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ANALYSIS

Race, Place, And Structural Racism: A Review Of Health And History In Washington, D.C.

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ABSTRACT **Recent events have amplified the debilitating effects of systemic racism on the health of the United States. In an effort to improve population health and dismantle more than 400 years of racial injustice, retrospective examinations of policies, practices, and events that have sustained and continue to undergird racial hierarchy are necessary. In this historical review we feature Washington, D.C.—a city with a legacy of Black plurality. We begin with an overview of contemporary place-based health and socioeconomic disparities. To express the etiology of the trends and uncover opportunities to undo the damage, we reflect on the national landscape as well as on policies and events that socially, economically, and politically disenfranchised Black residents, yielding stark differences in health outcomes among Washington, D.C., populations. In the spirit of atonement in policy and practice, we hope that this approach will inspire policy makers and practitioners in communities across the nation to conduct similar examinations.**

Racism and race-based residential segregation are often measured at a particular point in time. However, it is essential to use a historical analysis to truly understand their effects on health. Illustrating this, when she was asked about apartheid in South Africa while giving a radio interview in 2004, Nelson Mandela's daughter Zindzi argued that "racism is not an event. It is a process."[1] Racism and racial inequities in health are each complex problems. Disagreement about the nature and causes of racial health inequities and the most viable and impactful solutions are common.[2] Part of the source of the disagreement is that policies and practices that might not appear to be driven by beliefs and ideologies about race and ethnicity nonetheless have important implications for how societal resources that are critical for health and well-being are allocated.[3]

Rebecca Blank and colleagues note that although some behaviors, policies, and other actions are intentionally designed to treat specific groups less favorably than others, other such actions have different impacts on population health and well-being even though that was not the intention of the actors.[4] It is critical to understand the differential benefits and harms of actions regardless of intention because they have implications for how resources that shape health and well-being are allocated.[5] Recognition of how structural racism is operationalized and its influence on health also is critical. According to Zinzi Bailey and colleagues, structural racism is "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."[5]

To improve population health, it is imperative to identify and examine the policies, practices, and events that have sustained and continue to

undergird racial inequities. In this historical review we illustrate how structural racism and historical events socially, economically, and politically disenfranchised Black residents in Washington, D.C., yielding stark differences in health outcomes by race and place. We emphasize not only how race-based residential segregation undergirds and helps explain contemporary racial disparities in health but also how it grew out of local and federal policies as well as their cultural underpinnings. We also share examples of novel policy solutions to alter the context in which health is shaped.

Health Inequities: A Tale Of Race And Place

Washington, D.C., is home to nearly 718,000 residents.[6] Colloquially known as "Chocolate City," the city has seen gentrification lead to a downward trend in the population of Black residents.[7] Black residents now represent nearly 44 percent of the population, compared with more than 70 percent in the 1970s.[6,8] White representation is trending upward; that demographic group reflected 42 percent of the total population in 2021 compared with 28 percent in the 1970s. Hispanic or Latino residents represented 12 percent of the population in 2021.[6] The median annual household income was $86,420 for the period 2015–19.[9] Nearly 60 percent of people older than age twenty-five have a bachelor's degree or higher.[10]

When compared with those of other cities, the overall health profile of the city is laudable. In prior years the American College of Sports Medicine American Fitness Index ranked the D.C. area (an area encompassing Washington, D.C., as well as parts of Maryland, Virginia, and West Virginia) as the nation's healthiest metropolitan area.[11] However, when health indicators are stratified by race, a different and compelling narrative unfolds: Black men and Black women in Washington, D.C., can expect to live seventeen and twelve years less than their White counterparts, respectively.[12] These racial gaps in life expectancy are among the largest in the nation and have persisted for decades.[12,13] When compared with White D.C. residents, the percentage of Black residents living with diabetes is nearly six times higher, and the percentages of those living with high blood pressure and dying from heart disease are more than two times higher.[14–16] The infant mortality rate—an internationally recognized indicator of population health and health care quality—is nearly five times higher in Black than in White infants.[17,18]

Socioeconomic indicators such as income and education reflect similar patterns. A 2013–14 investigation found that the typical White household in Washington, D.C., had a net worth that was eighty-one times greater than that of the typical Black household.[19] When compared with all other races and ethnicities, non-Hispanic Black residents had the lowest percentage of bachelor's degree attainment at age twenty-five and older in Washington, D.C., in 2015–19.[10]

A history of local and federal policies that structurally disenfranchised people of color is culpable for a racially divided city (exhibit 1). Later in the article we return to a discussion of the events in exhibit 1. Race-based residential segregation is a key predictor of differences in access to opportunity and social mobility.[20]

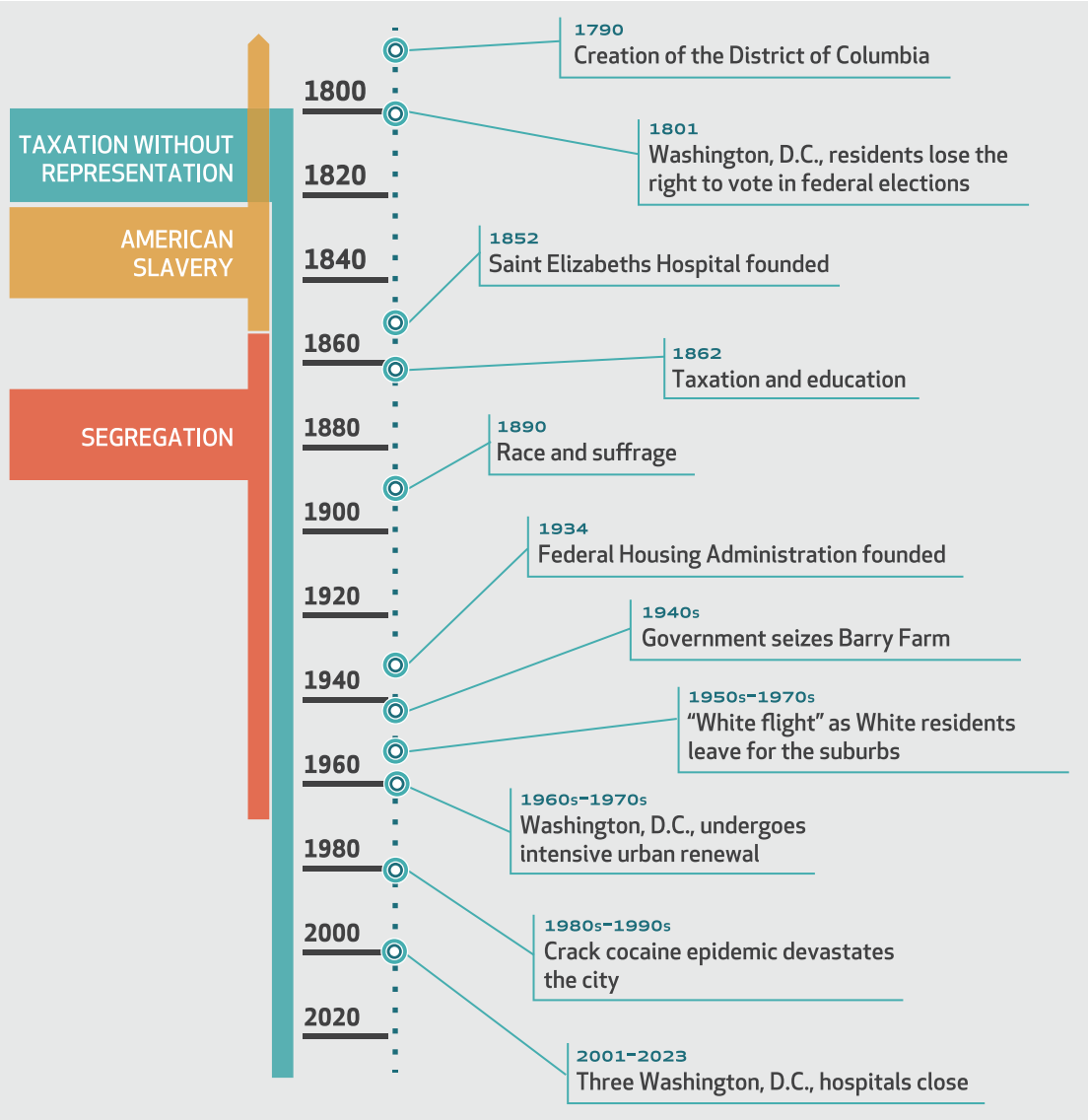
The city is divided into eight municipal units known as wards. Wards east of the Anacostia River are predominantly Black; the profile reverses toward the west. There is a sixteen-year gap in life expectancy between Ward 8, which is majority Black, and Ward 3, which is majority White, and the infant mortality rate is six times higher in Ward 8 than in Ward 3[17,18] (exhibit 2) (see the online appendix for a map of life expectancy and infant mortality rates by ward).[21] The median income is $112,873 in Ward 3 but only $30,910 in Ward 8.[17] There are also significant differences in access to food. Only three full-service grocery stores exist for the 161,503 residents who reside in Wards 7 and 8 combined. Ward 3, in comparison, has sixteen full-service grocery stores for its 84,869 residents.[22]

Despite a high rate of health insurance across racial groups in Washington, D.C., there are striking disparities in measures that serve as proxies for delaying or forgoing preventive care. Preventable hospitalizations for ambulatory care–sensitive conditions among Medicare enrollees are more than two times higher among Black residents than White residents.[23] Residents from wards with high percentages of Black residents disproportionately represent ambulatory care–sensitive hospitalizations.[24] Although high morbidity rates and limited access to services may influence the patterns, residents cite other issues such as competing day-to-day survival priorities and limited access to behavioral health services.[25] Experiences with or perceptions of discrimination, bias, and racism also have also been reported.[25] These experiences may result in deferral of preventive care and late-stage disease detection.[26]

Washington, D.C.'s designation as a "federal district" also has had health and health care implications, particularly during times of public health crisis. Congress must approve the city's budget, and during the height of the HIV/AIDS epidemic (1997–2008) the city was not permitted to use its own tax dollars for needle exchange

EXHIBIT 1

Timeline of historical events and policies that have influenced the health of Black residents of Washington, D.C.



SOURCES See notes 19, 25, 35, 38, 40–43, and 47–55 in text. **NOTE** FHA is Federal Housing Administration.

programs. Although the ban on these programs was lifted in 2007, some epidemiologists posit that the city lost a significant opportunity to reduce HIV transmission rates and deaths, particularly among Black residents, who were disproportionately affected by the virus.[27,28] Inequitable federal funding allocations are well documented.[29] Most recently, Mayor Muriel Bowser called for parity in the distribution of federal support in the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, as the city received up to $755 million less than states, including states with smaller populations than Washington, D.C., and states whose residents pay less in federal taxes.[30,31]

The Intersection Of Taxation Without Representation And Race

Washington, D.C., does not operate with the same autonomy and representation as US states. The founders believed that if the capital were a state, members of government would be unduly beholden to the state. Since the passage in 1801 of what became known as the Organic Act, residents have not had voting rights in Congress and are solely represented by a nonvoting House delegate. Because of the District's growing Black population in the late 1800s, there was widespread political will to maintain the status quo. In 1890, according to Sen. John Tyler Morgan of Alabama, "after the negroes came into this

EXHIBIT 2

Racial composition and health indicators in Washington, D.C., by ward

Indicators	Wards 1	2	3	4	5	6	7	8
Racial distribution, %								
Black	21	13	5	45	61	38	92	92
White	58	69	81	31	31	49	3	4
Other	21	18	14	24	8	13	5	4
Life expectancy, years								
72–76							•	•
>76–81	•			•	•	•		
>81–88		•	•					
Infant mortality rate per 1,000 live births								
0–1.3			•					
>1.3–5				•		•		
>5–7.1	•	•						
>7.1–12.5					•		•	•

SOURCES Life expectancy estimates are from the US Small Area Life Expectancy Estimates Project, 2018, as published in DC Health. Health equity report for the District of Columbia 2018 (note 17 in text). For racial distribution data (2021), see note 6 in text. For infant mortality data (2019), see note 18 in text. **NOTE** Circles indicate the life expectancy and infant mortality category into which any ward falls.

District," it became necessary to "deny the right of suffrage to every human being. It was necessary to burn down the barn to get rid of the rats."[32] This statement reflects how race and racism factor into efforts to preserve D.C.'s federal district status and disenfranchise its residents from congressional representation.[32,33]

As a consequence, residents of a city with a Black plurality have been excluded from shaping national policy and precluded from exercising sovereignty over local affairs. Nonetheless, they pay federal taxes, serve on juries, serve in the military, and contribute to the national economy. The slogan "taxation without representation" has become symbolic of the entitlements that residents of states enjoy that Washington, D.C., residents do not.

What Has Influenced The Health Of Black D.C. Residents

Race and racism have played a critical role in the history and health of the city. We present here a timeline of policies and practices that were designed to have differential effects by race and those that have had differential effects despite lacking intent (exhibit 1). This review offers a new vantage point for examining racial inequities and inspires unconventional solutions to achieve racial justice and improve health.

1852: SAINT ELIZABETHS HOSPITAL FOUNDED Race-based biological fallacies have been entrenched in the evolution of modern medicine.[34] In 1852 Congress appropriated funds for what became known as Saint Elizabeths Hospital, intended to serve as the nation's preeminent leading institution in teaching and research in psychiatric care. Although the hospital did admit Black patients, they were segregated in "colored wards" and experienced substandard care in poorly ventilated, overcrowded spaces.[35] Because of perceived biological differences, new treatment methods pioneered by the institution, such as psychotherapy, were withheld from Black patients. The story of Saint Elizabeths had a local and national impact: Unequal and unjust treatment shaped Black residents' negative perceptions about the medical community, and between 1914 and 1933 doctors at the institution published ten influential studies that reinforced belief systems at the intersection of eugenics and medicine.[35]

1862: TAXATION AND EDUCATION The positive correlation between educational attainment and good self-reported health status is well established.[36,37] Because of segregation and community disinvestment, appropriating tax dollars to fund public education inextricably stymied the social advancement and well-being of Black residents of Washington, D.C. The disparity can be seen starkly in education policy and resource allocation stemming from an 1862 law[38] designating a portion of taxes paid by Black people for use by Black schools. Those taxes amounted to a mere $410 of support for Black schools in 1863 compared with much higher support for White schools ($65,000), which Black students were not permitted to attend.[19]

Inequitable access to education would have a ripple effect on Black families for generations to come. For example, during 2015–19, 27 percent of Black residents older than age twenty-five had a bachelor's degree, compared with 92 percent of Whites.[10] These trends have significant health implications. A report recently released by the DC Department of Health highlights correlations between level of education and incidence of diabetes, asthma, stroke, and heart disease.[17]

1934: REDLINING AND THE FEDERAL HOUSING ADMINISTRATION In the US, homeownership is a vehicle for wealth building.[39] Established in 1934, the Federal Housing Administration (FHA) redlined communities to determine the desirability of neighborhoods and promote racial exclusivity in mortgage lending.[40] By 1960, the value of FHA-insured property in majority-Black neighborhoods in Washington, D.C., was less than a seventh of that in White suburban jurisdictions.[19] The discriminatory practices resulted in asset accumulation and wealth building among White homeowners and concentrated poverty among Black homeowners.[19] Exclusion-

ary zoning practices were a key driver for differences in the structural conditions of neighborhoods east of the Anacostia River. Lack of investment in those communities has sustained lower property values and gaps in resources that facilitate health and well-being.[7,17,19]

1940s: Government seizes Barry Farm At the end of the Civil War, hundreds of free Black families developed Barry Farm, which grew to contain a vibrant community of emerging Black intellectuals and entrepreneurs, including Frederick Douglass.[41] Unsettled by their activism, many White residents expressed disdain for the flourishing community of landowners.[19] Barry Farm residents were threatened, and there was increased political will to destroy the community.[19,41] To construct public housing in the 1940s, the government seized thirty-four acres and demolished homes, businesses, and other assets.[41] Suitland Parkway was constructed in 1944, structurally dividing the neighborhood.[19,41] The loss of property and homeownership accompanying the destruction of community assets stripped the Black families who lived there of generational wealth accumulation.

1950s–1970s: 'White flight' During the 1950s through the 1970s, "White flight" was a trend experienced in cities across the country, including Washington, D.C., as White Americans took advantage of federal affordable housing policies that facilitated their migration to suburban communities.[40] During the thirty-year period, 308,000 White residents, or 60 percent of the city's White population, left the city.[42] The exodus had a substantive impact on municipal revenue, which led to a decline in social services and quality of life. Moreover, the structural conditions caused by vacant and abandoned properties left Black residents especially vulnerable to the impending crack cocaine epidemic.[40,43]

1960s–1970s: Urban renewal Urban renewal or gentrification has been linked to poor health for Black and low-income residents.[44,45] In the 1960s Washington, D.C., experienced urban renewal, including in predominantly Black neighborhoods in Southwest, where many Black-owned businesses and homes were destroyed and thousands of Black residents were displaced in the process.[19] Urban renewal not only led to the dissolution of emerging Black communities but also kept thousands of residents from accumulating assets and generating wealth.

1980s–1990s: Crack epidemic Residential segregation and discriminatory practices left Black residents especially vulnerable to the crack cocaine epidemic of the 1980s and 1990s. In 1986 Congress passed the Anti–Drug Abuse Act, which included mandatory sentences for cocaine possession (including the derivative known as crack) by quantity. Possession of more than five grams of crack would result in a five-year minimum sentence for first-time offenses, whereas possession of 500 grams of powder cocaine carried the same sentence.[43] This era would be known for mass incarceration and racial disparities in arrests and sentencing because crack was relatively inexpensive, and small amounts were both more accessible and more pervasive in Black and poor communities than in wealthier and Whiter areas. Cocaine in its powder form, in contrast, was both more costly and more often used by affluent White people.[43]

With Black men in particular disproportionately affected by the crack epidemic, it had a profound impact on families. Some researchers suggest that the epidemic was a key contributor to the modern-day Black-White gaps in education, housing, and income.[46]

2001–23: Closure of hospitals and service lines Recent closures of hospitals and specialty care service lines in Black communities have restricted access to convenient and timely medical care. From 2001 to 2020 closures were the outcome of the institutions' extensive histories of fiscal challenges, partially because of payer mix, as well as a proliferation of trends in mergers, acquisitions, and consolidation.[25,47–55] Shuttering of health care services stressed the city's health care ecosystem, resulting in long wait times for neighboring facilities and transportation barriers for patients.[47–55]

▶ **District of Columbia General Hospital (2001):** After almost 200 years, inpatient services and trauma wards at DC General Hospital closed in 2001. The public hospital was known for its culturally nuanced care, and it served as the medical home for the disenfranchised, low income, and uninsured. It was also instrumental in medical education.[48,49]

▶ **Providence Hospital (2019):** Providence Hospital closed in 2019 after having served the community for nearly 160 years. The hospital provided inpatient and emergency department services. Shuttering of obstetrics and behavioral health services exacerbated preexisting specialty care gaps for city residents.[17,50] With the hospital having been located in Ward 5, Black residents were likely to be disproportionately affected, as they make up 55 percent of residents in Ward 5.[56]

▶ **United Medical Center (2020–23):** Located in Ward 8, United Medical Center is the only hospital east of the Anacostia River.[25] Many services have recently shuttered, including a skilled nursing facility and obstetrics ward,[52] and there are plans to close the hospital by 2023.[51] The closures were the result of a confluence of factors, including declining patient vol-

ume, inability to compete with more attractive and centralized medical establishments, and events that negatively affected the hospital's brand and community perception.[52–54] The absence of prenatal services east of the Anacostia River creates another obstacle in a citywide effort to reduce high rates of infant and maternal mortality.[55]

The Path Forward

In this article we have illustrated how contemporary health inequities in Washington, D.C., are born from events that took place during the past two centuries. Many articles have documented racial inequities by race and place, as well as the role that race-based residential segregation plays in stymieing access to opportunity.[20,57,58] These trends grew out of a legacy of slavery and Jim Crow segregation, as well as events and policies that may appear to have little to do with health. There are data supporting the notion that statehood for the District of Columbia would have health benefits for its residents. For example, Thomas LaVeist found a strong relationship between political representation and Black-White inequities in infant mortality in a national sample of US residents at the city level.[58]

The COVID-19 pandemic is a noteworthy reminder of how inequitable practices leave communities especially vulnerable in the face of a public health emergency. Extensive evidence elucidates the relationship between community deprivation and likelihood of delaying care or having a preventable readmission.[59,60] The recent closure of hospitals and specialty care services located in the city's Black neighborhoods represents a seemingly cyclical burden for residents and should be a concern for the city's entire health care infrastructure.

Interventions that solely focus on health behavior will not close the chasm in racial health inequities. And although attention is increasingly being paid to social determinants of health in efforts to advance population health, outcomes cannot be fully realized without racial justice, which requires unconventional approaches to identify and dismantle norms that are deep seated in policies, systems, and structures.

Citywide efforts are under way in Washington, D.C., to facilitate progress. In 2015 the DC Office of Health Equity was established. Guided by nine key drivers—education, employment, income, housing, transportation, food environment, medical care, outdoor environment, and community safety—the office applies a health equity and health-in-all-policies lens across government agencies.[61] In 2020 the Council of the District of Columbia unanimously passed the Racial Equity Achieves Results (REACH) Amendment Act, which created an Office of Racial Equity; a racial equity advisory board; and a commission to facilitate a coordinated approach for racial equity, social justice, and economic inclusion.[62]

The city also employs Racial Equity Impact Assessments to uncover whether or how a racial group might be negatively affected by imminent legislation or an organizational policy.[63] Normalizing such assessments can help maintain operational awareness of how vestiges of the past persist within and across institutions and social systems.

Policies that promote racial equity and help level the playing field are also necessary. For example, in a commitment to breaking the cycle of poverty, the DC Council recently approved the Child Wealth Building Act of 2021, which puts up to $1,000 per year into a trust fund for low-income children. After children reach age eighteen, those funds can be used for college, buying a home or business, investing in a business, or making a contribution to a retirement fund.[64]

Conclusion

Achieving racial justice in Washington, D.C., would make an important statement about the nation's commitment to life, liberty, and the pursuit of happiness. The pathway forward requires operational awareness that the injustices being pursued and eliminated are intersectional and historically rooted. Therefore, unconventional practices are needed to identify and dismantle systems, policies, processes, and cultural norms that perpetuate racial inequities. ■

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