The U.S. Healthcare System

SUMMARY:

After considering the extent to which systemic racism has permeated the lives of people of color in the U.S. thus far, it is no surprise that racism is intertwined with the U.S. healthcare system as well. Lower quality healthcare is provided to black people, largely due to implicit biases about people of color that improperly inform providers' healthcare decisions. This leads to inaccurate diagnoses, undesirable treatments, and a sense of mistrust among patients of color. This mistrust can lead to some patients refusing needed care, exacerbating negative health outcomes.

Racism in healthcare extends beyond administration of care. Systematically experiencing racism elevates stress levels, leading to chronic, toxic stress that is immensely detrimental to health outcomes. Chronic stress contributes to the disproportionate rates at which black individuals experience hypertension, inflammation, anemia, gestational diabetes, and maternal and infant mortality rates. This stress is so severe that the black infant mortality rate increases with education level.

Residential segregation also contributes to disproportionately negative health outcomes for black Americans. Segregated, predominantly black communities often have limited access to healthcare, and many residents are uninsured or underinsured. Segregated communities are more likely to be located in "food deserts" with no nearby supermarkets stocked with healthy foods. On the other hand, there are plentiful supplies of fast food chains, which fuel unhealthy eating habits and negative health outcomes. Moreover, these neighborhoods tend to lack the infrastructure necessary to adequately support recreational activity in the community, such as sidewalks or parks. These factors contribute to the prevalence of obesity and other chronic illnesses, such as diabetes, heart disease, and HIV/AIDS, as well as the overall racial disparity in life expectancy that persists to this day.

To address these flaws, educational and training initiatives within healthcare must explicitly call attention to unintended racial biases in the dispersion of medical care to people of color. Additionally, discretion among health officials, which fuels the discriminatory administration of care, must be minimized, and continued data collection is needed to track, monitor, and adjust efforts to equalize healthcare administration across racial groups. Moreover, healthcare officials must take a community health approach, actively working with government officials and

community leaders to address other forms of systemic racism in the community that continue to generate disparate racial health outcomes.

> ***"Doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients' income, education, and personality characteristics were taken into account" (Institute of Medicine, 2002).***

Racism has permeated the American healthcare system since its inception. Since arriving in America as slaves, blacks have received the worst healthcare and have experienced the worst health outcomes of any racial or ethnic group. Prominent scientists, doctors, and philosophers incorrectly concurred that blacks were biologically inferior to whites. In fact, such notions were taught in schools as early as the 18th century and continued well into the 20th century. These entrenched racial inferiority stereotypes, coupled with hundreds of years of slavery, contributed to major medical and scientific abuses of the black community, including unethical experimentation and the use of blacks as test subjects for teaching and training efforts (Byrd & Clayton, 2001).

Today, racial health disparities remain pervasive in U.S. society. One way in which systemic racism plagues the U.S. healthcare system is in the form of implicitly biased care orchestrated by healthcare professionals. According to the *Institute of Medicine,* doctors viewed patients of color as less intelligent and more likely to practice unhealthy habits and not follow medical advice (2002). These biases directly impact the quality of care that is provided to patients of color. For instance, a bidirectional, distrusting relationship is established between doctors and patients of color. Doctors are less likely to believe the symptoms and pain levels described by their black patients, and as a result, black people are 22 percent less likely to be prescribed painkillers and are more likely to have inaccurate diagnoses (Sabin, 2020). Furthermore, blacks are most likely to receive undesirable treatments, such as partial or total limb amputations (Institute of Medicine, 2002). These outcomes stem from implicit, or subconscious, biases that falsely assume blacks can tolerate more pain, coupled with an inability for providers to recognize pain on black faces as readily as white faces (Sabin, 2020). Perhaps due to these persisting biases, and/or their historical exploitation by healthcare professionals, black patients are more likely than white patients to report "mistrust" in healthcare settings. This sometimes leads to black patients refusing appropriate care (Institute of Medicine, 2002). Unintended or not, the racial biases of healthcare providers have very *real,* detrimental effects on patients of color and must be

addressed and remediated.

While every person of color is not entangled in *each* of the aforementioned, systemically racist structures discussed in this report, every person of color is inevitably impacted by systemic racism in *some* way.

These aforementioned systems of racial oppression generate chronic stress, contributing to inequitable health outcomes observed by people of color. While stress has negative health consequences for people of all races, people of color are disproportionately stressed, and are thus more likely to suffer negative health outcomes. Recent studies indicate that black individuals are more likely to experience "high exposure" to stress as opposed to their white counterparts and are inadequately equipped with "low resources" to manage stress (Moore, 2019). The experiences and hardships of being black in America cause toxic stress and are damaging to the body. Toxic stress on the body occurs when someone experiences frequent, prolonged adversity and is based off of the aggressions and insults directed towards them. This has been proven to physically affect an individual's body, causing it to "weather" from the inside and age prematurely (PBS NewsHour, 2018). This increases black individuals' risk for stress-related adverse health outcomes, including hypertension, inflammation, and pregnancy-related health outcomes (Moore, 2019; PBS NewsHour, 2018).

In fact, maternal and infant mortality among black women are still very prevalent in the United States and have even worsened in the past twenty-five years.

> ***Today, black infants are more than twice as likely to die as opposed to white babies. This racial health gap is even greater than it was in 1850, fifteen years prior to the abolition of slavery. Likewise, black women are three to four times as likely to die from complications relating to their pregnancy than white women. <u>These disparities persist even when controlling for education levels and socioeconomic status.</u>***

Limited or low-quality prenatal care may contribute to these negative outcomes. According to a 2019 CDC report, compared to white mothers, black mothers were 2.3 times as likely to receive late or no prenatal care, and nearly twice as likely to receive no care during the entire first-trimester (Solzhenitsyn, 2020). However, prenatal care alone does not explain the disproportionate rate at which black infants die. Black women who received prenatal care in the first trimester were still more likely to lose their babies than white women who received late or no prenatal care at all (Novoa & Taylor, 2018). Astonishingly, even well-educated black women face significantly higher risks of losing their babies than white women who dropped out of school before high school (PBS NewsHour, 2018).

Similarly, maternal mortality rates are higher for black women across socioeconomic status. Even tennis champion, Serena Williams, who is one of the highest paid female athletes in the world, nearly died from issues with her pregnancy (Novoa & Taylor, 2018). Hypertension, anemia, pre-eclampsia and gestational diabetes, all pregnancy risk factors, disproportionately affect people of color and are intensified by stress related to racial discrimination and insufficient healthcare (Chalhoub & Rimar, 2018). For instance, black women were 60 percent more likely to experience pre-eclampsia than white women, which is characterized by high blood pressure (Norton Healthcare, 2018). When you're dealing with a stressful situation, your body releases adrenaline and cortisol (stress hormones) to help your "fight or flight" in response to the stressful event. This temporarily elevates your blood pressure, and once the stressful event is over, your blood pressure returns to normal (American Heart Association, 2016). However, if you are in a state of constant, chronic stress, because you're experiencing systemic racism, for instance, your body may not have a chance to recover and return to normal. Thus, chronic, racism-induced stress helps explain these initially puzzling maternal and infant mortality rates that persist among black women of high socioeconomic status.

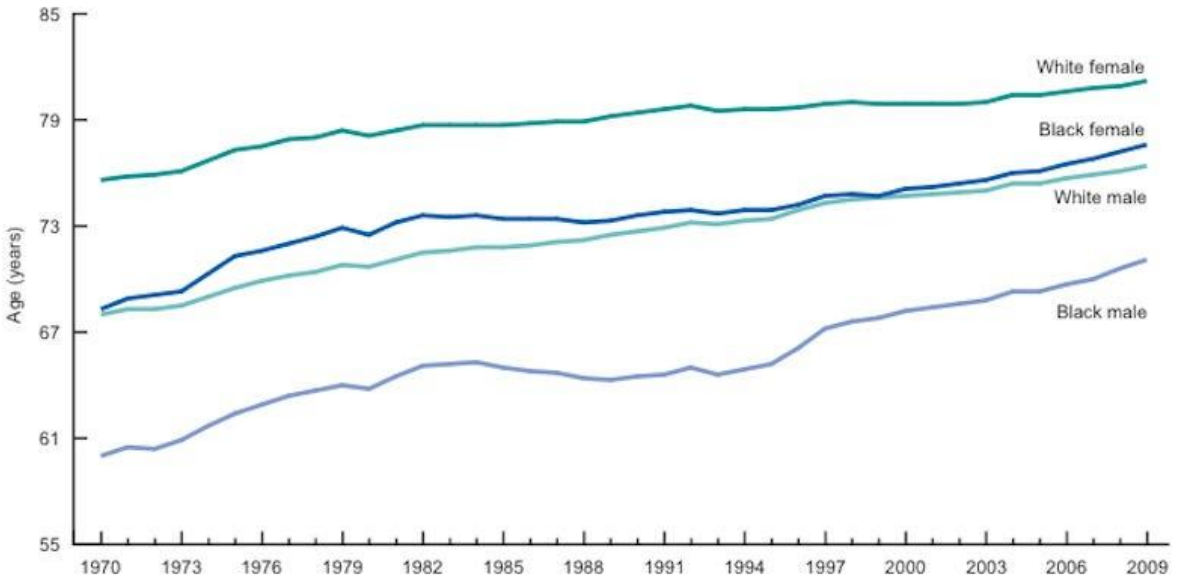
As was previously discussed, racism and poverty are inextricably linked, and low income and impoverished individuals are significantly more likely to experience negative health outcomes than their affluent counterparts. Although uninsurance rates dropped from 18.9 percent to 11.7 percent in the black community following the passage of the Affordable Care Act, black people are still less likely to be insured and more likely to face barriers to healthcare than their white counterparts (Bailey et al., 2017). Moreover, net worth is "significantly associated" with "poor" and "fair" health statuses (Pollack et al., 2013). Clearly, these racially charged policy actions of the past have not only impacted the financial wellbeing of people of color, they have also had measurable consequences on their health outcomes as well.

Further, residential segregation directly impacts health outcomes for communities of color, including mothers of color. Cumulative disadvantage from residential segregation and inequality are associated with preterm births in the black community as well. Black mothers experience preterm births at a rate that is double that of whites and 25 percent higher than Hispanic women. Both black and Hispanic mothers are more at risk for experiencing negative health outcomes from preterm births compared to white mothers who deliver prematurely (Reagan & Salisbury, 2005). In fact, preterm births are directly linked to the infant mortality rate, since preterm babies are more likely to have low birth weights, and black babies are 3.2 times as likely to die from complications associated with low birth rates (Novoa & Taylor, 2018).

Other adverse racial health outcomes are mediated by residential segregation. The prevalence of obesity is disproportionately concentrated in communities of color, with 48 percent of blacks being obese. This is linked to the divestment that occurs in many of these segregated neighborhoods, and their designation as "food deserts." A food desert is an area that does not have access to affordable,

nutritious food. Instead, these communities have a high density of fast food restaurants, and minimal neighborhood recreational structures for physical activity. Studies demonstrate a strong association between obesity risk and limited access to supermarkets that offer healthy food options, whereas the density of fast food locations is correlated with higher fat intake. The concentration of poverty and crime that often manifests from residential segregation further inhibits healthy habits for neighborhood residents, as it may not be safe to go out into the streets to walk or partake in other forms of physical activity. Additionally, a lack of infrastructure to support recreational activities, such as sidewalks and parks, also mediates the obesogenic risk associated with residentially segregated communities (Goodman et al., 2018).

People of color are also more likely to experience chronic diseases such as diabetes, heart disease, and HIV/AIDS. In fact, the diagnosis rate for blacks is over 8.5 times that of whites (Bailey et al., 2017). Similarly, people of color are much more likely to have diabetes than whites. While 12 percent of blacks over the age of 18 experience diabetes, only 7 percent of whites do. Moreover, white individuals are more likely to experience Type 1 diabetes, which is an autoimmune disease, whereas blacks are more likely to have type 2 diabetes, which is largely preventable (Centers for Disease Control and Prevention, 2019). Finally, while black Americans are just as likely as white Americans to report psychological distress and mental health issues, white Americans are more than twice as likely to actually receive treatment (Celestine, 2019). This may be associated with the devastating impact suicide has on black youth. In 2017, black girls in grades 9-12 were 70 percent more likely to attempt suicide than their white peers, and suicide was the second leading cause of death for black youth aged 15 to 24 (U.S. Department of Health and Human Services Office of Minority Health, 2019).



Although life expectancy has been increasing for both whites and blacks since 1970, the racial gap in life expectancy persists

(CDC/NCHS & National Vital Statistics Team via Friedman, 2014).

The amalgamation of these disparate health outcomes is the life expectancy gap between whites and blacks. Despite average life expectancies rising across all races since 1970, the racial gap in life expectancy has stubbornly persisted. In 2009, the average life expectancy for a black person was 75 years, which reflects the approximate life expectancy of an average white person *30 years ago* (Friedman, 2014).

Drastic action must be taken to improve health outcomes for people of color, especially since disparities originate from various forms of systemic racism and racial biases in healthcare administration. Healthcare education and training must explicitly cover racial health biases and how acknowledging them is the first step in mitigating them. From there, strategies to minimize discretion, and subsequent bias, should be implemented to ensure equitable healthcare is administered to all patients. Data should be continuously collected and analyzed to ensure these objectives are being met (Sabin, 2020). Additionally, as many of these disparate outcomes stem from systemic racism in other arenas, such as residential segregation and chronic stress from repeated racist encounters, continued efforts to end those forms of structural racism must be addressed as well.