

Editorial

The Morality of Solidarity Matters

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The history of health care in America for people of African descent calls into question the sense of morality. Years of bias and immorality based on race casts a shadow on every aspect of daily living, and health care is no exception. The point is, health care is a matter of morality**.** From a moral perspective, disparities in health outcomes are a stain on the hearts of powerful people. Those who governor and accept inequity as a part of life owe a debt to those left behind. In the late 1990's America blamed much of health disparities on the lack of health insurance (Smith, 1999). However, it was the forward thinking by President Obama that created the Patient Protection Affordable Care Act in 2010 which erased lack of health insurance as the cause of inequities in health outcomes among races.

Solidarity through health insurance would appear to be a moral standpoint that all could agree upon. In fact, there have been times in America when the notion of solidarity was embraced, albeit with some hesitation. The concept of solidarity honors the social importance of protecting all its members with the cost spread equitably among all the members. Smith (1999) notes how group solidarity has been effective in guilds, craft unions and churches. His point is well established as other developed counties have maintained what is ultimately known as, universal-type health insurance programs.

Smith's (1999) reminds us of how the 1896 Plessy v. Ferguson Supreme Court decision, which ruled it legal in Louisiana to separate Black & White railroad cars, set the stage for discrimination throughout the nation. This pervasive attitude swept the nation and became the backdrop of modern practices even in health care**.** Around the turn of the century, most life insurance companies would not write health insurance policies for Blacks (Smith, 1999). Deemed as uninsurable risks in the 1930's, Negros, along with Chinese, Japanese, Mexicans and persons with more than a quarter Indian were not afforded the same group solidarity as their White counterparts.

In 1938, voluntary health insurance systems were created as a defense against public programs run by the U.S. government which only postponed compulsory type insurance plans. Defeated in the 1950's, national health insurance was not established in America. Thus each of society's members did not take on any responsibility for its fair share of the less fortunate members, according to Smith (1999). Racial division between private and publicly funded health insurance programs enlarged the gap between Black and White health disparities. Smith clarifies how health insurance premiums were based on individual health risks instead of pooling risk across all community members. According to Smith, moral tones began to take form in the process of writing health insurance policies. Very similar to life insurance policies, 'good risks' were given policies while the others remained uninsured.

To add insult to injury, the discovery of sickle-cell trait among Blacks supported the notion of a genetic marker of "Negro blood". Influenced by culture, politics, economics, and ideology Wailoo (1997) pointed out how the health field, particularly medicine has used science to suggest that Blacks are physically inferiority for many years. Using World War II as an example, a time when Blacks were not encouraged to join the armed services, Wailoo recalls the history of how physicians, researchers and pharmaceutical companies shaped the belief that "Negro blood" was not only different but inferior.

Mayberry, Mili and Ofili (2002) demonstrated that uninsured and Medicaid populations were less likely to have cardiac procedures than privately insured populations. Type of insurance coverage was found to be a predictor of mental health hospitalizations within a Los Angeles cohort in the 1990s (Padgett, Patrick, Burns, & Schlesinger, 1994). Type of health insurance coverage has also been found to explain the difference in emergency room use in a survey comprised of 1,049 ambulatory patients by Baker, Stevens and Brook (1996). In fact, they concluded that race/ethnicity was not a determinant of emergency room use after controlling for health insurance coverage.

History seems to indicate morality escaped the minds and hearts of many. Without a sense of right and wrong, decisions of appropriate and inappropriate behaviors were elusive. For example, beyond the interface of race and solidarity relative to health care insurance, the history of health in Black Americans highlights immorality among those with power. A fear of the health care system, most prevalent among poor Blacks, has also had an impact on the health of Blacks. Some fears stem from a long history where northern White medical schools used southern Negro corpses for teaching and studying the anatomy (Smith, 1999). Smith highlights how data from 1933 documents the use of Black cadaver for student's learning the fundamentals of human anatomy.

Vanessa Northington Gamble (2002) writes about health care, or the lack thereof, among Blacks in the U.S. and pointed to the lack the power to protect their dead; this being a part of the sequela where Blacks were seen as property with no right of refusal. Moreover, Gamble articulates how the Tuskegee Syphilis Study was just a reflection of medical mindsets and government policies that justifiably fuels fears among Blacks. Gamble insists that fear of genocide and mistrust of the medical establishment goes far beyond just the Tuskegee Syphilis Study. She backed-up her view with examples of incidents where the U.S. government pledged to create hospitals designed exclusively for Blacks in 1923; however, these hospitals turned out to be headed and operated, in part, by Ku Klux Klan members.

Citing results of a survey from 1,056 participants of a Southern Christian Leadership Conference, Gamble reports that 35% of the participants believed that AIDS is a form of genocide. When a racial group represents 54% of the people with a particular infectious disease, the average U.S. resident is left to wonder why. The history of health care in Black America is marred by unacknowledged lifestyles and behaviors on the part of both Blacks and Whites. Whether myth or reality, Blacks believe that much of America remains ambivalent if not hostile toward Blacks and this belief is reflected in every facet of health care (Gamble, 2002).

Unfortunately, Erving (2014) still makes the point that there are still those who hold on to the view that Blacks are inferior relative to Whites. In fact, Erving explains that some scholars posit that Blacks remain in the lowest status racial group, when compared to Asian and Latino Americans. Most distributing is the point that not even middle class or upper-middle class status shields Blacks from feeling the sting of 'blackness'.

Until the morality of solidarity matters to leadership, the affliction of chronic diseases, poor health outcomes and lack of equity remains a real and present danger to the Black community. Once the morality issue has been addressed, we can start closing of the gap, and excessive death and disease will improve for all race/ethnicities. It is only through moral awareness and sensitivity that improved access to and utilization of health care services, positive health behaviors and successful outcomes will be attained, for Blacks as well as other racial and ethnic groups. It is time for history to be a thing of the past and everyone embrace health care as a moral obligation.

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