To what extent and in which ways do you believe racism is a root cause of racial health inequities in the United States?

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1. Statement: I believe to a great extent in many ways that racism is a root cause of racial health inequities in the United States.
2. INTRODUCTION

The survival gap between the richest and poorest Americans is widening, with low-income Americans being left further behind. Since 2001, the poorest 5% of Americans have experienced no gains in survival, while middle and high income Americans have seen their life expectancy increase by 2 years. Today, the richest 1% of Americans live 10-15 years longer than the poorest.

 The gap in life expectancy between the poorest 20% and the wealthiest 20% of Americans will increase by nearly a decade in a single generation – from 77 to 82 for the poorest and wealthiest Americans born in 1930, to 76 and 89 for those born in 1960.1

 The rising economic insecurity among poor and middle class Americans has led to the persistence of smoking and the rise of obesity and opioid epidemics, with adverse consequences for health and life expectancy. At the same time, paying for health care in the USA today can bankrupt households and impoverish families.

 The ACT’s Medicaid expansion targeted the poorest Americans, but 19 states – mostly southern states with large minority populations and poor records of health care access – chose to opt out. Even if the ACA were not altered or repealed, an estimated 28 million people would remain uninsured in 2024. Health care access inequalities among income groups are stark – in 2015, 25.2% of poor Americans were uninsured, compared to 7.6% of non-poor Americans.

 Republican proposals focus on market based reforms that would slash federal funding for Medicaid, replace the ACA’s subsidies with regressive tax credits, and further privatise Medicare. Rather than improve the health inequalities that remain a grave problem even in the era of the Affordable Care Act, this approach would only make things worse.1

 In addition, later in the term, justices will again take up the Affordable Care Act, examining whether the government must pay billions of dollars to health insurers who sold coverage on exchanges under the Obama-era health law. It is possible the justices could face a second ACA case later int eh term that seeks to invalidate the entire health law.2

1. Structural Racism
* The US is one of the most unequal countries in the OECD – only Chile, Turkey and Mexico are more unequal.
* The poorest fifth of Americans spend 6% of their income on private insurance – nearly twice what the wealthiest fifth pay at 3.2%

Structural racism refers to all way in which systems foster inequitable outcomes, whether in housing, education, employment, media, health care or the criminal justice system. All have profound effects on health.1

It is a system of concentrated advantage for white people and concentrated disadvantage for people of color.3

Despite the passage of civil rights laws in 1960s, structural racism in public and private policy – from discrimination in hiring decisions and housing to tough sentencing laws for drugs – contributes to health inequalities. Residential segregation relegates many black Americans to neighborhoods with over-priced, substandard housing, often near busy roads and other sources of air pollution (such as factories, toxic sites). Residents experience under-funded public schools, few employment opportunities, increased rates of crime, and (as in the case of the Flint lead water contamination crisis) can suffer government neglect of public heath issues.1

Significant health disparities exist among racial groups. For instance, the rate of infant mortality is twice as high for black Americans compared to white Americans. And, in 2013, median family wealth for the non-Hispanic white population was 10 times that of Hispanics and more than 12 times that of African-Americans.

In 2015, inequalities remain: 25.2% of poor Americans are uninsured, compared to 7.6% of non-poor Americans; 27.7% for Hispanics, 14.4% for non-Hispanic blacks and 8.7% for non-Hispanic whites.

1. Mechanisms by which systemic racism influences health equity.

I believe that discrimination is a major mechanism by which systemic racism influences health inequity in the U.S. The mechanisms by which discrimination operates include overt, intentional treatment as well as inadvertent, subconscious treatment of individuals in ways that systematically differ so that minorities are treated worse than nonminorities.

Perceived discrimination may be associated with worse mental health, greater engagement in risky behaviors decreased neurological responses, reduced likelihood of some health protecting behaviors and poorer health-related outcomes such as pre-term delivery.4

Though people may experience overt forms of racism (e.g. being unfairly fired on the basis of race), the adverse health effects of racism appear to stem primarily from the stress of chronic exposure to seemingly minor forms of “everyday racism” (i.e., racial microaggressions), such as being treated with less respect by others, being stopped by police for no apparent reason, or being monitored by salespeople while shopping. The chronic exposure contributes to stress-related physiological effects. Thus, discrimination appears to exert its greatest effects not because of exposure to a single life traumatic incident but because people must mentally and physically contend with seemingly minor insults and assaults on a near continual basis. The implications appear to be greatest for stress-related conditions such as those tied to hypertension, mental health outcomes, substance abuse behaviors, and birth related.4

 I believe that another major mechanism by which systemic-racism influences health inequality in the U.S. is defined as implicit bias – a mechanism of unconscious discrimination – as a form of racial or other bias that operates beneath the level of consciousness. Research conducted over more than four decades finds that individuals hold racial biases of which they are not aware and, importantly, that discriminatory behaviors can be predicted based on this construct. The effects are greatest in situations marked by ambiguity, stress and time constraints. Implicit bias is not an arbitrary personal preference that individuals hold; for example, “I just happen to prefer pears over apples.” Rather, the nature and discretion of individuals’ biases are structured by the racial stratification and norms of society. As a result, they are predictable.4

 Much of the public health literature has focused on the implicit biases of health care providers, who with little time to devote to each patient can provide care that is systematically worse for African American patients than for white patients even though the health care provider never intended to do so. The evidence is clear that unconscious racialized perceptions contribute to differences in how various individuals, including health care providers, perceive others and treat them. Based on psychology lab experiments, functional magnetic resonance imaging (fMRI) pictures of the brain, and other tools, researchers find that white providers hold implicit biases against African Americans and that, to a lesser degree, some minority providers may also hold these biases. Although not limited to health care professionals, the biases lead providers to link negative characteristics (e.g., bad) and emotions (e.g., fear) with people or images they perceive as being African American. As a result of such implicit biases, physicians treat patients differently depending on the patient’s race, ethnicity, gender, or other assumed or actual characteristics.4

 There’s been ample debate over the years about the root cause of health care inequities. Some say it’s a lack of cultural competency training. Others say language differences are a factor. Still others say it’s an unwitting bias held by doctors. There is clearly a problem, but no one involved – regulators, medical schools, trade organizations or hospital groups – seems willing to call out racism as the issue and offer concrete steps towards improving outcomes.5

 Racial and ethnic minority providers play an important role in addressing disparities because they help bridge cultural gulfs, and greater proportions of them serve minority and socially disadvantaged communities; however, these providers are underrepresented in the health professions, and they face challenges that may constrain their professional development and the quality of care they are able to provide. Specifically, they are more likely to serve patients in resource-poorer areas and lack professional privileges associated with academic and other resource-rich institutions.4

 Other studies identified the patient-physician interaction as another factor, and that many racial and minority ethnic groups feel more comfortable interacting with physicians of their own background. Health plans are not required to track race data or designed to take the patient-doctor relationship into consideration when making providers available. Indeed, the government rarely tracks performance on health equity measures.

 Further complicating matters is the dearth of black and Latino medical students. Only 6.5 percent of medical school graduates are black or Latino, according to the Association of Medical Colleges.5

 I believe that segregation is also a major mechanism by which system racism influences health equity. Residential segregation – that is, the degree to which groups live separately from one another – can exacerbate the rates of disease among minorities, and social isolation can reduce the public’s sense of urgency about the need to intervene. The effects of racial segregation differ from those of socioeconomic segregation. Lower SES whites are more likely to live in areas with a range of SES levels, which affords even the poorest residents of these communities access to shared resources (e.g., parks, schools) that buffer against the effects of poverty. By contrast, racial and ethnic minorities are more likely to live in areas of concentrated poverty. Indeed, if shared resources are of poor quality, they may compound the low SES challenges an individual faces. Racial segregation contributes to disparities in a variety of ways. It limits the socioeconomic resources available to residents of minority neighborhoods as employers and higher SES individuals leave the neighborhoods; it reduces health care provider density in predominately African American communities, which affects access to health care; it constrains opportunities to engage in recommended health behaviors such as walking; it may be associated with greater density of alcohol outlets, tobacco advertisements, and fast food outlets in African American and other minority neighborhoods; it increases the risk for exposure to environmental hazards; and it contributes to the mental and physical consequences of prevalent violence, including gun violence and aggressive policing.4

1. Specific Groups Subject to Racism and Racial Health Inequities.

The following are three minority groups here in the United States where I believe racism is a root case of racial health inequities.

1. African Americans

 In the United States, the health of African Americans lags behind most other racial minority groups. Compared to whites, black men and women face higher risks of chronic illness, infection, and injuries. Taken altogether, the average life span for African Americans is 6 years less compared to whites.6

 The strongest predictor of health is socioeconomic status (SES). While financial instability is considered the fundamental cause of health disparities, this association between socioeconomic status and health is dependent upon race.

 For instance, the morality rate for babies born to black mothers with a masters or doctorate degree is far worse than the morality rate for babies born to white mothers with less than an 8th grade education. And black women are far less likely to have breast cancer, yet 40% more likely to die from it.

 Today, a black woman is 22% more likely to die from heart disease than a white woman. A black woman is 71% more likely to die from cervical cancer than a white woman. A black woman is 243% more likely to die from pregnancy or childbirth-related causes than a white woman.

 Even after controlling for age, gender, marital status, region of residence, employment status and insurance coverage, African Americans have worse health outcomes than whites in nearly every illness category.

 African Americans have the highest mortality rate of any racial and ethnic group for all cancers combined and for most major cancers individually. They are almost twice as likely to be diagnosed with diabetes as white, and are 40% more likely to have high blood pressure.7

 The health care disparities that exist in the African American community are prevalent in the cities, suburbs and rural areas. Nineteen percent of African Americans have not health insurance and they spend a higher percentage of their income on health care costs compared to whites. Forty-eight percent of African American adults suffer from chronic diseases and more than 25% do not have a regular doctor, compared with only one-fifth of whites.8

 Clearly, the information above points to an ongoing, systemic racial bias throughout the American healthcare system, to the severe detriment of African Americans.

1. Latinos

 According to the 2017 U.S. Census Bureau population estimates, there are 58.8 million Hispanics living in the U.S., which represents 18.1% of the total U.S. population.

 Hispanics have the highest uninsured rates of any racial or ethnic group within the U.S.9

 Hispanic health is often shaped by factors such as language/cultural barriers, lack of access to preventive care, and the lack of health insurance. The Centers for Disease control and Prevention has cited some of the leading causes of illness and death among Hispanics, which include heart disease, cancer, unintentional injuries (accidents), stroke, and diabetes. Some other health conditions and risk factors that significantly affect Hispanics are asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease. Hispanics also have a higher rate of obesity than whites.9

 Once again, racism plays a great role in the lack of equal access to health care by Latinos here in America, compounded by additional language and cultural barriers.

1. Native Americans

 As of 2017, there were an estimated 5.6 million people who identified as American Indian and Alaska Native comprising 1.7% of the total U.S. population. Currently there are 573 federally recognized tribes. Among Native Americans, 21.9% live at the poverty level, compared to 9/6% of whites.10

 Members of 573 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS is an agency within the Department of Health and Human Services that provides a comprehensive health service delivery system for approximately 2.2 million of the nation’s estimated 3.7 million American Indians and Alaska Natives.

 The American Indians have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.11

 Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian deaths.

 American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively).

 American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.11

 American Indians/Alaska Natives also have a high prevalence and risk factors for mental health and suicide, unintentional injuries, obesity, substance abuse, sudden infant death syndrome (SIDS), teenage pregnancy, diabetes, liver disease and hepatitis. The tuberculosis rate in 2017 was almost 4 times higher for American Indians with an incidence rate of 3.9, as compared to 0.5 for the white population.10

 Additional access-to-care issues include:

* + - Lack of education and pervasive poverty
		- Lack of cultural appropriate services
		- Mistrust with which many American Indians relate to their health care providers
		- Continuing lack of accurate data and research on American Indians
		- Lack of appropriate intervention strategies (including integration of mental health and primary health care services)
		- Mental health professional shortages and high turnover

 The availability of mental health services is severely limited by the rural, isolated location of many American Indian communities. In addition, most clinics and hospitals of Indian Health Service are located on reservations, yet the majority of American Indians no longer reside on reservations.

 Native Americans also suffer from another form of structural (systemic) racism known as historical trauma, which is a collective trauma inflicted on a group of people who share a specific group identity or affiliation, manifests from the past treatment of certain racial and ethnic groups, especially Native Americans. This type of racism continues to shape the opportunities, risks, and health outcomes of these populations today. The past consignment of Native Americans to reservations with limited resources continues to constrain physical and mental health in these communities; however, the methods to support research on this topic have not yet been fully developed.4

1. Conclusion

I believe it is abundantly clear that here in the United States Americans of color receive lower-quality health care services than white Americans do, and these inequalities are remarkably consistent across a range of illnesses and health care services.13

The ability to access adequate health care is influenced by the neighborhoods in which one lives and works. The importance of neighborhoods in understanding racial differences in health is hard to overstate in fact identified racial residential segregation as a fundamental cause of racial disparities in health. We documented above that blacks tend to live in different and poorer neighborhoods than whites. In turn, residing in poor and segregated neighborhoods has been linked to poor health and mortality.

Segregated black neighborhoods have poorer fire and police protection and crime rates are higher. Nationally, the age-adjusted death rate from homicide for African Americans is more than five times as high as that for white Americans.

Environmental exposures in minority neighborhoods are 5 to 20 times as high as exposures in white neighborhoods, toxic environmental exposures contribute to disease and poor birth outcomes.

Hospitals in neighborhoods with more black residents have fewer technological resources, specialists and board-certified physicians, and higher rates of negligent adverse events and morality for both black and white patients.13

 Efforts to implement reforms to dismantle racism and its resultant effects on health inequities have repeatedly encountered serious obstacles and backlash from institutions, communities, and individuals seeking to preserve their racial privilege. Without a vision of health equity and the commitment to tackle structural racism, health inequities will persist, thwarting efforts to eliminate disparities and improve the health of all groups – the overarching goals for U.S. health policy as enunciated by the official Healthy People 2020 objectives.14

 I believe that there may be some suggested actions for confronting the issue of persistent racism and health inequities include:

1. Stand up for and speak out about racism, class exploitation, gender inequality, and power imbalance, as well as the effects of social exclusion to staff, other agencies, elected officials, the public and the media.
2. Applying knowledge and training around bias and structural racism in program policy work.
3. Engage in meaningful ways with communities experiencing inequities in

order to develop a shared agenda to advance health equity.

1. Promoting policies and practices to explicitly assess and address power imbalances, racial equity, and the disproportionate impacts of oppression in your organization’s work.
2. Influencing, developing, and/or implementing policies to improve social and economic conditions in your jurisdiction, especially for populations of color and others experiencing health inequities.
3. Applying participatory budget tools and/or processes to health department programs and city/county/state decision making to enable community decision-making on where funding should be allocated.
4. Using tools such as data collection, reports, presentations, assessment, and program evaluation to identify health inequities and demonstrate how they are connected to policy, system, and environmental conditions and opportunities.
5. Developing and utilizing frameworks or theories of change that acknowledge and address the role of power on social, racial, and health inequities.15

 Only if and when this challenge of confronting the ongoing issue of racism is confronted here in our country head-on will we finally begin to right these ongoing injustices and disparities that have haunted our country’s sense of rightness and well-being since it’s inception. The time is long past to put aside racism and all its associated and implicit bias, and racial health inequities provide an equal and just access to healthcare for all Americans regardless of their ethnic identity or the color of their skin.

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