

“If Only They Would Make Better Choices . . . ”

Confronting Myths About Ethnoracial Health Disparities

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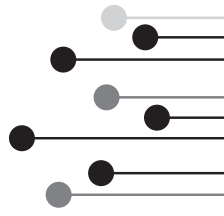
Without exception, Black, Indigenous, and people of color (BIPOC) in the United States face numerous health inequities. Non-Hispanic Black Americans (hereafter referred to as “Black Americans”) have the lowest life expectancy of all groups at 76.2 years, followed by American Indians at 76.7. Non-Hispanic White Americans (hereafter referred to as “White”) can expect to live between 2 to 3 years longer than these groups, until 79.0 years of age. Latinx life expectancy is 84.1 years and Asians have the longest life expectancy of all groups, at 85.5 years (Lewis & Gluskin, 2018).

The lower life expectancies and poorer health for some BIPOC groups relative to Whites lead many to believe that these outcomes are due to poor lifestyle choices. In the general discourse on obesity, for instance, Black Americans are characterized as overweight due to “cultural traditions” that devalue the importance of healthy eating or exercise. Similarly, American Indian/Alaska Native groups are often presumed to lack the control to avoid heavy alcohol use. These beliefs suggest that BIPOC groups, and low-income ones in particular, choose to lead lifestyles that are conducive to early death. As the conventional wisdom suggests, “If they would just make better food choices/stop smoking/go to the doctor more often, they would live as long as Whites.” However, a sociological examination of health and illness among BIPOC people reveals myriad structural, rather than individual, causes for these health inequities.

In the next section, we briefly review epidemiological patterns of illness for hypertension, diabetes, heart disease, and stroke/cardiovascular disease—patterns that indicate there is nothing random about who gets sick and who remains well in this country.

A Brief Epidemiological Profile of the United States

To gain a better understanding of some of the health problems that plague BIPOC people in the United States, we can explore epidemiological patterns for hypertension, diabetes, heart disease, and stroke based on race and Hispanic origin. Figure 22.1 displays the age-adjusted prevalence of these



conditions and Figure 22.2 displays the years of potential life lost due to these conditions. *Prevalence* refers to the proportion of existing cases of illness in a population while *years of potential life lost* (YPLL) is a measure of premature death that assumes, based on life expectancy trends, that every American should live until the age of 75. YPLL is calculated by subtracting age at death from the current age standard of 75, such that a person who dies at age 43 would have 32 years of potential life lost. Before proceeding, it is important to note that differences in health conditions exist based not only on ethnoracial background but also on gender, differences we will highlight throughout this essay whenever possible. (Also, where possible, we present rates for non-Hispanic Whites and non-Hispanic Blacks as opposed to those of Hispanic origin in these groups.)

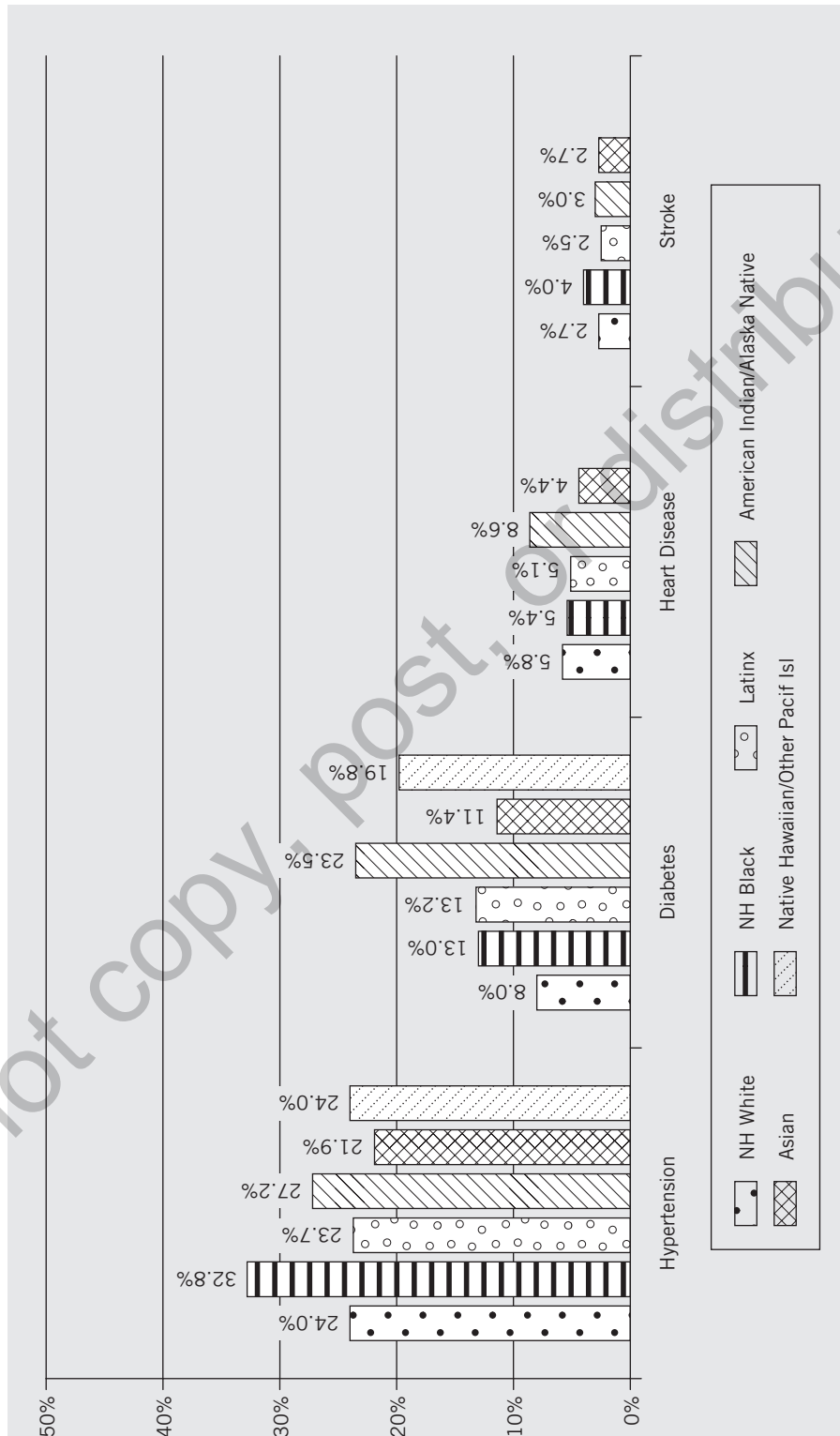
Hypertension. Hypertension (i.e., high blood pressure) can harden the arteries and lead to decreased blood and oxygen flow to the heart, potentially causing a heart attack. Ranked as the 14th leading cause of death (Heron, 2019), hypertension can also affect the brain (potentially causing a stroke) or the kidneys (potentially leading to chronic kidney disease) (Centers for Disease Control and Prevention, 2014). Age-adjusted hypertension prevalence is highest among Black and American Indian/Alaska Native adults. (The Native Hawaiian/Other Pacific Islander group has conventionally been combined with the Asian racial category, despite considerably higher socioeconomic status among Asians. In light of this awareness, the OMB Directive 15 [1997] called for the use of two separate categories for Asian and Native Hawaiian/Other Pacific Islander. Where possible, we will present separate data for these two groups.)

Essentially, almost 1 in 3 Black Americans (32.8%) and more than 1 in 4 (27.4%) American Indians/Alaska Natives meet the criteria for hypertension. Hypertension prevalence for other ethnoracial groups is lower, hovering between 22% and 24% (National Center for Health Statistics, 2019a; see Figure 22.1). Although YPLL data are not available for hypertension, other epidemiological reports indicate that it ranks as the 10th leading cause of death for both Black men and Black women. Yet aside from Asian/Native Hawaiian and Other Pacific Islander women (for whom it ranks as the 9th leading cause of death), hypertension does not rank as a leading cause of death for men and women in any other ethnoracial group (National Center for Health Statistics, 2019b).

Diabetes. Diabetes is a disease in which the pancreas fails to release insulin after the body turns food into sugars (i.e., glucose). In a normally functioning system, insulin opens the body's cells so glucose can enter and be used for energy. With diabetes, that system fails and can lead to damage of the eyes, kidneys, nerves, and heart (Diabetes Research Institute, 2016). Diabetes ranks as the 7th leading cause of death for all adults living in the United States (Heron, 2019). American Indian/Alaska Native adults have the highest age-adjusted prevalence of diabetes (23.5%), followed by Native Hawaiian/Other Pacific Islander adults (19.8%). Intermediate rates can be found for Black adults (13.0%), Latinx adults (13.2%), and Asian adults (11.4%) while diabetes prevalence is notably lower among White adults (8.0%) (National Center for Health Statistics, 2019a; see Figure 22.1).

Race/Hispanic origin also strongly patterns age-adjusted mortality rates due to diabetes. Despite having the third highest prevalence of diabetes,

Figure 22.1 Age-Adjusted Prevalence of Selected Conditions, by Race/Hispanic Origin, United States, 2018

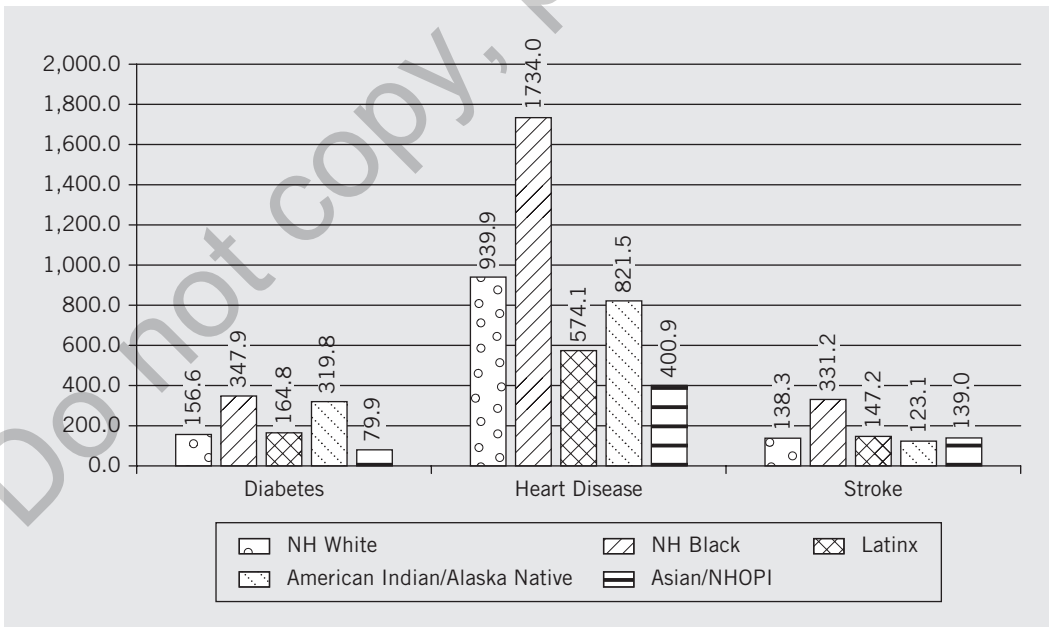


Sources: Age-adjusted prevalence for hypertension, heart disease, and stroke was derived from the National Center for Health Statistics (2019a, Table A-1a). Age-adjusted prevalence for diabetes was derived from the National Center for Health Statistics (2019a, Table A-4a).

Black adults exhibit the most numbers of years of potential life lost, more than twice that of Whites (347.9 vs. 156.6 person-years, respectively) (National Center for Health Statistics, 2018). Relative to Whites, American Indian/Alaska Native adults also experience more than twice the number of YPLL (347.9 person-years) while Asian adults have half the number of YPLL (79.9 person-years) (National Center for Health Statistics, 2019b; see Figure 22.2).

Heart Disease. Heart disease (i.e., cardiovascular disease) is the leading cause of death for all adults living in the United States, regardless of race and Hispanic origin (Heron, 2019). The term is actually used to describe a number of conditions, including coronary artery disease and heart rhythm problems. Narrowed or blocked blood vessels can lead to heart attack, chest pain (angina), or stroke (Mayo Clinic Staff, 2014). Age-adjusted prevalence of heart disease is disproportionately higher among American Indian/Alaska Native adults (8.6%) but relatively similar among White adults (5.8%), Black adults (5.4%), Latinx adults (5.1%), and Asian adults (4.4%) (Heron, 2019; see Figure 22.1). Despite the relatively low prevalence of heart disease among Black Americans, they experience, by far, the most premature death due to heart disease (1,734 YPLL vs. 939.9 YPLL for Whites) (National Center for Health Statistics, 2019b). Premature death due to heart disease is lower among all other groups relative to Whites (National Center for Health Statistics, 2019b; see Figure 22.2).

Figure 22.2 Years of Potential Life Lost for Selected Conditions (in Person-Years), by Race/Hispanic Origin, United States, 2016



Source: National Center for Health Statistics (2019b).

Stroke. Stroke is a type of cerebrovascular disease that affects blood supply to the brain. It occurs when a blood vessel that carries oxygen and nutrients to the brain is blocked by a clot or bursts, which prevents blood and oxygen from getting to brain cells, thus causing those brain cells to die. A stroke can damage parts of the brain that control specific activities (e.g., speech, mobility), causing parts of the body not to work as they did before (American Stroke Association, 2017). Although the prevalence of stroke is relatively low in the adult U.S. population (ranging from 2.5% among Latinx adults to 4.0% among Black adults), cerebrovascular disease/stroke ranks as the 5th leading cause of death in the U.S. population (Heron, 2019). Black Americans face an overwhelmingly disproportionate burden of premature death due to stroke, however. They experience more than twice the number of years of potential life lost (331.2 person-years) compared to every remaining ethnoracial group (National Center for Health Statistics, 2019b; see Figure 22.2).

The above patterns reveal that health represents a form of systematic inequality that disproportionately burdens BIPOC groups, especially those who are socioeconomically disadvantaged. The question is: Why do these disparities exist? Next, we investigate—and weigh the evidence for—three common explanations of ethnoracial health disparities in the United States: socioeconomic status, health behaviors, and institutional racism.

Common Explanations for Ethnoracial Health Disparities

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Argument 1: Health Disparities Are Due to Differences in Socioeconomic Status

The landmark Whitehall studies are a longitudinal data collection effort that seeks to investigate social determinants of health and mortality among British civil servants. The first cohort (Whitehall I) began in 1967 and was composed of more than 18,000 White men aged 20 to 64 who were followed over a 10-year period to identify risks for morbidity (illness) and mortality (death) due to heart disease and other causes. The second Whitehall cohort (Whitehall II) included more than 10,000 male *and* female British civil servants aged 35 to 55 and began in 1985. Follow-up data collection is ongoing.

The major contribution of the Whitehall studies was their discovery of a trend called the *social gradient in health*, or the empirical finding that as socioeconomic status (SES) rises, health status improves. The primary finding from Whitehall I was that men in the lowest occupational grade had the highest risk of 10-year mortality, with the lowest mortality rates among men in the highest occupational grade and intermediate mortality rates along the middle of the spectrum (Marmot et al., 1984). In other words, men with lower-status jobs (i.e., men in blue-collar or manual-labor jobs characterized by high levels of demand and low levels of control) had the highest risk of death within 10 years. Conversely, men with the highest-status jobs had the lowest risk of death and those men with middle-class jobs had an intermediate level of risk. The social gradient in mortality was later replicated for both

physical and mental health morbidity in Whitehall II (Ferrie et al., 2002; Marmot et al., 1991) and in a multitude of U.S. studies using indicators of SES that are more standard in the U.S. context (e.g., income, educational attainment, and wealth) (Adler & Ostrove, 1999).

Based on the social gradient in health, the common reasoning is that BIPOC people experience higher rates of illness and mortality because they have lower SES than Whites. For example, more than 1 in 5 American Indian/Alaska Native adults (23.7%) and Black adults (22.5%) live below the federal poverty level, more than twice the rate of White (9.5%) and Asian adults (10.8%) (U.S. Census Bureau, 2019a). Latinx adults (18.8%) and Native Hawaiians/Other Pacific Islander adults (16.7%) have intermediate poverty rates between the two extremes. In general, Asians have similar or higher SES compared with Whites. Therefore, they are the only BIPOC group that does not face socioeconomic disadvantage as a whole, although many face substantial racial discrimination—experiences that are also detrimental to health (Gee et al., 2009).

Unemployment rates are highest among American Indian/Alaska Native (6.6%) and Black adults (6.5%), followed by Native Hawaiian/Other Pacific Islander (5.3%) and Latinx adults (4.7%). The lowest rates of unemployment can be found among White (3.5%) and Asian Americans (3.0%) (U.S. Bureau of Labor Statistics, 2019). Educational attainment shows a very similar pattern, with the highest SES among White and Asian adults and the lowest SES among Black and American Indian/Alaska Native adults. For example, although more than half (55.0%) of Asians and 36.3% of Whites have earned at least a bachelor's degree, only 22.0% of Black adults, 18.5% of Native Hawaiian/Other Pacific Islander adults, 17.0% of Latinx adults, and 15.2% of American Indian/Alaska Native adults have at least a bachelor's degree (U.S. Census Bureau, 2019b). Finally, the racial wealth gap has reached unprecedented highs. In 2017, White households had a median net worth of \$171,700, followed by \$157,400 for Asian households, \$25,000 for Latinx households, and only \$9,567 for Black households (U.S. Census Bureau, 2020).

What do these statistics on poverty status, unemployment, educational attainment, and wealth mean for one's health status? Among other things, higher SES typically affords the material resources to practice a healthy lifestyle. This may include having enough disposable income to purchase healthier but often costlier food options or the ability to afford a gym membership. In addition, higher SES status means one is better able to live in a “safe” neighborhood where one feels comfortable jogging or walking, or a neighborhood that has ready access to grocery stores where fresh fruits and vegetables can be purchased (Gordon-Larsen et al., 2006; more on these factors later in the essay). When we consider access to these kinds of resources, health disparities look less like the result of “poor choices” and more like a systemic issue reflecting race and class inequities.

Although the focus of health disparities research has traditionally been on the goods and services that tangible resources such as money can buy, increasing attention has been directed toward the physiological burden imposed by the stress of having low SES. In a normal stress response, when encountering a perceived threat, the body activates itself through mechanisms such as increased blood flow and the release of hormones such as cortisol and norepinephrine (adrenaline). In the short term, the stress response

is adaptive, with its heightened physiological resources making either a “fight” response (face the threat) or a “flight” response (flee the threat) possible. But when one is constantly assailed by chronic stressors such as poverty and racial discrimination, the stress response remains activated, leading to wear and tear on the body, a phenomenon measured in part by biomarkers for accelerated aging, or *allostatic load* (McEwen & Stellar, 1993). Poverty is a common chronic stressor for BIPOC groups; important landmark studies find that although allostatic load levels are similar among Blacks and Whites at age 20, Black Americans accumulate allostatic load at a more rapid rate than Whites across the life course. This is evidence of cumulative disadvantage that results in the “weathering” (accelerated aging) of Black bodies (e.g., Geronimus et al., 2006). Similar weathering was found among low-income individuals relative to those with higher income. Although this study did not include other groups besides White and Black Americans, it is reasonable to believe that these biological processes also operate among BIPOC people.

Following the social gradient argument, we would expect that controlling for SES—that is, comparing apples to apples (high-status White people to high-status BIPOC people)—would eliminate the persistent ethnoraacial disparities we have witnessed for decades. In other words, the argument is often made that *BIPOC folks experience worse health outcomes relative to Whites because they are more likely to be poor and have lower educational attainment; if that weren't the case, ethnoraacial health inequities would disappear*. But is this true?

A simple and customary way to answer this question is by comparing the earnings of White and BIPOC people *at the same level of education*. All things being equal, if SES can explain the worse health profiles of BIPOC groups relative to Whites, then there should be no health differences between low-SES White and low-SES BIPOC people (and by extension, no health differences between high-SES White and high-SES BIPOC people).

Using the argument that lower SES accounts for health inequities facing BIPOC groups, we would expect that BIPOC adults with at least a bachelor's degree would have the same earnings as Whites with at least a bachelor's degree; in essence, (high) educational similarity would erase the negative health consequences associated with being part of a BIPOC group. But does this argument hold weight? Among those with the highest education (at least a bachelor's degree), White men and Asian men earn \$1,550 and \$1,685 per week, respectively, compared with far lower earnings among the highest-educated Black men (\$1,139) and Latinx men (\$1,234). Similar but weaker patterns exist among women; the highest-educated White and Asian women outearn the highest-educated Black and Latinx women (U.S. Bureau of Labor Statistics, 2019). In other words, achieving advanced education does not afford the same economic benefits for Black and Latinx adults as it does for White and Asian adults.

The “diminishing returns” pattern between SES and health has been detailed extensively by others (Farmer & Ferraro, 2005; Williams & Sternthal, 2010). After controlling for SES indicators such as educational attainment and income, Black adults (and to a less consistent degree, Latinx adults) still have more negative health profiles than White adults (Braveman et al., 2010; Kawachi et al., 2005; Williams, 2012). In other words, when comparing high-SES BIPOC adults with high-SES White adults, health disparities persist. Taken together, the body of evidence for this argument is

weak at best. Existing data clearly debunk the notion that BIPOC adults exhibit poor health outcomes simply because they are more likely to rank low on indicators of SES. Ethnoracial disparities persist even after accounting for lower SES among BIPOC people.

Argument 2: Health Disparities Are Due to Unhealthy Behaviors Among BIPOC People

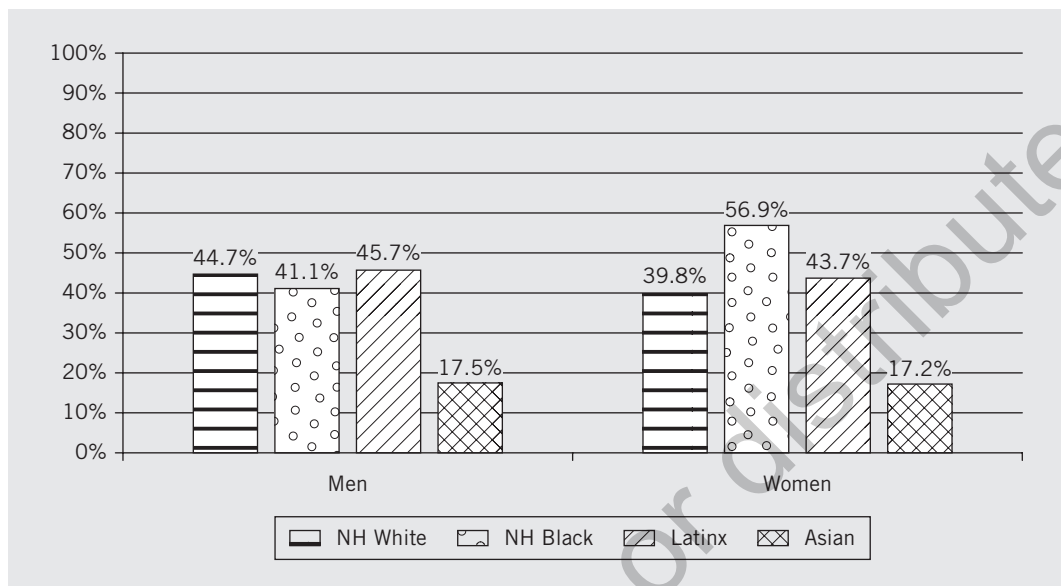
Another common trope to explain poor health outcomes among BIPOC people is that they are more likely to engage in unhealthy behaviors than Whites are. Many of these behaviors (e.g., smoking, unhealthy eating, drinking, and lack of exercise) are indeed major risk factors for many of the chronic illnesses discussed in the previous epidemiological overview. Next, we detail the evidence for the health behaviors argument, using both data from federal governmental agencies (e.g., Centers for Disease Control and Prevention) and empirical evidence from the longitudinal Whitehall studies.

Healthy Eating. Diet is a well-known risk factor for virtually every single chronic illness. People who eat healthfully have markedly lower risk of mortality, heart disease, cardiovascular disease, diabetes, some cancers, and a host of other chronic conditions. Obesity is the most common measure of healthy eating and is an important independent risk factor in that people who eat in an unhealthy fashion are more likely to both acquire and die from these chronic illnesses. (It is important to note that rates of overweight and obesity are only a rough proxy for healthy eating. Recent evidence shows that other factors are also implicated, though to a lesser degree than healthy eating (i.e., genes and family history, conditions such as hypothyroidism and Cushing's syndrome) (National Heart, Lung, and Blood Institute, 2012).

Body weight categories are typically constructed based on body mass index, or BMI (weight in pounds/height in inches \times 703). *Overweight* is defined as having a BMI between 25 and 29.9, and *obesity* is defined as having a BMI of 30 or higher. More than 1 in 3 American adults (31.6%) are currently overweight and almost 4 in 10 (39.6%) are obese (Fryar et al., 2018).

Are there ethnoracial differences in the prevalence of overweight/obesity? If so, the logic goes, these differences could help explain the enduring ethnoracial health disparities in this country. Based on the age-adjusted prevalence data in Figure 22.3, there are important differences in body mass index among men, though perhaps not as stark as expected (Hales et al., 2020). Among men, 45.7% of Latinx men are obese, but notably, White men have the second-highest prevalence of obesity (44.7%), followed by Black men (41.1%). Also notable is the fact that Asian men dramatically trail other men in terms of obesity (17.5%). Given the comparable levels of obesity among White versus Black and Latinx men, an argument cannot be made that these BIPOC men eat in an unhealthier fashion than White men. The obesity trends for women are admittedly starker, however. Approximately 56.9% of Black women are obese, followed by 43.7% of Latinx women, 39.8% of White women, and only 17.2% of Asian women (Hales et al., 2020). This trend fits well with the health behaviors argument, but as we will demonstrate later in this essay, alternative explanations are also highly plausible. Taken together, there is little evidence that overweight/obesity (measured as

Figure 22.3 Prevalence of Age-Adjusted Obesity Among Adults, by Race/Hispanic Origin and Gender, United States, 2017–2018



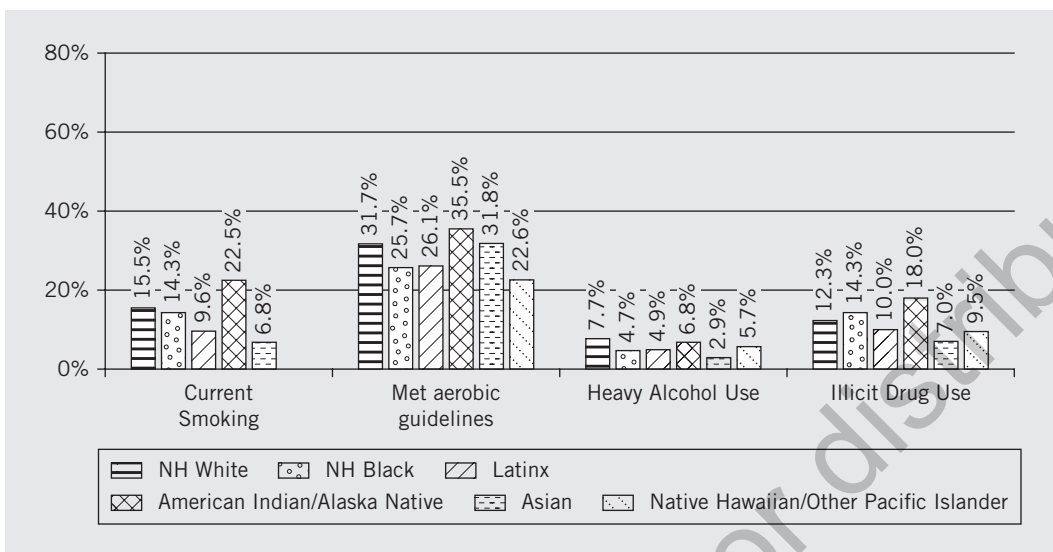
Source: Hales et al. (2020).

a proxy for the health behavior of healthy eating) can account for ethnoracial health inequities among men, although the patterns for women suggest that it may represent important risk factors for Black and Latinx women.

Smoking. Data on age-adjusted prevalence of current cigarette smoking by race/Hispanic origin can be found in Figure 22.4 (National Center for Health Statistics, 2019a). American Indian/Alaska Native adults exhibit the highest rate of current smoking (22.5%), followed by White (15.5%) and Black adults (14.3%). Smoking prevalence is considerably lower among Latinx (9.6%) and Asian adults (6.8%). As a whole, this means that although American Indian/Alaska Native adults often have the highest rate of current smoking (fitting squarely within the health behaviors argument), smoking prevalence among Whites is also quite high. Because Black and White adults have similar rates of current smoking while Latinx and Asian adults have lower rates of smoking than Whites, smoking does not appear to be an important driver of ethnoracial health inequities for most BIPOC groups.

Exercise. Similar to unhealthy eating, lack of exercise is a major risk factor for many chronic illnesses. Based on guidelines from the federal government, adults in the United States should engage in 150 minutes per week of moderate-intense activity (e.g., brisk walking, gardening) or 75 minutes per week of vigorous-intense activity. In 2018, 35.5% of American Indian/Alaska Native adults, 31.8% of Asian adults, and 31.7% of Whites adults (53.7%) met full guidelines for aerobic activity. Rates of exercise were somewhat lower for Latinx (26.1%), Black (25.7%), and Native Hawaiian/Other

Figure 22.4 Age-Adjusted Prevalence of Select Health Behaviors by Race/Hispanic Origin, United States, 2018



Sources: Current smoking and aerobic guidelines were derived from the National Center for Health Statistics (2019a, Tables A-12a and A-14a). Heavy alcohol use and illicit drug use were derived from the Substance Abuse and Mental Health Services Administration (2019a, Tables 2.21B).

Pacific Islander adults (22.6%; National Center for Health Statistics, 2019a). With two important exceptions (American Indian/Alaska Native and Asians adults), these patterns suggest moderately lower rates of physical activity among BIPOC groups than among White people (see Figure 22.4). Although these patterns partially support the health behaviors argument, we will consider other explanations for these trends later in this essay.

Substance Use. Data on heavy alcohol use and illicit drug use can be found in Figure 22.4. Heavy alcohol use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days. By definition, all heavy alcohol users are also binge alcohol users (drinking five or more drinks on the same occasion on at least 1 day in the past 30 days). In 2018, 7.7% of White adults met the criteria for heavy drinking in the past month, the highest prevalence of all groups, followed by 6.8% of American Indian/Alaska Native and 5.7% of Native Hawaiian/Other Pacific Islander adults. Heavy drinking is less common among Latinx adults (4.9%), Black adults (4.7%), and is especially rare among Asian adults (2.9%) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019a). This means that Whites are actually *more likely* to be heavy drinkers than BIPOC people, a finding that contradicts the health behaviors argument.

Figure 22.4 also displays data on any illicit drug use within the past month (SAMHSA, 2019b). American Indian/Alaska Natives adults have the

highest prevalence of any illicit drug use in the past year (18.0%), and rates of illicit drug use were relatively similar for Black and White adults (14.3% and 12.3%, respectively). Rates of illicit drug use were lower among the remaining groups (10.0% for Hispanic/Latinx adults, 9.5% for Native Hawaiian/Other Pacific Islander adults, and 7.0% for Asian adults). It is also important to note that the recent opioid epidemic is heavily concentrated among Whites. A total of 76% of opioid overdose deaths in 2014 occurred among Whites, while only 13% of such deaths occurred among Blacks and only 9% occurred among those who were Latinx (Kaiser Family Foundation, 2018). In fact, the unprecedented recent drop in life expectancy among those in the United States has almost wholly been attributed to the opioid epidemic, a phenomenon that occurs far more often among Whites than BIPOC people. As a whole, the available data suggest that rates of substance use are neither consistently nor considerably higher among BIPOC groups than among Whites; as such, it is highly unlikely that substance use accounts for the intractable ethnoracial disparities in health in the United States.

Health Behaviors in the Whitehall Studies. In addition to documenting the social gradient in health, findings from the Whitehall studies have offered essential contributions to our understanding of the extent to which health behaviors can explain health inequities. A study using 25 years of Whitehall data found that health behaviors accounted for only one third of the socioeconomic difference in mortality. In other words, two thirds of mortality differences between those of low SES and those of higher SES were explained *by causes other than health behaviors* (Van Rossum et al., 2000). These patterns were subsequently replicated in the United States using nationally representative data from the Americans' Changing Lives survey. Even after controlling for cigarette smoking, alcohol drinking, BMI, and physical activity, those with high income had far lower risk of mortality over 7 years than those with the lowest and middle income (Lantz et al., 1998). Although these findings are based on socioeconomic disparities in health (rather than ethnoracial health disparities, specifically), the findings are instructive and suggest that, given the large overlap between race and SES, health behaviors contribute modestly, at best, to ethnoracial health disparities.

Overall, the epidemiological evidence for the health behaviors argument is mixed. Although BIPOC people sometimes exhibit poorer health behaviors than Whites (e.g., lower rates of exercise and higher rates of overweight/obesity among women), Whites are either equally likely or more likely to engage in certain unhealthy behaviors (e.g., cigarette smoking, heavy drinking, and illicit drug use) than most BIPOC groups, with the occasional exception of American Indian/Alaska Native adults. Another problem with the health behaviors argument is that it presumes a moral failing among BIPOC—that they could easily choose to engage in healthy behaviors but simply opt not to. Before falling into such simplistic thinking, however, it is imperative to consider the social context in which these health behaviors arise, by considering characteristics of the social and economic environment that often preclude BIPOC from making healthier “choices.” We undertake this argument in the following section.

Argument 3: Health Disparities Are Due to Unequal Neighborhoods That Constrain Healthy Choices for BIPOC People

The Centers for Disease Control and Prevention (2021) defines *social determinants of health* as “the conditions in which people are born, grow, live, work and age,” further stating that these conditions “are shaped by the distribution of money, power and resources at global, national and local levels.” SES and health behavior—the focus of the two previous arguments for understanding ethnoracial health disparities—are social determinants of health that largely operate at the individual level. To be clear, it certainly matters whether or not people smoke, exercise, or eat a high-fat diet. Yet a singular focus on individual-level factors will do little to address health injustices facing BIPOC communities. This is because individual characteristics such as health behaviors and SES are largely shaped by broader, more wide-ranging social determinants of health that influence, for example, the opportunities to achieve high SES or engage in healthy behaviors. Unequal neighborhoods—and the historical forces that shaped their development (e.g., residential segregation)—better explain the ethnoracial health disparities than do individual-level factors such as health behaviors.

The legacy of residential segregation has relegated many BIPOC people to living in underresourced neighborhoods characterized by concentrated poverty. Although beyond the scope of this particular essay, it is important to know that residential segregation was not a natural event. Instead, it was created by federal housing policy established by President Roosevelt’s New Deal legislation in the 1930s and reinforced by subsequent state and local policies and practices that limited access to residential mortgages for BIPOC people, especially outside of poor neighborhoods (see Ioanide in this volume). Residential segregation is an example of institutionalized racism, or unfair treatment toward BIPOC people that is embedded in social systems such as the labor market, the criminal justice and educational systems, and public policy broadly speaking (as opposed to discriminatory acts that occur at the individual level, between people). Of all racial/ethnic groups, rates of Black–White residential segregation show the starkest patterns. For example, in 2010, 59% of Black people would have had to move to another neighborhood in order for White and Black populations to be evenly distributed across neighborhoods. Conversely, 49% of Latinx and 41% of Asian people would have had to move to achieve equal racial composition across neighborhoods (Logan, 2013).

Neighborhoods directly pattern life opportunities in a multitude of ways that influence health (LaVeist, Gaskin, & Trujillo, 2011). For one, the built environment of neighborhoods determines the availability of amenities and resources that can impact health. For example, the ability to exercise is strongly influenced by whether or not a neighborhood has safe parks, sidewalks, and recreational facilities. The ability to seek health care—preventive or otherwise—depends largely on a neighborhood’s availability of health care facilities and providers. The ability to eat healthy foods is strongly contingent on the presence of large-scale supermarkets in a neighborhood, stores that are far more likely to carry a wide range of fresh fruits and vegetables than corner stores or bodegas. In addition to these healthy

neighborhood resources, neighborhoods can also be characterized by the presence of negative resources that are harmful to health. Density of liquor stores and fast-food outlets is also known to negatively impact rates of alcohol use and unhealthy eating (LaVeist, Pollack, Thorpe, et al., 2011).

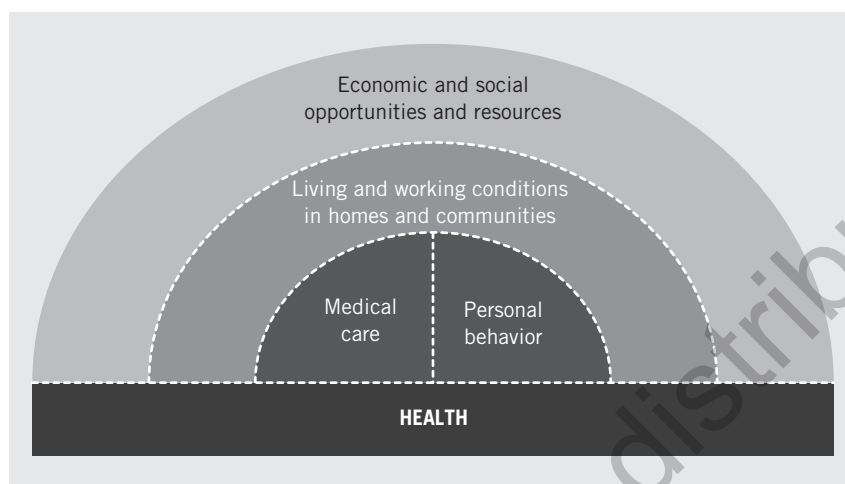
Although neighborhood parks, recreational facilities, health care facilities, and supermarkets can directly affect the opportunity to achieve good health, other neighborhood characteristics and institutions can indirectly affect health disparities. For example, the quality of public schools available in a community largely predicts college readiness and later economic success. Given the aforementioned links between SES and health, the inability to attain higher education has important implications for future health status. Likewise, employment opportunities or lack thereof (another indicator of SES) matter for health. Sociologist William Julius Wilson (1990) has studied the “spatial mismatch” at length, finding a direct link between the flight of jobs from urban communities and long periods of Black joblessness, especially among men.

Policing is another neighborhood social determinant of health that has recently gained traction both in the popular media and in the scientific literature. Police violence contributes to unnecessary and unfair loss of life among men and women in BIPOC communities. Notably, “legal intervention” (*deaths caused by police and other persons with legal authority to use deadly force, excluding legal executions*) is a leading cause of death for young Black and Latinx men age 15 to 19 and 20 to 24. Legal intervention is also a leading cause of death for American Indian men aged 10 to 14, 20 to 24, and 25 to 34 (Heron, 2019). Beyond police violence, overpolicing and aggressive policing tactics within disadvantaged communities can lead to hypervigilance and other negative mental health consequences for BIPOC people (Sewell et al., 2016). Mass incarceration—a trend largely targeting low-income and BIPOC communities—also has lifelong consequences for health (Schnittker et al., 2011).

Unfortunately, health-promoting features of neighborhoods (e.g., sidewalks and safe parks, recreational facilities, health care services, supermarkets, quality educational systems, access to employment opportunities) are far more prevalent in affluent White communities, while health-damaging characteristics (e.g., liquor stores, fast-food outlets, failing public schools, overpolicing, unemployment and underemployment) are far more prevalent in low-income BIPOC communities (LaVeist, Pollack, Thorpe, et al., 2011). Therefore, disadvantaged BIPOC people must often confront an insidious combination of lack of health-promoting resources and an abundance of health-depleting characteristics, which decreases the range of healthful options available to them.

A useful (ecological) theoretical model for understanding social determinants of health can be found in Figure 22.5. SES, health behavior, and medical care (the innermost circles) are examples of social determinants of health at the individual level. These downstream factors are most proximal to health outcomes and, as such, are often targeted as the main causes of health disparities. Such an approach is extremely shortsighted, however. These factors are shaped by broader upstream forces, such as living and working conditions at the meso level (the intermediate set of circles) and economic and social opportunities and resources at the macro level (the largest overlapping concentric circles). The macro level shapes social conditions

Figure 22.5 Upstream and Downstream Social Determinants of Health



Source: Adapted from Braveman, P., Egerter, S., & Williams, D. R. (2010). The social determinants of health: Coming of age. *Annual Reviews of Public Health*, 32, 381–398.

at the meso level, which also helps determine opportunities and constraints at the individual level. Put simply, individual-level characteristics (e.g., health behavior) do not occur in a vacuum.

Relatedly, although initially developed to explain health disparities based on gender, the *theory of constrained choices* can and should be applied to the study of ethnoracial health disparities. This theory takes as its starting point the notion that not all subgroups have the same range of opportunities to live a healthy lifestyle (Bird & Rieker, 2008). Essentially, health education approaches that seek to teach BIPOC people either the value of healthy eating or how to eat in a healthy fashion will fail spectacularly in communities that lack supermarkets. Teaching the value of physical activity (more pointedly, assuming that people of color do not already value exercise) will do little to improve rates of physical inactivity when there are no sidewalks on which to walk, safe parks in which to walk or jog, or affordable recreation centers or gyms in which to exercise.

What is the evidence supporting neighborhoods as the key driver of ethnoracial health inequities? Data from the Exploring Health Disparities in Integrated Communities (EHDIC) study provide a prime site to test this argument directly. EHDIC is a multisite cohort study of health disparities in racially integrated communities across the United States. Its first site in southwest Baltimore (EHDIC-SWB) features a community in which Blacks and Whites have similar household incomes, effectively isolating Black–White differences in health disparities by controlling for socioeconomic status (SES). Therefore, studies from the EHDIC data collection effort allow for the comparison of Black and White adults with similar SES who live under identical neighborhood conditions.

One important EHDIC study found that Black–White disparities in hypertension, diabetes, obesity, and the use of health care services were

either wholly eliminated or narrowed substantially among women in this neighborhood (LaVeist, Pollack, Thorpe, et al., 2011). Other EHDIC studies compared Black–White health disparities in southwest Baltimore (again, where Whites and Blacks live in equal residential contexts) to Black–White health disparities in national data sets (that are unable to make neighborhood adjustments). When considering health behaviors such as binge drinking and physical activity and health outcomes such as diabetes and hypertension, EHDIC studies show minimal or no health disadvantage among Black Americans relative to White Americans. Conversely, Black–White health disparities are sizable in national data sets that control for individual SES and health behaviors but do not consider neighborhood context (Fesahazion et al., 2012; LaVeist et al., 2009; Thorpe et al., 2008; Wilson-Frederick et al., 2014). Findings from the EHDIC studies strongly support the notion that ethnoracial health disparities are due neither to individual-level SES differences nor differences in individual human behaviors. Instead, they are strongly patterned by systematic differences in neighborhood context.

COVID-19: A Contemporary Application of the Individual Behavior “Blame Game”

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In March 2020, our nation was brought to a standstill as COVID-19 began spreading unchecked through the U.S. population. Unsurprisingly, COVID-19 has struck BIPOC and low-income populations at a disproportionate and alarming rate. As the old adage goes, “When White America gets a cold, Black America gets pneumonia.” As the United States has witnessed during the pandemic, this sentiment extends to other disadvantaged BIPOC groups as well. According to the COVID Tracking Project (2020), mortality rates due to COVID-19 are 2.4 times higher among Black people, 1.55 times higher among American Indian/Alaska Native people, and 1.47 times higher among Latinx people as compared to White people. COVID-19 mortality rates are equal for Asian, White, and Native Hawaiian/Other Pacific Islander adults.

On April 10, 2020, former president Donald Trump, along with members of the Coronavirus Task Force, held a press briefing to address concerns about the rapid spike in cases across the United States. During this briefing, Jerome Adams, MD, offered remarks in his role as Surgeon General of the United States. Dr. Adams, a Black man, began his remarks with a surprising and seemingly sociological analysis of the COVID-19 epidemiological trends, initially noting that key precautions that prevent the spread of COVID-19 (e.g., social distancing, working from home, and handwashing) are options not readily available for BIPOC populations (see Figure 22.6).

With his acknowledgment of the constrained choices BIPOC people experience—and particularly his explicitly rejecting biological and genetic explanations for ethnoracial health inequities—one could almost mistake Dr. Adams for an undercover sociologist. Yet as he concluded his remarks just a few minutes later, he admonished these same communities, figuratively wagging his finger to say, “I need you to know: You are not helpless. And it’s even more important that, in communities of color, we adhere to the task force guidelines to slow the spread. . . . we need you to step up and help stop the spread so that we can protect those who are most vulnerable” (see Figure 22.6).

Figure 22.6 Remarks by Surgeon General Jerome Adams, MD, on COVID-19 Inequities Among BIPOC and Low-Income Populations, April 10, 2020

EARLY REMARKS

The chronic burden of medical ills is likely to make people of color especially less resilient to the ravages of COVID-19. And it's possibly—in fact, likely—that the burden of social ills is also contributing.

Social distancing and teleworking, we know, are critical, and you've heard Dr. Birx and Dr. Fauci talk about how they prevent the spread of coronavirus. Yet only one in five African Americans and one in six Hispanics has a job that lets them work from home.

People of color are more likely to live in densely packed areas and in multi-generational housing, which—situations which create higher risk for spread of a highly contagious disease like COVID-19. We tell people to wash their hands, but as studies showed, 30 percent of the homes on Navajo Nation don't have running water. So how are they going to do that?

In summary, people of color experience both more likely exposure to COVID-19 and increased complications from it. But let me be crystal clear: We do not think people of color are biologically or genetically predisposed to get COVID-19. There is nothing inherently wrong with you. But they are socially predisposed to coronavirus exposure and to have a higher incidence of the very diseases that puts you at risk for severe complications of coronavirus.

CONCLUDING REMARKS

And I want to close by saying that while your state and local health departments and those of us in public service are working day and night to help stop the spread of COVID-19 and to protect you regardless of your color, your creed, or your geography, I need you to know: You are not helpless. And it's even more important that, in communities of color, we adhere to the task force guidelines to slow the spread.

Stay at home, if possible. If you must go out, maintain six feet of distance between you and everyone else, and wear a mask if you're going to be within six feet of others. Wash your hands more often than you ever dreamed possible. Avoid alcohol, tobacco, and drugs. And call your friends and family. Check in on your mother; she wants to hear from you right now.

And speaking of mothers, we need you to do this, if not for yourself, then for your *abuela*. Do it for your granddaddy. Do it for your Big Mama. Do it for your Pop-Pop. We need you to understand—especially in communities of color, we need you to step up and help stop the spread so that we can protect those who are most vulnerable.

Source: The White House (2020). [Remarks by Surgeon General Jerome Adams]. <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-24/>

In these concluding remarks, Dr. Adams suggests that even though upstream forces such as racial residential segregation and the concentration of BIPOC in low-wage service jobs that require contact with the public (and do not afford work-from-home opportunities) predispose these groups to COVID-19 exposure, their downstream *individual efforts* can somehow mitigate these larger structural factors. With his recommendation for these groups to “avoid alcohol, tobacco, and drugs” (none of which are established risk factors for COVID-19), Dr. Adams clearly reinforced two long-standing myths: (1) that

BIPOC people have considerably higher rates of substance abuse and (2) that individual health behaviors are the driving force behind health inequities. In deviating from his initial train of thought, which highlighted structural risks related to COVID-19 transmission, the Surgeon General missed an important opportunity to spark national conversations surrounding labor market inequities for BIPOC groups, racial residential segregation for Black and Latinx families, and water injustice for Indigenous communities.

We always encourage students to think more critically when encountering or offering solutions that blame the disadvantaged for their circumstances. Inequality is not a natural event. It is not some benign outcome that just happens. As such, it is imperative to study both the historical events that created the inequality and the contemporary social and political circumstances that reproduce it over time. Ethnoracial health disparities are not due merely to differences in SES or health behavior. Therefore, they will not be fixed using simplistic approaches such as health awareness and education programs. Likewise, policy initiatives based on the faulty premise that poor health outcomes among BIPOC people are due to their poor choices will greatly exacerbate health inequities that already exist, further fueling these stereotypes. Unless and until this country musters the political will to address inequitable neighborhoods, BIPOC people will continue to unfairly live shorter and sicker lives than their White counterparts.

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SUGGESTED ADDITIONAL RESOURCES

Laster Pirtle, W. N. (2020). Racial capitalism: A fundamental cause of novel coronavirus (COVID-19) pandemic inequities in the United States. *Health Education & Behavior, 47*(4), 504–508. <https://doi.org/10.1177/1090198120922942>

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QUESTIONS FOR FURTHER DISCUSSION

1. What, if any, of the health issues discussed here are problems for members of your own family? What are some of the reasons why, according to family discussions? How are those explanations similar to or different from those discussed by the author?
2. Why is it important to think about health outcomes at the individual and group levels? How do these differences connect to patterns discussed in other essays in this volume? How does this specifically manifest in the COVID-19 epidemic?

REACHING BEYOND THE COLOR LINE

1. With other members of your class, take some time to build a “health map” of your neighborhood or community. Identify the parks, playgrounds, places with sidewalks, gyms, and so forth. What patterns can you see?
2. In 2015, the average Supplemental Nutritional Assistance Program (SNAP, formerly known as “food stamps”) benefit per month was \$142 for a single person. Using information from the U.S. Department of Agriculture on the five food groups, brainstorm with your classmates about how to use the monthly SNAP benefit allotment to eat (for the full month) according to USDA recommendations. What challenges do you face?
3. Living at, near, or below the poverty line can be stressful. Go to <http://playspent.org> and explore some of the daily stressors experienced by people living in poverty. How might those experiences affect health?
4. Find the COVID-19 data for your state, county, or city. Do you see race or class disparities in these numbers? Given the information in this essay, how would you explain any disparities that might exist? If you don't see disparities, speculate on why.

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