of sickness and death has been observed for decades, as long as we have monitored population health. As the former U.S. Surgeon General David Satcher suggests, racial disparities emerging from seemingly unrelated historical moments, such as Hurricane Katrina and COVID-19, stem from the same fundamental source: At its core, this is a story about racial power imbalance made natural by American culture.

Cultural ideology sets the stage by dictating whose lives are more valuable than others and, by extension, whose are expendable in a quest for social and economic advancement ([Mills 1997](#); [Mbembe 2019](#); [Hicken et al 2021](#)). In other words, our underlying culture addresses the silent question, *whose life counts?* – and the answer has always been deeply entwined with race.

As humanist Henry Giroux writes ([2006](#)), “The category ‘waste’ includes no longer simply material goods but also human beings. ... Defined primarily through the combined discourses of character, personal responsibility, and cultural homogeneity, entire populations expelled from the benefits of the marketplace are reified as products without any value, to be disposed of....”

Because American culture has integrated race into its calculus on the value of human lives, it is Black and brown bodies that have been historically situated in Giroux’s rhetorical category of American “waste” – and those who have suffered the consequences of being so labeled.

If American culture dictates an answer to the question “*whose life counts?*”, our social structure is the way the answer plays out -- sometimes in complicated ways, but almost always in ways that devalue the lives of people of color.

Take, for example, our criminal justice system. It may seem to operate in a silo. But as sociologist Loic Wacquant argues in [Deadly Symbiosis](#), to understand mass imprisonment, we must pay attention to the relationship between racially segregated, under-resourced neighborhoods and the prison system. Both are products of a long history of racial violence but are also bound to one another in service of maintaining racial control, pushing Black people to the margins. Cities and private organizations operate to invest in certain neighborhoods and pull back from others, leaving working-class Black families living in neglected and over-polluted areas ([Purifoy and Seamster 2021](#); [Pulido 2017](#)).

Wacquant describes these neighborhoods as prisons; meanwhile, penitentiaries operate as segregated, under-resourced neighborhoods. These two institutions have historically operated together to control Black families, ultimately resulting in long-standing racial disparities in premature death.

Social institutions are symbiotic and connected -- alter one, and the others change their policies and practices ([Wacquant 2001](#)). So, when we attempt to steer toward equity in one institution, other institutions move to re-enforce the underlying assumption that Black and brown lives are marginal ([Alexander 2010](#), [Blackmon 2008](#), [Roberts 2001](#)). This does not – as we discuss below – suggest that concentrated efforts to make changes within one system (e.g., social movements demanding racial equality in political institutions) are entirely ineffectual for dismantling broader disparities. Rather, we contend that until we intervene on the underlying racist ideology motivating nearly *all* institutions to place a premium on white over Black lives, long-standing inequalities in health will continue.

Structurally racist institutions, policies, and practices appear neutral and rational because it is commonly understood that some lives have less value than others. That belief in “*whose lives matter?*”, along with a faith in meritocracy, prevents Americans from seeing the process that generates persistent inequity in our nation. Mills states that “The Racial Contract prescribes for its signatories an inverted epistemology, an epistemology of ignorance, a particular pattern of localized and global cognitive dysfunctions (which are psychologically and socially functional), producing the ironic outcome that whites will in general be unable to understand the world they themselves have made” ([p.18](#)). This self-delusion is not accidental; it’s an integral part of the system.

In this report, our goal is *not* to articulate every institution, actor, or discrete process that has participated in the production of racial health disparities, in some form or another, throughout history. Instead, our aim is to highlight the deep persistence of racial health inequality in the U.S., as well as introduce a generalized framework for understanding how this disparity has

managed to reproduce itself over *decades* of technological and societal change. In particular, we proceed:

- First, by documenting health outcomes over a century of change in the United States, demonstrating that Black-white inequalities in illness and disease are not new, but instead are persistent and reproduced across eras.
- Then, a look at ways in which racial power and political and economic power operate together across institutions – among them, the education system, the criminal justice system, the housing and job markets – to create, maintain, and amplify health disparities, even as the health of the population overall has improved.
- We show that explanations for racial health disparities based upon assumed genetic and biological differences between the races are inadequate and reflect racism in and of themselves. And we demonstrate that technological medical advances often amplify health inequalities within a landscape where social systems are fundamentally unequal.
- To be sure, these systems of power and knowledge production have always been contested. Therefore, we also focus on the Black public sphere (e.g., scholars marginalized from university-based researchers at historically white institutions, such as W.E.B. Dubois, and social movements) as a constant source of antiracist knowledge production, where health inequities were first understood, discussed, and protested.

The upshot: Until we address the root power imbalances and racist social relations that fundamentally drive welfare, Black people as a class will not enjoy the healthy and long lives that white people often can take for granted.

Describing Black-White Health Disparities

Black and brown populations have historically experienced worse health than their white contemporaries. The exact expression of this inequality has been recast over time, bending itself around innovations in medical technology and new, predominant forms of illness and disease. Here we document Black-white disparities in key health indicators over time, using data spanning a century of societal change to demonstrate how this inequality persists.

Mortality-related outcomes

Life expectancy provides a clear illustration of how racial disparities in U.S. health have persisted over a century of social and technological change. Figure 1, adapted from [Wrigley-Field \(2020\)](#), demonstrates life expectancy at birth among Black and white populations between the years 1900 and 2017. Figure 2 presents the difference between Black and white life expectancies at birth within this same period.

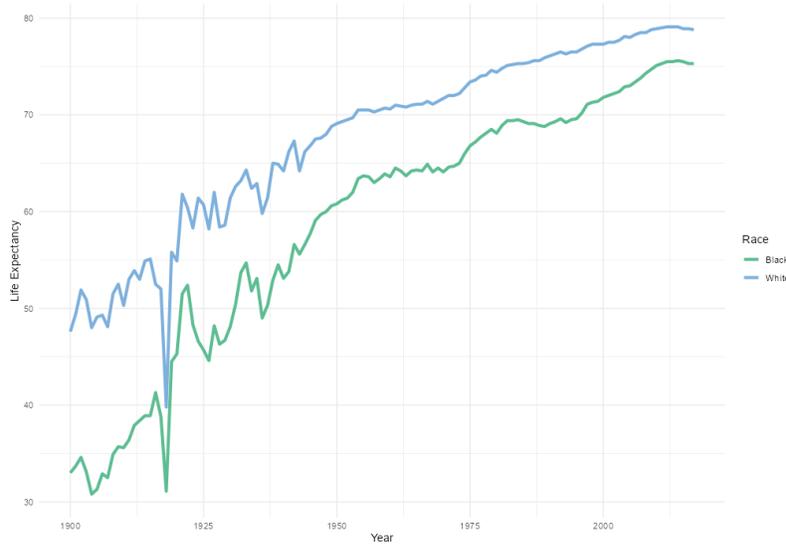


Figure 1. Life expectancy at birth, Black and white Americans, 1900-2017. *Note:* figure is recreated from data provided in Wrigley-Field (2020).



Figure 2. Difference in life expectancy at birth between white and Black Americans, 1900 - 2017. *Note:* figure is recreated from data provided in Wrigley-Field (2020).

As an alternative indicator of the persistent mortality burden experienced by Black populations, Figure 3 plots trends in *excess deaths* for Black Americans across the 20th century (Jackman and Shauman 2020). Note that, here, “excess deaths” refer to the percentage of deaths that *did* occur among Black Americans within a period that, hypothetically, would have been avoided had mortality rates among Black and white populations been equal to one another.

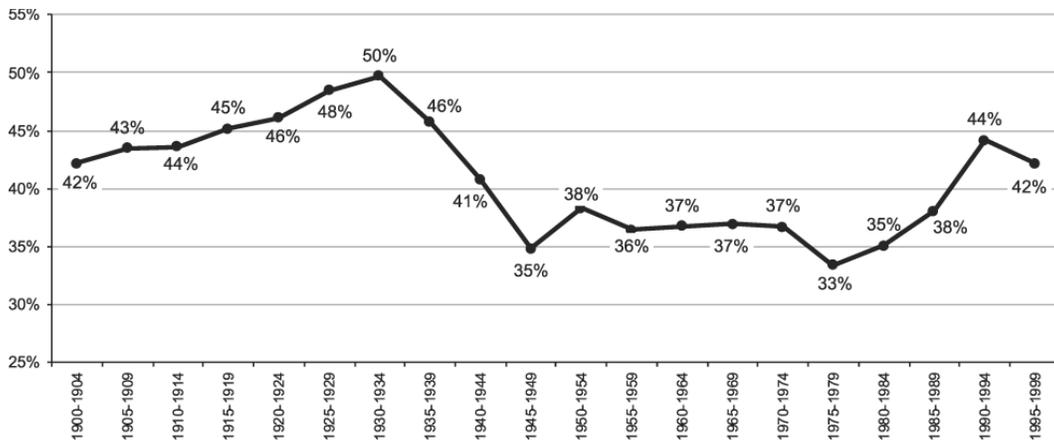


Figure 3. Percentage of total observed deaths that were excess for Black Americans, aged 0-79, across time. *Note:* Figure is adapted from Jackman and Shauman (2020).

Across morality indicators, the pattern is clear: Black Americans bearing a heavy load of premature death is not just a new phenomenon that emerged only in specific historical moments, such as the COVID-19 pandemic.

To be sure, this disparity has trended downward in the aftermath of slavery. Still, at any given point within the past 120 years, white populations have generally had a greater chance of living long and healthy lives than Black populations.

Consider that in 1900, Black Americans had significantly shorter life expectancies than white Americans; Black individuals could be expected to live about 33 years, while white individuals could be expected to live nearly 15 years longer. As the scholar [W.E.B Du Bois \(1899\)](#) argued, this great disparity stemmed not from (fictional) genetic differences between the two populations, but rather from the conditions to which Black Americans were subjected at the time.

Indeed, though the harsh and violent realities of slavery were no more (e.g., [Kyeré 2020](#)), living conditions of Black Americans at the start of the 20th century often bred illness and disease. Black communities were routinely segregated into neighborhoods that lacked sanitary environmental conditions and housing offering things like proper ventilation or protection from the cold – all of which lead to considerably shortened lives ([Roberts 2009](#); [Williams and Sternthal 2010](#); [White et. al. 2021](#)).

Over the decades, life expectancy improved among all populations within the U.S. Advances to medical technology and concentrated public health initiatives (for example, improved sanitation infrastructure, mass vaccinations campaigns and the development of antibiotics) allowed the state to rein in exposure to -- and death from -- diseases that once terrorized the country ([CDC 1999](#); [Feigenbaum et. al. 2018](#)). And yet, in the face of these sweeping, foundational changes to

the national landscape of health and well-being, white people continued to live longer than Black people.

For instance, despite steady, universal improvements to life expectancy between 1950 and 2000, white life expectancy was consistently five to eight years longer than Black life expectancy within any given year. Even today, against a backdrop of medical technology that offers unprecedented control over disease, Black Americans tend to live 3.6 fewer years than white Americans ([Schwandt et al. 2021](#)). Though that's a quarter of the gap at the beginning of the 20th century, it's still a chasm.

But historical trends in the national Black-white life-expectancy gap mask significant variation in progress in areas such as gender, class, and geography:

- Between 1990 and 2009, for example, the gap increased for men in Alaska, Hawaii, Maine, New Hampshire, Wisconsin and Washington, D.C. ([Harper et al. 2014](#)).
- In 2009, the racial life-expectancy gap among men and women in D.C. (where roughly half of residents are Black) was 14.7 and 10.6 years, respectively -- twice that of the second most unequal state, Wisconsin. By 2016, the gap between white and Black men in D.C. increased to 17.2 years. The leading cause of this disparity? Heart disease ([Roberts et al. 2020](#)).
- The Black-white gap has radically changed in specific places affected by specific public health crises. For example, the HIV/AIDS epidemic in New York City contributed to widening the national Black-white life-expectancy gap, and progress in disease control subsequently helped to close the gap ([Elo et al. 2014](#)).
- And recent studies have demonstrated that the COVID-19 pandemic has massively widened Black-white life-expectancy gaps again: The impact on life expectancy has been three times higher for Blacks than for whites, erasing more than 10 years of progress in closing the national gap ([Andrasfay & Goldman 2021](#)).

Beyond trends in expected length of life over the 20th century, race(ism) has featured in shifts in the health conditions that cause death among Americans. For example, Figure 4, adapted from [Hahn et al. \(2018\)](#), displays age-adjusted death rates – the number of individuals per 100,000 people who died of a given cause within a particular year – for women of different populations, beginning in 1900.¹ Figure 5, adapted from [Jones et al. \(2020\)](#), similarly displays age-adjusted death rates for men over the same time span.

¹ Note that, as described in Hahn et al. (2018), comprehensive cause-of-death data specific to the U.S. Black population became available beginning in 1970. The otherwise fraught category “Nonwhite” links trends among several racialized groups to summarize disparities prior to this point in time; see Hahn et al. (2018) and Jones et al. (2020) for additional information.

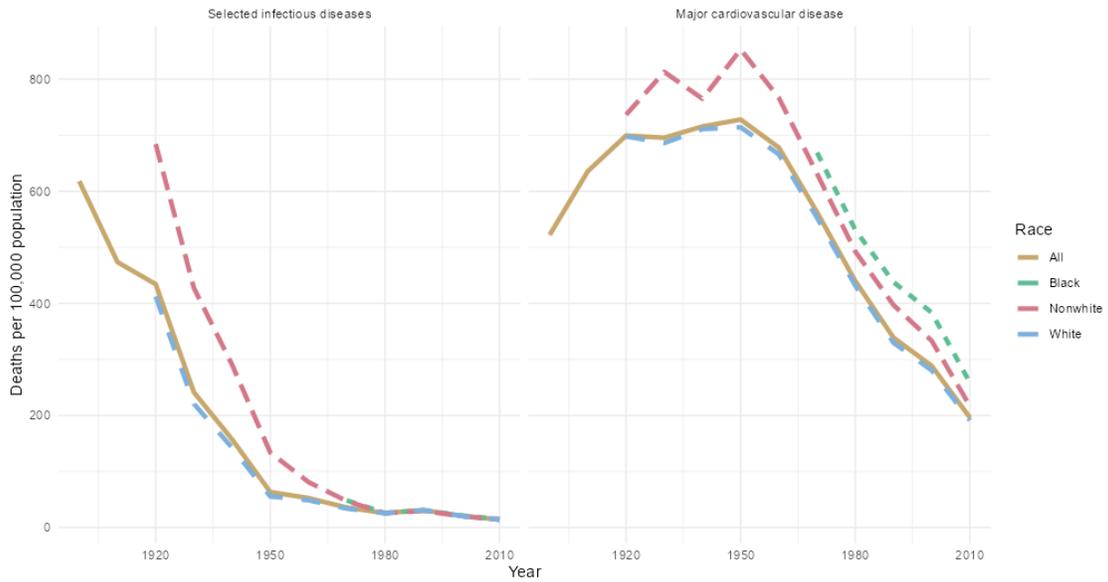


Figure 4. Age-adjusted death rates for selected causes, for females, 1900-2010. *Note:* age-adjusted rates are per 100,000 population. *Selected infectious diseases* include deaths due to influenza and pneumonia; tuberculosis; and enteritis and diarrhea. Figure is created from data provided in Hahn et. al. (2018).

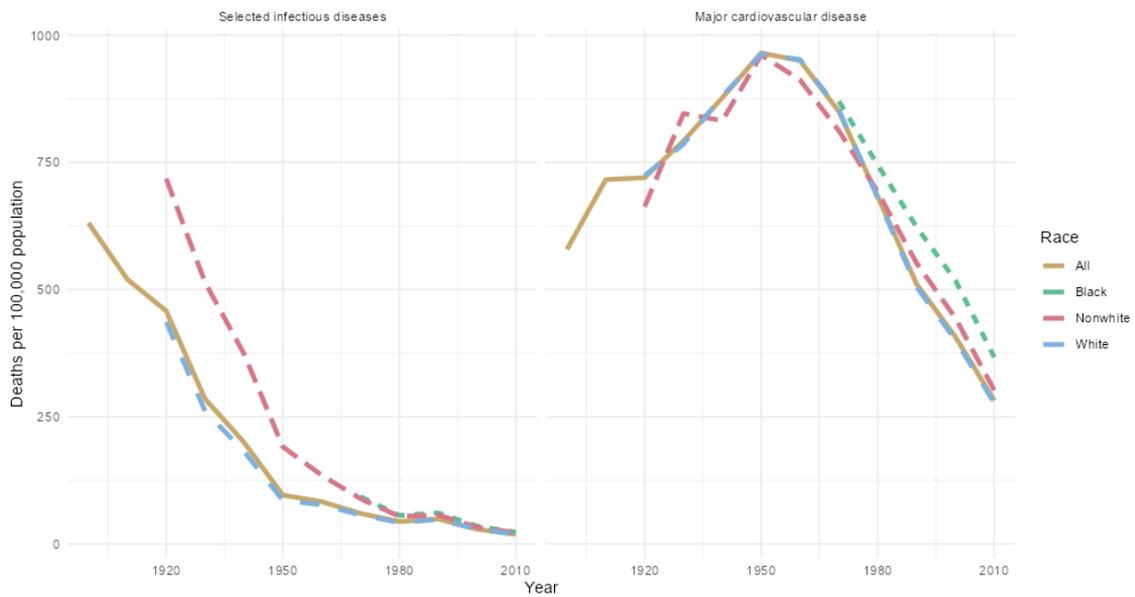


Figure 5. Age-adjusted death rates for selected causes, for males, 1900-2010. *Note:* age-adjusted rates are per 100,000 population. *Selected infectious diseases* include deaths due to influenza and pneumonia; tuberculosis; and enteritis and diarrhea. Figure is created from data provided in Jones et. al. (2020).

Figures 4 and 5 illustrate the dynamic nature of U.S mortality across the 20th century. In the early years, deaths due to infectious disease began to rapidly decline: For example, in 1900, approximately 618 of every 100,000 females died from either influenza and pneumonia; tuberculosis; or enteritis and diarrhea. Only 10 years later, this rate declined to 474 deaths per 100,000, and by the middle of the century, this rate fell to 63 deaths per 100,000 females. By 2010, deaths due to these once common causes of death were all but eliminated in the U.S., with only 14 per 100,000 females and 19 per 100,000 males succumbing to these forms of illness.

The precipitous drop in deaths due to infectious disease across the U.S. population brought an end to one way in which the lives of people in minority communities were shortened more than those of White people.

Indeed, in 1920, “nonwhite” females were at nearly 1.7 times the risk of dying from causes such as influenza, tuberculosis, or enteritis compared to white females. As time progressed, and the country gained a degree of control over infection, racial disparities in these specific causes of death were all but eradicated as well: For example, by 1980, Black, nonwhite and white women faced almost identical risk of dying from influenza and pneumonia; tuberculosis; or enteritis and diarrhea.

The same pattern holds for men: In 1920, 718 of every 100,000 nonwhite males died of complications from these infectious diseases compared with 436 of every 100,000 white males. In 2010, this disparity nearly evaporated, with 19, 22, and 23 deaths incurred per 100,000 persons among white, nonwhite and Black populations, respectively. Overall, infectious diseases that once predominated – and served as a major vector for racial disparities in premature death – fell to the wayside.

Still, gains in racial health equity due to improvements in prevention and treatment of infectious disease were offset by significant disparities in deaths due to emerging, chronic forms of illness.

Mortalities due to major cardiovascular diseases (CVDs) – disorders of the heart and blood vessels ([CDC 2022](#)) – accelerated at the start of the 20th century. In 1900, for instance, 522 per 100,000 females and 579 per 100,000 males died of CVDs; by 1950, these rates jumped to 728 and 965 deaths per 100,000 population, respectively.

As these – and similar (e.g., diabetes; hypertension; stroke) – health conditions began to take the place of infections as the primary cause of death among Americans, racial disparities escalated. For instance, in 1920, 698 per 100,000 white women and 736 per 100,000 nonwhite women died from major forms of CVD – a difference in rates of 38 deaths per 100,000 population. In 1950, this grew to a difference in rates of 139 – 714 CVD deaths among every 100,000 white women and 853 CVD deaths among every 100,000 nonwhite women. Among men, racial disparities in

major cardiovascular disease death followed a more complicated path, but still eventually reached the same end. By 2010, Black and nonwhite men experienced death rates via CVDs that were 1.32 and 1.09 times higher than White men, respectively. Overall, despite sweeping transformations to how individuals died in the U.S. over the past century – shifting from acute and violent infections to more long-term disorders – Black and brown Americans remained at a higher risk of premature mortality than their white counterparts.

Or consider infant mortality. This measure is sometimes referred to as a “social mirror” ([Wise and Pursley 1999](#)), given its sensitivity to broader social, economic, and environmental conditions. Figure 6 charts the progression of infant mortality rates throughout time. It shows that risk of death during early childhood improved significantly over the past 100-years – contributing to overall gains in life expectancy over the same period. In 1915, for example, 99.9 of every 1,000 live births ended in infant death, while in 2017, this rate fell to 5.8 deaths per 1,000 births ([Singh and Yu 2019](#)).

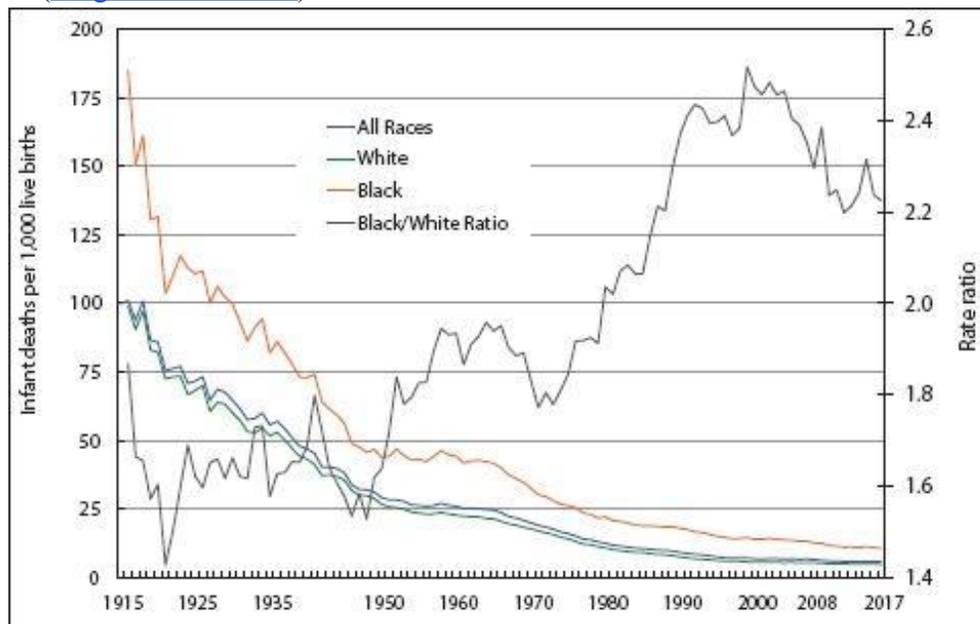


Figure 6. Infant mortality rate by race, 1915-2017. *Note:* Rates encode deaths per 1,000 live births. Figure is taken from Singh and Yu (2019).

Still, as observed in general mortality rates, widespread gains in preventing infant death did not bring racial equality. During the early portion of the 20th century, infant mortality rates among white Americans were considerably lower than rates among Black Americans: Approximately 99 of every 1,000 white children born in 1915 died before their first birthday, compared to 185 of every 1,000 Black infants. The relative gap in these rates only grew with time. By 2017, 4.9 of every 1,000 white infants and 10.8 of every 1,000 Black infants died before turning 1. This roughly indicates that Black children were at 1.86 times higher risk of dying in infancy than white children in 1915 – but nearly 2.2 times higher the risk in 2017.

Historical analysis suggests that this form of inequality worsened during moments of medical care innovation; for instance, Table 1 shows how racial disparities in infant mortality widened after the introduction of a crucial treatment for respiratory distress syndrome – a once leading cause of death among infants nationally ([Parker Frisbie et. al 2004](#); [NIH 2021](#)).

	1989–1990		1995–1998		Rate Ratios (Blacks/Whites)		Absolute Change in Rates 1995–1998 to 1989–1990	
	Whites	Blacks	Whites	Blacks	1989–1990	1995–1998	Whites	Blacks
All Birth Weights								
IMR	6.17	13.89	4.78	11.12	2.25	2.33	-1.39	-2.77
RDS	0.42	1.10	0.17	0.53	2.62	3.12	-0.25	-0.57
Other causes	5.75	12.79	4.61	10.59	2.22	2.30	-1.14	-2.20
Low Birth Weights								
IMR	69.54	78.25	52.81	68.40	1.13	1.30	-16.73	-9.85
RDS	9.14	9.26	3.49	4.64	1.01	1.33	-5.65	-4.62
Other causes	60.40	68.99	49.32	63.76	1.14	1.29	-11.08	-5.23

Table 1. Infant Mortality Rates (IMR) per 1,000 live singleton-births, by race, 1989-1990 and 1995-1998. *Note:* table is from [Parker Frisbie et. al \(2004\)](#). *RDS* indicates deaths due to respiratory distress syndrome. The first period of observation (i.e., 1989-1990) summarizes infant mortality prior to FDA approval of *surfactant therapy* – a medical technology of “substantial efficacy in the treatment of RDS” – while the second period (i.e., 1995-1998) summarizes infant mortality rates shortly after the introduction of this intervention.

Racial gaps in mortality have generally narrowed over time, but still remain significant – despite substantial changes to the health of the U.S as a whole. And the disparities we’ve discussed extend to new forms of illness when they appear, such as COVID-19 (Table 2).

Population	Risk of COVID-19 death compared to Whites
American Indian/Alaska Native	2.2
Asian	0.8
Black	1.7
Hispanic/Latinx	1.9

Table 2. Risk of death from COVID-19 by race and ethnicity compared to Non-Hispanic whites. *Note:* numbers are ratios of age-adjusted death rates and are provided by [CDC \(2022\)](#) and describe patterns through January 15, 2022. Accessed February 16, 2022.

Chronic physical conditions

Deaths are far from the only marker of well-being in which disparities arise. Chronic conditions are especially important to discuss here, given that about six in 10 U.S adults currently live with some form of chronic illness ([CDC 2022](#)), and that disparities in these forms of illness underpin broader inequalities in risk of premature death.

One of the most common chronic physical conditions is hypertension. Recent estimates suggest that nearly half of all U.S. adults experience this long-term condition, which is characterized by having blood pressure levels high enough to cause serious damage to the heart and blood vessels ([CDC 2021](#)). Figure 7, adapted from [Dorans et. al. \(2018\)](#), demonstrates the prevalence of hypertension by race in the 21st century.

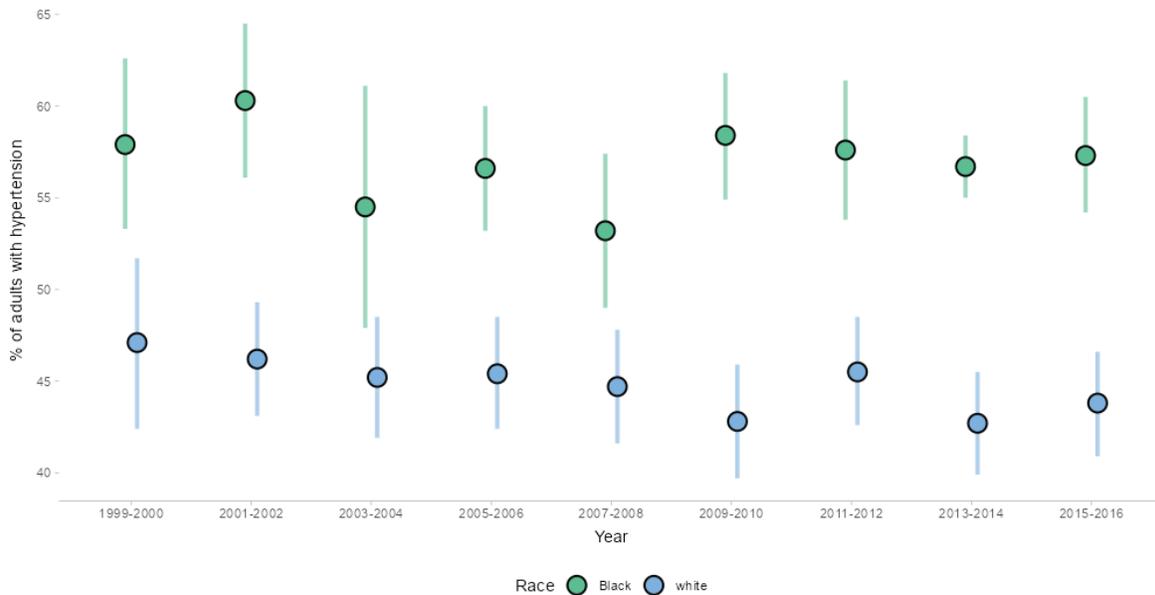


Figure 7. Estimated age-adjusted hypertension prevalence among U.S. adults by race, 1999-2016. *Note:* figure is created from data provided in Dorans et. al. (2018). 95% confidence intervals for prevalence estimates are marked by shaded bars.

Across a nearly 15-year time span, from 1999 to 2016, Black adults consistently experienced higher risk of hypertension than White adults.

At the beginning of this period, 47.1% of white adults had blood pressure levels that were classified as hypertensive under the 2017 American College of Cardiology/American Heart Association blood pressure guidelines. At the same time, prevalence was nearly 1.2 times greater among Black adults, with 57.9 of every 100 Black individuals experiencing this condition.

A decade and half later, little had changed: Hypertension among Black adults (57.3%) was approximately 1.3 times as high as it was among White adults (43.8%).

Another chronic condition that demonstrates the persistence of racial health disparities is diabetes. This long-term condition is relatively common in the U.S., with nearly 37.3 million individuals living with diabetes today ([CDC 2022](#)). And like hypertension, populations of color have been at consistently higher risk of developing this condition in the 21st century; Figure 8, for instance, displays estimates of diabetes prevalence among racialized populations over the past 20 years ([Benoit et. al 2019](#)).

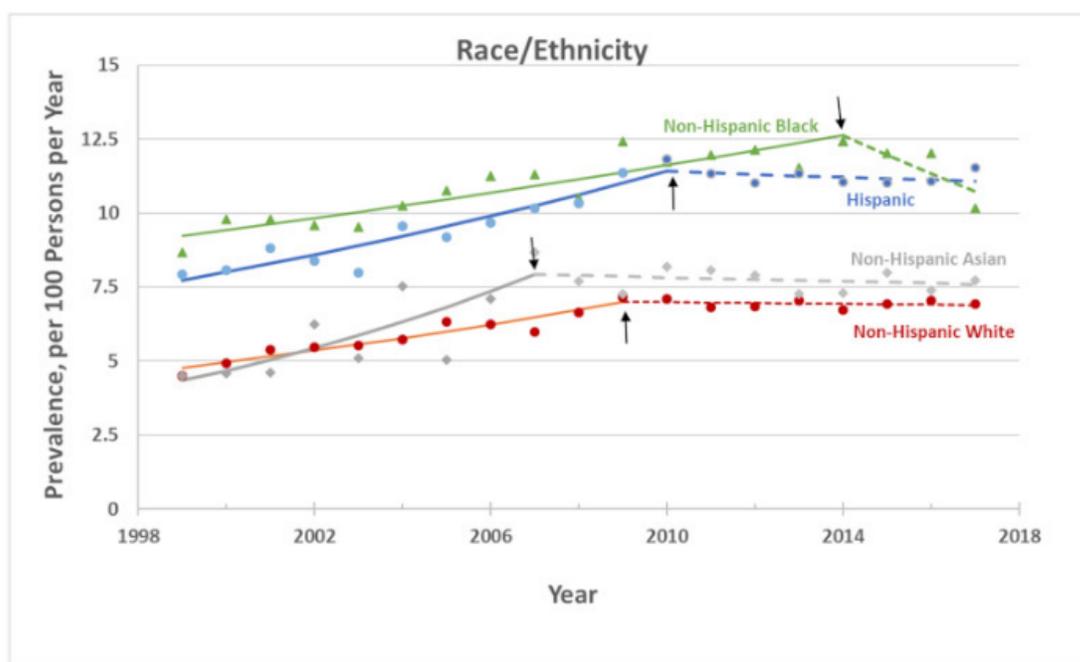


Figure 8. Prevalence of diagnosed diabetes among adults (aged 18-79), 1999 - 2017. *Note:* estimates are age-adjusted. Figure taken from Benoit et. al (2019).

Overall, as was the case with death rates, racial disparities in chronic physical conditions seem set into the base structure of the United States. Whether it's hypertension, diabetes, asthma (e.g., [Mehta et. al. 2013](#)), dementia (e.g., Figure 9; [Power et. al. 2021](#)) or other chronic ailments, Black and brown populations have generally borne a disproportionate load of illness and disease across time.

To be sure, these inequities have narrowed and sometimes widened at times, but generally, white Americans have always enjoyed better health and longevity.

Biology is sometimes used to explain Black-White disparities in chronic health conditions, with assertions like, “Black individuals are simply genetically predisposed to higher blood pressure.” But such explanations don’t stand up to close examination ([Lujan and DiCarlo 2018](#); [Chowkwanyun & Reed 2020](#)).

Consider studies comparing the health of Black populations in the United States, certain African countries like Nigeria and Caribbean countries like Jamaica. Those in Africa usually have the lowest prevalence of chronic illness, sometimes with rates lower than the U.S. white population (e.g., [Cooper et. al. 1997](#)). This suggests that racial health disparities are mostly a result of the circumstances of American Black lives and the institutions that shape them, rather than genetics or shared ancestry.

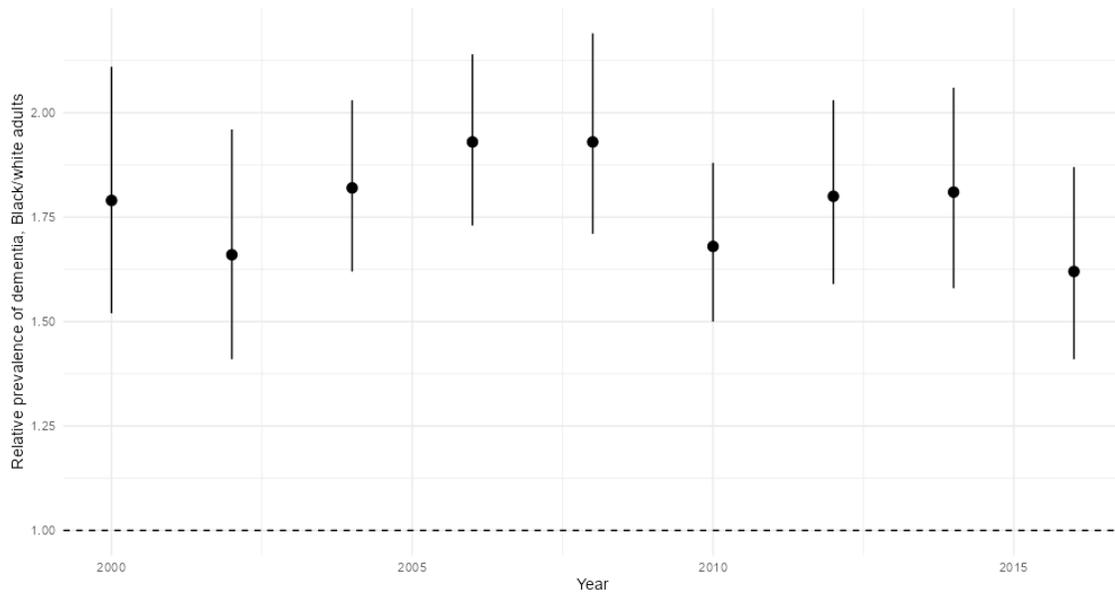


Figure 9. Relative prevalence of dementia across Black and white Americans, 2000-2016. *Note:* data used to create the figure are drawn from the standardized, “Expert model” estimates provided in Power et. al. (2021).

Mental health outcomes

Unlikely disparities in mortality and chronic physical conditions, succinctly characterizing racialized disparities in mental health is somewhat difficult. For example, evidence on the rate of depression across racialized populations is mixed: Some studies suggest that Black individuals are at an increased risk of this common mental health condition, while many others suggest that rates of depression are lower, or at least equal to, rates among whites. Among other factors,

differences in study design and measurement contribute to these variable findings; see [Ettman et. al. \(2020\)](#) and [Jackson et. al. \(2004\)](#) for more. Still, as an example of the prevalence of this crucial mood disorder, Figure 10 displays the percentage of adults living with varying degrees of depressive symptoms by race in 2019 ([Villarroel and Terlizzi 2020](#)).

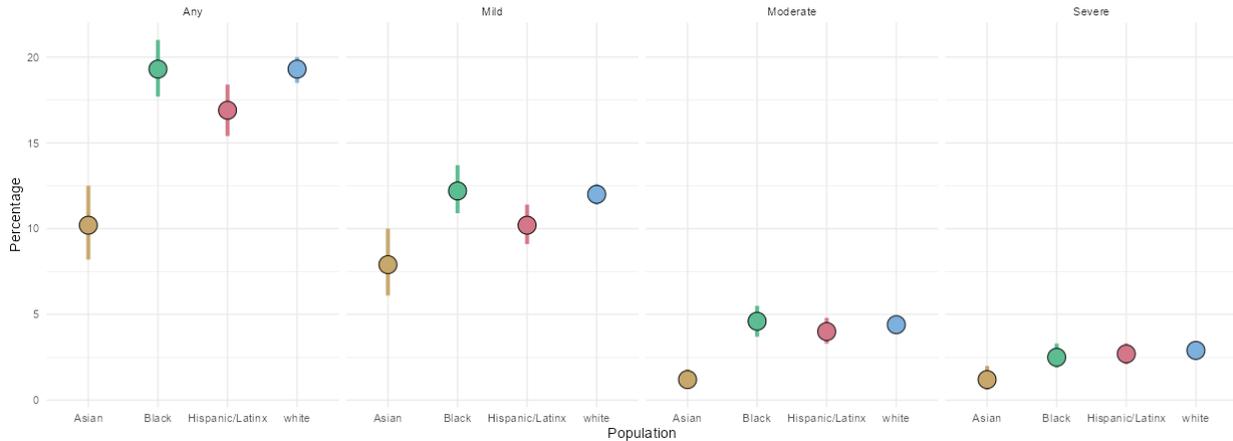


Figure 10. Percentage of adults aged 18 and over with symptoms of depression in the past 2 weeks, by race and symptom severity, 2019. *Note:* figure is adapted from data provided in Villarroel and Terlizzi (2020). 95% uncertainty intervals are marked by bars.

Suicide statistics are also complicated. Historically, suicide rates have been considerably higher among white and American Indian/Alaskan Native populations than other groups. For example, Figure 11, adapted from [Ramchand et. al. \(2021\)](#), shows age-adjusted suicide rates by race over a 20-year period (i.e., 1999-2019):

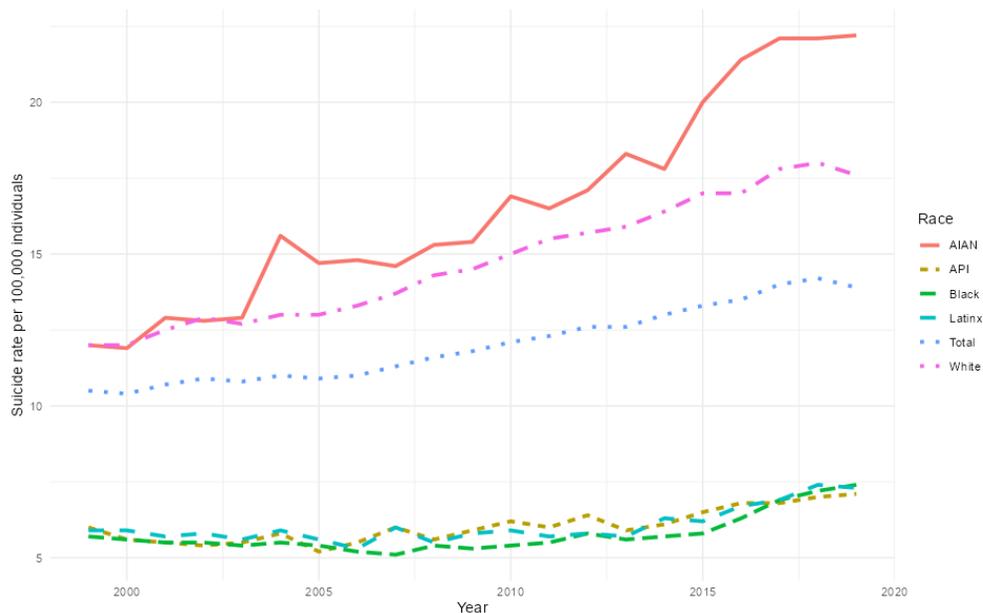


Figure 11. Age-adjusted suicide rates by race, 1999 to 2019. *Note:* figure is adapted from Ramchand et. al. (2021). *Note:* *AIAN* and *API* stand for “American Indian/Alaskan Native” and “Asian or Pacific Islander,” respectively.

In the most recent year of observation, 2019, the U.S. white population had a suicide rate of 17.6 deaths per 100,000 individuals, while the Black population’s rate was 7.4. These national trends suggest that white individuals are well over two times as likely to kill themselves as their Black counterparts.

But a closer examination of the statistics muddies the water. One study, [Bridge et. al. \(2018\)](#), examines the age-specific suicide rates among Black and white youths ages 5 to 17, between the years 2001 and 2015:

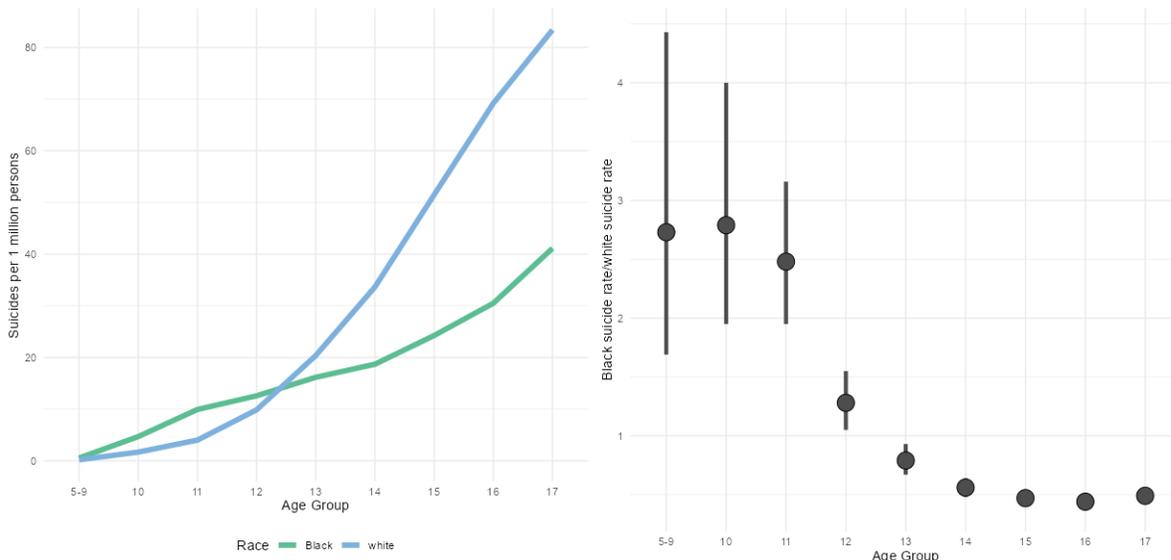


Figure 12. Comparison of age-specific suicide rates among Black and white youth, 2001-2015. *Left:* Suicide rates per 1-million population by race and age. *Right:* Ratio of age-specific suicide rates (e.g., suicide rates among Black individuals/suicide rates among white individuals). *Notes:* figure is created using data provided in Bridge et. al. (2018). 95% uncertainty intervals for rate ratios are marked by bars.

Black children between the ages of 5 and 12 had more than twice the risk of suicide as white children of the same age group. As children moved into adolescence, however, these numbers reversed, with Black youth between the ages of 13 and 17 at about half the risk of suicide death as their white peers. And a sharp increase in suicides among Black youth in recent years (e.g., [Gordon 2020](#); [Congressional Black Caucus 2020](#)) further complicates the situation.

Similar nuances are present across other mental health conditions as well. [Vanderminden and Esala \(2019\)](#), for instance, show that, above and beyond their actual symptoms, a person’s race (and gender) are key predictors of whether the person is diagnosed with anxiety disorders. Such differences in the diagnosis of conditions like these – as well as other forms of mental illness (see [Pattani 2019](#)) – cloud our understanding of mental health across racialized groups.

Countervailing relationships between physical and mental welfare also complicate matters. Unhealthy coping behaviors like smoking and overeating driven by chronic psychological stress may decrease mental health problems among Black populations, while increasing sickness and death ([James et. al. 2010](#)).

Ultimately, examining broad, national trends likely masks a deeper, more intricate entanglement of race and mental and emotional wellbeing in the U.S. overtime. While a full treatment of the complicated history of race, racism, and the measurement and expression of mental health is somewhat beyond the current project, we direct readers to [Thomas and Sillen \(1972\)](#); [Metzl \(2009\)](#); [Doyle \(2016\)](#); [Summers \(2019\)](#); [Raz \(2016\)](#) (and others) for rich analysis of these connections.

Summary

Over the past century, where we have reliable data, healthcare, medical technology, and public health practices have shifted dramatically - and yet, in face of these changing conditions, significant racial disparities in health and mortality have been reliably reproduced.

As we will discuss shortly, the construction, maintenance, and reproduction of health inequality is premised on the racialization of people and places within a system of racism. And here, it is important to note that these processes of racialization are fluid and dynamic – as the definitions of “white,” “Black,” “Latino,” and other monolithic ethno-racial categories expand and contract over time ([Zuberi 2001](#), [Zuberi et al. 2015](#), [Prewitt 2013](#)). An implication for interpreting historical population trends, as noted by demographer and sociologist Tukufu Zuberi, is that the data presented above are not simply “demographic facts” based on some perfectly measured individual characteristic of “race,” but in part a reflection of social and policy choices regarding the measurement of race itself.²

² For instance, the Black immigrant population in the U.S. has been steadily increasing over the past 40-years. In 1980, 3% of the total Black population was foreign-born, compared to 10% in 2019 ([Tamir and Anderson 2022](#)). Though both US- and foreign-born Black individuals are often swept into the same broad census category (“Black”) in analyses, these groups demonstrate considerably different health profiles from one another – with foreign-born Black individuals typically experiencing elevated levels of health and well-being compared to their U.S-born peers (e.g., [Palarino 2021](#); [Larimore et. al. 2021](#)). Some degree of change (or “progress”) in racialized health gaps likely reflects fundamental compositional changes like these – to who falls into blunt, ethnoracial categories across over time.

Turning to Section 3, we discuss how economic and political processes of racialization (i.e., the construction of “race” itself) are necessary components in reproducing a broader system of white supremacy – the *root cause* of racial health inequity in the United States.

Finding the “Cause of Causes”: The Role of Power in Explaining Racial Health Disparities

“Race is not a biological category that naturally produces health disparities because of genetic differences. Race is a political category that has staggering biological consequences because of the impact of social inequality on people’s health. Understanding race as a political category does not erase its impact on biology; instead, it redirects attention from genetic explanations to social ones” - Dorothy Roberts ([Fatal Invention](#), 2011, p. 129)

Why have racial health disparities in the United States been so pervasive over time? This is largely a story of power. In [The Condition of the Working Class in England](#), Friedrich Engels (1845) documented differences in life expectancy according to occupation in Liverpool, England. Engels found that the economic relation between workers and capitalists was the fundamental cause of these disparities. Borrowing a term he learned from workers, he accused the ruling class of “social murder.” While hazardous working conditions may have been the proximal cause of poor health and premature mortality among workers, Engels ultimately blamed the power relation through which employers compelled this exploitative labor. This is a key characteristic of the political economy of health tradition ([Harvey 2021](#)) -- the concept that political and economic institutions play a major role in health outcomes: “The underlying hypothesis [of the political economy of health] is that economic and political institutions and decisions that create, enforce, and perpetuate economic and social privilege and inequality are root — or ‘fundamental’ — causes of social inequalities in health ...

“Core questions include: how does prioritizing capital accumulation over human need affect health, as evinced through injurious workplace organization and exposure to occupational hazards, inadequate pay scales, profligate pollution, and rampant commodification of virtually every human activity, need, and desire” ([Krieger 2001](#), p. 670).

By focusing on the “cause of causes,” this framework offers insights as to why health inequality is so pervasive over time, despite dramatic shifts in healthcare technology and the general incidence of various health conditions.

Racism is a key organizing force in the political economy of health in the United States. In *The Philadelphia Negro*, sociologist W.E.B. Du Bois emphasized how health outcomes could only be understood through a deep understanding of racist social relations ([Du Bois 1898, 1899](#)). This framework has been extended to examine how racism becomes embedded in the law and economy itself to influence health, including the incorporation of critical race theory ([Ford and](#)

[Airhihenbuwa 2010; 2018](#)) and theories of racial capitalism ([Laster Pirtle 2020](#); [McClure et al. 2020](#)).

In explaining racial disparities in health, the stakes are high. Statistics on racial health disparities have been, and continue to be, wielded against Black communities. Eugenicists argued that Black people were biologically inferior; racial stereotypes served to explain behavior; neighborhoods and communities were stigmatized racially ([Roberts 2011](#); [Zuberi 2001](#); [Ford and Airhihenbuwa 2010](#); [Wacquant 2008](#); [Chowkwanyun & Reed 2020](#)).

While racism is central to understanding the political economy of health, it is also central to the telling of history itself. As Nancy Krieger describes in *Epidemiology and the People's Health*, there have been concerted efforts to downplay the importance of racist capitalist economic relations in producing health inequality. And as Tukufu Zuberi writes in *Thicker than Blood*, common explanations of racial health differences arose in large part from the widespread eugenics movement, long influential in policy and academic circles. Today, biomedical and behavioral explanations are spread by many organizations that are nominally focused on racial health equity, and much funding from the National Institutes of Health is still channeled to biomedical (e.g., clinical trials) and behavioral (e.g., diet, exercise) initiatives to combat racial inequalities instead of going to the root causes.

A historical perspective is critical for understanding racial health by focusing on racism and the political economy of health. In describing what he calls “the strange disappearance of history from racial health disparities research,” Merlin Chowkwanyun writes, “By locating such factors and the human agents, decision-making, and the exercise of political power behind them, we are reminded that these disparities are not natural but created and thus undoable, however awesome the task ... history forces us to reflect on the very way we interpret these inequalities, often exposing long, sometimes disturbing, lineages behind current ways of thinking” ([Chowkwanyun 2011](#), p. 266).

In this section, our aim is not to articulate every historical and contemporary racialized process producing the political economy of health we have in the United States today. Our aim is also not to describe the myriad mechanisms through which these processes become “embodied” as illness and ultimately death. Our aim in this section is to articulate a general framework, including several case studies, for understanding why these power relations exist and how to understand the ways in which they pattern access to health-relevant resources for differently racialized groups.

Identifying the “Cause of Causes”

The fundamental causes of population health

Why do health inequalities exist and, what is more important, why are they so reliably reproduced over time, despite dramatic shifts in disease burdens, technologies, and health care practices? To understand these dynamics, we first consider two types of resources:

--There are *health-relevant resources* – also known as “risk factors” or “proximal determinants of health” – that are directly linked to different health outcomes, including *health care, nutrition, health education, stress, lifestyle, and physical safety*.

--There are also *flexible resources* which pattern access to these resources, including *money, knowledge, power, prestige, and social networks*. In other words, these are the resources that place particular individuals at “the risk of [health] risks” ([Link and Phelan 1995](#); [Phelan and Link 2015](#); [Phelan et. al. 2010](#)).

Access to flexible resources is essential to avoiding illness and early death, given that specific diseases are tied to specific health-relevant resources in unique ways. For example, cardiovascular disease is heavily influenced by stress (e.g., [Steptoe and Kivimaki 2012](#)). Stress, however, is a less well-established risk factor for the development of asthma, with other factors – such as exposure to air pollution – playing more prominent roles (e.g., [EPA 2018](#)).

Still, both outcomes are shaped in part by things like *money* and *power*, which affect exposure to both chronic stress (for example, by reducing economic insecurity) and air pollution (by allowing individuals to avoid polluted living/working conditions) and thus lessen the risk of developing both cardiovascular disease and asthma ([Tawakol et. al. 2019](#); [Bryant-Stephens et. al. 2021](#)).

Access to flexible resources is crucial for allowing individuals to adapt easily to diseases as they arise -- for example, by easing access to new, health-relevant technologies and behaviors (such as vaccines and working from home) for a new infection like COVID-19.

As we discussed previously, the unequal distribution of flexible resources provides a roadmap for understanding how health disparities continue despite dramatic shifts -- for example, during the transition from primarily infectious ailments like pneumonia or tuberculosis to non-communicable illnesses like cardiovascular disease and cancers in the United States over the past century. As technology and disease burden evolve over time, those with greater access to flexible resources are able to take advantage of those resources to adapt to new health challenges quickly and effectively. A key implication: As a result of the unequal distribution of these flexible resources, new biomedical innovations like vaccines and chemotherapy will often *increase* health inequality; as we discussed, [Parker Frisbie et. al \(2004\)](#) demonstrates this phenomenon in the context of infant mortality. And health disparities widened after the introduction of surfactant therapy helped to eradicate respiratory distress syndrome, once a leading cause of death among infants.

If access to flexible resources is a key reason why certain groups and individuals are able to maintain their health in the face of evolving challenges while others are not, what then determines the unequal distribution of these crucial resources, like *money* or *social networks*?

Public health research on disparities often relies on broad theories of social inequality, with a common focus on labor market inequality and residential segregation. For example, residential segregation shapes peoples' ability to access important resources like high-quality housing stock; residence in neighborhoods without serious chemical and physical hazards; and proximity to health care services ([Williams, Lawrence, and Davis 2019](#)). These explanations often treat characteristics such as *homeowner* or *college education* as “upstream” socioeconomic positions (or “social determinants of health”), in the sense that people in these positions have certain advantages (for example, being in the socioeconomic position of “college educated” affects access to economic resources, which in turn connect to resources like access to high-quality medical technology).

In contrast, there has been much less focus on the relational systems of power that maintain these connections and give these socioeconomic positions meaning: *the political economy of health*.

Health power resources and the political economy of health

To the extent they are used to explain health inequality, socioeconomic positions are largely thought of as individual characteristics such as education and employment rather than as *social relations* (like, the exchange of education credentials in the labor market or the power relation between worker and employer). The political economy of health tradition more closely examines these social relations ([Harvey 2021](#)). To really understand how socioeconomic position and flexible resources operate as fundamental causes of health, we have to understand the power relations that serve to distribute and translate them to health-relevant resources in different ways for different groups ([Reynolds 2021](#)). As was emphasized in the introduction to this report, we must ask: *What are the relevant economic and political institutions? Are they designed for the public good -- for example, health and well-being -- or to consolidate capitalist and racial power?*

The concept of “power” as a flexible resource in relation to health is often left vague. Power is typically conceived as being derived from one’s socioeconomic position: *socioeconomic position* leads to *power*, which leads to *health-relevant resources*, which result in *health outcomes*.

But broader forms of power consolidation under capitalism, such as white supremacy and neoliberalism, bring about the distribution of socioeconomic positions (and by extension, flexible resources) via *stratification*, as well as how those factors are translated into health via *commodification, discrimination, and devitalization* ([Reynolds 2021](#)).

Stratification of socioeconomic positions is, in part, the result of power consolidation within the institutions which set the “rules of the game” ([Beckfield et al. 2015](#)). For example, we can consider how the Black-white homeownership gap resulted from racial power consolidation among public and private institutions during the New Deal and post-war era ([Rothstein 2017](#); [Sugrue 1996](#); [Taylor 2019](#); [Winling and Michney 2021](#)). As we will discuss below, a theory of property value conflating “race” with mortgage default risk and home equity growth was codified during this period to largely exclude Black Americans from high-value homeownership ([Faber 2020](#); [Krieger, van Wye, et al. 2020](#); [McClure et al. 2019](#)). Similar patterns of racial stratification have been documented in subprime mortgage lending leading to the 2008 recession ([Rugh and Massey 2010](#)) and contemporary mortgage credit ([Loya & Flippen 2021](#)).

Given racial stratification, how do power relations *translate* socioeconomic categories such as “homeowner” or “college education” into health-relevant resources and, by extension, health outcomes? The first factor maintaining these connections is the *commodification* of health-relevant resources. In the United States, virtually all health-relevant resources are commodified; in other words, access to essential health-relevant resources is dependent on market position rather than given as a right. Most Americans are only eligible for health insurance provided by employers or through the private marketplace. Disruptions to employment or housing (perhaps via eviction or foreclosure) can therefore have a strong influence on access to important health-relevant resources (for example, employer-sponsored health care). That would not be the case if health insurance were *decommodified* -- if, for example, there was universal health care ([Reynolds 2021](#)).

Second, power imbalances alter how socioeconomic position can ultimately be translated into flexible and thus health-relevant resources – a process called *discrimination* or “differential returns” ([Boen 2016](#); [Brown 2018](#); [Brown et al. 2016](#)). For example, power relations like structural racism in the home mortgage market shape how “homeownership” is ultimately tied to health-relevant resources differently for Black vs. White Americans, via unequal mortgage costs, debt burdens, and public investments in neighborhoods such as parks and schools. In other words, not all homeownership is made equal and thus not all homeownership “returns” the same benefits to health ([Sewell 2016, 2021](#); [Williams and Sternthal 2010](#)).

Third, power imbalances can deprive people of the ability to act and can affect their perceptions of self-worth, leading to chronic stress and other debilities and riskier health behaviors – a process known as *devitalization* ([Reynolds 2021](#)). For example, within neighborhoods characterized by concentrated poverty and social stigmatization, awareness of neighbors’ struggles can exacerbate the sense that little can be done to improve matters ([Desmond and Travis 2018](#)). Homeowners have historically enjoyed much greater political muscle through collective organizing (using such tools as political lobbies and homeowners’ associations) and a vested interest from institutional actors like banks and real estate interests ([Geismer 2015](#);

[Jackson 1987](#)). Successes of organized resistance, such as tenant unions, provide an important counterexample (e.g., [Michener & SoRelle 2022](#)).

Placing explicit focus on the *racial political economy of health* reveals how the relations between public and private actors is critically important in understanding how broader systems of power like racism lead to unequal population health ([Bailey, Feldman, and Bassett 2020](#); [Phelan and Link 2015](#); [Sewell 2016](#)).

Case study: Housing, education, and health

To help demonstrate this generalized process, let's look at how racism embedded in two essential, interlocking, contemporary institutions – the housing market and educational system – contributes to the considerable racial health disparities that we observe today.

In the United States, affordable housing is stratified through deeply entrenched residential segregation resulting from a racist theory of property value built into many public-private partnerships, spanning federal agencies, banks, academics, and real estate agents. Residential segregation leads to the *stratification* of other resources, such as educational opportunity. Without broad investment in public education targeting racial equity, school funding has historically reflected existing residential segregation – resulting in large racial differences in educational credentials (e.g., [American Council of Education 2017](#)).

Given the accelerating association between educational position and well-being in America, (e.g., [Zajacova and Lawrence 2018](#)) the starkly unequal, racial stratification of educational credentials has important implications for racial health equity. Many studies have documented the strong and persistent correlation of educational attainment and health, but many rely on vague individualistic explanations rather than structural, relational explanations of what maintains this relationship ([Williams 2019](#)).

In fact, the same systems of power consolidation that serve to stratify educational opportunity also operate to *translate* educational credentials into health-relevant resources. For instance, income scales quickly with educational position: The median weekly earnings of college-educated Americans is \$1,305, while those holding less than a high school diploma typically earn \$619 per week ([BLS 2021](#)). In the U.S., the “earnings boost” from additional education can be a matter of life and death. For example, individuals holding college degrees are able to translate these credentials into significantly greater access to buying various health resources, including medicines and treatments, healthy food options, materials that facilitate exercise and more ([Warren et. al. 2020](#)). On the other hand, union membership has reduced dramatically over the past 50 years, which reduced workplace health and safety in a way that disproportionately affects those without a college degree (see [Leigh & Chakalov 2021](#) for a review of the relationship

between unions and health). These social relations all combine to produce what we see to be the “health return” of a college degree.

Labor market outcomes that are linked to educational position contribute to this. For instance, employment opportunities are tied to educational credentials and access to health care is primarily through employer-sponsored health insurance plans. Systematic denial of educational opportunity to Black Americans doubles as a denial of flexible resources needed to navigate systems producing health risks and benefits. A key implication is that education would be much less related to health if associated health-relevant resources were not commodified.

The racist allocation of educational opportunity is not the only process through which disparities arise here: Racial health inequity is also the result of *discrimination* in the translation of educational position into flexible and health-relevant resources. For example, due to labor market segmentation (e.g., [Hamilton et. al. 2011](#)) and claims-making processes within organizations (e.g., [Avent-Holt and Tomaskovic-Devey 2013](#)), Black Americans tend to receive lower wages and face higher risk of unemployment at the *same* level of educational attainment than their white peers.

In 2015, for example, Black individuals holding a college degree were estimated to receive wages that were 80% of the earnings of white graduates ([Wilson 2016](#)). This discrimination has direct consequences for health and well-being. It means that the Black degree-holder has less access to health-relevant resources, which increases health inequity across the board. Figure 13, adapted from [Sasson \(2016\)](#), shows this idea in action, demonstrating how the same educational credentials are able to be translated into different levels of premature death among Black and white men and women. These data suggest that, although educational attainment does improve life expectancy for those who are Black, the health gains from a college degree still lag behind the health gains experienced by comparably educated individuals who are white. A key implication is that simply equalizing access to educational opportunity would not in itself alleviate the many ways in which education is tied to racial health inequity.

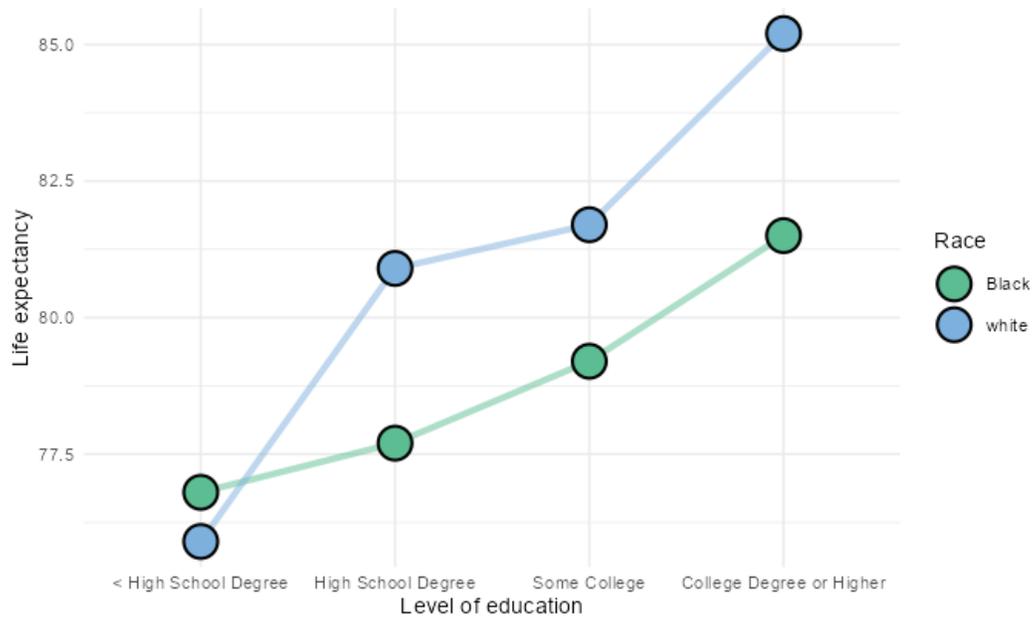


Figure 13. Estimated life expectancy (conditional on reaching age 25) by education and race among women, 2010. *Note:* data used to create the figure are drawn from Sasson (2016). Educational categories are imputed using typical (but imperfect) cut-points: <High School Diploma, High School Diploma, Some College, and College Degree or Higher.

In addition, Black Americans with college degrees often find themselves crossing into spaces that are predominantly white to make use of their credentials (Anderson 2015). Navigating these spaces is fraught with psychosocial risks such as racially discriminatory interactions -- or, perhaps what is even more important, the constant *anticipation* of racist treatment (Lee and Hicken 2016). This can get “under the skin” by placing an individual in a vigilant state of chronic stress that disrupts feelings of self-worth and adds considerable wear and tear on the body over time (Goosby et. al. 2018), a process often referred to as “weathering”(Geronimus et. al. 2006) This added stress burden has been shown to mitigate the health benefits of socioeconomic positions like “college educated” for Black adults (Hudson et. al. 2020; Hudson et. al. 2012).

A key implication is that by shaping the social contexts necessary for navigating everyday life, the broader system of white supremacy also has a negative impact on the distribution of flexible resources and their translation to effective health-enhancing resources for Black people. It is important to reiterate that resultant psychosocial stress stems not just from a few bad actors but from social contexts that are unequal by design.

Thus, contemporary housing and educational systems affect both the allocation and use of flexible and health-relevant resources among Black and White populations that in turn produce racial health disparities. Nothing about these arrangements is natural or inevitable and there are many pathways through which these power relations might be changed to improve health equity,

among them: universal health care; strong enforcement of worker rights and anti-discrimination laws; and a focus on dismantling the culture of white supremacy within public and private organizations (e.g., [Kalev et. al. 2006](#), [Cogburn 2019](#)).

Still, structural decisions made by public and private officials across U.S. history have instead often prioritized capital accumulation over human well-being, and the effect has been injurious to Black health. Below, we highlight four historical periods that illustrate how this has happened.

1930s-1950s: The racialized commodification of housing

The history of American housing policy has demonstrated how the state influences the production and configuration of urban space by way of decisions about what to legislate (and actively enforce) and what to leave unregulated (and passively neglect). In this way, federal policy has had a particularly great impact.

In the 1930s, the New Deal laid the groundwork for the two-tiered federal housing system: federally backed mortgages and subsidies for private homeowners vs. public housing ([Radford 1996](#)). Racial segregation was reinforced during post-World War II suburbanization by the GI Bill of 1944, followed by huge federal investments (often carried out through local governments) in urban renewal, transportation infrastructure, and the razing of public housing to spur (white) suburbanization ([Geismer 2015](#); [Sugrue 1996](#); [Taylor 2019](#)).

During this time, racial discrimination continued to be enshrined in federal housing policy via redlining maps of “undesirable” Black neighborhoods drawn by the Home Owners’ Loan Corporation (HOLC) in the 1930s ([Rothstein 2017](#)).

Contemporary health outcomes appear to be directly associated with historic redlining practices, such as HOLC grades. Due to historical trajectories spurred by decades of concentrated disinvestment, present-day residents of “Grade D” neighborhoods experience significantly poorer health than residents of “Grade A” neighborhoods for such outcomes as late-stage cancer diagnosis ([Krieger, Wright, et. al. 2020](#)), preterm birth ([Krieger, Van Wye, et. al. 2020](#)), severe asthma-related outcomes ([Nardone et. al. 2020](#)), self-rated health ([McClure et. al. 2019](#)), and life expectancy ([Graetz and Esposito 2022](#); [Richardson et. al. 2020](#)). The bulk of studies here align with the notion of HOLC mapping as a violent, state-sanctioned, racist intervention that, despite nearly a century of change, can still be held responsible for bad health and mortality within these same neighborhoods.

Still, as long noted by historians, geographers, and sociologists, the ramifications of the broader project of redlining extend far beyond the original HOLC maps into racial systems of finance and appraisal governing the racialized dual mortgage market today ([Sugrue 1996](#); [Fields and Raymond 2021](#); [Rugh and Massey 2010](#); [Howell and Kover-Glenn 2018](#); [Dantzler 2021](#); [Zaimi 2020](#)).

When taken in context, the mapping of neighborhoods by HOLC was only one manifestation of the broader redlining project of codifying a racist theory of value that conflated “race” with “financial risk” – a logic that shaped the historical and contemporary practice of public-private partnerships in real estate long after the 1968 Fair Housing Act. This broad, embedded, racist theory of property value has served to systematically deny Black individuals access to an important socioeconomic position (“homeowner”), which has in turn served to massively undermine access to flexible resources (e.g., wealth) and, therefore, well-being even to this day ([Taylor 2019](#); [Howell and Kover-Glenn 2018](#); [Braveman et. al. 2018](#)).

1950s-1960s: The Civil Rights movement and a narrowing of disparities

It is important to note that, although considerable and deeply embedded within American institutions, the racial power imbalance that has fueled U.S. health inequalities is neither natural nor inevitable. Racialized populations are not entirely vulnerable actors, defenseless in the face of powerful economic interests and/or social structures; instead, targeted collective action and mass social movements organized by communities throughout U.S. history have demonstrated that power dynamics *can* be contested in ways that further health equity.

The Civil Rights movement provides an example of how collective action attending to racism within institutions, particularly concerning unequal distributions of power, can lead to measurable improvements in population health and a narrowing of health disparities. In a careful investigation, for example, [Krieger et al. \(2013\)](#) demonstrate a significant change in infant deaths among Black Americans following the passage of the 1964 Civil Rights Act. Indeed, from 1960 to 1964, Black communities living in states that formally sanctioned racial discrimination across sectors -- with laws legalizing discrimination in education, transportation, housing, and more -- had infant death rates 1.19 times higher than Black populations elsewhere. After the passage of federal legislation abolishing such “Jim Crow” laws nationally, infant death rates quickly converged among Black populations situated across states, at least temporarily.

Among other things, this example illustrates how social movements can drive institutional change that corrects power imbalances between groups. Legislation that requires non-discrimination can also critically change resource allocations between unequal groups, such as the 1968 Fair Housing Act. Actions that explicitly target unequal structural arrangements can result in significant improvements to the health of Black and brown communities. A handful of additional studies document improvements to Black mortality, as well as some convergence in mortality between Black and white communities, in the 15 years after the passage of the Civil Rights Act (e.g., [Almond et al. 2006](#), [Krieger et al. 2013](#), [Krieger et al. 2014](#), [Chay et al. 2000](#)).

1970s-1990s: Neoliberalism, racial backlash, and the rise of the carceral state

Still, the decades following the Civil Rights Act were characterized by white racial backlash to the movement and the disarming of associated legislation. The result? Failure to make lasting, continued progress in fighting racial health inequality.

While the backlash had many facets, a central feature was the strengthening of racialized neoliberalism ([Robinson 2016, 2021](#)). Neoliberal logics – that generally emphasize individual responsibility, free markets, privatization, and property rights – are deeply tied to white supremacy, as evidenced by the weakening of the welfare state (including public housing) through the use of Black “welfare queen” tropes ([Harris-Perry 2011](#)). They also can be seen in government initiatives like [The Moynihan Report in 1965](#), which attributed racial inequality to so-called deficiencies in Black family structure, particularly Black single motherhood ([Geary 2015](#)).

The unprecedented rise of the carceral state, beginning in the 1980s, and the disproportionate effect of mass incarceration on minorities has been attributed to neoliberalism in criminal justice – in particular Nixon’s war on crime and Reagan’s war on drugs, which led to changes in sentencing law and disproportionately impacted working-class Black and Latinx populations³. Blame also has been cast on a broader neoliberal economic agenda, which privatized a significant portion of the prison system ([Beckett and Francis 2020](#); [Chowbay 2021](#); [Gilmore 2007](#); [Hinton 2017](#); [Waquant 2009](#)).

Indeed, since the 1970s, the U.S. incarcerated population has grown by 500% ([ACLU 2022](#)). With over 2 million people in jail or prison today, the U.S. has the largest prison population in the world ([Szmigiera 2021](#)). Incarceration is especially common in working-class communities of color, where nearly 70% of Black men who did not finish high school and are approaching midlife will have been in prison at some point in their lives ([Pettit and Western 2004](#)). There have been recent declines in incarceration due to changes in sentencing practices, but that has been coupled with an increase in community supervision. The growth of probation and parole has resulted in an estimated 4.4 million people today who are subject to post-conviction surveillance and court-ordered rules ([BLS 2019](#)).

As we’ve noted, prisons do not operate independently but are closely tied to other institutions, including but not limited to housing institutions. Prior work has shown the tight linkages, sometimes even described as *symbiotic relationships*, between racial residential segregation, public housing, and incarceration ([Waquant 2001](#)). These systematically under-resourced and economically isolated geographic areas are also sites of over-policing and can serve as a revolving door into jails and prisons ([Massoglia et. al. 2012](#)). Indeed, the *Million Dollar Blocks*

³ For example, the Anti-Drug Abuse Act of 1986 included a provision imposing the same federal criminal penalties for the possession of an amount of crack cocaine that was 1/100th the amount of powder cocaine, leading to a disproportionate number of Blacks being sentenced for drug offenses.

Project ([Center for Spatial Research 2022](#)) has shown how large segments of racially segregated communities are currently imprisoned.

A growing body of research directly links mass incarceration to persistent racial disparities in health and well-being over recent decades ([Wildeman and Lee 2021](#)). Conditions of confinement – including lack of quality health care, poor sanitation, safety concerns, crowding and other factors – can be sources of poor mental and physical health ([Massoglia and Pridemore 2015](#)). The high rates of COVID-19 infection and death within jails and prisons reflects these conditions ([Saloner et al. 2020](#); [Marquez et al. 2021](#)).

Some work suggests incarceration may have beneficial effects on health, especially in reducing mortality risk for Black men ([Patterson 2010](#)). However, this is less related to the limited health services of jails and prisons and more closely to conditions on the outside, in the segregated communities where working-class Black populations reside. After release, formerly incarcerated persons face multiple health risks, including lack of access to health care, limited economic opportunities, housing instability, stigma and additional stressors that affect health and well-being ([Miller 2021](#); [Schnittker, Massoglia, and Uggen 2011](#)). These health impacts spill over to corrode the health and well-being of those connected to incarcerated persons, including family members, romantic partners, friends, and community members ([Wildeman and Lee 2021](#); [Wildeman and Wang 2017](#)).

Highly educated Black Americans are also affected by an expansive criminal justice system. They experience stigma and risk of being criminalized because of their race, and must also anticipate the possibility of these experiences for themselves and those that they care about *on a daily basis*, which serves as a significant source of chronic stress, with destructive health implications ([Asad and Clair 2018](#)). Such experiences are poignantly described by [Melody Cooper \(2020\)](#), where she discussed her motivations for posting a video on social media of her brother Christian Cooper, a Black man who was birdwatching in New York City’s Central Park when he encountered a white woman walking her dog unleashed in an area where leashing is required. After Cooper told her to leash her dog, she called the police and feigned being in danger.

Because even though he walked away, and even though I’m relieved, there still has been a toll. We felt it even before the incident with Amy Cooper. Every time we walk out of our door, we have cause to worry. My brother worries when he sneaks through the trees to catch a glimpse of a beautiful warbler. I worry when I check in late to an Airbnb, and every time my son gets in the car. Others wonder if a trip to the corner store or gas station might result in a phone call that will end their lives. So many of us in cities and towns across America are done with having to wonder if we’ll be put at risk by our mere existence. – Melody Cooper, New York Times, May 20, 2020

2000s: Financialization, The Great Recession, and the COVID-19 pandemic

Compared to the blunt instruments of redlining maps, policing, and urban renewal projects, structural racism in housing and labor markets has become more complex, but no less violent. During the 1990s into the 2000s, the predatory inclusion of Black homebuyers in subprime mortgages and the securitization of debt was in many ways more technically sophisticated than the mapping of neighborhood grade. But it functionally operated by the same racist logic: expanding profit opportunities for investors by pooling risk across the most marginalized, disenfranchised populations ([Rugh and Massey 2010](#)).

In the fallout of the Great Recession, when the subprime mortgage market collapsed, health impacts could be observed almost immediately. Direct wealth shocks were linked to increasing physiological stress response and changes in cardiovascular function. For example, losses in net worth from the pre-to the post-recession period were associated with increases in systolic blood pressure and C-reactive protein ([Boen and Yang 2016](#)).

The logic of financialization -- creating new assets and securitizing debts -- has extended into new sectors, such as rental housing and health care. Following the recession, large private equity firms invested a massive amount of capital into single-family rentals, especially by purchasing foreclosed homes -- largely concentrated in communities of color hardest hit by the subprime mortgage crisis ([Fields and Raymond 2021](#)).

This pattern has extended to the current housing crisis spurred by the global coronavirus pandemic, as families struggle to pay mortgages and real estate investors have learned how lucrative single-family homes in working-class neighborhoods can be as assets ([Christophers 2021](#)). In 2021, an analysis across 40 large metro areas found that 30% of all sales in majority-Black neighborhoods were to real estate investors, compared to 12% in other ZIP codes ([Schaul and O'Connell 2022](#)).

This translates to new population health risks in these communities -- it is more difficult to purchase a home as prices skyrocket and competition with investors increases, investors represent a powerful new political coalition lobbying local policymakers, and large absentee owners tend to evict more than do individual owners ([Gomory 2021](#)), which leads to increased physical and mental health risks ([Hoke and Boen 2021](#); [Benfer et al. 2021](#)). Indeed, several studies during the COVID-19 pandemic have demonstrated the impact of eviction freezes on reducing mortality ([Leifheit et al. 2021](#), [Sandoval-Olascoaga et al. 2021](#)) and how eviction increases health-care spending while reducing health-care access ([Schwartz et al. 2022](#)).

Along with the housing market, speculative investors have crept further into health care delivery since the late 1990s. This is driven in part by the increasing intensity of financialization and profit-seeking in health-care delivery. Health-care spending increased by \$933.5 billion between 1996 and 2013, from \$1.2 to 2.1 trillion, and roughly half of this increase was accounted for by increases in service price and intensity; factors related to population size and aging, disease prevalence, and service utilization were much smaller contributors ([Dieleman et al. 2017](#)). Payment systems incentivize sick care and those who are sickest are often people of color, a pattern that has been described as the [racial capitalism of care](#).

Meanwhile, private equity ownership of safety-net hospitals serving historically Black neighborhoods has led to increased instability in access and worse patient outcomes ([Bruch et. al. 2020](#)). Consider the case of Philadelphia, one of the poorest large cities in the United States, where for-profit hospitals began spreading in 1998 ([Pomorski 2021](#)). Hahnemann Hospital, a safety-net facility serving a majority-Black portion of North Philadelphia, was acquired by American Academic Health System LLC in 2018. President and founder Joel Freedman, based in Southern California, was in the business of purchasing financially vulnerable health care facilities and reorganizing service delivery schemes in order to turn a profit. Freedman did not anticipate the nuances of why Hahnemann was struggling to stay afloat in Philadelphia and moved to file for bankruptcy in 2019 ([Brubaker 2019](#)), abruptly closing hospital doors and preparing to sell the real estate despite a coordinated campaign from the city and local activists to keep the hospital open. Hahnemann sat empty during 2020 as the [COVID-19 pandemic](#) surged across Philadelphia, largely affecting communities of color, many of whom were previously served by the hospital. In March 2020, city officials tried to negotiate with Freedman to temporarily open Hahnemann to house COVID-19 patients during the anticipated surge, but talks quickly stalled after Freedman asked for over \$400,000 per month to lease the facility ([Pomorski 2021](#)).

Social movements and the epistemology of health disparities

There have always been social movements that have resisted the oppressive arrangements that produce racial disparities in death and disease, and these movements have long been the source of critical analyses recognizing political economy and power as the fundamental cause of racial health disparities.

The intersection of health activism and broader racial justice activism has a [long history](#), including many social movements for Black health: the National Negro Health week movement, the Black anti-tuberculosis movement, the Black mental health movement, Black reproductive justice movements, and the Black movement for official attention to HIV/AIDS. This organizing has been a direct reaction to several factors, including the explicit targeting of Black communities because of their economic and political vulnerability in the [siting of hazardous facilities](#), the [concentration of infectious disease](#), and the [segregation of health care](#).

For example, analyses of racial political economy and power fueled efforts against the [concentration of tuberculosis in Black communities](#) in the 1870s-1920s and more recently the disproportionate [concentration of HIV/AIDS among Black Americans](#). These critical analyses were used to combat mainstream academic and policy responses that often blamed genetics and behavior for racial disparities in infectious disease. Movements in response to death and disease were intertwined with efforts to [dismantle segregated health care](#) across the 20th century. Black-led efforts to combat white racism in health care contributed to the development of Black nursing and led to the [1972 creation of the National Black Nurses Association](#). Black physicians also became leaders in the fight for [desegregation of the Jim Crow hospital system](#) in the South.

While many of these movements were a direct response to health disparities, they also contributed to building a critical analysis that linked population health with broader activism for racial justice. This was shaped by the understanding that death and disease can spur activism. For example, Alondra Nelson (2013) describes in *Body and Soul* how health offered a [new moral terrain for racial justice activists](#). Nelson shows how during the 1960s and 1970s, the Black Panthers worked on campaigns for educating and testing people of color for sickle-cell anemia, as well as supporting the creation of community clinics.

And Jenna Loyd (2014) illustrates how [health organizing also became connected to international justice efforts](#), using the example of the rise of the defense industry in postwar Los Angeles. Loyd traces how activists responded to public subsidies for private housing for White defense workers -- subsidies that reinforced existing White privilege and came at the expense of state and federal investment in public housing and health care.

While disproportionate disease and illness can serve as a catalyst for organizing and critical analyses of political economy and power, it can also lead to divisiveness by [challenging ideas about who belongs in the community](#) in ways that are gendered and racialized. For example, Black gay men were separated from much of mainstream HIV/AIDS organizing. Stephen Inrig (2011) illustrates how policies pursued by the gay white community combined with poverty, lack of health care, and the war on drugs to [accelerate the spread of HIV/AIDS in the Black community](#): today, [half of people diagnosed with HIV are Black](#).

[Kevin Mumford](#) argues that this marginalization extended into the broader organizing sphere. Jennifer Nelson contends that [women of color have never received adequate credit crafting a reproductive rights agenda](#); for example, working to move organizations such as the Young Lords and Black Panthers away from notions of birth control and abortion as genocidal plots and instead linking these to the broader provision of adequate health care and childcare.

While social movements have been essential for identifying, understanding, and conceptualizing solutions to manifestations of racial health inequality across U.S. history, they have also been marginalized from mainstream policy and [academic conversation](#), often by the same powerful people who stand to benefit from the status quo.

[Many have written](#) about how tying COVID-19 outcomes to individual decisions and biology helps to avoid questions about power and profit, especially in regard to the national COVID-19 strategy across both the Trump and Biden administrations. But this is nothing new.

As with the case of HIV/AIDS, political and scientific leaders have historically found it more convenient to depict a disease as naturally falling upon specific racial populations rather than engaging with critiques of the real political and economic causes of racial disparities. Elites have long worked to brand political-economic analyses of racism and power as a fringe and dangerous perspective. For example, in [The Scholar Denied](#), Aldon Morris describes how W.E.B. Du Bois and his foundational analyses of racism focused on power and political economy -- including descriptions of Black urban health -- and were marginalized and made invisible within the predominantly white academy. Epidemiologists [Nancy Krieger](#), [Carles Muntaner](#), and others have written about how the intersection of McCarthyism and academic population health, where egalitarian research agendas focused on politics and power under capitalism -- especially in the social medicine tradition from Central/Southern America -- were branded as dangerous Communist ideologies. These examples illustrate how analyses of the political economy of health are often erased by political and academic institutions. These efforts by those in positions of power to shape the narrative of population health have been effective not simply by erasing critical analyses of political economy originating from social movements, but also by actively co-opting, disarming, and diluting radical progressive language and concepts ([Yong 2021](#)) - or what Olúfẹ́mi Táíwò describes as “[elite capture](#).”

Many institutions, such as universities, have lifted the language of progressive social movements (e.g., harm reduction) and held “listening sessions” while at the same time continued to aggressively resist organized efforts aimed at student/staff unionization, abolishing university policing, addressing the role of the university in the gentrification and displacement of surrounding communities, and divesting university endowments from fossil fuels as climate change continues to disproportionately harm communities of color. This is just one example of how elites not only *erase* radical critiques of the political economy of health but also *co-opt* them in superficial ways without actually shifting the distribution of power or material resources.

It is essential to recognize that Black and brown communities have been active participants in documenting, theorizing, and confronting racial health disparities in the United States. The conception of power as the fundamental cause of health inequity has significant historical origins in social movements and other forms of collective action. But powerful players have worked to contort these critical analyses or render them invisible. Moving forward, it is important to emphasize perspectives on racial political economy and power borne from social movements in analyses of health inequality, a feature of what Chandra Ford and Collins Airhihenbuwa (2010) call a [Public Health Critical Race praxis](#). We must recognize that racial health disparities are the product of imbalanced power relations embedded in the institutions that govern the distribution and use of health-relevant resources.

Conclusion

We began this report with the contention that public health mirrors societal functioning, and that, in addition, broad-based population health is essential for society to function effectively. As the United States passes [1 million](#) counted deaths from COVID-19, the pandemic has laid bare how a health crisis can cripple an entire global economy and threaten democracy. No amount of power can protect any population burdened by poor mental and physical health. The health of the U.S. population even among well-resourced white populations rates poorly across multiple health conditions compared to their counterparts in industrialized countries ([Malat et. al. 2018](#)). Strikingly, a recent study found that White U.S. citizens in the 1% and 5% highest-income counties had worse outcomes for infant and maternal mortality, colon cancer, childhood acute lymphocytic leukemia, and acute myocardial infarction compared with average citizens of other industrialized democracies ([Emanuel et al. 2020](#)).

The U.S. was already ranked low in life expectancy compared to its peer high-income countries, and even some middle-income countries, and has continued to lose ground with recent declines in life expectancy ([NAS 2021](#)). As depicted in Figure 14, while U.S. life expectancy increased from 1950 to 2010, compared to peer countries,⁴ it often did so at a slower pace. While increases in U.S. life expectancy in the 1970s were on par with or sometimes surpassed those in peer countries, year-over-year increases in the U.S. began shrinking in the late 1970s and did not keep pace during the 1980s, 1990s, or 2000s. In the early-2010s, increases in U.S. life expectancy first stalled and then reversed, with declines arising between 2014 and 2016, while life expectancies for peer countries continued to increase.

It should be noted that while the racial/ethnic diversity of the U.S. population distinguishes it from the populations of its 16 peer countries, there is little evidence that racial/ethnic diversity explains the U.S. life expectancy gap. Indeed, the stall and subsequent decline in U.S. life expectancy after 2010 occurred among the U.S. Black, white, and Hispanic male and female populations ([NAS 2021](#)).

The U.S. is a sick society and one that will become sicker if we do not address and understand how economic, political and racial power operate in tandem to affect health and well-being and address the macro-structural factors driving health ([NAS 2021](#)). As prior social movements have proclaimed for decades, we know what causes poor health and it is killing our nation – populations of color and poor populations may be the first to die in a deeply unequal society, defined by its heavily stratified commodified health-resources, but they will not be the last.

⁴ *Note:* peer countries include: Australia, Austria, Canada, Denmark, Finland, France, Germany, Italy, Japan, Norway, Portugal, Spain, Sweden, Switzerland, the Netherlands, and the United Kingdom.

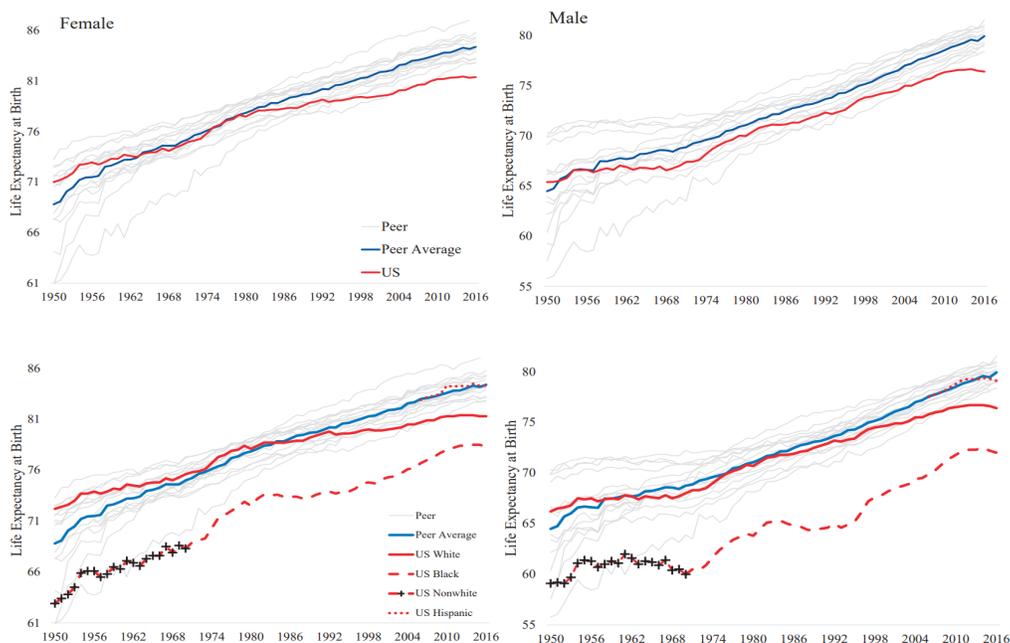


Figure 14. Female and male life expectancy at birth in the United States and peer countries, 1950–2016. Figure and notes below drawn from [Mullan Harris et. al. \(2021\)](#).

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