

# The “Slave Health Deficit:” The Case for Reparations to Bring Health Parity to African Americans

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**O**n becoming the president-elect of the National Medical Association (NMA) in August 1999, I became increasingly aware of the following grim health statistic: African Americans possessed the worst health status of all Americans. As an African-American physician poised to assume the presidency of the oldest health organization representing over 25,000 physicians of African descent, I felt an obligation to make the issue of health disparities within the African-American community my primary focus. Earlier in that year, under the auspices of then president, Dr. Gary C. Dennis, the NMA hosted a press conference to shed light on racism in medicine. The panelists' presentations have been compiled as a supplement in an upcoming issue of the *Journal*.

During the formulation of my presidential agenda, I determined to emphasize the history, the causes and the solutions for the elimination of racial and ethnic health disparities—especially within the African-American community. To successfully tackle this aggressive agenda, I needed to understand and to be able to convey not only the *what* and, the *why*, but *ways* to solve the problem. I therefore sought to first *define* the problem (what), seek to *understand* (why) the problem and, finally, to discover *remedies* (ways) to solve the problem.

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## Defining Health Disparities

In the 1980s, then Secretary of the Department of Health and Human Services (DHHS), Dr. Louis Sullivan launched Healthy People 2000.<sup>1</sup> The goal of this program was to address racial and ethnic health disparities by significantly reducing the disparate health outcomes in the U.S. by the year 2000. Sometime later, Dr. David Satcher, under the direction of President Clinton, took the bold and unprecedented step of raising the bar to totally eliminate all racial and ethnic health disparities within the U.S. by the year 2010, resulting in the development and implementation of Healthy People 2010.<sup>2</sup> This program outlines 467 objectives to improve the health of all Americans by the year 2010 and sets forth two goals: (a) increase the quality and years of healthy life; and (b) eliminate health disparities.

Since 1980 African Americans have experienced the highest death rates in 14 of 16 leading causes of death.<sup>3,4</sup> Blacks suffer one of the highest infant mortality rates in the U.S. and the black men have the shortest life expectancy rates.

However, African-American health disparities have been chronicled for quite some time, including as far back as the early part of the 20th Century, when many African-American scholars documented health disparities, including W.E.B. Du Bois,<sup>4-7</sup> Julian Lewis (*The Biology of the Negro* in 1942) and W. Montague Cobb.<sup>7</sup> For the past 80 years the *Journal of the National Medical Association* has also served as an avenue for the publication of articles documenting health disparities in blacks, but more recent contri-

butions have been provided by Drs. W. Michael Byrd and Linda Clayton.<sup>4,8-10</sup> In later years, such chronicling has come to include the 1985 landmark Department of Health and Human Services investigation, "The Report of the Secretary's Task Force on Black and Minority Health,"<sup>11</sup> and more recent studies documenting significant racial and ethnic health disparities in health status, access, services, and outcomes.<sup>12-16</sup>

## Understanding the Problem of Racial and Ethnic Health Disparities

A review of numerous publications, including *An American Health Dilemma: Volume I, A Medical History of African Americans and the Problem of Race: Beginnings to 1900*, by Byrd and Clayton, have been extremely helpful in providing insights to explaining the circumstances that resulted in the "slave health deficit," a term coined by Byrd and Clayton in 1991 to describe current African-American health disparities.<sup>8-10</sup> This review compelled me to conclude that the poor health of African-Americans is not a biological act of nature nor 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.

## Historical Perspective

**African Continent Round-Up Period.** According to Byrd and Clayton, some historians estimate that the Atlantic slave trade exacted a mortality rate in African natives as high as 50% before the transatlantic voyage. Pre-voyage mortality was the result of gathering the Africans from the interior and their transfer to the African coast in preparation for the transatlantic voyage. The process included generating artificial slave wars, rounding up the captive Africans and marching slave coffles from the interior to the African coast. Africans who had been isolated from many indigenous and exogenous diseases were now intermingled with local African diseases among large populations of nonimmune Africans. Thus, epidemics of new diseases and the spread of local diseases occurred among the African captives in transit. Compounding the problem was inhumane treatment and unsanitary conditions. About 40–100 million Africans were enslaved, with 15–25 million surviving the transatlantic voyage.

**Transatlantic Middle Passage.** Byrd and Clayton

conclude that the transporting of slaves from Africa to the Americas had a profound health effect on the various displaced populations. This catastrophe most negatively affected the African and Native American populations, traumatically ending their epidemiological isolation. For example, the slave trade transported malaria and yellow fever to the New World, which devastated the Native American populations. Black Africans were now exposed to multiple European indigenous diseases such as tuberculosis, influenza, small pox, measles, and syphilis.

Additionally, during the Middle Passage, black Africans were exposed to horribly inhumane and unsanitary conditions in the ship's slave quarters. They contracted diseases such as dysentery, diarrhea, ophthalmia, malaria, scurvy, worms, yaws, and typhoid fever. Slaves also suffered from friction sores, ulcers, injuries and wounds resulting from iron chains, accidents, fights and whippings. But by far the greatest killer disease during the Middle Passage was the bloody flux: amoebic dysentery. Byrd and Clayton assert that the overall mortality from this traumatic, disease-ridden, transatlantic experience was around 15%–20%, and sometimes climbing to 50%–80%.

Given these historic points, I postulate that a current leading cause of death among African Americans, hypertension, may be traced to this traumatic transatlantic voyage.<sup>17</sup> Since the major killer of slaves was dysentery with resultant dehydration,<sup>4</sup> those slaves with better salt or sodium retention may have fared better during the voyage. Previous studies show that many African Americans maintain higher sodium sensitivity associated with high levels of hypertension. Panza, for example, found that blacks demonstrated an altered reactive hypertension response to stress compared to whites.<sup>18</sup> This response was mediated by nitric oxide, a chemical that is released with stressful stimuli and acts as a vasodilator. Blacks exhibited a blunted response to this chemical and higher blood pressures.

**Institution of Chattel Slavery (1619–1865).** Byrd and Clayton emphasize that a critical period in the health of slaves was the "breaking-in period," lasting from six months to three years after arrival in the Americas. Medically, the break-in period was one of increased risk for slaves, including the shock of adjusting to the new diseases, the environment, and a strange, indigenous population. The added stress of being torn away from home and familiar environ-

ments, combined with the American slave institution of deculturation were compounding factors. According to the authors' research, the overall result of this fatal mix of a contagious, cruel and stressful environment was a 30%–50% mortality rate for newly arrived slaves during this break-in period.

Those slaves surviving this period would be subjected to a lifetime of little or no health care and forced to live under unsanitary and cruel conditions that created the foundation for the poor health status and outcomes still present today.

Another complicating factor was the dissemination of 'scientific' proof of black inferiority to justify chattel slavery and inequitable social, economic and medical treatment. From the 17th century and continuing, as many critics purport, well into the 20th century, the mainstream medical establishment taught and practiced scientific racism in the form of black inferiority through the use of such theories as the Great Chain of Being (describing blacks as derived from apes and inferior to Europeans); phrenology (using skull size and capacity to demonstrate lesser intelligence in blacks and Native Americans); and blaming slaves for diseases they acquired from their captors.<sup>3,4,8–10,19–23</sup>

**Post-Slavery Period (1865 to 1965).** The time frame includes the reconstruction and post-reconstruction periods. Immediately after slavery, the health of newly freed blacks was so dire that immediate redress was sought to avert annihilation of blacks before the end of the century. Subsequently, legislation during the reconstruction period resulted in the creation of separate but unequal medical clinics, hospitals and medical schools. Byrd and Clayton maintain that there was significant improvement in black health during this brief period. However, with the end of reconstruction and the start of Jim Crow, the health status of African Americans entered another period of deterioration. Black patients and physicians were forced into a substandard health system marked by the inadequate allocation of resources and the inability to access mainstream medical hospitals, clinics, and medical schools, as well as the inability to influence health policy.

Black physicians' response to these inequities resulted in the founding of the National Medical Association in 1895, given their exclusion in the American Medical Association (established in 1847). For the first 23 years of its existence, the AMA would informally exclude African-American physicians based upon medical-social custom. In 1870, that

discriminatory behavior became a formal AMA policy that remained in place for most of the following century.

After less than a half century, the U.S. government formally reneged on promises given during the reconstruction period. In 1910, the Flexner report recommended the closure of many medical schools due to concerns of lack of quality in medical education.<sup>24</sup> Mr. Flexner's recommendations resulted in the closure of five black medical schools, leaving only Howard and Meharry Medical Schools to educate physicians to serve the severely underserved black population. I believe this decision along with discriminatory practices barring blacks from entering mainstream medical institutions, are directly linked to today's critical shortage of black physicians, who currently represent less than 3% of the U.S. physician workforce.

At the turn of the 20th century, eugenics, the science of selective breeding to foster social improvement, was used to explain differences between the 'haves and have nots.' According to eugenics proponents, intelligence and life success were hereditary, thus, the fate of the poor, non-whites, and other disadvantaged groups was predetermined.<sup>4,25</sup> However, I believe, the teaching of black physical appearance as "inferior" subsided in the latter part of the 20th century, but the assault on the black intellect has continued. Today, we witness incorporation of Afrocentric physical traits,<sup>26</sup> linguistic and cultural traits of expression, into European culture. However, a deeper examination into this European "hip culture consciousness" should not mask the stark reality that—black intellectual inferiority continues to be taught overtly and subliminally in America's mainstream forums and most prestigious educational institutions.<sup>25,27–31</sup>

**The Civil Rights Health Period.** In 1965, enactment of Title VII Civil Rights legislation resulted in the formulation of two major health programs:—Medicare and Medicaid, which gave the poor, elderly and underserved populations access to mainstream healthcare, and resulted in the desegregation of organized medicine. It should be noted that the NMA strongly advocated for the passage of this health legislation while the AMA simultaneously opposed it as too socialistic. It is ironic that today, the physician members of both organizations would find it difficult to maintain their financial independence without these programs. Byrd and Clayton describe this era as one in which blacks experienced

significant improvement in their health status and outcomes.

**Post-Civil Rights Period.** Since 1980, there has been continual deterioration in African-American health status. As indicated earlier, this has resulted in blacks currently experiencing the worst death rates in 14 of the 16 leading causes of death. The policies implemented during the Civil Rights Era have been curtailed. We are now witnessing the negative health effects from welfare reform, with decreased health access and increased uninsured rates, managed care implementation without a proven record in many underserved populations and anti-affirmative initiatives, which have hindered the numbers of under-represented minorities in the nation's medical schools. This concern is further exemplified by the failure of the 3000 by 2000 Program initiated by the Association of American Medical Colleges (AAMC),<sup>31-33</sup> a program which fell far short of its goal to infuse 3000 new medical students from the underrepresented minorities into medical schools by the year 2000. If the current anti-affirmative action movement continues, we may instead refer to the AAMC Program as 3000 by 3000—creating a worsening health crisis in the already vulnerable communities.

## Remedy

I believe that a potential remedy to the disparate health of African Americans can be found within the thoughtful insights into the issues of racism, slavery and reparations so eloquently raised in *The Debt: What America Owes to Blacks* by Randall Robinson.<sup>34</sup> The issue of reparations for the wrongs of slavery is clearly an emotional, controversial and frequently misunderstood issue for all Americans. Legislation introduced in 1993 by African-American Congressman, John Conyers (D-MI), asked Congress to establish a commission to study the effects of slavery. This bill, which did not ask for reparations, only received the support of 28 of 435 legislators (18 of whom were African American). The bill was referred to a House subcommittee where it never made it out of committee.

It is imperative for America to recognize and address the unique health circumstances present in the African-American community. To that end, the NMA has planned several educational forums on cultural diversity and racism in medicine, including a Diversity Symposium, in partnership with the Uni-

versity of California San Diego Medical School, National Hispanic Medical Association and the Association of American Indian Physicians that will take place in San Diego, CA, May 3-5, 2001, as well as a colloquium on racial and ethnic health disparities and the effect of racism on African-American health.

NMA also provides aggressive advocacy for health policies and legislation that will improve the plight of African-American physicians and restore better health to the African-American community. Most recently, after a three-year effort—by the NMA leadership and Health Policy Division,—the S.1880, "Minority Health Fairness Act of 2000" was passed. This legislation elevates the National Institutes of Health (NIH) Office of Research and Minority Health to an NIH center and effectively increases resources for minority research and education. Advocacy on the part of the NMA has also resulted in congressional approval for a study by the Institute of Medicine (IOM) on ethnic health disparities and the influence of racism. A final report is scheduled for presentation to Congress in early 2002.

Lastly, the NMA is developing a Health Policy and Research Institute,<sup>23</sup> whose mission is to develop, evaluate and implement strategies for the elimination of ethnic health disparities and racism in medicine by promoting wellness solutions to improve the health status of the African-American community and thereby improve the health of all Americans. To date, a committee of experts has been appointed and charged with the development and creation of strategies that will eliminate health care disparities in the African-American community and to address the issues surrounding the impact of racism in health care.

The institute and its five 'core' centers—African-American Health Center Think Tank, Health Policy and Advocacy Center, Research, Surveillance and Professional Education Center, Community/Public Media Information Center, Mobilization and Participation Action Center—will serve as a specific and achievable response to the U.S. Surgeon General's and the American Public Health Association's "Call to the Nation to Eliminate Racial and Ethnic Disparities in Health," with the hope that organizations and individuals throughout the country will endorse and commit to achieving this historic goal by the year 2010.<sup>35</sup> However, the success of the institute will require support and generous funding from the private and public sectors. I call upon the nation's

public and private sectors to unite behind this ambitious but just and critical endeavor. Additionally, I call upon all individuals of conscience to unite and engage in a rational dialogue on this critical issue that is long overdue.

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