

# HEALTH EQUITY

How Opportunities for Health are Shaped by Race and Ethnicity

Across the jurisdictions served by the Metropolitan Washington Council of Governments (COG) and throughout the nation, health outcomes vary starkly by race and ethnicity. The coronavirus pandemic has provided a harsh example, but the problem of health inequities is larger and older. For generations, African Americans have experienced higher mortality rates than whites, and Hispanic Americans have died at higher rates from diabetes and other chronic diseases. Such inequities help explain why life expectancy varies by 28 years across the COG region. African Americans account for 93% of the population in the five census tracts with the lowest life expectancies but only 7% of the population where life expectancy is highest.

Health is shaped by more than our individual choices or health care. Health is also influenced by place, and health inequities are influenced by structural racism, the “systems, social forces, institutions, ideologies, and processes that generate and reinforce inequities among racial and ethnic groups.” Minority communities often have lower

household income and less access to education, healthy foods, green space, affordable housing and transportation, and health care. And they often face greater health threats such as air pollution and violence. A study by Virginia Commonwealth University’s Center on Society and Health estimated that nearly half (47%) of the variation in health across census tracts in the COG region was associated with race and immigrant status.

The neighborhood disadvantages that exist for many people of color did not arise by chance; they are products of policies, both past and present. Disparities in today’s communities were shaped by decades of exclusionary practices—from post-Reconstruction racial violence and Jim Crow laws to exclusionary housing policies (e.g., redlining) that isolated people of color from white neighborhoods. Non-white families were prevented from acquiring property and transferring generational wealth, reducing revenue for schools, neighborhood infrastructure, economic development, and jobs. Exclusionary policies continue to reinforce inequities today, perpetuating trans-generational poverty, blight, and disparate treatment—conscious and unconscious—in school, labor, and criminal justice systems.



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Health is also damaged by exposure to discrimination itself, which systematically devalues marginalized groups—including women (e.g., sexism), racial and ethnic groups (e.g., racism), immigrants (e.g., xenophobia), the LGBTQ community (e.g., homophobia), and religious faiths. African and Hispanic Americans in particular have lived not only with subtle and overt expressions of interpersonal racism but also the institutional racism that exists in the courts, education, employment, lending, and other facets of life. Daily exposure

to prejudice produces chronic stress and harms the body, causing changes in the brain, hormones, and immune system. Genetic research suggests that racism can alter chromosomes, transmitting the trauma of past generations to today's descendants.

Many jurisdictions in the COG region have committed themselves to equity initiatives to reduce health inequities. They are addressing neighborhood conditions that restrict opportunities for good health and economic mobility, and are hosting open

discussions about racism, dismantling exclusionary policies that disadvantage groups, investing in neglected neighborhoods, and curbing gentrification and the displacement of residents. They seek a future in which the opportunity for good health is available to all residents.

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For more resources on health equity, visit: [mwcog.org/healthindicatorsreport/](http://mwcog.org/healthindicatorsreport/)

