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Uprooting Institutionalized Racism as Public Health Practice

See also Morabia, p. 426; Sundwall, p. 449; Woolhandler and Himmelstein, p. 451; Gottfried, p. 452; Moffit, p. 453; Olden, p. 454; Zimmer, p. 456; and Kirkham, p. 458.

Well into the 21st century, Black people in the United States are still sicker and still die younger than do their White counterparts. This is not new. Such racial gaps were noted with the tabulation of vital statistics in colonial America. A recent review of Black health disadvantage found that relative racial disparities began at birth and continued up to age 65 years.[1] Sharing this experience of lives cut short are American Indians and Alaska Natives, who experience the highest rate of premature mortality among US racial/ethnic groups.[2] Overall mortality has declined across all groups, but these stubborn relative racial gaps persist.

The racial gap is not normal. It should not exist. As a group, all human beings are equal. We should get sick and die equally. The differential patterning of premature mortality by race is not a reflection of biological difference or some inherent predilection for ill health by people of African descent and the indigenous. Stated plainly: the past and present racial patterning of disease reflects institutionalized racism, present not just in one of our institutions but in them all. When we no longer observe these racial variations in disease occurrence and outcome, our society will have at last vanquished racism. This effort begins with recognition that racist ideas shaped public health practice.

The phrase "institutional racism" refers to ways both state and nonstate institutions discriminate, through policies and practices, on the basis of racialized group membership.[3] There are two main racist ideas that dominate explanations of Black–White disparities in health, arguments extended to all non-Whites. The first argument is the biological inferiority of non-Whites. The second, presently more dominant, holds that defects among Blacks lie not in genetic makeup, but in behavior.

GENES OR BEHAVIOR

The genetic hypothesis dominated early US medical and public health thinking. Much 18th- and 19th-century medical literature explored the inherent inferiority of enslaved Africans.[4] Debate centered on whether Blacks and Whites were even members of the same species. Other examples now appear equally ridiculous. Take Drapetomania, the disease that caused enslaved Africans to run away.[5] The recommended prevention is not hard to guess: whipping. At the end of the 19th century, the statistician Frederick Hoffman used actuarial data to argue that high mortality rates of freed Blacks reflected the intrinsic lack of fitness of the Black population.[6] Today, various genetic markers or different genomes are announced regularly to explain racial variation.

The behavioral hypothesis invokes racial variation to explain the many risk factors for common diseases—obesity, lack of exercise, unsafe sex—that could be modified by personal action. As a result, although Blacks are born equal, these preventable risk factors accumulate because of lack of knowledge and flawed decision-making. The argument goes like this: Yes, life is tough but you don't *have* to overeat, get too little exercise, engage in violence, ignore medical advice, and so on. This "lifestyle hypothesis" assigns responsibility to individuals without reference to the context of their lives. In addition to dismissing racial patterning of power and opportunity, it ignores the toll of daily and lifelong experiences of discrimination. Like the genetic hypothesis, it is a racist idea.

WHITE VS BLACK MORTALITY

The narrative of failed personal responsibility often recedes when the victims are White. This has long been true. For Jane Addams, revered settlement house pioneer, the social ills of European immigrants were attributed to the trauma of immigration and the challenges of cultural adaptation.[7]

The contemporary opioid epidemic shows the durability of such racialized interpretations. Quadrupling of painkiller prescriptions triggered the current epidemic following pharmaceutical industry marketing campaigns. Patients who got these drugs are portrayed as pain victims because of hardworking lives. The system—pharmaceutical companies and medical professionals—failed, not the people.

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What followed was a shift in how opioid addiction is approached, with a focus on treatment and not punishment. By contrast, Black people living with heroin and crack cocaine addiction are portrayed as conniving and criminal. The dual narratives—one for Whites that sees poor health driven by difficult life circumstances and one for Blacks that sees personal deficiency—reflect the enduring power of racist ideas.

ANTIRACIST PUBLIC HEALTH PRACTICE

Rejecting these two central explanatory models of racial differences in disease and mortality patterns—the genetic and the behavioral—is important because ideas influence action. Instead, public health practitioners should acknowledge the centrality of racism—the entrenched discriminatory practices of institutions, not only people. This frame shift, from people to institutional policies and practices, reconceives both the problem and its response. Residential segregation is not the result of personal preference or private prejudice, but the result of policies enabled by governments.[8]

In all matters of Black disadvantage, the first question is often, "What is wrong with Black people?" If instead you ask, "What is wrong with the policies and institutions?" you no longer focus on education about healthy food and imploring individuals to take responsibility for food choice but point to food deserts where few stores offer healthy food, the high cost of fruits and vegetables, and the rapacious marketing of unhealthy products in communities of color. This is the litmus test: any framework that identifies the problem as people should be challenged.[9] Communities are vulnerable because of bad policies and disinvestment, not because of the people who live in them.

The overall decline in mortality is good news, but we can do better. We can be a country where the color of our skin does not determine our chance for a long and healthy life. The first step is acknowledging the impact of racism on health. The next step is antiracist public health practice. AJPH

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M. T. Bassett conceptualized, drafted, and revised the content of this editorial. J. D. Graves contributed to the conceptualization and revision.

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Kirkham Responds

See also Morabia, p. 426; Sundwall, p. 449; Woolhandler and Himmelstein, p. 451; Gottfried, p. 452; Moffit, p. 453; Olden, p. 454; Zimmer, p. 456; and Bassett and Graves, p. 457.

The struggle against bias in the United States is a long and enduring one. As a people, we have come a great distance in trying to recognize and conquer it. We have eliminated many instances of de jure and overt cultural discrimination against and exclusion of individuals or groups. This has come across a broad spectrum, including race, gender, religion, mental and physical illness and disability, and sexual orientation. It took large numbers of women and men of great courage who made tremendous sacrifices, often well out of the public eye, to bring us this far. And yet we have a great distance still to travel. There is no denying that outcomes and opportunities are not the same for many Americans. Nor can we say that our culture openly and warmly embraces everyone. To be sure, there are still individuals and groups who continue to espouse hatred, division, and violence. They are worthy of our collective rebuke and contempt. Such attitudes have no place in our society and pull at the threads that make up the fabric of our civilization.

OVERSTATING THE CASE

Bassett and Graves, from the Department of Health and Mental Hygiene, argue that a disparity in health outcomes in White and non-White populations "reflects institutionalized racism, present not in just one of our institutions, but in them all." If this can be read as a sweeping condemnation of every public institution and by extension government program in the country as racist, it significantly overstates the case. A more nuanced approach acknowledges that bias (a broader term that can encompass racism and other forms of discrimination) certainly plays an important part in every aspect of the

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