Toward a Historically Informed Analysis of Racial Health Disparities Since 1619

See also Brown, p. 1309.

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

—*Martin Luther King, 1966*

There has never been a time in the United States without racial health disparities. Although the term "health disparities" is of recent origin, differential health outcomes between Blacks and Whites have been part of the American landscape for 400 years. The sophistication of the analytic approaches taken by journalists, social scientists, government agencies, or health scholars may differ, as do the objects of study, but the narratives are very much the same.[1] The reasons given for such disparities are supposedly either inherent in the Black body or inherent in the inequalities that have shaped the Black experience for centuries.

Yet, most studies of health disparities ignore the real historical past or, at best, classify it as a "variable."[2] If historical evidence is used at all, it is said to have two contradictory influences: to make change seem impossible or to make change seem inevitable if attention is given to choices made and not made.[3] At the same time, race and racism as factors in the production and maintenance of health disparities are grouped into unchanging categories requiring little definition or historical contextualization. A more appropriate and truly historical approach could help us see the past reasons for health disparities and how they link the body and the body politic. With this knowledge, public health practitioners can consider what to do to overcome these historical burdens that affect the life chances of African Americans.

RACIALLY DIVIDED HEALTH CARE

The consequences of slavery were to set up racially divided health care: slave owners saw Black bodies that needed to be disciplined and controlled to remain "sound," while enslaved Africans used skills brought from their homelands, making use of roots, herbs, and communal support to heal their communities. High rates of morbidity and mortality brought about by overwork, horrendous living conditions, sexual abuse, violence, and separation marked the life chances of enslaved Black Americans.

White physicians assumed Black bodies were fit for slavery and thrived under White control, and feared that once slaves were emancipated their increased rates of illness and demise were inevitable. These "logics of difference" between Blacks and Whites, based on Biblical readings or scientific dogma, would follow Black Americans through slavery and the Civil War.

RACIST PUBLIC HEALTH SYSTEM

In the immediate aftermath of the war, the rising rates of illness and death of newly emancipated Black citizens were caused by the loss of plantation health care; the illnesses and disease epidemics brought on by starvation, disruption, and lack of work; and the inability and unwillingness of an underdeveloped and racist southern public health system to take up the slack. Fear that "dependency" on governmental largess would undermine White authority and support Black citizenship made introduction of public health services difficult politically as well.

To counter these conditions, African Americans made demands on the local and federal governments, built up mutual aid societies, and formed separate medical and nursing schools when denied access to those controlled by Whites.[4] These efforts, however, could not be sustained by an economically distressed population alongside the social conditions that underlay the epidemics, poverty, and poor sanitation that caused widespread illness and death. Above all, the lack of political power in southern Black communities after the end of Reconstruction thwarted African Americans' abilities to make public health any kind of priority at a local or federal level.

Throughout the late 19th century and into the 20th century poor health and lack of access to health care, coupled with theories of innate weakness, followed African Americans out of the rural South and into the cities. The housing segregation, crowding, and heavy manual labor faced by Black men and women took their toll as infectious diseases spread. At the end of the 19th century, statistician Frederick Hoffman claimed that differential health outcomes were an inherent biological phenomenon. Sociologist W. E. B. DuBois countered, describing the social causes of illness in his monumental study

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The Philadelphia Negro.[5] These strikingly different arguments, which located the cause of disparities as either in the body alone or in social conditions, would continue to frame explanations by public health experts.

SEGREGATION

By the early 20th century, the understanding that disease would not stay on one side of the tracks separating Blacks and Whites had spread. Public health officials in some of the less segregated cities found that newer water purification and sewage systems, aimed at improving the health of White urban dwellers, could better the life chances of their Black neighbors too. With the organization of National Negro Health Week and various efforts by organized Black women's groups, more consciousness about what could be done both individually and collectively to improve health outcomes emerged. Health education, building of privies and wells, and a collective effort to make health care matter all had a positive impact. Yet, dismantling the segregated health care system that most Blacks experienced proved difficult.

Contemporary civil rights lawyer Bryan Stevenson noted that "slavery didn't end in 1865, it just evolved."[6] The same is true for the nation's segregated health care system; it evolved from a system of strict segregation to one riven with inequalities. Health disparities in the 20th century were produced both by practices based on ideologies of racial difference and by the fact that Blacks still were not recognized as full citizens whom public health interventions had to address.

MASS INCARCERATION

During the 20th century, through the work of Black churches, women's organizations, civil rights and radical political groups, and Black nurses and doctors, health became central to the continued struggle for equality. By the mid-1970s, structural injustices in health care came into sharper relief as US incarceration rates began to spiral upward, disproportionately affecting Black communities. Mass incarceration has also been recognized as a cause of ill health in Black communities, and not only for those imprisoned and subjected to the gross inadequacies of prison health care.[7] Separation of families, loss of income, and the return to their communities of untreated or badly treated formerly incarcerated individuals all affect health outcomes in Black communities.

Public health practitioners need to be teamed with community activists, criminal justice advocates, housing and job organizers, and radical politicians if there is ever to be change in this long story. Methodologically, we need analyses of health disparities that include greater engagement with history aimed toward examining the specific mechanisms and social factors that produced health disparities in the past. We need a better understanding of the individual effects of structural racism and inequalities in the body politic when inequality and racism become biologized.

HISTORICALLY INFORMED ANALYSES

Finally, we need historically informed analyses that reveal, rather than obscure, the forces that are intensifying health inequalities in the present. Unless this happens, the challenge for public health will alas remain unchanged from the era of slavery to the present: how to extend the benefits of public health interventions to the most vulnerable populations in our increasingly racially and ethnically diverse and economically stratified country. Discussions of the need for reparations ought to look at health outcomes, too, as an index of the cost of racism through the ages. AJPH

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The authors have no conflicts of interest to declare.

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