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Destined to Die Prematurely: An Examination of African American Life Expectancy

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Destined to Die Prematurely: An Examination of African American Life Expectancy

A Senior Honors Thesis

Submitted in Partial Fulfillment of the Requirements
for Graduation in the Honors College

By
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The College at Brockport
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Abstract

Throughout history, researchers have continuously noted the connections between health, its social determinants, and the role that systemic racism has had in creating health disparities including lower life expectancies for black Americans. When compared with other racial groups in the country, African American males and females have experienced shorter life expectancies than the national averages for centuries. People of color are geared toward certain lifestyles because of their history and are sometimes at a disadvantage in regards to achieving and maintaining good health. Rather than accept these instances in history as the causes of racial health disparities, many cite lifestyle as a primary cause, suggesting that health outcomes are simply a matter of individual choice. This ideology, known as healthism, fails to acknowledge how the social determinants of health can impact one's ability to directly control his or her own health within constrained conditions. The purpose of this study is to analyze the historical underpinnings of racial disparities in health and how they ultimately impact life expectancy in addition to displaying that the healthism ideology is not basis for biological explanation. A collection of articles pertaining to this subject matter were examined from authors in different disciplines including scientists, health professionals, and sociologists. Most writings consisted of studies completed and conclusions drawn from them. Although studies were done from different perspectives and in different disciplines, overall, authors agree that the vestiges of African American oppression in early American history have an influence on various social determinants, especially socioeconomic status, which in turn has an effect on health and ultimately life expectancy.

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I. Introduction

Dr. Martin Luther King Jr., a man who fought for equality and unity among all people once said “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” Dr. King has been gone for almost 50 years and while there have been improvements in racial inequalities in America within the past half-century, strong health discrepancies still exist between the races resulting in vast differences in life expectancy.

Overall health status of individuals, as well as communities and groups, is affected by various social determinants. As a result, these social determinants of health indirectly impact individual health status and life expectancies and consequently the overall health statuses and life expectancies of particular groups. According to the World Health Organization (2017a), “the social determinants of health are the conditions in which people are born, grow, live, work and age.” These historic conditions are formed by the “distribution of money, power, and resources at global, national, and local levels” and are responsible for the imbalanced and preventable disparities in health status seen within and between countries (World Health Organization, 2017a). The health disparities seen between the different races in the United States are reflected in the differences in life expectancy by race.

In recent decades, scholars have noted the correlations between health, socioeconomic status, and the role that individual, systemic, and institutional racism, legal and de-facto segregation, and criminalization (Wacquant, 2009) have had in producing health disparities, including unequal life expectancy rates between black Americans and other racial groups in the country. Many justify the lower life expectancies suffered by black Americans by citing the idea of healthism, an ideology claiming personal lifestyle factors are the primary cause of poor health, thereby suggesting that health outcomes are a simple matter of individual choice. This ideology

fails to acknowledge how social determinants such as one's household income, where he or she lives, and his/her educational attainment can impact one's ability to directly control their own health within constrained conditions (Cheek, 2008).

The lower life expectancies African Americans face are attributable to the discrimination faced by the group in early American history and its resulting health disparities. This study seeks to examine the historical and material underpinnings of the racial disparities in health and show how they ultimately impact life expectancy, thereby offering a critically informed alternative explanation that problematizes the dominant sociopolitical ideology of healthism.

The primary question that guided this preceding literature review was "Why do African Americans have shorter life expectancies than the national average?" This review investigates the racial oppression of African Americans in early American history and how the vestiges of this oppression have led to negative, cyclical consequences for black Americans that are still seen today and are still impacting numerous social determinants of health, health status, and consequently life expectancy.

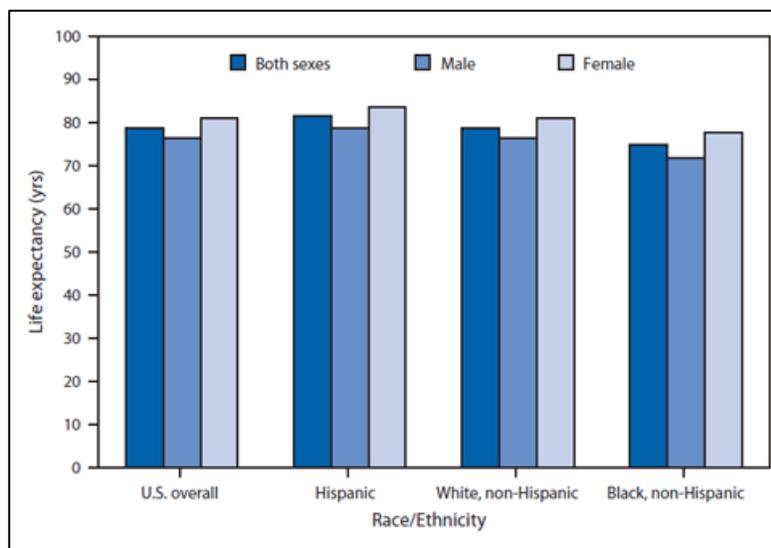
II. Life Expectancy

Merriam-Webster's online dictionary (2017a) defines life expectancy as "the average number of years that a person or animal can expect to live." Life expectancy, sometimes referred to as life expectancy at birth, is based on the statistical average of years lived of a particular group being studied and thus varies by geographical location and time period.

Life expectancy is calculated as an arithmetic mean. This means the sum of a group of numbers is found then divided by the number of terms in the set. To begin calculating life expectancy, age-specific death rates are required. To find these numbers, data groups with different mortality rates (e.g., substance abusers vs. non-abusers) are measured independently.

The preceding data are used to create life tables that estimate the probability that a person of a specific age will die before his/her next birthday. A set of comparable variables can be created to draw conclusions about life expectancy if adequate data is accessible; this permits the further calculation of both an individual's chance of living to any given age, and life expectancy remaining for people of all different ages. In simpler terms, average death rates and other factors are used to predict life expectancies for specific groups. The life expectancy projected for a specific year, is the age one born in that year can expect to live to. This system is not perfect however, and a person can live longer or shorter than predicted (Mandal, 2014).

Figure 1



In the United States, life expectancy at birth generally increases or remains the same each year. In 1993 however, there was a decrease from 75.8 years in 1992 to 75.5 years. The current estimated life expectancy for a U.S. citizen is 78.8 years, a decrease from 78.9 years in 2014; the first decrease in American life expectancy since 1993. Many epidemiologists believe that this is going to start a new trend in life expectancy and bigger decreases are in the near future (Tinker, 2016). While this trend in life expectancy is changing, other trends have remained the same for

years. In the United States, life expectancies are calculated by city, state, gender, race, etc. For the past century, women's predicted life expectancies at birth have been higher than males, as seen in Figure 1.

Another trend seen in Figure 1, are the differences in life expectancy by race (Centers for Disease Control and Prevention, 2014). In addition to women having higher life expectancies than the national averages for the past century, African Americans have continuously had shorter life expectancies than the national averages. A white baby born in 2014 (the most recent year with accurate life expectancy on record) could expect to live until age 79 while a black baby born the same year was projected to live to only see 75.6 years (Tavernise, 2016).

III. Overview of African American History

Before attributing the social determinants that affect the health of African Americans to the population's low life expectancies, African American history must be examined to understand the basis of said social determinants.

Africans did not willingly come to the Western Hemisphere. African slave labor was first introduced to the New World by the Dutch in the early 1600s. There was a vast amount of work to be done in the newly settled colonies, and with a shortage of labor, slaves proved to be economically beneficial. Soon the colonies became the United States of America and after the invention of the cotton gin in 1793, cotton replaced tobacco as the southern United States' cash crop. Slavery became even more advantageous and lucrative, resulting in millions of Africans being appropriated from their homes, packed tightly into ships, and brought to the states. Once purchased, slaves endured brutal and degrading treatment from owners such as beatings, whippings, sexual abuse, and shackling. Families, including those with small children, were often separated. Education of slaves was restricted in most states in fear of exposing slaves to the

outside world and encouraging rebellion. As the morality of slavery began to be questioned, white southerners defended its use by arguing that the slaves were not intelligent enough to take care of themselves and were taken care of in terms of food and shelter.

In 1860, anti-slavery president Abraham Lincoln was elected; the South seceded from the Union shortly after, and not too long after that, the Civil War began. Although the war was not intended to determine the fate of slavery in America, it did. In September 1862, after a major victory at Antietam by the North, President Lincoln introduced the Emancipation Proclamation. The document stated that southern slaves would have to be freed by January 1, 1863 and about three million were indeed freed by this deadline. It wasn't until December 6, 1865 that the thirteenth amendment to the constitution was adopted, abolishing slavery in the United States (Civil War Trust, 2014).

The era of political turmoil after the Civil War is known as Reconstruction. Even with the decline of the agriculture industry in the south, many freed slaves continued to work on plantations as sharecroppers. During this time, two more amendments in addition to the thirteenth were added to the constitution that changed America forever. The fourteenth amendment granted birth right citizenship to freed slaves and the fifteenth amendment allowed free male slaves to vote. These amendments as well as the election of African Americans to political positions led to the resentment of many white southerners and increased violence resulted. Southern state governments introduced new rules called black codes to control former slaves. Eventually, the independent southern state governments accepted the political affiliation of the rest of the country; however, racism remained very prominent in both the North and South. Reconstruction officially ended in 1876, however the consequences generated by slavery's abolition continued in the country (History, 2017a).

African Americans still lived in a blatantly unequal society of disenfranchisement, segregation, and persecution long after Reconstruction ended with Jim Crow laws being heavily to blame. These laws enforced legal segregation at the local and state levels and barred black people from schools, bathrooms, busses, etc. In 1954, the Supreme Court ruled that segregation continued but be “separate but equal.”

The civil rights movement of the 1960s once again saw African Americans fighting for the political, economic, and social equality that they had never truly received. Nonviolent protest and civil disobedience were used by civil rights advocates to publicly articulate the injustices black people faced during this time. Individual and small group demonstrations eventually led to the rise of new, aggressive movements, leaders, and associations. The government took some responsive action by providing new legislation, and finally blatant discrimination and legal segregation ended. Protests dropped in frequency after the 1960s, but the movement left an everlasting mark on American society (History, 2017b).

Racial oppression and discernment continued to be a substantial issue in American society in spite of the progressions made during the 1960s. There was a switch from outright, legal, de jure segregation to de facto, by fact and not law, segregation. Integration did little in the lives of poor blacks. As a direct response to the gains made in civil rights during this period, “the distribution of the nation’s wealth and income moved toward greater inequality during the 1970s and 1980s” (History, 2017b).

Approximately six million African Americans moved from the southern U.S. to the North, West, and Midwest starting in the 1910s and ending in the 1970s. Now known as the Great Migration, the majority moved to cities in the North to take advantage of industrial work opportunities and to flee entrenched mob violence by organizations such as the KKK (History,

2017c). Many of those that stayed behind however, continued life in rural areas working in agriculture. With the southern agriculture industry in distress, companies began to utilize industrial farms requiring fewer workers. Blacks in these areas began to endure higher rates of unemployment and poorer living conditions.

Following the postwar era of the early to mid-1900s, there was a considerable decline in industrial manufacturing in most urban cities in both the North and South due to outsourcing of labor, resulting in a decrease in industrial employment opportunities for the urban working class. Many urban Americans relocated to suburban communities in response to this as well as the inner-city contention of the 1960s. The ability to leave the inner city for the suburbs was not achievable for all city inhabitants, however. Many black families did not have the means to pick up and move and those that did had trouble doing so because of practices such as redlining, discrimination in real estate that withholds home loan funds or insurance from those applying for them (Pietila, 2009; “Redline,” 2017). Block busting, the encouragement of property owners in specific neighborhoods to sell quickly by appealing to a fear of diminished values because of increased minority presence and later reselling at inflated prices (Pietila, 2009; “Blockbusting,” 2017) also aided in the migration of middle-class white families into suburban areas, and forced many African Americans, including those with the finances to prosper, into geographically segregated neighborhoods (Andrews, Mower, & Silk, 2011).

Loïc Wacquant, an urban sociologist, connected the deindustrialization and the relocation of certain populaces, assets, and establishments from these specific neighborhoods to the shift from the communal ghetto to the hyperghetto (Wacquant, 2007). According to him, in the typical American hyperghetto, “macroeconomic and political policies [sic] combined to create ever more deteriorating, and increasingly isolated, economic, social, and physical environments.” The

majority of urban neighborhoods began to see increases in unemployment and decreases in economic and environmental growth throughout the 1970s and 1980s.

An African American underclass resulted in response to the hyperghettoization of once prosperous communities (Wacquant, 2007). The effects of the decline of the inner-city community are still seen today. Often, deprived, isolated, urban communities are characterized by “high mobility, low occupancy rates, high levels of abandoned buildings and grounds, relatively large numbers of commercial and industrial facilities, and inadequate municipal services and amenities, including police and fire protection” (Williams & Collins, 2001, p. 410). Because of the prevalence of disease and premature death in these neighborhoods, those living in urban areas are acknowledged as populations suffering from health disparities.

It is important to note that not all black Americans live in urban settings. As previously mentioned, many blacks remained in rural southern areas during the Great Migration. In fact, African Americans count for 8.2% of all people living in rural/small town areas. The experiences of rural minorities are generally disregarded because of their rather small populations (HAC Rural Research Brief, 2012), but their hardships and concomitant outcomes are parallel with those faced by urban minorities and reflect in the overall health of African Americans. Today, 36% of African Americans live in cities, 15% in metropolitan areas, and 10% live in rural areas (Ryan, 2016), clearly not all African Americans are accounted for in these numbers. The remaining 39% of African Americans live in suburbs.

Welfare programs introduced by president Lyndon B. Johnson during his War on Poverty in the mid-1960s aided in the creation of the African American underclass by contributing to the downfall of the black family as an unwavering establishment. Johnson aimed to help low income minorities living in inner cities but instead, aided in their demise.

Evidence of low household income was needed to meet the requirements for welfare benefits. Many financially struggling two-parent households made too much money to qualify for assistance and consequently, the need for marriage was discouraged by the welfare state, resulting in the increased development of one-parent families, especially in the black community. Means-tested welfare programs such as food stamps, subsidized housing, and Medicaid reprimanded married couples in terms of the benefits they received based on overall household income. A single parent usually received more money from welfare if he/she was on his/her own rather than married. Once married, his/her benefits were instantly diminished by 10% to 20%. Today, one parent families both black and white are generally on “the bottom rung of America’s economic ladder” (Horowitz & Perazzo, 2012).

As a result of welfare policies discouraging marriage, illegitimacy rates significantly rose amid all racial groups in America, but most notably in the black population.

“In the mid-1960s, the out-of-wedlock birth rate was scarcely 3% for whites, 7.7% for Americans overall, and 24.5% among blacks. By 1976, those figures had risen to nearly 10% for whites, 24.7% for Americans as a whole, and 50.3% for blacks in particular. Today the illegitimacy rates stand at 41% for the nation overall, and 73% for African Americans specifically” (Horowitz & Perazzo, 2012).

In addition to welfare discouraging marriage and the development of stable families, it also discouraged a healthy work ethic. If those that received welfare benefits entered the work force or earned a pay raise, they faced losing a dollar or more of assistance for each extra dollar they earned.

The purpose of national welfare programs is to lessen poverty and promote work. Conversely, these programs have discouraged hard work and higher earnings; “The more

benefits the government provides, the stronger the disincentive to work” (Horowitz & Perazzo, 2012). The anti-marriage, anti-working incentives that are part of the welfare system have worsened the problem of black poverty and have aided in forcing African Americans into socially segregated neighborhoods. Walter E. Williams, a George Mason University professor once said “The welfare state has done to black Americans what slavery couldn’t do, what Jim Crow couldn’t do, what the harshest racism couldn’t do, and that is to destroy the black family” (Horowitz & Perazzo, 2012).

The differences in health patterns seen between African Americans and the rest of the nation are partially reflective of the inequalities faced by those in both urban and rural neighborhoods causing the wide disparities seen in health and ultimately differences in life expectancy based on race.

IV. Previous Literature

There is a vast amount of literature discussing the gap in life expectancy and health inequities between black Americans and their white counterparts. Some authors have taken into account American history, its oppression of black Americans, and the systemic racism that still exists. For example, Jan Mutchler and Jeffrey Burr as well as Barber et al. assessed the continuous inequalities between white and African Americans and how they have powerfully affected health and socioeconomic status.

Additionally, other authors have provided evidence that racial health disparities would be non-existent if specific factors (e.g. socioeconomic status (SES), living environment, etc.) were controlled; something that has not been adequately studied. Kaplan et al. hypothesized that the differences in SES are to blame for health differences between the races.

While the aforementioned authors have contributed unique perspectives, a large amount of the written work regarding the differences in health among racial groups considers only specific factors and how they impact health status or a specific disease and/or mortality rate without taking into account the origins of the differences in said factors. There are a myriad of authors such as James P. Smith, Tammy Leonard, Amy Hughes, Sandi Pruitt, Zick et al., and Olle Lundberg that focus on definite factors and their exact health effects.

This is not to downplay the work of professionals such as Loïc Wacquant and other authors that have studied and continue to study the unequal life experiences of African Americans and how these experiences form health risks amid the group, rather make note of the lack of awareness and literature about racial origins and their consequences.

V. Purpose for Current Review

This review takes into account all that goes into the diminished life expectancy of African Americans. Many fail to recognize and/or consider the fact that race is socially constructed and that the racial disparities seen across all fields of study stem from the division of people according to phenotypical traits. As stated previously, much of the research written on this topic focuses on specific ideas and the current differences between the races without taking a critical epistemological look at why things are the way they are. This review attempts to display how the vestiges of early American history are still impacting the world, particularly in terms of health. The previous overview of early American history will be connected to the overdetermining reasons African Americans are projected to live shorter lives than their white counterparts. The main topics examined will be socioeconomic status, living conditions, healthcare access and quality, and finally, specific diseases including obesity, heart disease, diabetes, and cancer. This

review will also highlight attempts at improving the health disparities between certain populations and efforts to reduce the life expectancy gaps between the races.

VI. Search Criteria

Accessible, full-text works were analyzed after utilizing the College at Brockport's electronic databases. Google Scholar was also used to obtain relevant literature. Attempts to limit the amount of literature to be reviewed were challenging due to the quantity of information on health disparities between the races overlapping in several disciplines in addition to the recurrence of similar information. Primary focus was limited to the top non-genetic factors that influence life expectancy that this study is focusing on: socioeconomic status, living conditions, and healthcare quality. Searches initially included only the keywords African American and life expectancy; the words black, health, socioeconomic status, urban, rural, healthcare, access, and quality were then used in various groupings to find literature with a narrower focus.

Articles for each of these three topics were found separately. Some of the articles overlapped and were used in multiple sections.

Much of the relevant literature was over twenty years old. Keeping in mind the historical context of the issues, this literature was still reviewed to analyze the dated perspectives; searches continued after the dates on the databases were manipulated to show pertinent work printed within the last five years.

In the articles reviewed, there were many recurring ideas about the connections of race, socioeconomic status, and health status in addition to unique perspectives and new ideas about causes, consequences, and future progressions regarding race and health.

As for information regarding disease prevalence, credible organization's websites were used such as the Centers for Disease Control and Prevention, the National Institutes of Health, and the World Health Organization.

VII. Limitations

Attempts to limit the amount of reviewed literature were challenging due to the large quantity of information on health disparities between the races overlapping in several disciplines. The recurrence of similar information made reading through previous literature tedious.

Finding useful work that was recent (written within the last five years) also posed a challenge. Many recent articles focus on very specific ideas rather than the connections between certain factors and their impacts on health.

VIII. Overview of African American Health

Black Americans account for 12.2% of the population according to the 2010 U.S. Census, yet suffer a greater percentage of incidence of many leading illnesses in America. Racial health disparities have been and are still a focus for many researchers. High morbidity rates lead to high mortality rates, and in the U.S., blacks fall victim to this pattern often. African Americans tend to have poorer overall health when compared with other racial groups. Obesity, heart disease, diabetes, and cancer are diseases that affect Americans from all backgrounds with rates of all four rising more rapidly than ever before. African Americans are however disproportionately affected by some of these diseases; with the highest rates of obesity for any group in the United States and the highest rates of hypertension for any group worldwide (American Heart Association, 2016).

African Americans tend to be exposed to more disease risk factors and it shows in their morbidity rates. More specific information regarding the social determinants of health and their concomitant health outcomes will be further discussed.

IX. Socioeconomic Status

In their 2011 evaluation of United States health, the National Center for Health Statistics describes socioeconomic status (SES) as

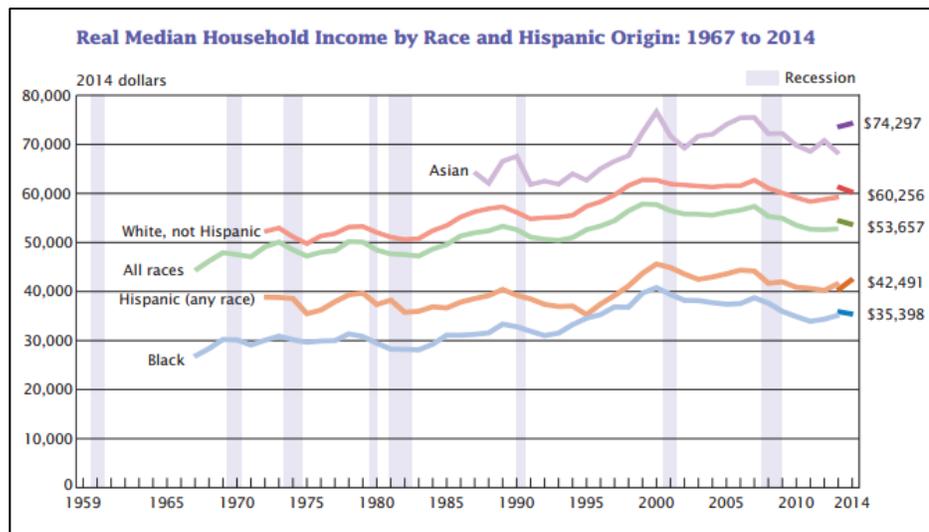
“a multidimensional concept comprising measures of resources such as income, wealth, and educational credentials, and the access to goods, services, and knowledge that these resources afford those who have them... it is a measure that allows comparisons between individuals, households, and groups” (National Center for Health Statistics, 2012).

The CDC credited socioeconomic status as a very important social determinant of health that contributes to health disparities (Centers for Disease Control and Prevention, 2017a).

Educational attainment, income or poverty status, and occupational status are the three factors most commonly used in calculating SES. Income includes wages, salaries, and any flow of earnings received (e.g. worker’s compensation, social security, pensions, governmental assistance, etc.). It is often calculated on a yearly basis. Education comes into play because income is unquestionably influenced by it. Earnings increase as educational attainment increases due to an increased range of available occupational opportunities and job security (increased education and unemployment are inversely related). Additionally, education is important in regards to pursuing jobs requiring specific skills sets. Greater advancements in education are correlated with superior economic outcomes. Both income and educational achievement comprise occupational status. Occupations are often rated on the level of skill involved. Generally, lower-skilled jobs earn less in comparison to more highly-skilled jobs.

SES is often measured by placing individuals or groups in one of three categories: high, middle, and low. These categories label families and/or individuals based on the income earned within a given period of time. In 2014, a household earning over \$125,000 per year was considered to have a high income, this accounted for 20% of the U.S. population. 51% of people were considered to be part of the middle class, earning between \$42,000 and \$125,000 per year. Households earning less than \$42,000 per year were considered low income households (Fry & Kochhar, 2016).

Figure 2



As seen in Figure 2, courtesy of the U.S. Census Bureau, “large income gaps between different racial and ethnic groups have been around for a long time and continue to exist” (Kiersz, 2014).

As of 2014, the median household income of African Americans was \$35,398 per year; a number classified as low income. Figure 2 shows that this is the lowest household income among all racial groups. The poverty rate for African Americans that same year was 26.2%, the highest among all racial groups with 10.8 million people living in poverty (DeNavas-Walt & Proctor,

2015). This number is ascribable to a number of factors that scholars have agreed contribute to low SES. There are multiple theorized causes of individual poverty. Amount of education, work/professional experience, and skill are related to occupation and ultimately income, as mentioned before. A lack of experience makes it harder for people to prosper. Health and SES inversely impact each other. Someone in poor health may have to work to survive and a health condition can make it hard to work consistently, if at all. Aggregate poverty, or poverty seen in a specific community as a whole, like the median household income for African Americans, has theorized causes as well. Some believe aggregate poverty is the sum of individual poverty within a group. Aggregate poverty can also be explained by economy wide problems such as an inadequate amount of non-poverty employment opportunities, and governmental (federal, state, or local) incomes (Srinivas, n.d.).

Some of these ideas can be seen in the oppressive history faced by African American as a group (e.g. inadequate education, lack of job opportunities, de facto segregation, etc.). Regardless of the Civil Rights Movement's successes, the already existent gap in income between blacks and other racial groups remained; previously being denied access to quality education and stable jobs did not provide hopeful black Americans with the tools to thrive. African Americans could not generate wealth like their white counterparts. In addition to this, the previously mentioned crisis of the American welfare state encouraged poor Americans to stay complacent in their financial situations.

The connections between SES and health have been studied for decades. Many professionals have written about the connections between the two in different contexts. For the purpose of this study, five articles pertaining to SES and health were selected to be reviewed based on the information and insights that were provided. All of the articles reviewed agreed that

a link between SES and health exists. While some articles offered specific reasons for these links, others discussed why it is hard to pinpoint the exact connections. A handful of the articles argued that while SES does effect health, health also effects SES. Some of the articles examined specific health-related behaviors influenced by SES and a couple of the articles argued that if there were not disparities in SES between the races, there would be no health disparities between the races. Finally, many of the articles reviewed offered ideas on how to decrease the health disparities between the races.

Many scholarly writings assess the health differences between whites and blacks. The generalized health status of African Americans is often credited to lifestyle, health practices, biology, and low SES. Many authors contribute the differences to SES and those that do not outright mention SES, relate the difference to a factor that can be connected to SES, such as living conditions and neighborhood safety. Mutchler and Burr (1991) hypothesized that it is SES that actually effects lifestyle and health practices throughout life contributing to health outcomes in older adulthood.

In their publication titled, “Racial Differences in Health and Health Care Service Utilization in Later Life: The Effect of Socioeconomic Status,” they noted that the ongoing inequalities between whites and African Americans in terms of education, economic success, and access to resources have strongly affected SES and health. The purpose of their study was to assess the differences between whites and blacks in older adulthood with the hypothesis that the differences in life experiences faced by each group, especially pertaining to SES, cause older black Americans to endure poorer health.

Their study involved an assessment of the health of older white and black Americans (55+ years) through the use of a survey. The survey had participants self-evaluate their own

health, reveal activities they needed assistance with, and provide the number of days they were bed ridden due to poor health within the four months prior to the study. A healthcare assessment was also included in the survey measuring how many days the participant had spent in the hospital and how many times he/she had visited a healthcare provider in the year prior to the study. The results of the study indicated that the older black population had poorer health than the white population. About a third of the whites evaluated themselves to be in good health while only 15% of blacks did. Blacks also reported needing assistance in more activities, more time spent in the hospital, and more doctor visits.

Net worth and educational attainment of each group were also assessed with whites having superior numbers in both categories. It can be concluded that education and net worth, two contributors to SES, are important factors in determining health status. Inequalities in education for blacks affected today's older population. Net worth reflects the accumulation of wealth throughout one's lifetime and there for "reflects socioeconomic standing throughout the life course more accurately than temporally-bound measures such as current income" (Mutchler & Burr, 1991).

In summary, the tougher life experiences endured by blacks determine income and net worth which is generally lower than those of their white counterparts. These economic differences lead to poorer health choices, more stress, etc., and eventually poorer overall health status.

James P. Smith (1998), had similar views to Mutchler and Burr. Taking into account the direct relationship between SES and health, he hypothesized that the "direct influence of SES on health may be strongest during childhood and early adulthood when levels and trajectories of health stocks become established" (p. 196). Because this study was published in 1998, the data

provided pertaining to income and perceived health status represents those that were young in the mid-1900s; these people dealt with drastic social changes and the preceding shifts in wealth which affected their life experiences and eventual health.

Adler et al. focused on the factors SES influences rather than SES as a main cause of health disparities in their 1994 publication titled “Socioeconomic Status and Health: The Challenge of The Gradient.” They believed SES had been studied too broadly in previous literature and pointed out that “SES affects biological functions that in turn, influence health status” (p. 18). Different components of SES, especially income, education, and occupation shape individuals’ life paths and impact the physical environment in which one lives and works including exposure to certain pathogens, carcinogens, and other environmental risks, in addition to the social environment one endures on a daily basis, how one was/is socialized, and specific health behaviors.

The specific health behaviors they looked into were smoking, alcohol consumption, physical activity, and mental health dynamics. Smoking is significantly correlated with morbidity and mortality due strongly in part to cardiovascular disease and cancer. While high, middle, and low SES groups have noteworthy amounts of smokers, people identified as those of low SES had the highest numbers. Alcohol consumption had unclear findings. Physical activity has a direct association with health outcomes; a lack of movement can lead to poor health. Physical activity was directly correlated with SES as less physical activity was seen in low SES groups while financially stable groups had higher rates of physical activity. As for mental health, negative psychological characteristics lead to increased morbidity and mortality rates. Low SES undoubtedly leads to poorer psychological function for multiple reasons. Those of low SES

experience higher rates of both depression and chronic stress due to experiencing more stressful life events beyond their control than those with higher incomes.

Kaplan, Haan, Syme, Minkler, & Winkleby acknowledged the links between SES and health in their 1987 article titled “Socioeconomic Status and Health,” however, they provided different reasons as to how SES influences health. Higher death and illness rates are prevalent in low SES populations. Specific reasons as to how SES effects health were given that included inadequate medical care, low income, poor nutrition, unemployment, race, and hazardous living conditions. Conversely, the authors described these factors as “inadequate” for proper explanation. They explained that while higher rates of morbidity and mortality are seen within low SES populations, these high rates are not exclusive to the group, rather there is a range; not all poor people are sick, and not all sick people are poor.

They believe the exact link between SES and health has to do with demands and resources as do Leonard, Hughes, and Pruitt (2017). Greater environmental demands are faced by those of low SES and usually, this population has insufficient resources (e.g. money, medical care, social support) to deal with said demands. This ideology explains why people identified as low SES are and are labeled unhealthy. Someone living on a fixed income may be in better health if he or she has friends that can be relied on for help when compared with a person in the same situation with fewer social networks.

Kaplan et. al.’s article did not focus on race and health, rather the drastic gaps in income in the United States and how they affect health. The authors believe closing the income gap is the key to health promotion and disease prevention. They also noted that if differences in household income were eliminated in collecting health related data, the health differences between the races would not exist. This common perception is shared and questioned by Mutchler and Burr (1991).

Without question, SES impacts health both directly and indirectly. While authors have different theories about the exact connections, the facts cannot be denied: those of low SES experience more morbidity and mortality. African Americans have more people that identify as those of low SES than any other racial group and consequently these trends in disease are seen within the black population.

X. Social & Physical Living Environment

Both the physical and social environment one grows up and or lives in are important social determinants of health. As stated before, 36% of African Americans live in cities, 15% in metropolitan areas, and 10% live in rural areas; these are all areas with unique living conditions. Socioeconomic status unquestionably assists in determining where one lives. Generally, inner city and rural areas are more affordable for people on a fixed income and as a result, these areas are often plagued with the negative characteristics associated with these areas (e.g. low income, high crime rates, high morbidity rates, etc.).

Urban areas are highly populated regions surrounding cities. They are usually very developed in terms of houses and apartments, commercial buildings, roads, and railways. The areas adjacent to urban areas are called metropolitan areas and as a result of their shared proximity to a city, urban and metropolitan areas are often characterized together. Rural areas are the opposite of urban areas. Often referred to as the country, rural areas have low population density and vast amounts of undeveloped land (National Geographic, 2017).

In addition to SES, historical events have impacted the specific populations comprising these areas. As previously mentioned, during the Great Migration, many blacks moved from the American South to cities in the North in order to take advantage of industrial work opportunities and to flee racially motivated violence. Some blacks did however remain in rural areas to try to

make it in the slowly declining agriculture industry. Due to outsourcing of labor in the mid-1900s, industrial manufacturing declined considerably in both the northern and southern cities resulting in a decrease in industrial employment opportunities. Many white urban Americans relocated to suburban communities in response. As previously stated, relocation to the suburbs was not achievable for all city inhabitants. Block busting and redlining forced many African Americans, including those attempting to prosper, into geographically segregated neighborhoods that still exist today.

Minority populations and those of lower SES status are more likely to live in urban areas. Areas classified as urban see larger inequalities in SES, crime and violence rates, and psychological stressors that are characterized by the increased density and variety of cities (Unite for Sight, 2015).

While the African American suburban population is slowly increasing, today only 39% of African Americans call a suburb “home.” Those that do not inhabit a suburb, live in urban and rural settings; two unique environments in regards to health. The high rates of morbidity and mortality within the black population in addition to the increased number of people living in urban and rural areas have contributed to the surge of studies about how one’s living environment impacts his/her health. Within more recent decades, connections between specific environmental factors and health outcomes have been made.

Urbanization level impacts the demographic, ecological, financial, and societal characteristics of specific areas. These characteristics effect the degree and types of health problems neighborhoods meet. Even though each living area has its own set of exclusive issues, the following are regularly seen within urban and rural environments: non-communicable diseases like heart disease, high blood pressure, diabetes and obesity, increased prevalence of

communicable diseases, increased risk of injury and violence, and increased incidence and prevalence of mental health disorders and substance abuse. These are linked especially with lifestyles in cities, overcrowded living conditions, etc. and will be discussed further. Exposure to negative environmental health factors like air pollution and second-hand smoke are also increased within these settings.

According to the Georgetown Health Policy Institute (2003), “the rural population is consistently less well-off than the urban population with respect to health. Rural citizens are more likely to engage in risky health-related behaviors and to experience higher rates of chronic conditions and activity limitations.” A lack of sidewalks, streetlights, and access to facilities discourages physical activity in rural areas. While poor air quality and crime rates are not as serious of an issue in rural areas, inadequacies in the built environment make it challenging for rural residents to sustain healthy behaviors.

Some of the major public health problems faced in both urban and rural areas are obesity, chronic stress, tobacco use, substance and alcohol abuse, and food security.

Scholars suggest countless theories as to exactly how the built environment affects health. In “Running to the Store? The Relationship Between Neighborhood Environments and the Risk of Obesity,” Zick et al. (2009) examined nutrition choices in low income neighborhoods. They argue that this factor is one of the most significant in causing health disparities seen in low income neighborhoods.

While their findings were not completely clear regarding nutrition choices, evidence was provided to confirm the strong association between neighborhood retail food options and the risk of obesity. The types of retail food options found in urban neighborhoods were analyzed. The average community generally has a variety of supermarkets, full-service restaurants, fast food

restaurants, and convenience stores. Many low-income neighborhoods may not have access to some of these resources, specifically supermarkets and full-service eateries. Often times, retailers that sell healthy food may shy away from locating in a low-income area for many different reasons, resulting in increased numbers of fast food chains and small convenience stores that sell calorically empty food. In poorer areas that do have a grocery store, proximity to one's home often becomes an issue. Zick et al. (2009) defined an individual's shopping neighborhood as the outlets he/she "can get to within a reasonable time frame." (p. 1494). While getting to a grocery store that is more than a half mile away may be a challenge for some to purchase healthy food, alternate research shows that being located too close to a grocery store can be detrimental to health by causing overconsumption and high BMIs. More scholars present research agreeing with the former rather than the latter and believe close proximity to healthy food outlets would provide a convenience that might increase fruit and vegetable consumption.

Ghosh-Dastidar et al. (2014) agree that while location of grocery stores and other healthy food outlets is important, the high prices of healthy food also negatively influence its consumption. Many inhabitants of low income areas grocery shop outside of their neighborhoods of residence, especially at low-price stores. There have been mixed findings correlating food price and consumption of said food. Some studies have noted that when healthier food is available at a reasonable price, its purchase is increased. Other studies have found that once someone enters a low-price store, specifically a person from a low SES background, their purchasing of healthy food increases in addition to their purchasing of unhealthy food; the overall low prices entice them to buy non-nutritious food as well. When high-price stores and low-price stores were compared, their availability of fruits and vegetable was similar. What was different however, was the advertising within each store. High-price stores advocated for buying

fresh produce while low-price stores “actively marketed junk foods” (Ghosh-Dastidar, 2014, p. 593). Marketing to easily swayed, vulnerable populations is not new, and clearly affects the choices people make.

In addition to analyzing the nutritional intake of those in low SES areas, Zick et al. (2009) examined exercise patterns in these areas. The lack of physical activity in urban areas is attributable to neighborhood safety, less walking space, and a lack of public recreation areas. Poor physical activity trends in rural areas are also due to an absence of resources encouraging physical activity like sidewalks and streetlights. These ideas as well as the social conditions in one’s built environment that can impact health were studied by Barber et al. in 2016.

Barber et al.’s study connected Heart Disease incidence among African American adults with neighborhood disadvantage and poor social conditions in their 2016 study. They took into account “the disproportionate exposure of African Americans to socioeconomically deprived residential settings” and investigated “how these contexts shape disease risk among the group” (p. 2219). Specific built and social environmental features link low income settings to higher disease risk. These neighborhoods are often times not conducive to physical activity because of high rates of crime, violence, and disorder. Access to outlets to engage in physical activity is poorer in these areas as well.

According to the World Health Organization (2017b), “the factors influencing urban health include urban governance; population characteristics; the natural and built environment; social and economic development; services and health emergency management; and food security.” Due to the decades of disinvestment in urban areas, low income neighborhoods with high rates of poverty and unemployment habitually endure higher rates of crime and physical decay. Barber et al. used social cohesion, violence, and physical disorder, three dimensions of

the neighborhood social environment to examine health trends in low SES neighborhoods. Neighborhoods that were rated negatively in all three of these categories were detrimental to health in regards to food choices and physical activity as well as stress. Increased stress can lead to mental health disorders, elevated blood pressure, and a myriad of other health issues leading to cardiovascular disease (CVD), the top cause of death for African Americans. Prolonged stress, such as the stresses of one's daily life, can result in continued heart rate and blood pressure elevation. Partaking in negative stress coping behaviors (e.g. smoking, increased alcohol consumption, activities with high rates in urban and rural areas) are results of high stress environments that also contribute to CVD.

Research has shown that neighborhood violence is connected to stress and other adverse health outcomes. Olofsson, Lindqvist, Shaw, and Danielsson (2012) pointed out that the timing of exposure to violence or trauma is important in determining its impact on health. Violence endured during childhood and/or adolescence can be extremely harmful in one's development because during this time, parts of the brain that guide one's cognition and decision-making are still emerging. Dealing with trauma while mentally developing can lead to negative long-term health effects. Olofsson et al. noted two theories explaining this connection. One theory highlights the "latent effects of adversities during critical periods" (p. 6). Existing evidence shows that violence exposure, abuse, and neglect in early childhood activates hormones and chemicals in the body that are related to stress. With continued stress exposure, these hormones and chemicals become toxic resulting in damaging physical effects on the body. The second theory Olofsson et al. discussed is how the accumulation of exposure to stressful experiences impacts health. If one experiences a continuous pattern of trauma or violence, he or she is more likely to engage in high-risk behaviors. Cyclical psychological pressure and wear and tear of the

body over the course of one's life can damagingly influence normal adaptations to stress as well as sensitivity to stress.

Without question, negative events early in life can impact one down the road. Lundberg (1991) showed that early exposure to specific environmental characteristics unique to urban and rural populations is no exception. He argued that the different hierarchical classes seen in the U.S. are a result of early American history. Health disparities exist as a result of the formation of these classes. Economic hardship and poor living conditions in childhood are associated with increased risk for both poor physical and mental health in adulthood. Social classes affect accessibility to proper nutrition, neighborhood safety, and a myriad of other factors. These factors and social mobility are inversely related. Health can impact one's possibility of rising to a higher social class. Growing up in an economically disadvantaged area increases the chances of being a semi-skilled or unskilled laborer rather than becoming a member of the middle or upper classes.

In addition to the social implications of the environment that can impact health, the physical environment plays a role in shaping individual as well as community health. With organizations such as the Environmental Protection Agency in existence, more awareness has been raised in recent decades of the growing threats to environmental health. Environmentalism however, is often forgotten about in urban and rural areas and issues such as air pollution, lead exposure, and poor water quality, oftentimes become serious issues.

Most air contamination is man-made and develops from poor burning of fossil and/or biomass fuels that leave toxic chemicals in the air. Both mobile sources (e.g. cars) and stationary sources (e.g. smoke stacks) add to outdoor air pollution. Main sources include exhaust fumes from vehicles, emissions from manufacturing facilities (e.g. factories), and power production.

Indoor air quality is also important in regards to health, and can sometimes be negatively affected by surrounding outdoor air pollution (World Health Organization, 2017c). One serious side effect of consistently breathing in contaminated air is asthma. Asthma can be induced because of inhalation of elevated quantities of airborne irritants. According to the Cleveland Clinic Journal of Medicine, “African Americans not only have a higher prevalence of asthma than whites, they also are encumbered with higher rates of asthma-associated morbidity and death” (Silvers & Lang, 2012). Research regarding air pollution’s effect on Sudden Infant Death Syndrome has shown there may be a link between the two. Other serious respiratory problems have been associated with air pollution as well.

According to the CDC, high levels of lead can be found in at least four million households that have children living in them (Centers for Disease Control and Prevention, 2017b). Exposure to lead is most detrimental for developing children. Lead-based paint was used in most U.S. homes constructed before 1978. Many older houses are still likely to contain lead-based paint on the walls with traces of lead in the nearby dust and dirt. Many of the homes in urban and rural neighborhoods are dated. While there are now laws set by the EPA to manage the buying and renting of homes with lead-based paint, high levels of lead are still seen in some homes. In addition, damage to health has already been done for those that have lived/been living in these homes in/since previous years. Because African Americans are more likely to live in older housing, black children are often the victims of lead poisoning. Lead poisoning contributes to a multitude of short term problems such as memory loss, constipation, and irritability. Long term health problems related to lead poisoning include learning disabilities, vitamin and mineral deficiencies, depression, and nausea (Centers for Disease Control and Prevention, 2017c).

In terms of water quality, both urban and rural areas are often at a disadvantage for different reasons. City water systems are sometimes fluoridated. The chemicals used in fluoridation can cause lead poisoning and all of the side effects associated with it, increase rates of premature births, and lead to complications associated with kidney failure and diabetes. Depending on where the main water source supplying water to a community is, other toxins such as pesticide and fertilizer chemicals from farms and bacteria from landfills can seep into the water and be transported into one's home. This is an issue in rural communities as well. In addition to this, many rural areas do not have a water system (water source, storage tank, and a distribution system) in place for community use. This results in the use of wells, springs, and cisterns as primary water sources, often leading to the use and consumption of contaminated water because of a lack of means to treat the water (Centers for Disease Control and Prevention, 2009).

Both the social and physical environment one inhabits can increase risk of disease and influence his/her overall health status. Unfortunately, living standards in low income areas are not always given the same attention as middle and high income areas; minority populations, especially African Americans, often feel the effects of this. As previously stated, life expectancy is calculated as an arithmetic mean, meaning the sum of a set is divided by the amount of numbers in said set. African Americans inhabiting urban and rural areas do not account for all African Americans, but the extreme disadvantages to health those living in these settings face results in higher morbidity and earlier mortality. The high death rates for these areas are calculated with the death rates of African Americans living in suburban areas and as a result, life expectancy is poor for the group as a whole. Barber et al. explained that "racial residential segregation places African Americans at increased risk for exposure to these health-damaging

neighborhood environments, implicating these contexts as important shapers of disease risk in this group” (p. 2225).

XI. Healthcare Access & Quality

The United States healthcare system is one of great controversy when compared with other developed nations. The U.S. spends between \$9,000 and \$10,000 on healthcare per person annually, more than any other high-income nation, yet when compared with the same nations has lower life expectancy and poorer overall health (Squires & Anderson, 2015).

Health insurance is a main staple of the U.S. healthcare system. Health insurance is a form of coverage that either provides or shares compensation of an insured person’s medical expenses (e.g. prescriptions, surgical procedures, etc.). The costs paid by an individual for medical/health services are dependent on the type of insurance coverage he or she has. The individual may pay out-of-pocket and then be recompensed, or the insurance provider makes direct payments to the medical provider (e.g. clinic, hospital, doctor, laboratory, health care practitioner, or pharmacy).

With health insurance being a large component of the American healthcare system, obtaining health insurance is very important for American citizens. The majority of Americans are insured through employers. Health insurance is normally encompassed in employer benefit packages and viewed as a perk of employment; the employer pays part of an employee’s healthcare related costs and the employee pays the rest. Those that do not receive insurance coverage through employment may buy coverage directly, be enrolled in a public-run governmental insurance program, or go uninsured.

Self-employed Americans purchase their own insurance, receiving tax deductions as an incentive. Americans utilizing private insurance companies pay the full cost of medical/health

related bills. Governmental insurance programs exist to provide coverage for special populations that may not be able to obtain health insurance coverage for a number of reasons. The main public insurance establishments are Medicare and Medicaid which provide coverage for vulnerable populations including the elderly, poor, and people with disabilities.

Regardless of the multiple sources of coverage available, in 2010, 47,000,000 Americans were uninsured. This high number is attributable to “gaps in the public insurance system and lack of access to affordable private coverage” (“Key facts about the uninsured population,” 2016).

In 2010, President Barack Obama signed the Patient Protection and Affordable Care Act. Referred to as simply the Affordable Care Act (ACA) or Obama Care, the almost 1,000-page piece of legislation aimed to bring tremendous reform to healthcare in America. The ACA “intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs” (National Conference of State Legislatures, 2011). Since going into full effect on January 1, 2014, 20,000,000 previously uninsured American citizens have obtained health coverage. Still, the complexity of the U.S. healthcare system is unquestionably reflected in its poor mortality and morbidity rates.

According to Dr. Bernice Roberts Kennedy, “Race and social class significantly influence the health status, access to healthcare, and the scope and quality of healthcare of minority populations” (Kennedy, 2013). The negative numbers in terms of healthcare seen in the black population are imputable to barriers faced in accessing adequate healthcare and the quality of said healthcare.

Inequities in ability to obtain health services affect both individuals and society. Access to health care influences health status, disease prevention and detection, overall quality of life, avoidable death, and life expectancy (Healthy People, 2017).

Healthy People 2020's website states that "Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone" (Healthy People, 2017). Successfully entering the healthcare system, close proximity to a healthcare site that provides needed services, and attaining a healthcare practitioner with whom the patient can communicate and trust are three important aspects in terms of access. These three aspects relate to the barriers reported by blacks in a 2006 study assessing access to outpatient medical care for blacks and whites in the rural south.

In the aforementioned study, blacks cited more barriers to gaining access to care than whites (Pathman, Fowler-Brown, Corbie-Smith, 2006). More blacks reported difficulty in receiving necessary care, no consistent source of care, seeking primary care in emergency rooms, difficulty finding transportation to care, and a lack of physicians in their communities. In another study examining racial disparities in healthcare and their effects on CVD, black adults reported residential segregation, limited income and insurance, and lack of knowledge about available services and new medical procedures as additional barriers (Rooks et al., 2008).

Having adequate health insurance could be the key to overcoming some of these barriers. As previously mentioned, the United States' healthcare system is based on health insurance. Obtaining health insurance is key to receiving medical care, however obtaining it is not easy for all, in fact Kennedy (2013) noted that one of the most significant barriers in accessing healthcare services is lack of health insurance. The implementation of the Affordable Care Act increased access to care for the poor and minorities by increasing funding to Medicare and Medicaid and

easing up on requirements for recipients, but as of 2015, 11.2% of African Americans under age 65 were still uninsured compared to 7.5% of whites of the same age (Centers for Disease Control and Prevention, 2017d; Centers for Disease Control and Prevention, 2017e). A high percentage of blacks do not have health insurance for multiple reasons including price, and specific requirements that insurance companies hold. This can explain the increased utilization of emergency rooms for primary care by blacks; emergency rooms treat everyone regardless of insurance coverage.

Oddly enough, with all of these obstacles and negative undertones regarding blacks and healthcare, the amount of physician visits per year between blacks and whites were similar among older populations. This led Rooks et al. as well as other scholars to research healthcare quality rather than access to understand the health disparities between blacks and whites.

In Pathman, Fowler-Brown, and Corbie-Smith's study, blacks were less satisfied than whites when it came to overall satisfaction of care, level of concern shown by physicians, and having confidence in their provider's ability to help them.

Poor provider sensitivity and a lack of knowledge of the historical and socioeconomic experience of minorities adds to the mistrust of physicians felt by blacks. Banks, Ong-Flaherty, and Sharifi (2016) attribute the discontentment with healthcare of blacks to the lack of culturally congruent care. They noted the lack of trust among African Americans of the healthcare system and healthcare providers in their 2016 article titled "Culture of Oppression in African-Americans With Heart Failure." This lack of trust and fear of exploitation, mistreatment, and misinformation is rooted in improprieties in medical research in past generations such as the Tuskegee Study, an experiment conducted by the Public Health Service and the Tuskegee Institute that examined black men with Syphilis for forty years. The men involved did not know their diagnosis or true

purpose of the study and when a cure for the disease was discovered, were barred from obtaining it. While this study was ruled unethical because of the lack of informed consent of participants, and initiated the creation of the Institutional Review Board, its negative legacy still prevails in the minds of many black Americans (Centers for Disease Control and Prevention, 2016).

Surprising to most, bias is a ubiquitous issue within the medical field. In his 2017 article titled “Can We Stop the Doctor Bias?,” author David Artavia discussed the racial bias healthcare professionals sometimes have and how it affects blacks as a whole and more specifically, gay black men living with HIV. Studies show that “implicit bias stops many doctors from providing high-quality care to black Americans” (Artavia, 2017).

Non-black doctors often treat pain differently for black patients and are also less engaged when communicating with them. These issues are even more troublesome for black men that are also part of the LGBTQ population, as this population deals with its own hardships within the medical field. Patients can be hesitant to have open conversations about anal sex and other sexual behaviors society labels as abnormal. Many physicians are unaware of these hesitancies and are not knowledgeable about what gay black males endure. Physicians that are not knowledgeable about minority health find it difficult to offer adequate treatment and preventive care for their patients. Because of this, many black men view going to the doctor as an unnecessary hassle and oftentimes skip the experience altogether, adding to increased disease prevalence and ultimately higher disease rates for the black population as a whole.

The aforesaid barriers that affect receipt of quality healthcare also impact the utilization of emergency rooms for primary healthcare. Today, 31% of black men and 18% of black women report not having primary care physicians (PCPs) for a myriad of reasons including those previously mentioned (Finnegan, 2017). Those lacking a PCP and/or health insurance often use

emergency rooms when in need of care because they will not be turned away; African Americans utilize emergency rooms more often than their white counterparts for non-emergent care. Pathman, Fowler-Brown, and Corbie-Smith, (2006) noted that the service provided and relationships between emergency care providers and patients is not comparable to the care found in physician's offices. PCPs have background information on their patients including knowledge of one's SES, medical history, and family history. This information allows physicians to make valuable decisions when providing care and prescribing medicine. PCPs can also promote health education and preventive care options more thoroughly than an emergency room physician. Missing out on the benefits a PCP can provide can lead to poorer health and poorer health management.

Research shows that adequate insurance coverage improves physical and mental health and reduces mortality rates. Those that are uninsured are less likely to receive preventive care and treatment for health conditions and chronic diseases. Serious health consequences can result for individuals and eventually whole populations when many members face the same troubles. The percentage of African Americans that have trouble accessing quality healthcare impacts the health of the race as a whole by increasing disease incidence and prevalence and mortality rates. The differences in healthcare by race and SES may explain racial differences in health.

XII. Black Morbidity

Without question, the social determinants of health, specifically the three already discussed, (SES, living environment, and healthcare access and quality) strongly affect the overall health status of African Americans as a group. Each of these factors indirectly affect life expectancy by directly impacting black morbidity rates.

As previously mentioned, African Americans have high rates of disease in terms of both communicable and non-communicable diseases. According to the CDC, the leading causes of death for black Americans are heart disease, cancer, and stroke (Centers for Disease Control and Prevention, 2017d). The high rates among African Americans for each of these diseases can be explained by outside influences rather than genetics.

While it is not one of the three leading causes of death among blacks, obesity is a disease that is very prevalent in the black community. Obesity is characterized by an excess of adipose tissue or fat on one's body. Obesity occurs over time as the body adapts to taking in more calories than are being used. Risk factors for obesity include family history of obesity, age, overeating, eating high calorie foods, and physical inactivity. Excess fat on the body increases levels of circulating fatty acids and inflammation increasing one's risk for comorbidity, especially with diabetes, heart diseases, stroke, and certain cancers (MedlinePlus, 2017a).

Obesity rates are highest among black Americans with 47.8% of the population being considered obese. More specifically, 37.1% of black men and 56.6% of black women (the highest American sub-group) were obese as of 2015. As for children, "overweight and obesity rates are higher, start at earlier ages, and increase faster among black and Latino children than among white children" (Trust for America's Health & Robert Wood Johnson Foundation, 2015). As previously discussed, many black Americans are at a disadvantage in terms of maintaining a nutritious diet and consistent physical activity; leading to higher rates of obesity, its possible preceding health conditions, and untimely death.

Recommended treatment for obese individuals is dependent on the severity of one's condition, his or her age, and other health related influences (National Heart, Lung, and Blood Institute, 2017). Physicians may suggest that patients take on healthy lifestyles by changing their

diet and increasing physical activity. Switching to a healthier lifestyle is not achievable for all however; costs, neighborhood safety, and access to resources heavily influences one's lifestyle decisions and while personal responsibility needs to be taken into account, if one isn't given the tools to make healthy choices, their odds of overcoming disease are narrowed. Weight loss medicines and surgical procedures are also options to overcome obesity. The U.S. healthcare system plays a role in the rates of these treatments. Both prescriptions and bariatric surgery can be costly if not covered by insurance. If a patient does however qualify to receive medicine or surgery, lifestyle still plays a role in losing and maintaining weight.

While heart disease is the leading cause of death for African Americans, it is also the leading cause of death for all American citizens. Heart disease is a broad name for a number of heart related conditions; the two most common being atherosclerosis and coronary artery disease. Atherosclerosis happens when cholesterol deposits, known as plaque, build up in the arteries that supply blood to the heart. Plaque buildup in one's arteries causes the inside of the arteries to narrow, making it hard for blood to travel through, resulting in coronary artery disease. Poor blood flow to the heart can result in high blood pressure, angina, a heart condition characterized by chest pain and discomfort, heart attack, and even heart failure (Centers for Disease Control and Prevention, 2015a).

As of 2008, 23.8% of all African American deaths resulted from some form of heart disease (Centers for Disease Control and Prevention, 2015b). Today, 46% of black men and nearly 48% of black women have some form of heart disease (Cleveland Clinic, 2017). While race and ethnicity are considered in determining risk factors for heart disease, heredity and age serve as more realistic risk factors. Keeping these in mind, the increased incidence of heart disease in America may however be attributable to an increase in poor diets and inactivity in

America. Research shows these two factors correlate with heart disease as well as many other non-communicable diseases. As previously discussed, many black Americans are at a disadvantage in terms of maintaining a nutritious diet and consistent physical activity; leading to higher rates of heart disease and untimely death.

Diabetes is another disease with a high prevalence among minority populations, especially the African American community. Diabetes occurs when the amount of glucose in one's blood gets too high due to issues with insulin regulation. Insulin is a hormone that allows glucose from food to be used as energy in the body cells; when the body does not have enough insulin, or it is not working properly, glucose can accumulate and remain in the blood leading to further health problems including but not limited to heart disease, stroke, kidney disease, and nerve damage (National Institutes of Health, 2017).

There are multiple types of diabetes, but the two most common are type 1 and type 2. Type 1 diabetes is an autoimmune disease in which one's pancreas is unable to make insulin. Although it can appear at any age, it is generally diagnosed in childhood and young adulthood. Type 2 diabetes is more common. It occurs when the body either repels the effects of insulin, or doesn't produce enough of it. Type 2 diabetes affects people of all ages but most commonly middle-aged and older people. Excess body fat, physical inactivity, and certain pre-existing health problems are risk factors for type 2 diabetes (National Institutes of Health, 2017). Black Americans have a high risk for type 2 diabetes. According to the American Diabetes Association, 13.2% of black Americans have diabetes (American Diabetes Association, 2017). In 2014, 13,435 black deaths were caused by diabetes (Kochanek, Murphy, Xu, & Tejada-Vera, 2016). Black Americans tend to have more diabetes risk factors when compared to other racial groups. Many of these risk factors are results of the social determinants already discussed.

The second leading cause of death for African Americans and Americans as a whole is cancer. Usually, as cells in the body die, new cells form as the body needs them. When new cells grow uncontrollably for no reason, the outcome is cancer. These extra cells may form dangerous masses of tissue called tumors that allow cells to invade and destroy nearby tissue (MedlinePlus, 2017b). Physicians use numbers 1 through 4 to categorize the different stages of cancer based on how advanced a person's specific case is; the further progressed the disease is, the poorer the prognosis, regardless of treatment.

Cancer treatment depends on where in the body the cancer is. The three main treatments used by physicians are surgery to remove tumors and/or extra cells, chemotherapy to chemically remove cancer cells, and radiation therapy which uses x-rays to kill cancerous cells; the goal of all three is to destroy cancerous cells and preserve healthy cells, although it is not always that simple. Cancer treatment is extremely expensive, costing patients and/or insurance companies tens of thousands of dollars each year, and with cancer rates continuously increasing, costs will continue to rise. (Cancer Treatment Centers of America, 2017). The Agency for Healthcare Research and Quality approximates that in 2014, the direct medical costs for cancer related treatment in America were near \$87.8 billion (American Cancer Society, 2017a).

There are over 100 different types of cancer that effect all different areas of the body. Today, "The most commonly diagnosed cancers among black men are prostate (31% of all cancers), lung (15%), and colon and rectum (9%). Among black women, the most common cancers are breast (32% of all cancers), lung (11%), and colon and rectum (9%)" (American Cancer Society, 2017b). According to the American Cancer Society, "the racial disparity has widened for breast cancer in women and remained constant for colorectal cancer in men, likely

due to inequalities in access to care, including screening and treatment” (American Cancer Society, 2017b).

Risk factors for cancer include inevitable potential causes including age and heredity as well as stoppable lifestyle factors such as alcohol and tobacco use, poor diet, obesity, exposure to radiation, and many more (National Cancer Institute, 2015). As previously mentioned cancer rates have been increasing worldwide for years. Researchers attribute these increases to increases in lifespan (as age increases, risk for cancer increases), poorer lifestyle choices including poor diets (increased consumption of processed foods and red meat), lack of physical activity, and environmental factors such as increased exposure to UV radiation, poor air quality, etc. (Jones, 2015). African Americans tend to have lifestyles (because of finances and where they live) that put them at a higher risk for developing cancer.

In addition to a rise in the amount of cancer cases, cancer survival rates have also been increasing within the past decades due to improvements in medical care. However, African Americans still have the highest death rate and shortest survival of any racial and ethnic group in America for most cancers. The American Cancer Society (2016) states that “the reasons for these racial and ethnic differences are not clear.” Poor healthcare access and quality within the black population are reflected in the group’s high cancer mortality rates. According to “*Cancer Facts & Figures 2017*, uninsured patients and those from many ethnic minority groups are substantially more likely to be diagnosed with cancer at a later stage, when treatment can be more extensive, costlier, and less successful” (American Cancer Society, 2017a). Not going to the doctor frequently due to distance, lack of insurance, or negative views of the healthcare system causes these patients to discover their cancer status in an unideal timeframe. When

already expensive treatment costs more patients, uninsured or not, are less likely to receive the quality care they need.

Without question, the high morbidity rates faced by the African American population are results of the many outside factors that influence lifestyle choices. The high morbidity rates among the group for the aforementioned diseases as well as many others contribute to mortality rates, and consequently shorter life expectancies.

XIII. Healthism

One of the aims of this literature review is to refute the idea of healthism as the primary reason for both individual and group health.

The term healthism was first introduced in 1980 by economist Robert Crawford in his article titled “Healthism and the Medicalization of Everyday Life.” In this article, he discussed how at the time, self-care, holistic care, and alternative medicine were gaining popularity as health consciousness began to become more important (Michel, 2012). The new ideology of healthism attributed health status solely to an individual’s lifestyle choices and due to increased media consumption in the twentieth century, this ideology became dominant in the minds of many Americans. In a 2012 article titled “Healthism”: A Neoliberal Version of Wellness,” Frann Michel wrote “Put bluntly, healthism entails seeing health as an individual matter, a primary value, and a moral index: basically, if you get sick, it’s your fault.”

While personal responsibility is important, healthism fails to acknowledge how social determinants such as those discussed (SES, living environment, and healthcare access and quality) can affect one’s capability of directly controlling his or her own health within restricted circumstances (Cheek, 2008). While discrimination doesn’t exist on the vast level it once did, its effects still linger.

When it comes to SES, there are undeniable correlations between SES and health status/morbidity. Some researchers believe that if the differences in SES were eliminated when collecting health related data, the racial disparities seen in health would decrease significantly or be non-existent. SES might be the most important social determinant of health it influences many of the others including where one lives, what kind of health insurance one has, and how/what an individual or family can spend on other aspects of health including nutritious food, opportunities for physical activity, etc. (discussed in more detail on pages 14-20). Being of low SES and/or having a low household income places a burden on families whether they are attempting to make healthy decisions or not; it is hard to make health conscious choices if one does not have the tools to do so.

While this study focuses on the disparities faced by African Americans, there are other specific populations whose overall health status is severely impacted by some of the same inequalities faced by black Americans.

The Appalachian region is an area of the United States along the Appalachian Mountains that stretches from New York to Mississippi. This region is generalized as being rural as over 67% of the counties within the region identify as rural. Poverty rates in this area surpass national averages with 15.4% of people living in poverty. More specific barriers to health in this region include a shortage of healthcare professionals, a lack of health insurance availability, and distrust by citizens in the medical system. In addition to high poverty rates, Appalachian citizens face high morbidity and mortality rates (Appalachian Translational Research Network, 2017).

The health status of this population is comparable to that of African Americans. Diabetes, heart disease, and stroke are very prevalent in the Appalachian region. Deaths resulting from heart disease in this region surpass national averages by over 15%. Cancer death rates are also

greater than the national averages; in the U.S., for every 100,000 people, 166.7 die from cancer, in the Appalachian region, 173.1 people die as a result of cancer for every 100,000 (Appalachian Translational Research Network, 2017).

The ironic part of the poor health status of the Appalachian region is that many Appalachians report health as a “valuable commodity” and know that self-reliance and lifestyle are important factors in improving and maintaining good health (Appalachian Translational Research Network, 2017). The majority of citizens’ circumstances (low poverty status, poor access to healthcare, etc.) make it difficult to make healthy decisions. Healthism cannot explain the poor overall health status of this community because there are conditions beyond citizens’ control that impact lifestyle and consequently, health.

Life patterns are cyclical; people are born into certain circumstances such as where they live and their family’s SES. In addition, ways of thinking and doing things are passed down through families from generation to generation until someone breaks said cycle. The historical and material underpinnings of the racial health disparities seen in America impact the lifestyles of many African Americans and are therefore reflected in the differences in life expectancy among the races.

XIV. Measures Already Taken to Improve African American Health

As mentioned numerous times throughout this literature review, inequalities in the social determinants of health result in the racial disparities seen in health, not genetics or just simply lifestyle choices. These disparities have existed for centuries and have improved very little over the years. Professionals from a wide array of disciplines have taken their own action and have reported on what has worked to decrease health discrepancies.

Dr. Bernice Roberts Kennedy (2013) discussed the practice of community empowerment as a “useful driving force in guiding [sic] communities with bringing change in the health of populations” (p. 158). Community empowerment is the urging of individuals to come together as a group to work on a common goal. Mutual sharing of knowledge, resources, and opportunities promotes relationships among community members and allows them to focus on strengths rather than weaknesses and solutions rather than settling with problems. The shared efforts of a community create far more superior results than individual results. Kaplan et al. (1987) evaluated a specific case involving community empowerment in the Tenderloin area of San Francisco. In the late 1980s, a program was underway in the area that aimed to increase social ties among isolated, elderly, and poor residents. Having these residents work together to solve community problems permitted them to increase their social resources and system resources (Meals on Wheels, home health aides, etc.) within the community, resulting in a reduction of some of the environmental demands of the area. The community saw reductions in neighborhood crime in addition to improved food access and indications of enhanced overall health.

Rochester, New York is a city with a high minority population; it has been called “resource rich and results poor.” Connected Communities is a partnership between residents of Beechwood and EMMA, two neighborhoods in Rochester, and many other local organizations whose aim is to break the poverty cycle in these specific neighborhoods by revitalizing education, housing, jobs, health, and more through community empowerment which they refer to as community development. The leaders of the partnership emphasize doing things *with* the community rather than *for* the community to instill change. This organization is fairly new, so there is not much data about the specific progress that has been made in these neighborhoods; its

leaders and the organization as a whole however, have been honored for their/its efforts (Connected Communities, 2017).

In addition to community empowerment/development, many professionals suggest reform in policy as the way to abolish the existent racial health disparities. Zick et al. (2009) studied food deserts and the correlation between living conditions and obesity. They noted that in some U.S. neighborhoods, policymakers interested in the obesity epidemic have argued for new legislation such as temporarily prohibiting the construction of fast food restaurants. While Zick et al. question the effectiveness of such policies, they do believe interventions in low-income communities that increase neighborhood food options and availability are helpful in decreasing the risk of obesity.

In regards to healthcare, reform has been advocated for for years. The Affordable Care Act intended to insure as many Americans without coverage as possible. Since its implementation, about 20,000,000 people have obtained insurance. Some of the newly insured benefited from another aspect of the ACA, the expansion of government funded insurance programs, especially Medicaid. Medicaid provides coverage for low-income elders, adults and children, pregnant women, and those with disabilities. Expanding coverage for these vulnerable populations has allowed more African Americans to visit doctors and receive treatment.

As discussed however, while access to healthcare is important, so is the quality of care received. Physicians can be biased when working with patients from different backgrounds whether it be a different race, nationality, or sexual orientation, and often do not provide treatment with the same quality as other patients. David Artavia (2017) discussed this bias and a website called HisHealth.org that trains physicians on how to work collaboratively with African American men who have sex with men. The website, which is run primarily by physicians who

are gay black men themselves, created the site to help health professionals, unlearn racial prejudice and better the quality of care given to this population. HisHealth provides accredited, expert-led educational courses that can count towards the credits medical professionals need to uphold their licenses. The site offers hour-long self-paced modules covering an array of topics such as transgender health, and PrEP, an anti-HIV medication sometimes taken by those at a high risk for becoming infected with HIV. HisHealth.org's aim is to address the communication gap between physicians and patients from vulnerable populations.

These are only highlights of what has been done to improve African American health. Different cities around the U.S. have taken measures tailored to specific situations. While these organizations and policies have been or are currently working toward decreasing health inequities, they still exist and more needs to be done to change them.

XV. Moving Forward in Eradicating Health Disparities

Additional change is needed to eradicate the health inequities that exist in society. Many fail to realize that most of the negative aspects regarding health and healthcare are preventable and exist because of the actions taken by humans. Spreading knowledge about the basis of health inequities for special populations is the first step in making permanent change, additionally however, more action needs to be taken.

Providing more in-depth health education to children could act as a form of preventive care if established. Most people know basic information about healthy eating and physical activity, but having children and teens learn about physical activity, what's really in their food, and how the body works in response to excess sugar, fat, salt, etc. in the diet on a scientific level may impose more permanent change. Providing this information at a young age allows children to develop positive habits and to take a more active role in their health status as they move

forward into adulthood. They would however need support and the proper tools to be able to see the benefits of such education.

In addition to advocating for community empowerment, Dr. Bernice Roberts Kennedy believes transformational development can bring positive change to communities in distress. Transformational development is a “model of community development which builds upon the foundation of community connectedness to improve the economic, social, political, physical, and spiritual conditions of communities” (Kennedy, 2013). It is an ongoing process and has resulted in continued behavioral change for both individuals and communities. Spreading awareness about this practice and getting cities across America to participate would guide African Americans in addressing health disparities in hopes of making community policy changes. There is power in numbers. Uniting for a cause would allow African Americans to take control of their health status and work toward improving it.

Kennedy cites policy development as another important action to take in improving African American health in addition to community empowerment. She noted that “social and public policy influence the health of populations” (Kennedy, 2013). American communities from state to state and even city to city vary in terms of assets, resources, priorities, and goals regarding the community as a whole and more specifically, health promotion. Kennedy believes the answers to specific health inequalities lie within communities. Public health professionals that work in vulnerable populations are in key positions to advocate for change and get neighborhood residents interested in taking control of their health. Those that have the power to make change need to let their voices be heard. Unity is also important in implementing new policies and public health programs for groups in need. New legislation can only be successful

when the majority of a community participates; only then will successful prevention and health promotion be achieved.

Barber et al. (2016) also discussed policy change as a means to improve African American health. They studied cardiovascular disease in black Americans and suggested that new neighborhood-level policies should address economic and social conditions to reduce the burden of CVD. New policies that take into account SES and a community's social conditions would allow for more specialized necessary changes to reduce racial health inequalities. Additionally, Barber et al. noted that for new policies to work, increased access to health-promoting resources is also important.

Mutchler and Burr (1991) believed that "health differences might be resolved in large part through the equalization of access to and utilization of health care services" (Mutchler & Burr, 1991). They analyzed the differences in private health insurance utilization between blacks and whites, and while their article is 26 years old, today there are still more blacks percentage-wise that are uninsured and more people of color utilizing government funded insurance. If access to insurance was expanded, or reform in the American healthcare system was seen, African American health would improve because of the availability of treatment and preventive care.

Acquiring health insurance will only be beneficial however, if the quality of care one receives is suitable. The creation of HisHealth.org, the website that provides courses on cultural competence for healthcare professionals mentioned in the previous section, is a step in the right direction toward ending bias in the health world. Banks, Ong-Flaherty, and Sharifi (2016) believe "The increasing lack of cultural congruence in care has impacted African-Americans as a people and a culture" and has "also contributed to a lack of trust, ineffective communication, and

safety of patients.” They propose cultural awareness training as a way to improve the quality of care minorities receive and describe it as a fundamental and crucial intervention that all healthcare providers should be subjected to. Patients are more apt to listen to a provider’s health recommendations when the relationship between the two is collaborative. A successful partnership between a physician and a patient allows physicians to educate more thoroughly and lets patients be empowered and have a voice in his or her care. This allows patients to accept and understand their health conditions and monitor their symptoms and disease progression. If physicians are forced to participate in training regarding cultural competency, the communication gap between health professionals and special populations will be improved resulting in better health outcomes for African Americans and eventually life expectancies comparable to the other races.

XVI. Conclusion

The numerous pieces of literature analyzed for the purposes of this project all had different study aims, hypotheses, and views on specific issues, but all attributed the poorer overall health status endured by African Americans to the inequities in the various social determinants of health.

The shorter life expectancies the group faces are indirect results of the racial persecution faced in early American history. The vestiges of this persecution and discrimination force many African Americans into living situations and lifestyles that can be detrimental to health and hard to overcome.

It is important to reiterate that these findings do not apply to all African Americans. Not all African Americans endure poor health, but a larger percentage of this group does endure poor health when compared to other racial group’s health statistics. Life expectancy takes into account

everyone included within the certain population it is being calculated for. There are many African Americans that do live long healthy lives, but the strong percentage that don't account for the five years lost in life expectancy between the national average and the average life expectancy for African Americans.

The ideology of healthism cannot provide a logical explanation for these issues because it fails to consider the social determinants of health and more importantly why things are the way they are. People are often taught facts and not how to think epistemologically; one can learn that African Americans suffer disproportionately high rates of obesity, see a black child in an urban neighborhood buy calorically empty snacks from a corner store, and proceed to go home and sit on the porch and make assumptions that that child chooses to be this way all while failing to question why there are only corner stores and not grocery stores within a 3-mile radius, why there are no parks in this neighborhood, and why said neighborhood is predominantly populated by black people?

Clearly, the connections made throughout this study are not new. The fact that some of the articles reviewed are dated by over 20 years shows that more progress need to be made in regards to the health disparities seen within the United States of America. Until past flaws are acknowledged and the lessons learned throughout history are more highly valued than the dates, it will be hard to move forward. Addressing the racial discrepancies in health and other social aspects and moving forward as a country rather than divided groups is the only way to eradicate health disparities for good.

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