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Structural Racism as a Fundamental Cause of Health Inequities in Delaware and Beyond:

What Does the Evidence Say?

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Introduction

Health inequities are described as differences in health among different groups of people. These are well documented, persistent, and even increasing for some health conditions across the U.S., including in Delaware (DE). Health inequities may be viewed in the context of race, gender, sexual orientation, income, education level, disability status, or geographic location, among others. Further, when it comes to health, the oppressions associated with each of these statuses can yield compounding negative health effects based on their identity or class (e.g., "female" and "immigrant"). Because these are socially constructed categories related to social hierarchy, and related differences in health do not derive from biology or genetics, experts consider such health differences to be socially produced. As such, we can conclude that "health inequities are not only unnecessary and avoidable, but in addition, are considered unfair and unjust."[1]

People of color in the U.S. experience some of the most pervasive and persistent heath inequities in our country. While it is important to recognize, examine and address health inequities that exist across various racial and ethnic groups, including Native people, Latinxs, and others, the historical context of slavery and persistent oppression among Black individuals in the U.S. warrants particular focus. This paper highlights the magnitude of health inequities experienced by Blacks in the U.S. and in Delaware. It defines structural racism, and provides an overview of the scientific literature regarding the role of structural racism in creating and perpetuating racial health inequities, with a particular focus on residential segregation, mass incarceration and implicit bias within the healthcare system. Much of its content is drawn from a policy brief, titled *Structural Racism as a Fundamental Cause of Health Inequities*[2] produced jointly by the Division of Public Health, Delaware Department of Health and Social Services (DHSS) and the University of Delaware, Partnership for Healthy Communities; and the *Health Equity Guide for Public Health Practitioners and Partners*[3] published by the Division of Public Health, DHSS.

Magnitude of Racial Health Inequities

Life expectancy and infant mortality are two of the biggest indicators considered in evaluating the overall health of a population. Using those two factors as a snapshot, one can get a sense of the magnitude of health inequities experienced by Black individuals in the US. Figure 1 highlights that while infant mortality rates have fallen among all racial and ethnic groups since 2000, the gap between groups persists, with Black, non-Hispanic women experiencing an infant mortality rate of 10.9 deaths per 1000 live births in 2014, compared with a rate of 4.9 per 1000 among White, non-Hispanic women.

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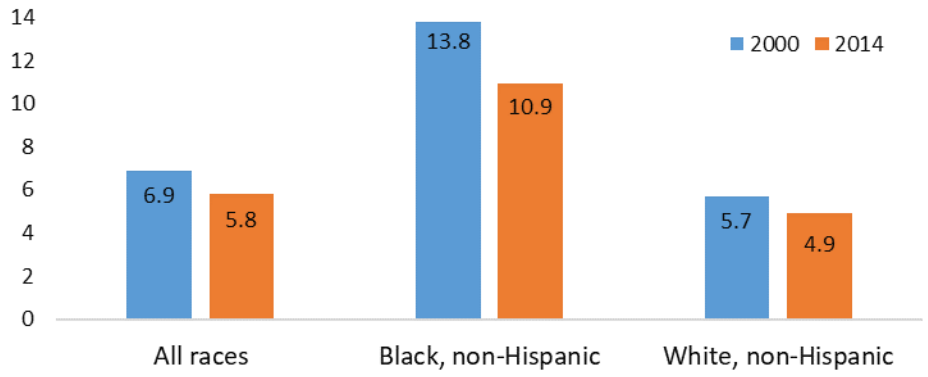
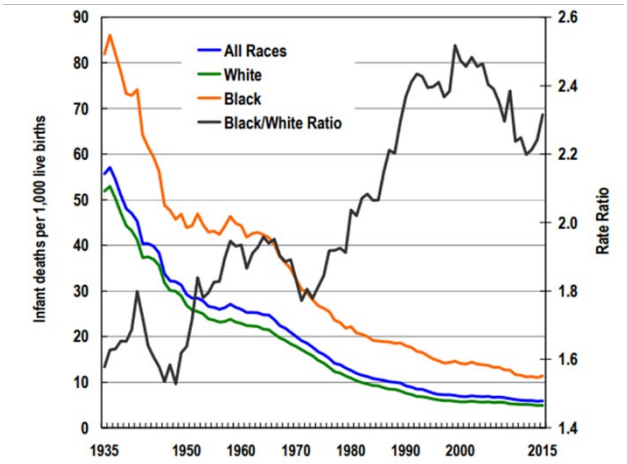
Figure 1. Infant mortality rate per 1,000 live births by maternal race, 2000 and 2014



Source: Kaiser Family Foundation analysis of data from Linked Birth/Infant Death Records 2000-2014, National Vital Statistics System, National Center for Health Statistics, CDC.
https://www.healthsystemtracker.org/indicator/health-well-being/mortality-rate/

Another way to look at the inequity in infant mortality is to examine the ratio of infant deaths across racial groups. Figure 2 highlights how this ratio (i.e. Black infant mortality divided by White infant mortality) has changed over the past 80 years. As seen in this figure, the Black-White infant mortality ratio reached a low of approximately 1.5 in 1948 and stayed below 2.0 prior to the mid-1980s, when it began to climb steadily until reaching a peak over 2.5 in 2000. This Black-White ratio has remained well above 2.0 in recent years and the most recent data from the Centers for Disease Control and Prevention indicate that the infant mortality rate for Black mothers is 2.3 times that of White mothers in the U.S.

Figure 2. Infant mortality rate by race, US, 1935-2015



Source: Singh GK, van Dyck PC. Infant Mortality in the United States. A 75th Anniversary Title V Publication. HRSA. 2010 (updated data) and CDC/NCHS.

Health inequities experienced by Black individuals in the US can also be seen in terms of life expectancy. Despite recent progress, especially among Black males, the gap in life expectancy between Blacks and Whites was still 3.4 years in 2015.[4] Further, a recent analysis of health status and outcome measures across different racial and ethnic groups found that Blacks fared worse

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than Whites on 24 out of 29 indicators, including rates of asthma, diabetes, heart disease, HIV, and cancer.[5] Among these findings is evidence that Black children also have higher rates of asthma, teen pregnancy, and obesity. Growing data and evidence are pointing to structural racism as being a root cause for persistent health inequities experienced by Black individuals in the US.

Structural Racism

Racism is a complex social phenomenon that can be defined in many ways and is expressed on different levels. It involves individual and collective attitudes, actions, processes and unequal power relations.[6] On an individual level, racism can be expressed as intentional or unintentional acts of commission or omission, based on assumptions that one race is superior to another. For example, a restaurant owner who refuses to serve a Black patron is committing an intentional act of racism, while a doctor who neglects to recommend the same surgery for a Black patient that is recommended for a White patient with identical symptoms may be unintentionally committing an act of omission. On an individual level, racism may also be internalized, such that members of a stigmatized race accept negative messages about their own abilities and intrinsic worth.[7] Internal racism may be expressed by Black individuals dropping out of school or referring to themselves using negative stereotypes.

Institutional or systemic racism can be defined as differential access to the goods, services and opportunities of society by race, which is often codified in our institutions as customary practice or even law.[7] The historic practice of redlining, such that Blacks were systematically denied mortgages in certain neighborhoods, or charged higher insurance premiums, are expressions of institutional racism. A subtler, but potentially just as serious, form of institutional racism may be seen in the content of public school curricula, or images in the media, that are biased towards the culture and experiences of the majority population. Institutional racism in one area or sector may reinforce or interact with racism in another, such as the ways in which discrimination in housing perpetuates problems with underfunded schools and limited educational opportunities for Black children living in segregated neighborhoods.[8]

Institutional racism is interconnected with individual forms of racism and often serves to reinforce discriminatory beliefs and values. For this reason, the concept of structural racism has been suggested as a way to reflect the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice".[9]

Structural racism can be described as:

> "A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with 'Whiteness' and disadvantages associated with 'color' to endure and adapt over time."[10]

Conceptually, we can think about this definition of structural racism in the context of the determinants of health model presented in Figure 3. This "rainbow" figure is frequently used to describe the social determinants of health. The model highlights levels of influence, with the most distal factor -- the prevailing socioeconomic and cultural conditions -- as the very structure of society in which each of the other levels function. The model puts living and working

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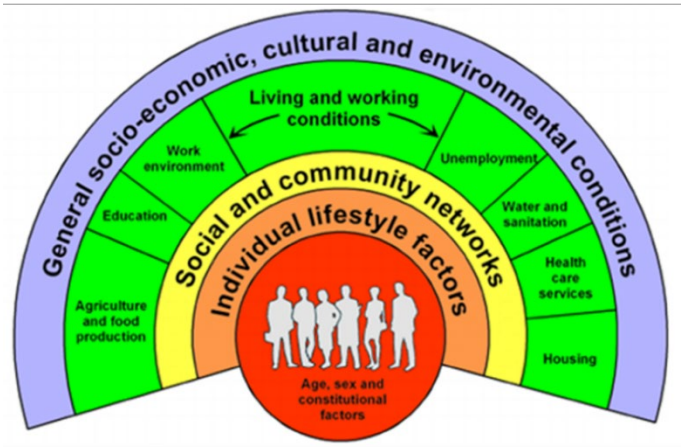
conditions, such as housing and education, within the context of these societal structures, suggesting that they are not naturally occurring conditions. Rather, living and working conditions come about as a result of overall societal structure, culture, and both historic and current public policies. Data suggest that living and working conditions are not inevitable; they are amenable to change. The model also highlights the fact that individual behavior and lifestyle choices are made within the context of one's social and community networks as well as the broader environment.



Source: Dahlgren & Whitehead, 1991

In thinking about health inequities, we can see how negative aspects of living and working conditions in Black communities are largely the result of structural racism, where historical and contemporary policies, practices, beliefs, and attitudes have resulted in an unequal distribution of resources across communities. More specifically, structural racism has led to many Black neighborhoods being characterized by a lack of employment opportunities, underfunded public schools, substandard housing, inadequate access to health insurance and health care, and lack of greenspace and recreational opportunities, as well as high concentrations of poverty, pollution, and violence — all of which threaten health directly and indirectly.[11]

While social networks may be strong and promote health and well-being in communities of color, policies and practices in our criminal justice system disproportionately incarcerate Black men, women and children, with direct health impacts on those who are incarcerated and potentially dismantling what would have otherwise been strong social support and community networks.[12,13] In addition, the stress of racial discrimination is associated with coping behaviors that are detrimental to health, such as smoking, alcohol, and drug use.[11] Ongoing stress associated with racism can also have direct physiological impacts on the body (i.e. allostatic load) and is associated with mental health problems such as anxiety and depression.[11] Black Americans are more likely to die from cancer and heart disease than White Americans, and are at greater risk for the onset of diabetes.[14] These negative influences and exposures can accumulate over time and across generations.[9] An understanding of how structural racism shapes the determinants of health for Black communities leads us to conclude that structural racism is a fundamental cause of health inequities for these populations.[7,15]

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Residential Segregation

"Residential segregation is a foundation of structural racism."[9] Residential segregation is the physical or spatial separation of two or more social groups within a geographic area. It is a fact of history in the U.S. and is long identified as the root of many social and racial inequities in American cities. While different racial and ethnic groups and immigrants have experienced segregation in the U.S., Blacks have been victims of an unparalleled level of deliberate segregation that is perpetuated through individual actions, institutional practices, and public policy.[16] Patterns of segregation among Blacks in the U.S. remain the highest across all racial/ethnic groups.[17] According to Dr. David Williams, a leading scholar on racism and health, "the single most important policy that continues to have pervasive adverse effects on the socioeconomic status and the health of African Americans is residential segregation."[18] Further, residents of segregated neighborhoods continue to be politically alienated and lack power such that conditions often remain entrenched.[19]

Segregation is a contemporary problem that persists in the U.S., despite the myth of integration.[20] While the latter half of the 20th century saw an end to explicit policies aimed at keeping Blacks from White neighborhoods (e.g. the Fair Housing Act of 1968), "such practices continue to be realized by purportedly color-blind policies that do not explicitly mention 'race' but bear racist intent."[9,] For a detailed historical analysis of segregation, including its roots in law, public policy, and public and private institutions, and its contemporary manifestations and enduring impacts see *A Century of Segregation: Race, Class and Disadvantage* by Leland Ware.[8]

An estimated 176,000 deaths were attributable to racial segregation in the U.S. in 2000[21] and there is a growing evidence base linking segregation to a range of indicators of the poor health status of Blacks living in segregated communities. Health inequities are "largely a function of the separate and unequal neighborhoods in which most Blacks and Whites reside."[16] Research demonstrates that racial health inequities grounded in segregation are more than a function of diminished socioeconomic status of individuals living in segregated communities, and that health inequities remain even after accounting for income and education levels. Rather, the places themselves and the nature of the social, political, built and physical environments affect health directly and indirectly in myriad ways.[9,11,12,22] Figure 4 provides an overview of the pathways through which residential segregation impacts health outcomes with strong supporting evidence.

Figure 4: Pathways and outcomes through which residential segregation harms health

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Pathways through which segregation is believed to contribute to health inequities

- Poor quality housing, including dampness, inadequate heat, noise, overcrowding, and presence of environmental hazards and allergens (Bailey et al., 2017: Williams & Collins, 2001; Williams & Mohammed, 2013)
- Negative social environments, including exposure to violence, crime, and systematic differences in policing and incarceration (Landrine & Corral, 2009; Williams & Mohammed, 2013; Williams & Williams, 2000)
- Substandard built environment, including higher exposure to fast food outlets and alcohol retailers, reduced access to supermarkets with fresh fruits and vegetables, and lower access to recreational facilities (Diez-Roux & Mair, 2010; Landrine & Corral, 2009; Moore et al., 2008; Moore et al., 2009; Williams & Collins, 2001)
- Exposure to pollutants, toxins, and other environmental hazards (Bravo et al., 2016; Landrine & Corral, 2009; Landrine et al., 2017; Mohai et al., 2008)
- Limited educational and employment opportunities and earning potential (Kramer & Hogue, 2009; Williams & Collins, 2001; Williams & Mohammed, 2013)
- Limited access to quality health care (Hayanga et al., 2009; Landrine & Corral, 2009; White, Haas, & Williams, 2012; Williams & Collins, 2001)

Health Outcomes with Evidence linked to Segregation

- Adverse birth outcomes, including low birthweight, pre-term birth and infant mortality (Grady, 2006; Kramer & Hogue, 2009; Mehra, Boyd, & Ickovics, 2017; Salow et al., 2018)
- Decreased life expectancy and increased mortality (Nuru-Jeter & LaVeist, 2011; Popescu et al., 2018; Williams & Collins, 2001)
- Increased risk of chronic diseases including CVD, heart disease, cancer, hypertension, asthma, and mental health problems such as anxiety and depression (Alexander & Curie, 2017; Kershaw et al., 2011; Kershaw & Albrecht, 2015; Landrine & Corral, 2009; Landrine et al., 2017; Paradies, 2016)
- Increased risk of homicide and other forms of violence (Diehr & McDaniel, 2018; Krivo et al., 2015)
- Increased risk of infectious diseases, including tuberculosis and HIV (Acevedo-Garcia, 2000; Ibragimov et al., 2018)

Source: Knight, E., Codes-Johnson, C., Rendon, S., & McDonough, K.,2019.

Mass Incarceration

The rate of incarceration among Blacks is higher than any other sub-population in the U.S.[23] Indeed, the incarceration rate among Black men is 3.8 to 10.5 times greater than among White men, depending on the age group. The greatest gap occurs among 18-19 year old Black males in this age group. Data showed that this population were more than 10 times more likely to be incarcerated than their White counterparts in 2014.[22] These rates translate into nearly one in three Black men being imprisoned in their lifetime.[13] Such high rates can be considered mass incarceration, which is defined as historically and comparatively extreme levels of imprisonment

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that are so heavily concentrated among some groups that incarceration has become a normal stage in the life course.[13,24]

Mass incarceration obviously affects individuals who are imprisoned, but also has a ripple effect on families and entire communities; nearly half of Black women have a family member who is imprisoned, and a Black child is much more likely to have a father in prison compared with a White child.[13]

There is strong evidence that the disproportionate rates of incarceration among Black communities are the result of discriminatory policies and practices in the criminal justice system, such as the "War on Drugs" era policies of the 1970s and 1980s.[9,25] Further, upon release from jail or prison, existing policies, such as denial of voting rights among those convicted of a felony crime, create barriers for individuals to become fully integrated back into society. Similar to the impacts of historical and persistent segregation, these "ostensibly color-blind policies have criminalized communities of color" and left a lasting legacy of cumulative disadvantage on individuals, families and communities with long-term impacts related to unemployment, low educational attainment, poverty, and violence.[9,13,26]

Not surprisingly, the high rates of incarceration in Black communities have negative health effects on incarcerated individuals, families, and entire communities. Given the magnitude of those affected by mass incarceration, it is believed to be a contributor to racial health inequities in the U.S. and may even help to explain inequities in health between the U.S. and other developed countries.[13] The United States has the highest incarceration rate in the world as of 2018, at 698 prisoners per 100,000 population. Other stable democracies such as United Kingdom, Portugal and Canada all have an incarceration rate less than 150 prisoners per 100,000 population.[27] Although there are a number of challenges in researching this topic and drawing conclusions about the nature of causality between incarceration and poor health, there is general consensus among experts that incarceration has strong negative effects on the health of inmates over their lifetime.[13] In a comprehensive review of the literature, researchers Wildeman and Wang summarize the evidence:

- Ironically, imprisonment may be protective in the short-term, as it provides reduced exposure to some forms of violence, alcohol, and drugs, and improved access to health care; but physical and psychological well-being worsens over time.
- Incarcerated individuals have higher rates of many infectious diseases and chronic conditions compared with non-incarcerated individuals.
- Family members of incarcerated individuals are negatively affected by impacts of incarceration, including financial hardships (i.e. decreased family earnings), relationship challenges from separation, and reduced social support, stress, and behavioral and mental health problems in children.
- Neighborhoods with high levels of incarceration are associated with poor health indicators at the community level, including high rates of asthma, sexually transmitted diseases, and poor mental health.[13]

Ultimately, mass incarceration is associated with a range of poor health indicators among those who are imprisoned as well as among their family and community members. The disproportionate incarceration of Black individuals, coupled with the poor health outcomes associated with incarceration, contributes to racial health inequities at the community, state, and

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national levels. Wildeman and Wang conclude that "the criminal justice system has become an institution — like the education system — that both reflects systematic and institutionalized racism and exacerbates existing inequities."[13]

Racism in Healthcare

In 1999, the U.S. Congress asked the Institute of Medicine (IOM) (now the National Academy of Medicine) to conduct an analysis of potential disparities in the types of care and quality of care received by racial and ethnic minorities within the U.S. health care system. Three years later, the IOM published their findings in the report, *Unequal treatment: Confronting racial and ethnic disparities in health care*, which was widely considered to be one of the most comprehensive analyses of the topic to date.[28] Over the course of nearly 800 pages, the report documents strong evidence from over 100 studies of "remarkably consistent" patterns of racial and ethnic disparities in care for a range of health conditions and types of treatment, which remain even after socioeconomic factors are controlled (e.g. income and insurance status) and even when patients present with the same symptoms, diagnoses, and comorbidities.

Various studies within the IOM report highlighted the existence of "implicit" or "unconscious" stereotypes or biases among potentially well-meaning providers that can have significant influence on interactions with patients and contribute to negative outcomes. The report also documents discrimination across systemic or institutional factors, such as the ways in which care is organized and financed that negatively impact access to quality care among racial and ethnic minorities. The authors argued that disparities in care "occur in the context of broader historic and contemporary social and economic inequality, and present evidence of persistent racial and ethnic discrimination in many sectors of American life." In effect, the report documented structural racism as it relates to the health care system.

Over the past 15 years, the federal government has continued to study and document trends in health care disparities in the *National Healthcare Quality and Disparities Report* that is mandated by Congress. The annual report is produced with the help of an inter-agency workgroup led by the Agency on Health Care Research and Quality (ARHQ) and can be found at https://www.ahrq.gov/research/findings/nhqrdr/nhqdr17/index.html. The most recent report finds that Blacks experience worse access to care compared with Whites for more than half of the measures used in the analysis.[29]

While the report concludes that some progress has been made in relation to the quality of care provided to Black patients, disparities remain for approximately 40% of the quality measures. For example, in 2015 the rate of adults with potentially avoidable hospital admissions for hypertension was 170.3 per 100,000 for Blacks, a rate more than five times as high as the rate of 33.9 per 100,000 for Whites. The report also reveals that approximately 20% of the quality measures show worsening disparities between Blacks and Whites, including children who visited the emergency department for asthma and a measure of exclusive breastfeeding through three months.[27] Numerous studies in the academic literature also document inequities in access and quality of health care grounded in unconscious bias and other discriminatory practices. In a systematic review by Hall and colleagues, the authors conclude that "most health care providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color."[30] Although the authors argued for more research to better understand the ways in which such bias contribute to poor outcomes, "there is widespread consensus that health care providers themselves contribute to racial health care inequalities."[28,31]

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White Privilege

One reason that unconscious or implicit bias may persist in even such a helping profession as health care is due to white privilege. White privilege is defined as "a system of benefits, advantages, and opportunities experienced by White persons in our society simply because of their skin color."[32] It involves greater access to power and resources among White people that are not earned, are unseen, and are often taken for granted. As Collins explains, subtle versions of white privilege can be seen as everyday conveniences that White people do not have to think about.[33] For instance, it is difficult to find children's books written by or about people of color; or when cashing a check, a person of color may worry that their financial credibility could be questioned. Collins explains that these everyday conveniences are privileges associated with the "power of normal," where White people are more likely to live their daily lives without thinking about their skin color.

While these everyday examples may seem benign to some, they reflect larger structural issues related to racism. Further, white privilege extends to other, potentially more impactful areas of everyday life, such as White people portrayed in positive roles on television and in movies; whereas Black people are often portrayed using negative stereo-types.[34] This contributes to things like racial profiling and its negative consequences. A sales associate may follow a Black person around a store in suspicion of possible misdeeds, whereas White people do not have to worry that their skin color may influence others' perceptions of their credibility, honesty, or innocence.[35]

According to Collins,

> "This privilege is invisible to many White people because it seems reasonable that a person should be extended compassion as they move through the world. It seems logical that a person should have the chance to prove themselves individually before they are judged. It's supposedly an American ideal. But it's a privilege often not granted to people of color."[31]

The implications of white privilege are readily seen when it comes to our criminal justice system. White people are less likely to be stopped by police because they looked suspicious, and people of color who are unarmed are still more likely to be killed by police than armed White people.[36]

White privilege can also help explain why Blacks are treated differently (with negative consequences) in our health care system. In his essay *White Privilege in a White Coat*, Dr. Max Romano, explains many of the ways in which medical education privileges those with white skin, such as being taught from an early age that White people can become doctors; the ease with which he could find mentors and role models who shared his race; and learning about medical discoveries made by White people, without acknowledging how "many of those discoveries were made through inhumane and non-consensual experimentation on people of color."[37] Such privileges have led to an entire system that is structured to favor White physicians and White patients. According to Romano, "most White doctors do not think race affects them or their clinical decisions… however, multiple studies reinforce the existence of racial bias among physicians and its negative implications for patient care."

Whether it is in relation to everyday conveniences, housing, education, criminal justice, or health care, these myriad privileges are ubiquitous and yet largely unseen. McIntosh likens white

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privilege to "an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codebooks, passports, visas, clothes, compasses, emergency gear and blank checks."[38] These privileges accumulate over time and space contributing to the large and persistent gaps in resources and status across racial and ethnic groups in the U.S. And while white privilege is not the same as racism, it exists because of historic and enduring racism. As McIntosh further explains, "white privilege is an invisible package of unearned assets that I can count on cashing in each day, but about which I was 'meant' to remain oblivious." Collins also argues that white privilege is unconsciously enjoyed but consciously perpetuated.[31] Acknowledging white privilege does not devalue or ignore individual accomplishments or hard work; but rather draws attention to unearned privileges simply granted due to the color of one's skin. Acknowledging white privilege calls on public health practitioners, health care providers, and policymakers to be more explicit and purposeful in addressing racism in order to advance health equity.

Structural Racism and Health Inequities in Delaware

Structural racism is believed to underlie many of the health inequities experienced by Black communities in our state. For instance, Blacks have an infant mortality rate that is approximately two and half times that of Whites; the homicide rate for Black men increased 116% between 2012 and 2016, and is seven times higher than for White men; although the death rate for HIV/AIDS has decreased in recent years, it is still 11 times higher for Blacks than Whites in Delaware.[39]

Delaware's history of residential segregation and its lasting impact on health is apparent in the ways in which health inequities can be viewed geographically. Table 1 provides estimates of segregation across Delaware counties and the City of Wilmington according to the dissimilarity index, which is a commonly used measure of residential segregation. Values of the index between 0 and 30 are considered low segregation; 30-60 are considered moderate; and >60 are considered highly segregated.[15] Wilmington has the highest level of segregation, and if we look across neighborhoods in the city, we can see how health varies dramatically by place and race. In figure 5 of Wilmington, the darker shaded areas have the highest percentage of Black residents. Life expectancy varies by approximately 16 years across Wilmington neighborhoods with Black communities generally experiencing the lowest life expectancy. Although not as dramatic, Dover sees approximately an 8-year gap in life expectancy across neighborhoods.

Table 1. Dissimilarity index by geographic area in Delaware

Geographic Area	**Dissimilarity Index***
New Castle County	45.2
Kent County	28.0
Sussex County	37.5
City of Wilmington	49.7
*Calculated using 5-year population estimates, 2013-2017, US Census	

Figure 5: Estimated percent of all people who are Black residing in Wilmington neighborhoods and life expectancy

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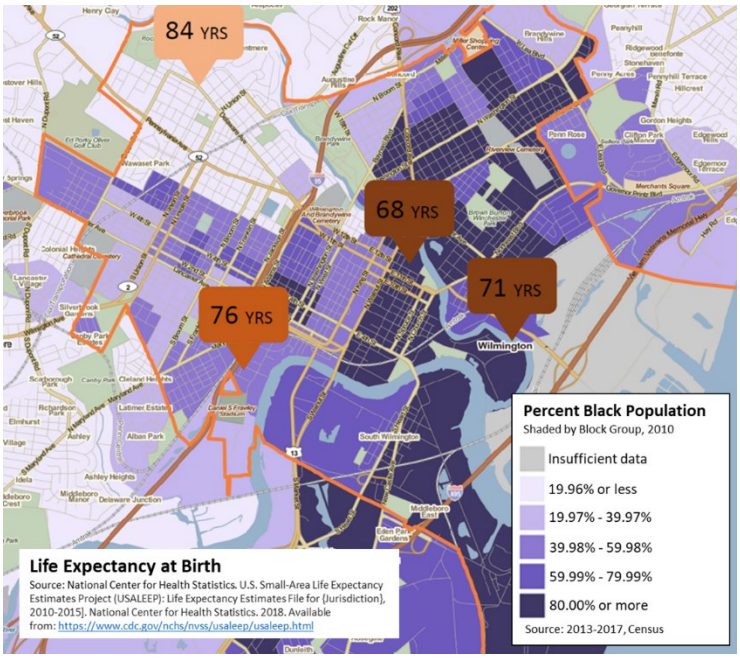

Conclusion

The impact of health inequities can be seen most recently in national data available regarding who is dying from, COVID-19. The mortality rate for African Americans is 2.4 times higher than Whites. For Asians and Latinxs, the mortality rate is 2.2 times higher than Whites. In addition, although African Americans represent 13 percent of the U.S. population, they represent 25 percent of the deaths. This health disparity is also becoming more prevalent among Latinxs, particularly in states and localities where a predominant number of "essential workers" are Latinxs. As it pertains to the Native American population, the effect on those communities is also troubling because local tribes suspended the services—like casinos and other private enterprises—that often fund vital community programs.[40] In Delaware, while Blacks make up 21.9% of the population, they make up 27% of COVID-19 positive individuals, and 26% of deaths. While Latinxs ethnically make up just 9% of the population, they make up 29% of those testing positive for COVID-19 but have a lower rate of deaths (6%) from the disease.

According to the Centers for Disease Control and Prevention, “health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.”[41] Given the review of literature presented above, it is evident that achieving health equity requires action on multiple fronts to dismantle structural racism.

First, addressing social conditions through policy change has long been recognized by experts as the best way to improve health and advance health equity. Place-based and cross-sector policy strategies are recommended to address the multitude of ways in which the housing market, education system, job market, and the built and physical environments interact to produce health. Investments in communities can have direct benefits that reduce health threats (such as crime and pollution) and indirect benefits that promote healthy behaviors (such as sidewalks, green space, and healthy food establishments). High quality, equitable education and safe, affordable housing

are fundamental to health improvement, as are promoting living wage jobs and access to quality health and social services.

However, improving neighborhood conditions is insufficient if the underlying structures and processes that determine the distribution of resources are not fundamentally changed. The evidence cited above suggests that conditions in Black communities have roots in historical and contemporary racism. Therefore, we must confront structural racism if we are to have a meaningful impact on health inequities. This means, among other things, a fundamental shift in power and decision-making with respect to public policy and distribution of resources from the local level to the federal level. Further, while improving conditions in Black neighborhoods is critical for health improvement, we must also address the issue of "separation that remains so pervasive and endemic to the American way of life that we rarely even question it."[19] We must debunk the myth that integration has been achieved and continue the unfinished work of the civil rights agenda.

Training and education continue to be important. It has been argued that training for health professionals should more systematically include content related to social determinants of health and specifically racism and health.[9] However, the need to work across sectors to address underlying neighborhood conditions to improve health calls for broadening the scope of such training to other sectors and disciplines. Just as there can be an accumulation of burdens and risks when racist policies and practices are perpetuated, dismantling such policies and practices in one sector can have a positive ripple effect in other areas.

Finally, there is much we can still learn through research about the ways in which racism impacts health, including for instance, the ways in which racism can be mediated, how racism interacts with other forms of oppression, or for understanding the generational health impacts of racism. There is also a need for improving the ways in which both racism and health are measured, and for using multilevel analyses to capture the complexity of factors in the racism and health equation. These and other research activities can improve our understanding of this complex issue and may be particularly important for addressing criticisms and skeptics. However, it seems evident that we know enough about racism as a determinant of health inequities to act. Further, where research may be most useful is in evaluating policy and practice changes meant to address racism and its consequences. For example, "The Equity Solution," a paper published in 2014 from the progressive think tank PolicyLink and co-authored with The University of Southern California (USC) Program for Environmental and Regional Equity (PERE), argues that racism isn't just morally abhorrent — it's economically destructive. The paper outlines that if the pay gap among racial groups was eliminated, the US might be 14% richer annually.[42] Similarly, research is needed on the most effective strategies for building public and political will for change, such as research on framing and social movements. Findings from these applied studies can help to further our collective efforts to advance equity in health.

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