No Health Without Hope

In many inner-city neighborhoods, community health depends heavily on political power.

By Anthony Iton

When it comes to your health, your zip code is more important than your genetic code. In the United States, your zip code is often just a proxy for your race and income. I came to understand this fundamental truth while in medical school, not from the training I received, but from the community in which I lived while there. In 1985, I left Montreal, Canada to attend Johns Hopkins medical school in Baltimore. My arrival coincided with the early years of both the AIDS and crack cocaine epidemics. Neither was as shocking as the dehumanizing living conditions in the East Baltimore neighborhoods immediately adjacent to the hospital and medical school. Stunned and confused, I recall asking an upperclassman, "When was there a war here?" His disdainful answer has haunted me for over 30 years. "What did you expect," he snarled, "it's the *inner-city*."

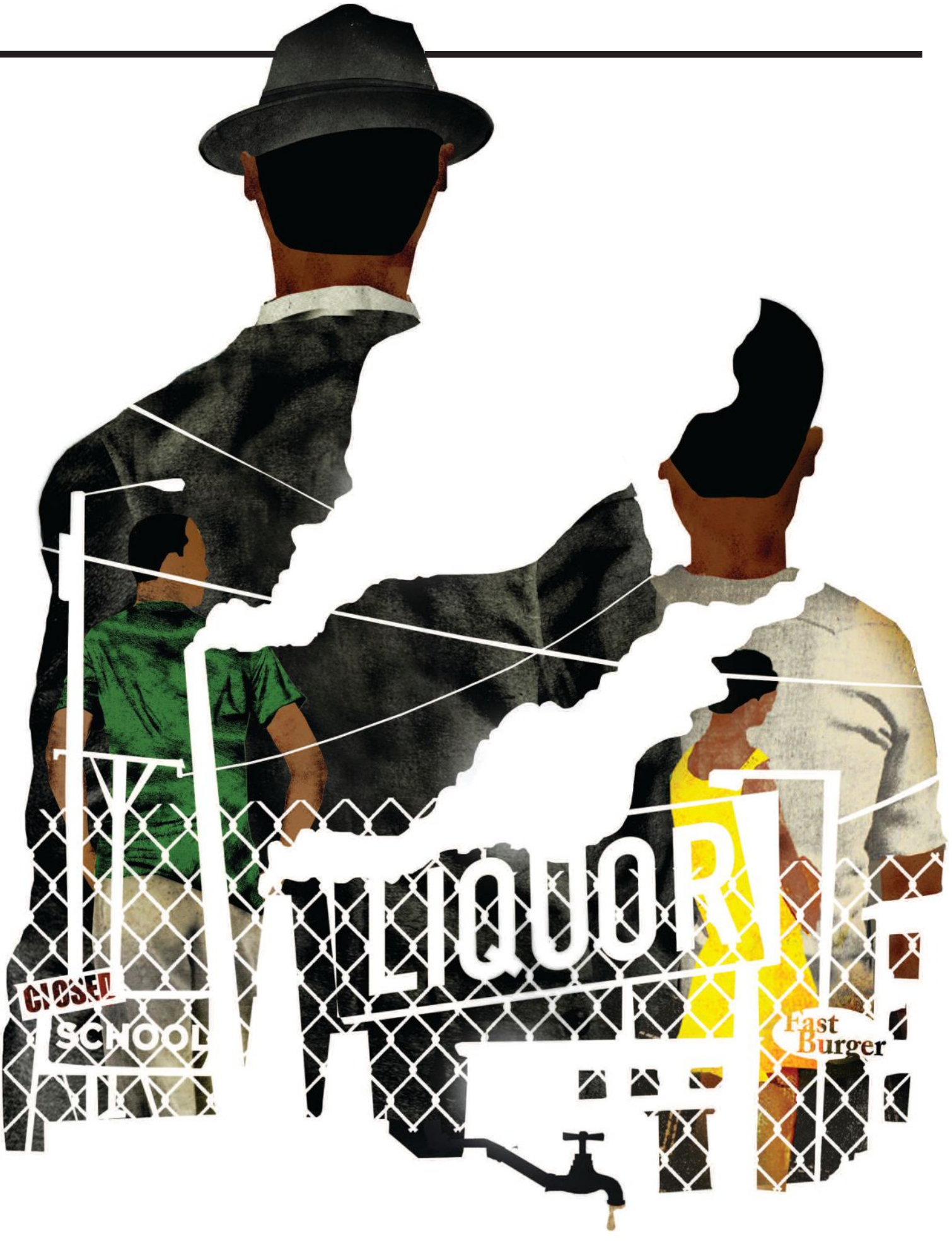
Although I was born in the U.S., I spent my childhood and adolescence in Canada and grew up as a young Black man in a society with universal single-payer health insurance, universal children's dental care, high quality K-12 schools, heavily subsidized postsecondary education, and high-quality neighborhood amenities such as parks, recreation facilities, grocery stores and community centers. Canada had invested in me, a Black American child. In East Baltimore, when I looked around at the decayed and burned-out buildings, garbage-strewn lots, neglected, rodent-infested schools, and hundreds and hundreds of unemployed adults, I wondered what I would have become had this been my childhood environment. Would I have survived, much less thrived, if constantly bombarded with the message that my life doesn't matter? I can honestly say, I don't know for sure.

As a young medical student working in the wards of Johns Hopkins Hospital, I saw severe injury and late-stage disease in my Black patients. Our professors taught us to expect health disparities between different racial groups. The way we were taught was to treat "socio-economic factors" as a catch-all risk factor for disease. What I saw, however, were health differences that were so clearly the byproduct of the absence of basic community resources and social benefits. Resources that existed elsewhere in Baltimore but not in East Baltimore. As a result, so many East Baltimore residents were enshrouded in a profound fog of unrelenting stress and despair. One could not help but witness a pervasive sense of futurelessness among many residents.

What my professors were calling differences due to race, were in fact differences due to *racism*. Calling them racial differences subtly implied that they were natural biological differences. It was becoming clear to me that the medical model had no answers for the virulent and starkly racialized poverty that clawed at the spirit of the patients I was treating. I began to see that there is no health without hope. The social conditions in and around East Baltimore incessantly siphoned hope from its residents. I was living in the middle of American apartheid. No child growing up in East Baltimore was any more responsible for that environment than I had been for my Canadian environment, yet the personal cost to the East Baltimore child in terms of health and well-being was profound.

The experience of four years in East Baltimore left me wanting to better understand the social costs of poverty in the U.S. and the extent to which these conditions persisted due to institutional and structural racism. Years later I became the Alameda County Public Health Director in Oakland, Calif. Neighborhood conditions in parts of Oakland reminded me of what I had encountered in East Baltimore and I was determined to demonstrate the profound and unnecessary impact that these conditions have on health. In Alameda County, we were able to calculate average life expectancy within very small geographic areas. In Oakland, we determined that a Black child born in West Oakland could expect to die 15 years sooner than a White child born in the Oakland hills. We published this data in maps that became front-page news in the Oakland Tribune and San Francisco Chronicle. I collaborated with colleagues across the country to replicate this analysis in Cleveland, Philadelphia, Denver, Detroit, Seattle, Los Angeles, Boston, Minneapolis-St. Paul and, of course, Baltimore. In many of these cities, these maps were reprinted on the front page of the local newspaper. The October 18, 2008 edition of the Baltimore Sun proclaimed

ILLUSTRATION BY BRIAN STAUFFER


LIQUOR
CLOSED
SCHOOL
Fast
Burger

As a nation, we spend three trillion dollars a year on health care, in part, trying to mitigate the health consequences of racist policy.

"20-year life gap separates city's poorest, wealthy." In East Baltimore some of the city's shortest life expectancies stood out on the map. Despite having an internationally renowned medical institution within spitting distance, African American residents of East Baltimore had among the lowest average life expectancies in the city, and perhaps the nation. This outrageous paradox is not unique to Baltimore and it is not due to health disparities; it is due to health inequity.

The fact is that 80 percent of what shapes our health happens outside of a doctor's office. These factors are often collectively referred to as the social determinants of health. Among them, the neighborhoods where we live, work, play and pray have a profound impact on our health. Because of this country's pernicious history of racial segregation, African Americans, as well as Native Americans and Latinos, have had to contend with neighborhoods that are largely devoid of necessary health protective resources. Many of these neighborhoods lack parks, good schools, full-service grocery stores, adequate community centers, and affordable housing. These communities also concentrate health risk with liquor stores, fast food, environmental pollutants, poor quality housing, military style policing, and high demand-low control jobs with inadequate wages and benefits. These neighborhood conditions produce enormous levels of chronic stress that result directly in higher rates of diabetes, heart disease, stroke, kidney failure, cancer, arthritis, depression, and many other chronic diseases. These inequitable conditions are man-made. As a nation, we spend three trillion dollars a year on health care, in part, trying to mitigate the health consequences of racist policy. However, we simply cannot treat our way out of this. We have to prevent these inevitable consequences by affirmatively dismantling the legacy of

structural racism and investing in equitable policies like the ones I benefitted from in Canada.

The neighborhood environment in East Baltimore, and places like it, is toxic. This toxicity steadily erodes the health of neighborhood residents beginning when they are children, and in some cases even before birth. The fundamental question for those that are concerned with eliminating health inequity is what forces created and maintain these environmental conditions? These community conditions are not natural. Liquor stores, fast food establishments, payday lending, and dilapidated school buildings and parks don't just spontaneously appear. Local, regional and state policies and institutional practices actively and passively facilitate the neglect and disinvestment in these communities. Past practices such as redlining, racially restrictive covenants and racial zoning forced African Americans into certain parts of town and actively stripped resources and amenities from Black neighborhoods. Present-day policies on school funding, affordable housing and transportation operate to maintain racial segregation. To improve the health of East Baltimore and similarly situated communities, we have to change health policies as well as non-health policies that have profound health impacts. We also have to look at institutional practices that may impede the implementation of policies designed to correct inequity.

Policies are not created in a vacuum. The status quo policy landscape is the product of a basically stable political equilibrium. Powerful interests protect that status quo. While government is anointed as the ostensible neutral referee of this status quo equilibrium, it is often not neutral and acts at the behest of powerful interests to resist and suppress change. The tools may be water cannons, police dogs, or as in the case of Freddie Gray, overt state violence. In fact, the lack of investment in places like East Baltimore is just a blunter, more insipid form of state violence. If one seeks to change policy one has to engage this system politically and disrupt the status quo power dynamics. Good policy ideas are useless unless they are enacted into law and implemented through

a political process. Health is political.

One definition of politics is that it is "the struggle over the allocation of scarce and precious social goods." When it comes to health, these scarce and precious social goods may be a park, or a grocery store. For example, if the residents of East Baltimore are not engaged at the decision-making table that has purview over where to invest park creation or maintenance dollars, then East Baltimore will not get an equitable share of those park resources. So improving the health of East Baltimore, or East Oakland, requires building social, political and economic power in a critical mass of residents so that they can participate and hold accountable the systems that decide where to invest new park resources.

Enormous barriers have been thrown up precisely to prevent this fundamental citizen engagement in the political process. Complex voter registration and voter ID laws, the disenfranchisement of the formerly incarcerated, and arcane local government public participation processes are just some of the ways that the beneficiaries of the status quo protect their influence and privilege. Many of these barriers were designed and enforced with explicit racial bias intended. These barriers have profound health and social consequences for low-income communities of color and must be dismantled. Improving community health in places like East Baltimore will require optimizing local democracy. Community health depends heavily on political power.

Policy is also shaped by narrative. A dominant narrative in this country is that some people are deserving and others are not. The narrative is insidious and can be seen in the use of simple terms like Medicare "beneficiaries" and Medicaid "recipients," which imply that those receiving Medicare benefits are deserving of those benefits but those receiving Medicaid are merely undeserving "takers." This narrative is extremely prevalent in our politics. Welfare recipients are routinely held up for public disgrace and welfare offices are designed to reinforce shame and denigrate the self-worth of those who receive benefits. However, homeowners who receive mortgage interest tax deductions, including on second homes

and yachts, are not seen as recipients of government welfare. This narrative is based on an ethos of exclusion. Exclusion is at the root of our apartheid system. When my medical school colleague disdainfully retorted, "What did you expect, it's the inner city," he was informing me that the inner city is where we put those people who do not belong. He was schooling me on the American narrative of exclusion.

The good news is that this narrative has always had to compete with a different and equally enduring narrative of inclusion. Its roots equally as old, are embedded in the very ideas that led to the founding of this country. All men are created equal is an idea that had to coexist with slavery for a century before the ideals represented in those words led to a political movement that overcame slavery and eventually led to women's suffrage and the civil rights movement. That narrative has rebounded recently with the Black Lives Matter movement, immigration reform and efforts to end mass incarceration. It is this inclusion that those of us who believe in health equity, and equity in general, must strengthen and elevate because a strong narrative of inclusion will drive policy change that facilitates the struggle for health equity in East Baltimore and throughout this country.

Health is fundamentally about hope. Once hope is lost, people feel that they cannot control what is happening to them so they stop caring about the future and live day to day. Communities that are forced to live day to day become socially vulnerable. Socially vulnerable communities easily fall victim to epidemics of crack cocaine, HIV/AIDS, a heat wave, or even a hurricane, as Katrina taught us. Preserving hope requires giving people a sense of control over what is happening to them, sometimes referred to as agency. Organizing people to build social, political and economic power builds individual and collective agency. The health challenges of the residents of East Baltimore are not medical; they are political.

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