

Talking About Racism, Racial Justice, and Health Care in the United States

This quick exercise is meant to help us think about and discuss the long-standing public health crisis of racism in the United States.

By taking some time to understand and explain the problem, we can start to address and change it in our workplaces and in our communities.

When we work together to confront racism, we take important steps toward building public policies, institution practices, and cultural expressions that promote equality for all people of different racial and ethnic backgrounds.

STEP ONE

Read the two short articles listed at right (approx. 20 minutes)

STEP TWO

Use the discussion guide to have a short conversation with a coworker, friend, or family member (this can be in a small or larger group)

STEP THREE

Reflect on next steps

INCLUDED MATERIALS:

- Article: *“Why doesn’t the United States have universal health care? The answer begins with policies enacted after the Civil War”*, by Jeneen Interlandi
- Article: *“Say her name: Dr. Susan Moore”*, by Aletha Maybank, Camara Phyllis Jones, Uché Blackstock, and Joia Crear Perry
- Discussion Guide



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Discussion Guide

1. Take a moment to share your general thoughts and opinions about what you learned about racism and U.S. health care from the articles.
 - What was familiar? What was challenging or confusing? What was new or surprising?
2. Consider the following quote from the *“Why doesn’t the United States have universal health care?”* article:

“One hundred and fifty years after the freed people of the South first petitioned the government for basic medical care, the United States remains the only high-income country in the world where such care is not guaranteed to every citizen. In the United States, racial health disparities have proved as foundational as democracy itself.”

 - How did these disparities play out in the article about the tragic death of Dr. Susan Moore?
 - How do you experience the ways that racial “disparity is built into the system” at your workplace and/or in your community?
3. Both of these articles indicate that consistent collective action is a crucial component of dismantling the public health threat of racism. What role do/can you and your union play in advancing the struggle for racial justice?



Dr. Susan Moore



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Reflection: Where Do We Go From Here?

By taking some time to understand and explain the problem, we can start to address and change it in our workplaces and in our communities.

I would like to learn more about:

List two or three ways you can contribute to the fight for racial justice in health care in the near future:

The steps I will take to learn more and get involved include:

Share your reflections with your study partner or group.
Schedule a date in your calendar to revisit what you wrote down.

Why doesn't the United States have universal health care? The answer begins with policies enacted after the Civil War.



By Jeneen Interlandi

The smallpox virus hopped across the post-Civil War South, invading the makeshift camps where many thousands of newly freed African-Americans had taken refuge but leaving surrounding white communities comparatively unscathed. This pattern of affliction was no mystery: In the late 1860s, doctors had yet to discover viruses, but they knew that poor nutrition made people more susceptible to illness and that poor sanitation contributed to the spread of disease. They also knew that quarantine and vaccination could stop an outbreak in its tracks; they had used those very tools to prevent a smallpox outbreak from ravaging the Union Army.

Smallpox was not the only health disparity facing the newly emancipated, who at the close of the Civil War faced a considerably higher mortality rate than that of whites. Despite their urgent pleas for assistance, white leaders were deeply ambivalent about intervening. They worried about black epidemics spilling into their own communities and wanted the formerly enslaved to be healthy enough to return to plantation work. But they also feared that free and healthy African-Americans would upend the racial hierarchy, the historian Jim Downs writes in his 2012 book, *"Sick From Freedom."*

Federal policy, he notes, reflected white ambivalence at every turn. Congress established the medical division of the Freedmen's Bureau — the nation's first federal health care program — to address the health crisis, but officials deployed just 120 or so doctors across the war-torn South, then ignored those doctors' pleas for personnel and equipment. They erected more than 40 hospitals but prematurely shuttered most of them.

White legislators argued that free assistance of any kind would breed dependence and that when it came to black infirmity, hard labor was a better salve than white medicine. As the death toll rose, they developed a new theory: Blacks were so ill suited to freedom that the entire race was going extinct. "No charitable black scheme can wash out the color of the Negro, change his inferior nature or save him from his inevitable fate," an Ohio congressman said.

One of the most eloquent rejoinders to the theory of black extinction came from Rebecca Lee Crumpler, the nation's first black female doctor. Crumpler was born free and trained and practiced in Boston. At the close of the war, she joined the Freedmen's Bureau and worked in the freed people's communities of Virginia. In 1883, she published one of the first treatises on the burden of disease in black communities. "They seem to forget there is a *cause* for every ailment," she wrote. "And that it may be in their power to remove it."

In the decades following Reconstruction, the former slave states came to wield enormous congressional power through a voting bloc that was uniformly segregationist and overwhelmingly Democratic. That bloc preserved the nation's racial stratification by securing local control of federal programs under a mantra of "states' rights" and, in some cases, by adding qualifications directly to federal laws with discriminatory intent.

As the Columbia University historian Ira Katznelson and others have documented, it was largely at the behest of Southern Democrats that farm and domestic workers — more than half the nation's black work force at the time — were excluded from New Deal policies, including the Social Security and Wagner Acts of 1935 (the Wagner Act ensured the right of workers to collective bargaining), and the Fair Labor Standards Act of 1938, which set a minimum wage and established the eight-hour workday. The same voting bloc ensured states controlled crucial programs like Aid to Dependent Children and the 1944 Servicemen's Readjustment Act, better known as the G.I. Bill, allowing state leaders to effectively exclude black people.

In 1945, when President Truman called on Congress to expand the nation's hospital system as part of a larger health care plan, Southern Democrats obtained key concessions that shaped the American medical landscape for decades to come. The Hill-Burton Act provided federal grants for hospital construction to communities in need, giving funding priority to rural areas (many of them in the South). But it also ensured that states controlled

the disbursement of funds and could segregate resulting facilities.

Professional societies like the American Medical Association barred black doctors; medical schools excluded black students, and most hospitals and health clinics segregated black patients. Federal health care policy was designed, both implicitly and explicitly, to exclude black Americans. As a result, they faced an array of inequities — including statistically shorter, sicker lives than their white counterparts. What's more, access to good medical care was predicated on a system of employer-based insurance that was inherently difficult for black Americans to get. "They were denied most of the jobs that offered coverage," says David Barton Smith, an emeritus historian of health care policy at Temple University. "And even when some of them got health insurance, as the Pullman porters did, they couldn't make use of white facilities."

In the shadows of this exclusion, black communities created their own health systems. Lay black women began a national community health care movement that included fund-raising for black health facilities; campaigns to educate black communities about nutrition, sanitation and disease prevention; and programs like National Negro Health Week that drew national attention to racial health disparities. Black doctors and nurses — most of them trained at one of two black medical colleges, Meharry and Howard — established their own professional organizations and began a concerted war against medical apartheid. By the 1950s, they were pushing for a federal health care system for all citizens.

That fight put the National Medical Association (the leading black medical society) into direct conflict with the A.M.A., which was opposed to any nationalized health plan. In the late 1930s and the 1940s, the group helped defeat two such proposals with a vitriolic campaign that informs present-day debates: They called the idea socialist and un-American and warned of government intervention in the doctor-patient relationship. The group used the same arguments in the mid-'60s, when proponents of national health insurance introduced Medicare. This time, the N.M.A.

developed a countermessage: Health care was a basic human right.

Medicare and Medicaid were part of a broader plan that finally brought the legal segregation of hospitals to an end: The 1964 Civil Rights Act outlawed segregation for any entity receiving federal funds, and the new health care programs soon placed every hospital in the country in that category. But they still excluded millions of Americans. Those who did not fit into specific age, employment or income groups had little to no access to health care.

In 2010, the Affordable Care Act brought health insurance to nearly 20 million previously uninsured adults. The biggest beneficiaries of this boon were people of color, many of whom obtained coverage through the law's Medicaid expansion. That coverage contributed to a measurable decrease in some racial health disparities, but the success was neither as enduring nor as widespread as it might have been. Several states, most of them in the former Confederacy, refused to participate in Medicaid expansion. And several are still trying to make access to the program contingent on onerous new work requirements. The results of both policies have been unequivocal. States that expanded Medicaid saw a drop in disease-related deaths, according to the National Bureau of Economic Research. But in Arkansas, the first state to implement work requirements, nearly 20,000 people were forced off the insurance plan.

One hundred and fifty years after the freed people of the South first petitioned the government for basic medical care, the United States remains the only high-income country in the world where such care is not guaranteed to every citizen. In the United States, racial health disparities have proved as foundational as democracy itself. "There has never been any period in American history where the health of blacks was equal to that of whites," Evelyn Hammonds, a historian of science at Harvard University, says. "Disparity is built into the system." Medicare, Medicaid and the Affordable Care Act have helped shrink those disparities. But no federal health policy yet has eradicated them. ♦

Say her name: Dr. Susan Moore

Opinion by **Aletha Maybank**, **Camara Phyllis Jones**, **Uché Blackstock** and **Joia Crear Perry**

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“I put forth and I maintain: If I was White, I wouldn’t have to go through that.”

That was Susan Moore, from her hospital bed in Indianapolis, where she was being treated for covid-19, and where, an oxygen tube in her nose, she summoned the strength to post a Facebook video about her treatment.

That was *Dr. Susan Moore*, family physician, University of Michigan Medical School graduate, Black woman. She described how the White doctor treating her “made me feel like I was a drug addict,” refusing to prescribe her additional narcotics when she complained of pain — even though he knew she was a fellow physician. She related how he rejected her plea for additional doses of remdesivir; how “he did not even listen to my lungs, he didn’t touch me in any way”; how he suggested she should just go home.

“This is how Black people get killed, when you send them home and they don’t know how to fight for themselves,” Moore said.

If anyone knew how to fight for herself, it would have been Moore. Still, she was sent home. Less than three weeks later, she was dead, at 52.

The deaths of Mr. George Floyd and so many others mistreated, injured or killed at the hands of our policing system have made us accustomed to seeing the video. But injustice in health care is rarely broadcast from cellphone videos or shared for thousands to witness.

This injustice often remains invisible to the public — unless, of course, you are a member of the community experiencing it.

Covid-19 has exposed the devastating realities of long-standing structural inequities experienced by Black and Brown people in this country. They are more likely than Whites to be infected, and more likely to die.

And the disease has taken a devastating toll, physical and emotional, on the nation’s health-care workers and the system as a whole.

Moore’s video offers a glimpse — even more enraging and heartbreaking in light of her death — of the injustice at the intersection of being a health-care provider and being a person of color during covid-19, and what happens when the

system does not work to adequately care for the very people who are there to uphold it.

Her experience offers stark confirmation that there remains a system of structuring opportunity and assigning value based on skin color in this country. That system has a name: racism. No matter how well-intentioned our health-care system is, it has not rooted out the false idea of a hierarchy of human valuation based on skin color and the false idea that, if there were such a hierarchy, “White” people would be at the top.

This white supremacist ideology has long shaped our values and practices, even in the health-care sector. Moore’s educational background makes her experience slightly more nuanced: Her being a physician brings the privilege of credibility and attracts the attention of many who do not believe that such mistreatment is pervasive.

Yet her experience is all too familiar in Black and Brown communities. That persistent experience of being ignored and harmed is the cornerstone of why Black and Brown people don’t trust our health-care system. Our collective and individual experiences with health-care systems and institutions that harm people of color are not only in the past — they are happening now.

A study in 2016 — only four years ago — showed that many White medical students and residents believed false race-based metrics and narratives, such as that Black people experience pain less than Whites. This is the same false belief held by J. Marion Sims, considered the father of modern gynecology, who performed vaginal surgical procedures on enslaved women without anesthesia.

Appropriate — and standard — pain management was only one of Moore’s calls for help.

If a physician can’t be heard by her own peers to save her life, then who will listen? Who will be held accountable? What actions are necessary to ensure that no one feels that their only way to survive and be heard is by posting a cellphone video on Facebook?

Over the past several months, since the public killing of Floyd, many health-care institutions and associations have made important commitments to acknowledge that racism is a public health threat and to pledge efforts to dismantle racism in the health care system. This is an important step forward. But these commitments are meaningless if not matched by urgent and sustained action.

As a nation, we need to understand four key messages about racism: Racism exists. Racism is a system. Racism saps the strength of the whole society. We must act to dismantle racism.

Say Susan Moore’s name. Heed her message. Do not let her death be in vain.