Essay - Transforming American health care to improve end results for African Americans people

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In 1928, Louis Israel Dublin wrote "*An improvement in Negro health, to the point where it would compare favorably with that of the white race, would at one stroke wipe out many disabilities from which the race suffers, improve its economic status and stimulate its native abilities as would no other single improvement. These are the social implications of the facts of Negro Health*".[1]

In mid-eighties, Margaret Heckler, then Secretary of Health and Human Services (HHS), dissatisfied with the way health disparities were being reported to Congress, provided the first comprehensive review of health disparities endured by black and minority groups, compared with whites. One of the most significant outcomes of the 1985 Report of the Secretary's Task Force[2] on Black and Minority Health, also known as the Heckler Report, was the creation of the Office of Minority Health in 1986[3], with the mission "*to improve the health or racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities.*" The Heckler Report called health disparities among minority groups an affront both to our ideals and to the ongoing genius of American medicine.

It has been 17 years since the publication of the Institute of Medicine's Unequal Treatment report, which synthesized a wide body of research demonstrating that U.S. racial and ethnic minorities are less likely to receive preventive medical treatments than whites and often receive lower quality care. Most startling, the analysis found that even after taking into account income, neighborhood, comorbid illnesses, and health insurance type — factors typically invoked to explain racial disparities — health outcomes among blacks, in particular, were still worse than whites. This research prompted the Institute of Medicine to add equity to a list of aims for the U.S. health care system, but efforts to ensure all Americans have equal opportunity to live long and healthy lives have been given less attention than have efforts to improve health care quality or reduce costs. A recent Institute for Healthcare Improvement white paper called equity "the forgotten aim," noting as did the 2010 Institute of Medicine report, How Far Have We Come in Reducing Health Disparities?, how little progress has been made.

Despite all efforts and important gains, African Americans still experience illness and infirmity at extremely high rates and have lower life expectancy than other racial and ethnic groups. They are also one of the most economically disadvantaged demographics in the USA. A rapid comparison for selected diseases is showing:

- The five-years survival rate for breast cancer was 80% for black-women and 91% for white women. The difference was attributed to both later stage detection and poorer stage-specific survival among black women[4],

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[1] Dublin L. The health of the Negro. Ann Am Acad Pol Soc Sci. 1928;140:77–85. doi: 10.1177/000271622814000111

[2] Heckler MM. U.S. Department of Health and Human Services. Report of the Secretary's Task Force Report on Black and Minority Health Volume I: Washington DC: Executive Summary.U.S. Government Printing Office; 1985.

[3] United States Department of Health and Human Services Office of Minority Health. 2016. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=1

[4] American Cancer Society, Cancer facts & Figures for African Americans 2016-2018 (ACS, 2016)

- A black woman is 22% more likely to die from heart disease than a white woman, 71% more likely to perish from cervical cancer, and 243 % more likely to die from pregnancy- or childbirth-related diseases[5].

To understand the root cause of the existing disparities, Noonan et al (2016)[6] used a modified social ecological model (figure 1) that includes the social determinants of health, health disparities, main health needs, and access to health services. This conceptual model allows to relate social (distal) determinants, with individual (proximal) determinants of health. Social determinants of health include the main variables of health inequalities, namely, race, poverty, and gender. These influence health needs (morbidity, mortality, and health risks). The social response to health needs is represented by health services (policies, access, utilization, and workforce), which in turn influences health needs and risks, by hopefully resolving or improving them.

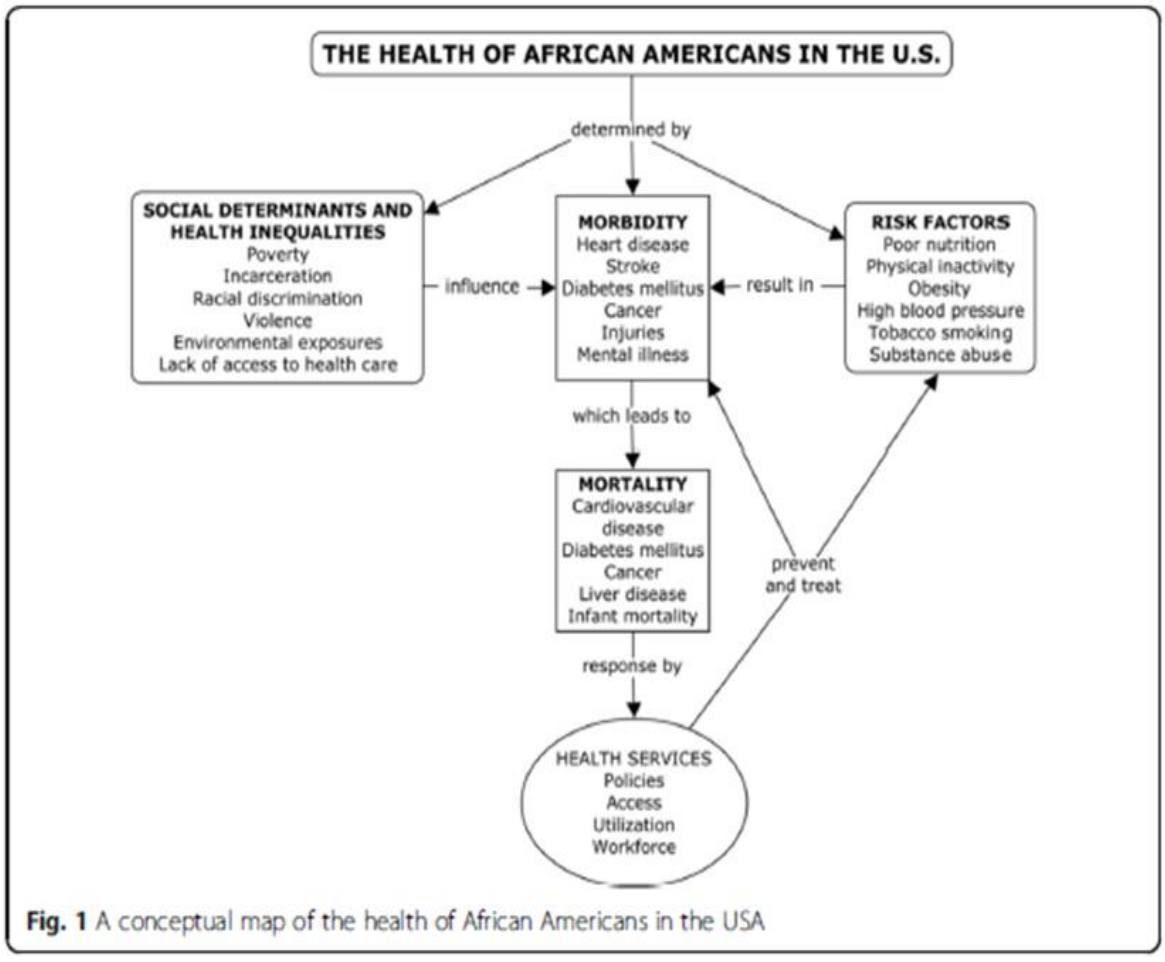

Fig. 1 A conceptual map of the health of African Americans in the USA

However, this model is not capturing the behavioral issues displayed by African Americans in seeking preventive health care. Researchers attribute the delay or underutilization of preventive healthcare to fatalism, socioeconomic barriers, limited health knowledge or awareness, and medical mistrust (Bowleg 2011[7], Powel 2010[8]). Powel (2010) discovered that mistrust of healthcare physicians and the healthcare system led to a delay in routine check-up

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[5] Martin N, Montagne R. Nothing protects Black women from dying in pregnancy and childbirth. ProPublica, Dec.17, 2017.

[6] Noonan et al. Improving the health of African Americans in the USA: an overdue opportunity for social justicePublic Health Reviews (2016) 37:12

[7] Bowleg L (2011). What does it take to be a man? What is a real man? ': Ideologies of masculinity and HIV sexual risk among Black heterosexual men. Culture, Health & Sexuality 13: 545 – 559.

[8] Powell WH (2010). Masculinity, medical mistrust, and preventive health services delays among community-dwelling African American men. J Gen Intern Med 25: 1300-8.

initiation. Medical mistrust also played a role in preventing African American males from obtaining recommended services. Furthermore, young American African adults often receive less information and intervention to encourage healthier lifestyle choices.

From this combination of literature, it can be concluded that despair, despondency, socioeconomic status, lack of knowledge, distrust of the medical system and physicians, and issues related to masculinity have all been associated with encumbering access to healthcare (Ravenelle 2008[9], Watson 2014[10]).

The indicators are clearly demonstrating the actual situation. The age-adjusted death rates in the Afro-American population had the highest age-adjusted death rate of any ethnic group in 2013 (1083.3 per 100,000 standard population for black males vs. 876.8 100,000 for white males, the second highest). The rate for the total population was 731.9 per 100,000 population making the black male rate 48 % higher than the total.

Years of Potential Life Lost (YPPL) is also illustrative. Overall, Afro-Americans remain the least healthy ethnic population. There seems to have been marked improvement in this picture by 2010. Afro-Americans ranked first in only four of the top 10 causes, but the listed causes had changed. Poisoning was added as a new cause and cirrhosis of the liver edged out HIV and diabetes (for both of which Afro-Americans were number one) for the tenth spot. Homicides are also a leading cause of death for African American. African American children are ten times more likely to die by gun violence than white children[11].

Infant mortality rates is providing the most transparent view of black health. It has always been at least 2.5 times greater than the white rate since data have been recorded. In 2005, the infant mortality rates were 6.86/100,000 for all births, 5.76/100,000 for whites, and 13.6/100,000 for blacks. The total US infant mortality rate was 5.96 infant deaths per 1000 live births in 2013, and that for African American infants was 11.1 per 100,000 live births. In 2019, the US DHHS is reporting an infant mortality rate of 5.8 / 100,000 for all births, 4.7/100,000 for whites and 11/100,00 for blacks[12].

The low birth weight (LBW) level was 6.98 % for non-Hispanic white women and 13.08 % for non-Hispanic black infants in 2013. And, in 2013, the rate of preterm deliveries was 1.6 times higher for African American women. In 2014, low birth weight and preterm births before 37 weeks gestation were the highest among black women, 13.17 and 11.1 %, respectively.

The Affordable Care Act (ACA) has helped to ensure health care coverage for millions of Americans. The uninsured rate among African Americans declined after the law was implemented: of the more than 20 million

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[9] Ravenelle JE (2008). According to him: barriers to healthcare among African American men. J Natl Med Assoc 100:1153-60

[10] Watson J (2014). Young African American Males: Barriers to Access to Health Care. Journal of Human Behavior in the Social Environment 24: 1004-9.

[11] Yolanda T. Mitchell and Tiffany L. Bromfield, "Gun Violence and the Minority Experience," National Council on Family Relations, January 10, 2019, https://www.ncfr.org/ncfr-report/winter-2018/gun-violence-and-minority-experience.

[12] "Infant Health Mortality and African Americans," U.S. Department of Health and Human Services Office of Minority Health, accessed November 17, 2019, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23.

people who have gained coverage under the ACA, 2.8 million of them are African American[13]. Yet, this population is still more likely to be uninsured than white Americans: as of 2018, the uninsured rate among African Americans was 9.7 percent, while it was just 5.4 percent among whites[14]. African Americans were more likely to be covered through employer-sponsored or private health insurance: 55 percent of African Americans used private health insurance in 2018, while 41.2 percent were enrolled in Medicaid or some other type of public health insurance[15].

While coverage expansions under the ACA have hastened the progress toward universal coverage, the continued high cost of many coverage options means that access to affordable health care is still a challenge for many Americans—particularly African Americans.

The average family spends $8,200 (or 11 percent of family income) per year on health care premiums, and out-of-pocket costs for things such as office visit copays, prescription drugs, and surprise or out of plan medical bills continue to wreak havoc on the financial security of families[16]. For African Americans, the average annual cost for health care premiums is almost 20 percent of the average household income—a major cost to bear, when taking into account income inequality and other economic challenges for this demographic.

The high cost of coverage has kept the number of uninsured and underinsured unacceptably high: of the 27.5 million people that still lack health insurance coverage[17], 45 percent cite cost as the reason for being uninsured[18]. Furthermore, the Commonwealth Fund estimates that an additional 87 million people (adults aged 19 to 64) are underinsured; that is, they have coverage, but their plan leads to unusually high out-of-pocket costs relative to income that can lead to a strain on personal finances or even debt. Of these underinsured adults, 18 percent are African American[19].

Several health care reform proposals (Table 1) have introduced by members of the US Congress and by 2020 presidential candidates.

Table 1: major public plan and hybrid plan proposals[20].

	Who Runs the Plan?	Who Qualifies for the Plan?	Can People Choosea Different Plan?	What Do EnrolleesPay?	What Do Enrollees Get?	How Much Do Providers Get Paid?
Medicare for All: S. 1129 (Sanders)	Medicare	All people	No	Taxes (no premiums)	Enhanced ACA benefits, including long-term care services, dental, vision, and reproductive care that includes abortion coverage; virtually no	Medicare payment rates

[13] Bowen Garret and Anju Gangopadhyaya, "Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?" Urban Institute and Robert Wood Johnson Foundation, December 2016, https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf.

[14] "Health Insurance Coverage in the United States: 2018," U.S. Census Bureau, November 2019, https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[15] Ibid

[16] "The Real Cost of Health Care: Interactive Calculator Estimates Both Direct and Hidden Household Spending," Henry J. Kaiser Family Foundation, February 21, 2019, https://www.kff.org/health-costs/press-release/interactive-calculator-estimates-both-direct-and-hidden-household-spending/.

[17] U.S. Census Bureau, "Health Insurance Coverage In The United States."

[18] "Key Facts About the Uninsured Population," Henry J. Kaiser Family Foundation, December 7, 2018, https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[19] Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, "Health Insurance Coverage Eight Years After The ACA: Fewer Uninsured Americans and Shorter Coverage Gaps," The Commonwealth Fund, February 7, 2019, https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.

[20] LAMBREW J. 2019. Comparison of Health Reform Legislation Creating Public Plans. https://tcf.org/content/commentary/comparison-health-reform-legislation-creating-public-plans/

					cost sharing	
Medicare Part E (Merkley: S 1261, Richmond: H.R. 2463)	Federal gov't	All non-elderly people except those Medicaid-orMedicare-eligible	Depends: Employers choose for workers; yes for others	Federal gov't-set premiums based on costs, decreased for low-income enrolleesand employer contribution (current law)	Enhanced ACA benefits, including abortion coverage; Gold-plan-level costsharing	Negotiated rates which fall between Medicare and average private rates
Medicaid Option (Schatz: S. 489 / Lujan: H.R. 1277)	States	All non-elderly people in such States	Yes	State-set premiums, decreased for low- income enrollees	Medicaid benefits plus reproductive carethat includes abortioncoverage. Reduced cost sharing.	Medicaid payment rates, Medicare rates for primary care
Public Option/ CHOICE Act (Whitehouse: S. 1033 / Schakowsky: H.R. 2085)	Federal gov't	People buying coverage on theirown and small businesses	Yes	Federal gov't-set premiums based on costs; decreased for low-income enrollees(current law)	ACA benefits plusabortion as part of reproductive health care. Includes cost sharing reductions (current law)	Negotiated rates which fall between Medicare rates and average private rates
Medicare X (Bennet: S. 981 / Delgado: H.R. 2000)	Federal gov't	People buying on their own and small businesses, in underserved areas initially	Yes	Federal gov't-set premiums based on costs; decreased for low-income enrollees(enhanced ACA tax credits)	ACA benefits and cost sharing reductions(current law)	Medicare payment rates (with increase for rural areas)
Medicare Buy-in at Age 55 (Stabenow: S. 1742 / Higgins: H.R. 1346)	Medicare	People ages 50 or 55to 64 without access to employer coverage	Yes	Federal gov't-set premiums based on costs; decreased for low-income enrollees (current law)	Medicare benefits and cost sharing, ACA costsharing reductions	Medicare payment rates
Medicare for All (Jayapal: H.R. 1384)	Federal gov't	All people	No	Taxes (no premiums)	Enhanced ACA benefits, including long-term care services, dental, vision, and reproductive care that includes abortion coverage with no cost sharing	Lump sum/"global budget" payments (fee schedule for individual providers)
Keeping Health Insurance Affordable Act/Public Option Deficit Reduction Act (Cardin: S. 3/DeFazio H.R. 1419)	Federal gov't	All people	Yes	Federal gov't-set premiums based on costs; decreased for low-income enrollees (current law)	ACA benefits	Medicare to start; can vary later
Medicare for America (DeLauro H.R. 2452)	Federal gov't	All people	Yes, if they have an employer option	Federal gov't-set premiums based on costs; decreased for low-income enrollees	Enhanced Medicare and Medicaid benefits, including dental, vision, and reproductive care that includes abortion coverage; reduced cost-sharing	Medicare payment rates, with increases for primary care and mental health services

The most widely known and promising plans that have gained traction and media coverage in recent months are "Medicare for all" and "Public Insurance option"[21]. Comprehensive health benefits under Medicare for All include medically necessary services in thirteen benefit categories, including home and community-based long-term care, dental care, hearing, vision care, comprehensive reproductive health care (including abortion services), and transportation to health care appointments for people with disabilities and low-income people[22]. Drug prices would be negotiated annually, and a formulary would be established. Medicare for All would also prohibit balance billing, also known as surprise billing, which happens when health providers bill patients for the difference in the total cost of a health care service and the amount paid by an insurer[23].

Public option plans call for a federal insurance option (President Bidden plan). These plans essentially build upon the ACA by adding a new option available to those seeking coverage. A key characteristic in the Biden plan, when compared with Medicare for All, is that it retains current public and private insurance sources. For people who like

[21] Luna Lopes, Liz Hamel, Audrey Kearny, and Mollyann Brodie, "KFF Health Tracking Poll—October 2019: Health Care in the Democratic Debates, Congress, and the Courts," Henry J. Kaiser Family Foundation, October 15, 2019, https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-october-2019/.

[22] H.R. 1384, Medicare for All, accessed November 18, 2019, https://www.congress.gov/116/bills/hr1384/BILLS-116hr1384ih.pdf.

[23] "Balanced Billing," U.S. Centers for Medicare and Medicaid Services—HealthCare.gov, accessed November 17, 2019, https://www.healthcare.gov/glossary/balance-billing/.

or prefer their private insurance, they can maintain it under the Biden plan. The Biden plan would retain major components of the ACA including protections for people with pre-existing conditions, premium subsidies, and Medicaid expansion, along with offering public insurance as an option to anyone who wants it[24]. Biden's public option plan also aims to reduce the cost of prescription drugs by allowing importation of them from other countries, empowering Medicare to negotiate drug prices, and supporting the development of generic drugs[25]. It would also offer tax credits to middle class families to help lower the cost of health insurance and eliminate the 400 percent federal poverty level income cap. The plan would eliminate balanced billing and be financed through capital gains taxes on rich individuals. Biden's plan also includes protecting access to contraception and abortion rights, as well as the promise to adopt California's strategy of public–private partnerships nationwide in addressing the U.S. maternal mortality crisis as major steps in building upon the ACA. Various versions of public insurance option legislation have also been introduced in Congress by Senator Ben Cardin, Representative Cedric Richmond, Senator Tim Kaine, Representative Jan Schakowsky, and others[26].

At this stage of the discussion, it would preferable to ask ourselves the following questions: How are Americans perceiving the proposed plans? Are reparations as a public health priority an adapted strategy for ending Black-white health disparities? How can we advance healthcare reform by stating principles for adequate, accessible and affordable health care?

1. Gallup News poll[27] conducted in November 1-14, 2019 showed 61 percent of white respondents prefer the private health insurance system, whereas 57 percent of nonwhite respondents prefer government-run insurance. The cost of health care is still of major concern for those people with private health insurance, more so than for those with public insurance sources[28].
2. A growing literature makes the moral, historical, legal, and economic arguments for Black reparations[29]. Black–White health gaps continue to characterize American health and, at the current pace of effort and investment, will continue to do so for decades to come. Perhaps the most important insight into why these gaps persist comes from work that focuses our thinking about fundamental causes of health[30]. This work shows that forces that shape our societal structures — including power, money, and access to resources — inevitably become embodied in health and will continue to shape health patterns unless they are addressed. This understanding clarifies that the Black–White health gap is inseparable from the enormous gap in resources between Blacks and

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[24] Dan Diamond, "Biden Unveils Health Care Plan: Affordable Care Act 2.0," Politico, July 15, 2019, https://www.politico.com/story/2019/07/15/joe-biden-health-care-plan-1415850.

[25] Ibid., and "Health Care," Joe Biden For President, accessed November 18, 2019, https://joebiden.com/healthcare/.

[26] Taylor J. 2019. Racism, Inequality, and Health Care for African Americans. The century foundation – https://tcf.org/content/report/racism-inequality-health-care-african-americans/

[27] Gallup News poll conducted November 1–14, 2019, available for download from https://news.gallup.com/file/poll/268988/191204GovtResponsibility.pdf.

[28] Tami Luhby, "Americans are still pretty happy with their private health insurance," CNN, December 9, 2019, https://www.cnn.com/2019/12/09/politics/gallup-private-health-insurance-satisfaction/index.html

[29] Darity WA, Mullen AK. From here to equality: reparations for Black Americans in the twenty-first century. Chapel Hill: University of North Carolina Press, 2020.

[30] Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Behav 1995; Spec No: 80-94.

Whites in the United States. Black Americans earn 65 cents for every dollar earned by White Americans. Even more dramatically, the average Black family has about $10 in assets for every $100 accrued by the average White family. In 2015, for example, the Federal Reserve Bank of Boston found a truly staggering racial gap in wealth in Boston: household assets averaged $8 for Black families and about $247,500 for White families. And power, money, and access to resources — good housing, better education, fair wages, safe workplaces, clean air, drinkable water, and healthier food — translate into good health. The crucial approach is represented by "access to resource" through Black reparations for slavery. Reparations will be one means that would target the underlying causes of black-white health gaps. However, Black reparations have been highly controversial, a proposition generally seen as politically untenable. Though supported by most Black Americans, reparations are opposed by a majority of Americans overall. Yet the tide is turning. Democratic presidential candidates discussed — and several supported — reparations during the 2019 primary debates.

At the 1963 March on Washington, Martin Luther King, Jr., proclaimed that "In a sense we've come to our nation's capital to cash a check." He explained: "America has given the Negro people a bad check, a check which has come back marked 'insufficient funds.'" From this, his famous "I Have a Dream" speech, we remember King's words about the content of our characters. But his remarks on the obligation to repair have often been overlooked.

Besides "the dream", Black reparations could be implemented in various ways, ranging from cash transfers to the creation of investment vehicles, and we need research to elucidate the most effective forms. It seems likely that no single approach will be sufficient to counterbalance the centuries-long deprivation that continues to harm the health of Black Americans today. But at the core, reparations would be an acknowledgment of the harms of slavery, a restitution of resources that have long been denied to people affected by slavery over generations, and would bring some closure to profound injustices that the country has long shamefully neglected[31].

3. Ensuring health care access and affordable coverage for African Americans should articulated around principles for adequate, accessible and affordable health care. The American Heart association[32] summarized the 7 principles:
    - All people living in the United States, regardless of health condition, should have comprehensive, understandable, and affordable health coverage.
    - All people living in the United States should receive high-quality, affordable, patient-centered health care.
    - All people living in the United States should have guaranteed access to evidence-based preventive services with minimal or no cost sharing, regardless of how they gain coverage.
    - Race, sex, gender, and geographic disparities in health and health care must be eliminated.

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[31] Basset MT, Galea S. (2020). Reparations as a public health priority – A strategy for ending Black-White health disparities. NEJM 383: 2101 - 3

[32] Warner J et al. Advancing Healthcare Reform: the AHA's 2020 statement of principles for adequate, accessible and affordable healthcare. Circulation. 141: e601 – 14.

- Public health infrastructure should be strengthened to effectively engage diverse stakeholders in multiple sectors, to adequately respond to social determinants of health, and to support the elimination of systemic inequities in health and health care.
- The US healthcare workforce should continue to grow and diversify through a sustained national commitment to culturally competent public health and medical education and clinical training.
- Support of biomedical and health services research should be a national priority, and inflation-adjusted funding for the NIH, CDC, and other agencies must be maintained and expanded.

More specifically, getting to universal health coverage will require that the following steps[33] be taken:

- Promote health equity by adequately addressing racism, bias, discrimination, and other systemic barriers within the health care system. To do this, policymakers must acknowledge the historical foundations of racism and ensure that health care providers, personnel and staff are substantively trained to recognize and eliminate all forms of bias in the health care system. Accountability measures at both the individual and systems levels should be in place, including measures that link payment, professional certification, and licensure to quality of care.
- Incorporate evidence-based tools to adequately address health disparities that focus on quality of care that extend beyond health insurance coverage, including the impact of racism on the health of African Americans throughout the life course. In health reform efforts, policymakers must take into account the social determinants and address how they impact health by working across sectors, including social support agencies and community-based providers with patient-centered approaches to care. Racist practices, such as those in the treatment and pain management of African Americans, should be eliminated.
- Protect and expanding access to insurance coverage and comprehensive benefits and bolstering the ACA benefit provisions and nondiscrimination guarantees. These efforts should include preserving coverage for people with pre-existing conditions by further codifying protections that ensure benefit inclusion and design decisions that do not result in limiting access to care. Policymakers should also build on the essential health benefits package to include important health care services currently omitted, such as long-term care and dental care.
- Protect the integrity of Medicaid, an important health insurance source for African Americans, by denying state efforts to impose draconian stipulations on coverage for enrollees such as work requirements. In order to close the coverage gap among African Americans, policymakers must also implement targeted strategies to incentivize and ensure Medicaid expansion in all southern states.
- Ensure access to quality providers and addressing provider shortages and hospital closures by anticipating increases in demand and working with HRSA to implement concrete strategies to close gaps

[33] Taylor J, Mishory J, "Health Reform's North Star: 10 Guidelines to Reach Universal Health Care Coverage," The Century Foundation, November 13, 2019, https://tcf.org/content/commentary/health-reforms-north-star-10-guidelines-reach-universal-health-care-coverage/.

in health care access for medically underserved areas/populations and health professional shortage areas. Strategies should include plans to not only increase the health care workforce, but also diversify it and offer technical support and training to minority-serving hospitals.

- Support the development of a robust, diverse, and culturally competent health care workforce by encouraging and facilitating diversity throughout the health care system and care teams, and adequately training all staff to be culturally sensitive. Payment rates and coverage guidelines for health care coverage should be developed in a way that supports fair, living wages and pay equity in the health care professions and jobs.
- Limit the cost of premiums and out-of-pocket costs, helping to make health insurance more affordable for individuals and families across the income spectrum. This should include limiting deductibles, prescription drug costs and other point-of-service charges, and completely eliminating surprise medical bills. All of these costs are major barriers to health care access, particularly for individuals and families with limited incomes.
- Strengthen access to trusted community-based providers currently available through safety-net programs, such as Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). These programs are often lifelines for marginalized communities and they disproportionately serve people of color. Policymakers should develop health reform plans that are intentional in ensuring continued access to these vital sources of care, as well as seamless coordination with health insurance payers for people with coverage seeking care from community-based providers

After 250 years of social segregation and discrimination, current health data confirm that African Americans are the least healthy ethnic group in the USA. Although the resources and policies to eliminate disparities exist in the USA, there has been inadequate long-term commitment to successful strategies and to the funding necessary to achieve health equity. African Americans have not been in the fiscal nor political positions to assure the successful implementation of long-term efforts; the health of African Americans has not been a priority for decision makers.

Usually, the black community is not present when strategies and programs addressing their poor health status are designed and prioritized, and planners have limited understanding of the social mores and history of the African American community. The administration of health and social organizations serving black communities is rarely in

the hands of those with this knowledge and commitment.

Current mortality disparities are evident in cardiovascular disease, cancer, diabetes, and infant mortality. These causes of death may be the most visible health problems for African Americans, but they do not tell the whole story. Mental illness is the second largest cause of morbidity in African Americans, and violence in

the form of homicide is the greatest cause of preventable death. High levels of poverty, lack of education, and excess incarceration further compound the poor health status of African Americans.

The USA is in the midst of a surge in training health professionals, but, for many reasons, the institutions (HBCUs) created to educate African Americans have not made much impact on advancing the health of African Americans. African Americans are under-represented in all of the professions responsible for the provision of intimate physical, mental, and social care.

All health providers should be required to obtain regular training and refreshing in the provision of equitable care; this includes providers of color. Training of young people of color in the health professions should be viewed as an urgent national objective requiring the rebuilding of many of social development and community health programs of the past which have been virtually extinguished by lack of funds. Outreach to young people of color encouraging them to pursue health careers should be given a much higher priority. The role of HBCUs in the preparation of young populations for health careers must be strengthened.

It is evident that focusing on health risks alone is not conducive to redressing health disparities among African Americans, given that structural factors primarily underlie their poorer health outcomes and shorter lifespans. Tackling the social determinants of health, from poverty to the built environment, racial discrimination, violence, and incarceration, is likely to elicit greater effects on black health than risk reduction programs. Even though the ACA has expanded access to African Americans, medical care for people with unhealthy lifestyles and social and cultural barriers to access will have limited effects on reducing health disparities of African Americans in the USA.

In practice, eliminating racial inequities in health requires three coordinated strategies. First, integrated efforts are needed to neutralize the ways in which racism truncates or blocks access to avenues of success by creating new place-based opportunities and enhancing existing ones to ensure that all individuals have access to the resources necessary to thrive. Second, initiatives are required to shift the health care system from a narrow focus on treatment to emphasize preventing disease and providing timely, appropriate, high-quality care for all that is tailored to the culture and context of each patient. Third, scientific and societal honesty is required to recognize the deleterious effect of racism and inform accordingly all components of the society. It is actually scientifically proven that exposure to racism or racial discrimination precipitates a chronic stress state, along with higher levels of PTSD and increased disease risk. Racism-related stress constitutes a double blow of socioenvironmental and neurobiological insults to those who are already most vulnerable. Interestingly, systemic changes in production of biological stress signals and biomarkers, such as “cfmtDNA” and “EVs” and an engagement of the immune system, may be the focal point for an increased risk of mental health disorders by a lifetime of exposure to racial discrimination stress. Finally, given the limited awareness of the existence of racial inequities in health and the lack of commitment to address them, new investments are needed to create the knowledge base to identify the optimal strategies that would enhance awareness of the nature and extent of racial inequities and build the needed empathy and political will to eradicate them.