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## Rooted in Racism: An Analysis of Health Disparities in Tennessee

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### Executive Summary

The disproportionate impact of COVID-19 on Black Americans is the latest of many examples of health disparities within this population. Dating back to the beginning of this nation, health disparities have existed and have plagued Black people and other people of color as a result of systemic racism, which influences every social determinant of health. Health disparities should be considered within the context of health inequities and the practices and policies that embody and reflect racism. One of the primary health inequities that causes poor health outcomes for Black people is the denial of access to health care because of political choices made by state leaders. Another factor is poor quality of care that is often linked to providers' implicit racial bias.

**Other than “Medicare for All” or some version of universal health care, expanding Medicaid to cover the uninsured, among which Black people are overrepresented, is one of the best, easiest options to address health disparities, including COVID-19.** Insurance status is a key factor in health and mortality.<sup>1</sup> Tennessee is one of eight Southern states that continue to reject Medicaid expansion under the Affordable Care Act, despite evidence showing that it improves coverage, access to care, and health outcomes, particularly for racial/ethnic minorities, and despite the economic and health benefits it would provide to help with pandemic recovery efforts.

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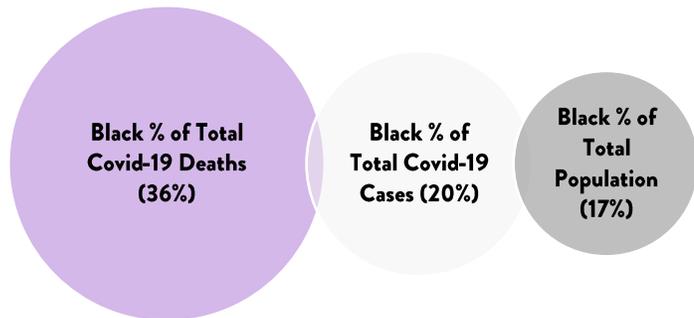
This rejection should be evaluated within the historical context of racism that is concentrated in the South and that has driven policy decisions ever since Africans were first forced into chattel slavery on this continent in 1619. Tennessee and other Southern states must reckon with this history, dismantle the racism that is driving political decisions, and finally adopt Medicaid expansion, which has been shown to reduce racial disparities.

### Health Disparities, Health Inequities & Social Factors

There are countless historic and current practices and policies that have perpetuated systemic racism and the oppression of Black people in this country, including the transatlantic slave trade, chattel slavery, sharecropping, lynching, Jim Crow, segregation, redlining, discrimination in employment,

housing, and education, voter suppression, predatory lending, criminalization of mental illness and substance use disorders, mass incarceration, and police brutality. One system that is less often mentioned when discussing racism, and yet is central to the discussion, is our healthcare system. Racism within the healthcare system is manifested in two major ways: health disparities – different groups have different health outcomes (e.g. higher rates of infant mortality and maternal mortality, higher rates of chronic conditions, and lower life expectancy among Black people<sup>2</sup>) – and health inequities – different groups have different access to resources (e.g. education, housing, food, transportation, employment, and health care). Any discussion of health disparities is incomplete unless health inequities are also addressed.

Health disparities existed long before COVID-19, but this pandemic has raised awareness about longstanding, pervasive inequities that have plagued this country. People of color have disproportionately higher rates of infection, hospitalization, and death. Based on data through the end of May from the Centers for Disease Control (CDC), Black and Hispanic/Latino residents of the United States have been three times as likely to become infected as White Americans and almost twice as likely to die from COVID-19.<sup>3</sup> These numbers are likely underestimated because hundreds of thousands of cases out of the nearly 1.5 million case records do not include information about race, ethnicity, and county of residence for every person who tests positive.<sup>4</sup> These data covered 974 counties representing over 50 percent of the U.S. population. They did not include any Tennessee cases, but similar disparities are evident in the data made publicly available by the state: Black Tennesseans account for 20% of COVID-19 cases and 36% of deaths but are only 17% of the state’s population, and 24% of cases are marked as “pending” for race/ethnicity.<sup>5</sup>



To explain the higher death rate, some experts have cited the higher rates of underlying health problems, such as diabetes and obesity, among Black people, but this fact does not answer the question of why there are higher infection rates. Answering that question requires an understanding of the health inequities that are at play. **The underlying reasons for the disparities in both infection and death rates are tied to social factors that cause racial inequities in access to food, types of employment, housing, and health care, which are also known as social determinants of health.** According to the CDC, social determinants of health are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.<sup>6</sup>

Communities of color have greater exposure to the virus because nationally, 43 percent of Black and Latino people work front-line jobs and cannot telecommute (compared to about 25% of White workers).<sup>7</sup> Also, due to income constraints, Black and Latino people are more likely to take public transportation or live in close quarters with multiple people, often including three generations, which adds to the risk of exposure. In addition to the higher risk of exposure due to employment, transportation, and housing factors, low-income people of color also face barriers concerning access

to testing and treatment. Black and Latino communities – at least near the beginning of the pandemic – had fewer testing locations, and Black and Latino people are less likely to receive a test even when they are in high-risk groups, present with symptoms, and request a test.<sup>8</sup> In Nashville and Memphis, testing centers in diverse neighborhoods were waiting for weeks to receive testing supplies and other equipment, while a significant volume of testing was already taking place at locations in majority white neighborhoods.<sup>9</sup>

Health equity seeks to eliminate health disparities that are based on social factors or demographics (such as race) by delivering resources in the amount and manner that is necessary to meet the needs of the individual, family, and community. When focusing on the disparity (such as higher obesity rates among Black, low-income people) without examining the underlying reasons for the disparity (e.g. lack of access to nutritious food; lack of access to safe spaces within the neighborhood for

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exercise), an opportunity to make systemic changes that would help achieve health equity is missed. An examination of the underlying reasons for health disparities would reveal systemic racism as the root cause. For example, there is a lasting impact of segregation, housing discrimination, and government “redlining” policies in the 1930s – under which Black

communities were excluded from mortgage lending programs and business investment. Such wealth as Black families managed to build was largely destroyed in the Great Recession, and as a result of the predatory lending practices that led up to it.<sup>10</sup> That means that today, many Black residents live in segregated neighborhoods that lack job opportunities, adequately funded schools, stable housing, grocery stores with healthy food, and other resources.

## **The Impact of Discrimination and Racial Bias on Health**

In 1992, Arline T. Geronimus introduced “the weathering hypothesis,” which stated “that the health of African-American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage.”<sup>11</sup> The weathering hypothesis has been cited extensively, and further studies have revealed evidence that poverty alone is not responsible for the racial inequalities in health that exist between Black and White Americans.<sup>12</sup> The concept of “allostatic load” – the cumulative deterioration of the body’s systems due to repeated stress responses – has been used to explain why Black Americans have poor health at younger ages than White Americans even among Black Americans who are not poor and have higher incomes than White Americans.<sup>13</sup> Studies have shown a connection between discrimination and violence and sleep disorders, abdominal fat, coronary artery calcification, fibroids, breast cancer, tobacco use, and illicit drug use, which all affect health.<sup>14</sup>

Discrimination by health care providers is also a factor impacting the health of Black people. Some health care providers still hold false beliefs (dating back to slavery) that Black people have a higher tolerance for pain and other physical attributes (e.g. “Black people’s skin is thicker than White people’s skin”; “Black people’s nerve-endings are less sensitive than White people’s nerve-endings”; “Blacks have stronger immune systems than Whites and are less likely to contract colds”), which influence their medical judgment and clinical approach.<sup>15</sup> In a study of white

medical students and residents, half of them falsely believed there are biological differences between Black and White people and rated a Black patient's pain as lower and made less accurate treatment recommendations.<sup>16</sup>

The effects of weathering and provider discrimination are particularly noted in maternal and infant mortality rates. Black women are three times more likely to die from a pregnancy related complication,<sup>17</sup> and Black infants are more than twice as likely to die before their first birthday.<sup>18</sup> Although disparities exist across socioeconomic status, access to preconception, prenatal, and pediatric care can improve outcomes.

Lack of obstetric services in rural Tennessee has created “maternal health deserts” that impact maternal and infant health.<sup>19</sup> According to the Tennessee Department of Health, “the worst primary care workforce shortages are in the field of Obstetrics,” and 38 out of 95 counties in Tennessee have no obstetric providers.<sup>20</sup> While most rural counties are predominately white, the Black and Hispanic populations are growing in rural and small towns, which in 2010 were 6.7% African American and 3.0% Hispanic in Tennessee.<sup>21</sup> According to 2016 data, a few rural areas in Tennessee had sizable Black populations,<sup>22</sup> particularly in West Tennessee's Delta Region.<sup>23</sup>

## **Historical Context Impacting Access to Health Care**

COVID-19 is not the first public health crisis to have a disproportionate impact on Black Americans. During the Civil War, a smallpox epidemic ravaged the South and killed 60,000 newly freed slaves.<sup>24</sup> The higher infection rates among Black people, which were due to the unsanitary living conditions and denial of basic needs like food, shelter, and health care, were interpreted as proof of “black inferiority.”<sup>25</sup> White leaders at the time were transparent about their indifference to the suffering of Black people, but as is the nature of public health matters, the smallpox epidemic could not be confined within the Black communities. The concern for the health of White people, as well as the need to ensure that enough Black people survived and were healthy enough to continue providing cheap labor, had to be weighed against the worry that if African Americans were (too) healthy it would disrupt the racial hierarchy on which this country's capitalist economic system was built.<sup>26</sup>

Created in 1865 by Congress, the Freedmen's Bureau was this nation's first federal health care program and provided, among other services, food, housing, and medical aid to Black people and poor White people in the South. It also helped in founding some of the earliest historically Black colleges and universities, including Fisk University in Nashville, Tennessee.<sup>27</sup> However, the program was severely underfunded, under-resourced, and mired in racist politics, and it was dismantled in 1872. Apathy concerning the plight of Black people and others living in poverty persisted.

Additionally, government policies, such as how health care funding was allocated, permitted racism in our healthcare system for decades after the Civil War. The Hill-Burton Act was passed in 1946 and provided federal grants to build hospitals in communities across the country, with priority to rural areas including those in the South, to provide free or reduced-cost health care. Southern Democrats negotiated to ensure that the act gave control over the allocation of funds to the states and allowed for segregated facilities under the “separate but equal” doctrine.<sup>28</sup> The racially

segregated facilities were certainly not equal, and Black Americans faced discrimination as patients, who were often denied treatment by white doctors; as students, who were excluded from most medical schools; and as physicians, who were refused admitting privileges at white hospitals. **A federal court ruled in 1963 that segregation in government-owned hospitals was unlawful, and the Civil Rights Act of 1964 prohibited discrimination under any program or activity that received federal funding, but the Medicare and Medicaid programs created in 1965 helped to finally end segregated hospitals by requiring desegregation as a condition of funding.**

In 1945, President Truman proposed a “universal national health insurance program” that would have provided federally subsidized coverage to all Americans. The American Medical Association (AMA), which at the time refused to allow Black doctors to be members, led a campaign that defeated the proposal by persuading the public that a government-sponsored health plan is socialism, un-American, and would lead to the government interfering with the doctor-patient relationship.<sup>29</sup> In the 1960s, the AMA made the same arguments when the idea of Medicare was introduced, but the National Medical Association (the Black doctors’ counterpart to the AMA) launched a successful campaign that argued health care is a basic human right.<sup>30</sup> Thereafter, the Medicare and Medicaid programs were established in 1965. Medicare provides health insurance to people over age 65 and certain younger people with disabilities. Medicaid provides health insurance to low-income parents, children, older adults, and people with disabilities. However, people who do not qualify for these insurance options have been left with limited pathways to coverage.

Employer-sponsored insurance (ESI) emerged during World War II and now covers nearly half of all Americans.<sup>31</sup> Under the ESI system, employers purchase insurance for employees, and the amount the employer contributes to the insurance premium is excluded from income and payroll taxes. Tax exclusion for ESI is estimated at nearly \$300 billion in tax subsidies this year.<sup>32</sup> The subsidy for the highest income families is three times the subsidy for the lowest income families, who pay more than 25% of their income for health insurance.<sup>33</sup> Tax subsidies for ESI, which primarily benefit higher-income taxpayers, are a form of government expenditures that is favorably viewed even though it may contribute to higher health costs by incentivizing employers to offer more expensive plans than they would purchase if they had to pay the full, unsubsidized cost.<sup>34</sup> Medicaid, on the other hand, is a government expenditure that primarily benefits low-income people (disproportionately people of color). As such, it is constantly under attack, with efforts to shrink spending on the program, even though it is far more efficient than ESI.<sup>35</sup>

As health care in the United States has become unaffordable to all but the wealthy, it has become impossible to access consistent, timely care without insurance coverage. It has long been known that Americans without coverage “live sicker and die sooner,” as explained in a series of authoritative reports from the Institute of Medicine.<sup>36</sup> Without insurance, even a single accident or illness can destroy a family’s financial security. And as the pandemic has shown, the inability of the uninsured to afford timely care jeopardizes the wellbeing of the entire community.<sup>37</sup>

## **Racial Disparities in Coverage Rates**

The tax subsidy for ESI is an example of selective socialism that has racial implications. From the outset, Black people were often excluded from the jobs that offered health insurance. Creating a system that ties health coverage to employment and then denying those types of employment to

Black people has allowed racial health disparities to persist. The fragility and inequities of this system are even more apparent now since unemployment levels have reached historic highs and

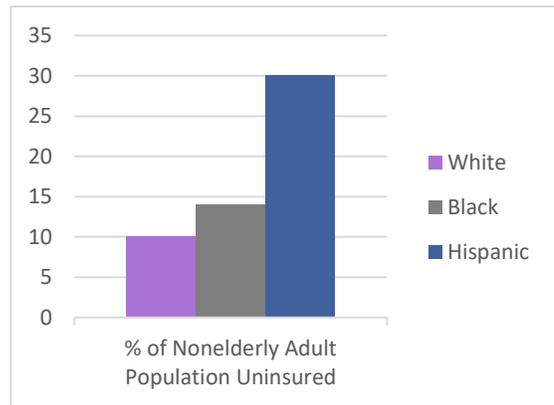
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people are losing their health insurance because of job losses due to the COVID-19 pandemic. In Tennessee, 122,000 people lost health coverage due to job loss between February and May 2020, bringing the state’s total uninsured adult population to 751,000.<sup>38</sup> Also, because unemployment rates are always higher among Black and Hispanic workers than White workers,

and people of color are more likely to work in industries that pay low wages where layoffs are more common, the pandemic-related job losses have had a disproportionate impact on communities of color.<sup>39</sup>

Today, lower health insurance coverage rates among racial and ethnic minorities is a dominant factor that drives differences in access to health care.<sup>40</sup> In Tennessee, the uninsured rate for

nonelderly White adults is 10% but for nonelderly Black adults it is 14% and for nonelderly Hispanic adults it is 30%.<sup>41</sup> Because Black and Hispanic people in the United States are more likely to be uninsured throughout adulthood, they are more likely to face significant health care barriers.<sup>42</sup> In Tennessee, among low-income African Americans who are uninsured, 61% reported they cannot afford to see a doctor; 63% reported they do not have a regular doctor; and 38% reported they had not had a routine check-up in the past year.<sup>43</sup> Uninsured African Americans were much more likely to experience these issues than their insured counterparts.<sup>44</sup> Because of their lack of access to a regular source of care, African Americans are more likely to be relegated to long waits in emergency rooms, resulting in costly, discontinuous care.<sup>45</sup>



Most health care providers do not treat uninsured patients unless they can pay fees that are much higher than those charged to patients covered by insurance.<sup>46</sup> People in the low- to middle-income bracket cannot afford to pay for health insurance if their employer does not provide it. As noted above, Black and Hispanic Americans are more likely to work low-wage jobs that do not offer health benefits.<sup>47</sup> They are also more likely to experience “churn” – gaining and losing coverage several times during their lifetime.<sup>48</sup> Without steady coverage, Black and Hispanic people are unable to develop and maintain long-term relationships with their physicians and are less likely to receive trusted medical advice, information about available resources to address social needs, and preventative services or consistent care to manage chronic conditions, which are essential to physical and mental health. Therefore, increasing rates of insurance can increase access to regular care that would help improve health and reduce health disparities.

Medicaid has its shortcomings--providers can refuse to accept Medicaid altogether or limit the number of Medicaid patients they accept, and lower reimbursement rates create a financial incentive

to discriminate against Medicaid patients. However, Medicaid provides comprehensive coverage, which is necessary to gain access to hospitals, doctors, and other providers for preventative care, early detection of problems, and treatment. Access to health care is an essential first step to achieve health equity.<sup>49</sup>

## Progress Under the Affordable Care Act

The passage of the Affordable Care Act (ACA) in 2010 was immediately met with criticism and defiance, which included calling the ACA “Obamacare” – a thinly veiled attempt to inflame opposition to the law among people who disliked President Obama. The backlash against the ACA is not entirely attributable to racism or the fact that it was enacted by this country’s first Black President,<sup>50</sup> since prior attempts to bring about universal health care had been defeated by labeling the concept as “socialism.” In the past, linking health insurance to socialism has effectively invoked ideas of welfare and the misconceptions of who primarily benefits from welfare programs. However, the ACA has become more popular in recent years, and **the majority of people across the political spectrum view Medicaid as primarily a health insurance program rather than a welfare program.**<sup>51</sup>

Key features of the ACA that contributed to a reduction in health disparities included:

- Providing outreach in multiple languages to remove linguistic barriers to enrolling in both public and private insurance among Hispanic and Asian people;
- Strengthening federal prohibitions against discrimination by health care providers receiving federal funds; and
- Prohibiting insurers from denying coverage based on preexisting conditions.

Perhaps the greatest contribution to the reduction of racial disparities was made by the ACA provision that extended Medicaid to low-wage workers whose employers typically do not provide health coverage and who cannot afford to buy it on their own. Under the ACA, states were required to extend Medicaid to everyone with incomes below 138% of the federal poverty level (FPL), or about \$17,609 for a single person. As explained above, this population is comprised disproportionately of people of color. Expanding Medicaid to them is crucial to eliminate the racial gap, because, unless they have health care, it is impossible to close the racial divide in health care access, morbidity, and mortality.

The ACA also established an online, government-facilitated marketplace where individuals with incomes above the Medicaid eligibility limit can buy subsidized insurance. The cost of such coverage is federally subsidized for those with incomes above 138% FPL, all the way up to 400% FPL (or about \$51,040 for a single person). In this way, the ACA was designed to provide coverage for the poor and near-poor through Medicaid, and for more affluent individuals through subsidized commercial coverage.

The ACA has also been useful to address health disparities by allowing Medicaid to pay for community health workers, who improve access to care for racial minorities by serving as a trusted source of information and connecting people to helpful resources. It is necessary to focus on trust building to resolve the distrust of health providers among Black people and other communities of color that experience discrimination or mistreatment by health care providers themselves or are

aware of abuses that have happened to friends or family members as well as historical examples, such as the Tuskegee syphilis experiment<sup>52</sup> and the story of Henrietta Lacks.<sup>53</sup>

## Tennessee's Refusal to Permit Medicaid Expansion Perpetuates Racial Inequities

In 2012, the Supreme Court held that it was unconstitutional for the federal government to mandate that states expand Medicaid, making it optional for each state to decide whether to do so.<sup>54</sup> In states

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that choose not to expand, low-income residents fall into a “coverage gap” which means they don’t qualify for Medicaid, and they don’t qualify for ACA marketplace subsidies, but they earn too little to afford a private insurance plan.

The need for Medicaid expansion is more urgent due to the current pandemic and recession, as it would provide a safety net for people who lose their employer-sponsored

coverage as layoffs continue. An additional 1.9 million Americans – including 86,000 Tennesseans – who previously had employer-sponsored insurance and lost their jobs are projected to fall into the coverage gap by January 2021.<sup>55</sup>

To date, 38 states (including Washington, D.C.) have implemented or adopted Medicaid expansion.<sup>56</sup> The politics of Medicaid expansion have changed, as more conservative states adopt it and it is shown to increase health care coverage, provide fiscal benefits to states, help rural hospitals remain open, and save thousands of lives.<sup>57</sup>

Under the ACA, coverage and access to care have increased through the marketplace plans as well as Medicaid. In states that expanded Medicaid, racial disparities concerning access to care have been reduced as Black people have gained health insurance.<sup>58</sup> Studies show Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security among the low-income population.<sup>59</sup> Some recent analyses show that expansion is associated with decreased mortality overall and for certain specific conditions; reductions in rates of food insecurity, poverty, and home evictions; and improvements in measures of self-reported health and healthy behaviors.<sup>60</sup>

Eight of the 13 states that still refuse to expand Medicaid are in the South- North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Texas, and Tennessee. The racial effects of these states’ refusal to allow Medicaid expansion are stark. The South is home to 58% of the United States’ entire Black population.<sup>61</sup> If all remaining non-expansion states were to expand Medicaid, the majority of the uninsured people who would become Medicaid eligible are people of color.<sup>62</sup> Thus, not expanding Medicaid disproportionately impacts low income, Black people, perpetuating inequities that result in preventable suffering and death.

The majority of people who live in non-expansion states (61%) are in favor of their state expanding Medicaid.<sup>63</sup> By refusing to expand access to care, without any valid reason, and despite popular demand, these states are perpetuating racial health disparities. In Tennessee, elected officials defend their refusal to expand Medicaid by arguing that it would be too costly to the state. Under the ACA, the federal government provides 90% of the cost of Medicaid expansion, while states fund 10%. But

former Governor Bill Haslam obtained a commitment from hospitals that they would pay the state’s 10% share of costs, so that there would be no cost at all to the state. Opponents’ claim that the state “cannot afford” to expand coverage is therefore baseless.

Ironically, it is the refusal to expand coverage, rather than expansion itself, which is costly to Tennesseans. The state’s own analyses show that expanding Medicaid would bring \$1.4 billion per year into the state,<sup>64</sup> which would financially support hospitals, create 15,000 health care jobs,<sup>65</sup> and provide health insurance to over 300,000 Tennesseans who are in the coverage gap<sup>66</sup> – 26% of whom are African Americans.<sup>67</sup> The additional federal funds (\$3.8 million flowing to Tennessee per day) will provide much needed fiscal relief that will help protect jobs.<sup>68</sup> Without expansion, Tennessee has seen 13 rural hospitals close since 2010, the highest rate per capita in the nation, and scores of other hospitals are at risk of closure.<sup>69</sup> Hospital closures are devastating to communities during normal times, but they are especially so during a pandemic.

Medicaid expansion would also help the state respond to the COVID-19 public health crisis. When people have comprehensive coverage, they are more likely to seek testing and treatment because they are not concerned about not being able to afford it.<sup>70</sup> More testing is important to identify cases and slow the spread of the virus. Comprehensive coverage would also enable people to get medical care for chronic conditions unrelated to COVID-19 and preventative services. Given that communities of color have higher rates of infection, hospitalization, and death due to social factors and are more likely to work front-line or essential jobs that create greater exposure risks, slowing the spread of the virus by closing the coverage gap would be a great benefit to communities of color and the public.

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<sup>1</sup> Tennessee does not collect this data point for coronavirus cases. Early in the pandemic, race and ethnicity were also not included in data reported by the CDC and states until advocates and leaders demanded this information be made publicly available.

<sup>2</sup> U.S. Department of Health and Human Services Office of Minority Health, “Profile: Black/African Americans,” <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61> (last accessed on July 20, 2020).

<sup>3</sup> Richard A. Oppel Jr., Robert Gebeloff, K.K. Rebecca Lai, Will Wright and Mitch Smith, “The Fullest Look Yet at the Racial Inequity of Coronavirus,” July 5, 2020, <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html?searchResultPosition=1>.

<sup>4</sup> Id.

<sup>5</sup> Tennessee Dept. of Health, Epidemiology and Surveillance Data, available at <https://www.tn.gov/content/tn/health/cedep/ncov/data.html> (last accessed on July 19, 2020).

<sup>6</sup> <https://www.cdc.gov/socialdeterminants/index.htm>

<sup>7</sup> Richard A. Oppel Jr., Robert Gebeloff, K.K. Rebecca Lai, Will Wright and Mitch Smith, “The Fullest Look Yet at the Racial Inequity of Coronavirus,” July 5, 2020, <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html?searchResultPosition=1>.

<sup>8</sup> Blake Farmer, “The Coronavirus Doesn’t Discriminate, But U.S. Health Care Showing Familiar Biases,” April 2, 2020, <https://www.npr.org/sections/health-shots/2020/04/02/825730141/the-coronavirus-doesnt-discriminate-but-u-s-health-care-showing-familiar-biases>

<sup>9</sup> Id.

<sup>10</sup> Michael Powell, “Blacks in Memphis Lose Decades of Economic Gains”, *New York Times*, May 30, 2010; <https://www.nytimes.com/2010/05/31/business/economy/31memphis.html>.

<sup>11</sup> A T Geronimus, “The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations,” 1992, available at <https://pubmed.ncbi.nlm.nih.gov/1467758/>.

<sup>12</sup> Arline T. Geronimus, ScD, Margaret Hicken, MPH, Danya Keene, MAT, and John Bound, PhD, “‘Weathering’ and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States, May 2006, available at <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2004.060749>.

<sup>13</sup> Id.

<sup>14</sup> William Heisel, “Racism’s impact on health and health care goes beyond bad apples, July 6, 2020, available at <https://www.centerforhealthjournalism.org/2020/06/19/racism-s-impact-health-and-health-care-goes-beyond-bad-apples>.

<sup>15</sup> Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver, “Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites,” April 2016, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/>.

<sup>16</sup> Id.

<sup>17</sup> <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm>

<sup>18</sup> <https://www.marchofdimes.org/mission/health-disparities.aspx#fn4>.

<sup>19</sup> Tennessee Commission on Children and Youth, “Kids Count: The State of the Child in Tennessee, Policy and Issue Guide,” Sept. 2019, <https://www.tn.gov/content/dam/tn/tccy/documents/kc/tccy-kcsoc/kcsoc19.pdf>

<sup>20</sup> Tennessee Dept. of Health, “Uninsured Adult Healthcare Safety Net Report, 2019 Annual Report, [https://www.tn.gov/content/dam/tn/health/program-areas/reports\\_and\\_publications/Safety\\_Net\\_Report\\_FY19.pdf](https://www.tn.gov/content/dam/tn/health/program-areas/reports_and_publications/Safety_Net_Report_FY19.pdf).

<sup>21</sup> Housing Assistance Council, Rural Research Brief, April 2012, [http://www.ruralhome.org/storage/research\\_notes/rrn-race-and-ethnicity-web.pdf](http://www.ruralhome.org/storage/research_notes/rrn-race-and-ethnicity-web.pdf)

<sup>22</sup> Think Tennessee, “By the numbers: Rural and urban Tennessee, Aug. 4, 2017, <https://www.jacksonsun.com/story/news/2017/08/04/numbers-rural-and-urban-tennessee/539651001/>

<sup>23</sup> <https://www.tn.gov/health/cedep/environmental/healthy-places/healthy-places/land-use/lu/rural-areas.html>

<sup>24</sup> Jim Downs, “A Neglected Epidemic during the Civil War,” Feb. 2, 2017, <https://www.civilwarmed.org/contraband1/>.

<sup>25</sup> Id.

<sup>26</sup> Jeneen Interlandi, “Why Doesn’t the United States Have Universal Healthcare? The Answer has Everything to do with Race.” Aug. 14. 2019, available at <https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html>

<sup>27</sup> <https://www.history.com/topics/black-history/freedmens-bureau>, accessed July 22, 2020.

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