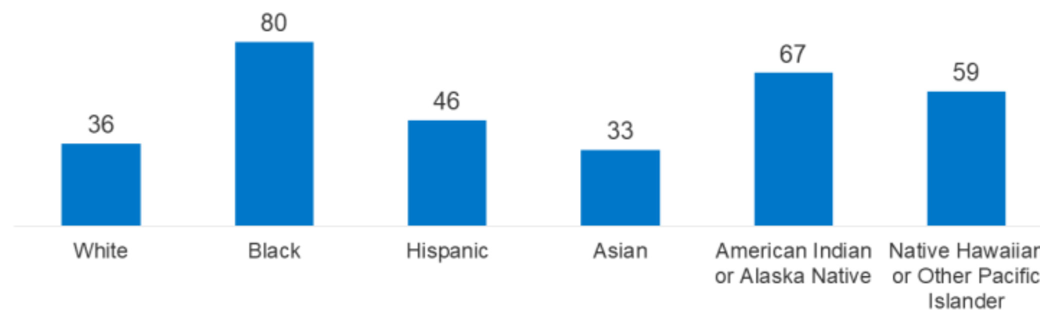
RACIAL DISPARITIES IN HEALTHCARE

From the beginning of our nation's history, Black, Native and non-white people were considered inferior to white people with grave consequences for the health of the country and its people, then and now. Today, racism shows through in the glaring disparities between the health of white and non-white Americans. All it took was a pandemic to expose what people of color have known and experienced from the beginning.



HISTORICAL BACKDROP

Article I of the U.S. constitution had what is known as the "three-fifths" clause. Non-free people – that is, enslaved persons -- were counted as three-fifths of a person for the purpose of taxation and determining the number of representatives sent to Congress from each state. (Indentured servants who were mostly white were counted as whole persons.) Laws were enacted proclaiming African slaves to be chattel property. Food, shelter, clothing and safety – and yes, medical care -- were subject to the priorities and whims of owners. In later years, segregation and Jim Crow laws further affected the ability of African Americans to obtain the housing, education, and employment enjoyed by whites. Jim Crow laws applied to healthcare too. Throughout the first half of the 20th century, laws allowed physicians and hospitals to refuse care to non-white people. Like most "separate but equal" institutions, must of the care available to non-white persons, and the quality of the facilities available to them, were inferior.

As recently as 1946, congress enacted the Hill-Burton Act, which allowed a continuation of

segregated hospital facilities, and a controversial approval of “separate but equal” policy was adopted by the courts. These laws were in effect until Medicare came on the scene in 1966 tempting hospitals to become integrated to receive Medicare funds. However, some hospitals held out until as late as 1979.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin. In spite of this law, people of color often experience barriers to obtaining the same level of healthcare available to whites. In addition, people of color are more exposed to stress and socioeconomic factors that undermine health. Stress contributes to cardiovascular disease and the premature death rate from heart disease and stroke is highest among Black Americans.

CAUSES OF RACIAL HEALTH DISPARITIES

A common myth is that poor health outcomes for African Americans are entirely due to socioeconomic factors such as income, wealth and education. While socioeconomic factors contribute to health, studies show that health disparities for African Americans exist across all levels of education, wealth and income. Racism is a factor that runs through all social determinants of health, including the health care system.

Harvard sociologist David R. William’s research shows that racial disparities in death rates pertain at "every level of income." In a 2002 paper he wrote: "This pattern has been observed across multiple health outcomes, and for some indicators of health … the racial gap becomes larger as [the socioeconomic status] increases."

Another example is the Black/white maternal mortality gap which spans all socioeconomic strata. Black women, regardless of education and economic status, are more likely than white women to have complications or die from childbirth. Black infant mortality is twice that of white babies.

Racial health disparities arise through multiple pathways and are complex. Racism and discrimination – explicit, implicit and structural – run through all of them, adding stress, mistrust and multi-generational or historical trauma.

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provide Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	Quality of Care
Medical Bills	Playgrounds	Higher Education		Stress	
Support	Walkability				
	Zip Code/ Geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Racism overlays all of these social determinants of health. Chief among them for its key role in health outcomes is racial residential segregation.

White Americans live in primarily white neighborhoods while Black and Hispanic Americans primarily live in mixed neighborhoods. Health care facilities are often located at a distance from the Black and Hispanic neighborhoods, and limited income can make transportation difficult. People of color are often employed in service-sector jobs which do not provide employer paid health insurance. Lack of education may hinder the acquisition of health literacy.

Implicit bias is another factor in health disparities, impacting the quality of health care from a health professional. Implicit bias is unconscious bias that we all have and is outside of our awareness. Everyone, including health professionals, has implicit biases that affect our actions and decisions. Studies show that most health care providers have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color, no different from the general (primarily white) population.

Poor health care experiences due to unconscious racism (implicit bias) can make health care uncomfortable and less productive, and can affect the desire to obtain preventive care and to follow advice for healthy living practices.

The Racial Divide in Health Care Experiences And COVID-19 Impacts

Health Care

Say the **health care system often treats people unfairly** based on their race or ethnic background

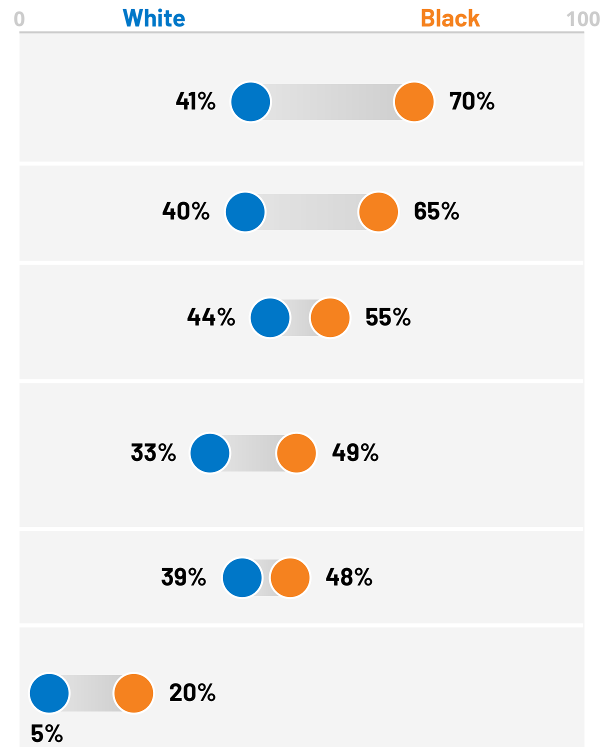
Say it is **difficult to find a doctor who shares their background** and experience

Trust the health care system only some or almost none of the time to do what is right for their community

Would definitely or probably **not get a coronavirus vaccine** if it was determined to be safe by scientists and available for free to anyone who wants it

Say it is **difficult to find health care they can afford**

Have personally **been treated unfairly based on their race while getting health care** for themselves or a family member in the past 12 months

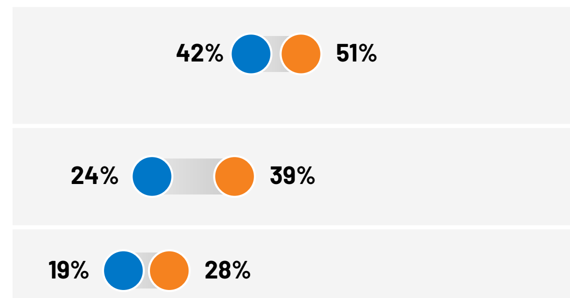


COVID-19

Say someone in their household has **lost a job, been placed on furlough, or had their hours or income reduced** as a result of the COVID-19 pandemic

Know someone who has died from coronavirus

Say the pandemic has had a **major negative impact on their mental health**



SOURCE: KFF/The Undefeated Survey on Race and Health (conducted Aug. 20-Sept. 14, 2020)

KFF

There is another important barrier to good health care, only recently studied and reported. The stress of enduring racial inequity in the past generations, in health care, housing, education, jobs, and safety and justice, as well as in personal interactions, has caused a condition that is now described as multigenerational trauma, generational trauma, or historical trauma.

WHAT IS MULTIGENERATIONAL TRAUMA?

Current research into the differences in health outcomes between majority and minority groups in our country indicates that an underlying driver of poor health may be multigenerational trauma. The US Department of Health and Human Services describes historical, or multigenerational, trauma as "trauma experienced by a specific cultural, racial, or ethnic group. It is related to major events that oppressed a particular group of people because of their status as oppressed, such as slavery, the Holocaust, forced migration, and the violent colonization of Native Americans." Not everyone in these groups is affected by multigenerational trauma, but those who are affected may experience poor overall physical and behavioral health, including low self-esteem, depression, self-destructive behavior, marked propensity for aggressive behavior, substance misuse and addiction, and high rates of suicide and cardiovascular disease, according to the Department of Health and Human Services (HHS). These effects are remarkably similar to those experienced by persons with PTSD (post-traumatic stress disorder), such as soldiers and others who have been through physically or emotionally traumatic events.

The HHS report further states that:

- Current lifespan trauma, superimposed upon a traumatic ancestral past, creates additional adversity.

- Historical trauma is cumulative and reverberates across generations. Descendants who have not directly experienced a traumatic event can exhibit the signs and symptoms of trauma, such as depression, fixation on trauma, low self-esteem, anger, and self-destructive behavior.

- People coming into systems of services and support from communities who have been subjected to historical trauma may believe the systems do not support them. They may experience triggers that are retraumatizing.

More information: https://www.acf.hhs.gov/trauma-toolkit/trauma-concept

WHAT ARE THE EFFECTS OF ADDITIONAL STRESS ON INDIVIDUALS WHO ARE AFFECTED BY MULTIGENERATIONAL TRAUMA?

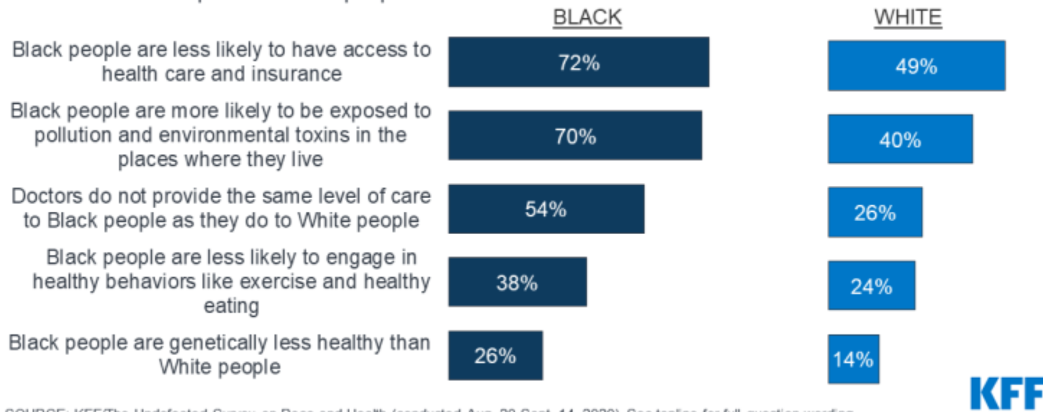
The stress response entails a release of “fight or flight” hormones which cause various physiological responses in the body; these are not dangerous in small amounts, but when produced for longer periods result in harmful effects. We all experience brief and occasional stresses as part of normal life; however, toxic stress that is prolonged, severe, or chronic can cause significant problems with health and development. The US Department of Health and Human Services names some of these stressors that are likely to cause adverse reactions : exposure to violence, such as child abuse or domestic violence; threats of violence in neighborhoods with high rates of violent crime; experiences of war, terrorism, or natural disasters; chronic stresses such as insecurity about basic needs such as housing, food, or home energy. These toxic stresses can cause long-lasting health problems such as heart disease, depression and anxiety disorders, substance misuse, and difficulty with relationship development. The addition of toxic stress to those who are already compromised by experiencing the effects of multigenerational trauma can further exacerbate the health effects of the underlying condition.

More information: https://www.acf.hhs.gov/trauma-toolkit/toxic-stress

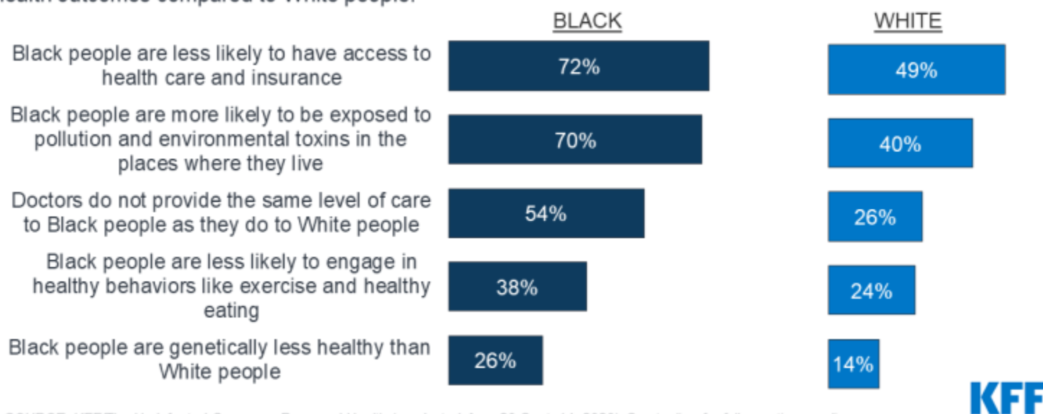
RACIAL HEALTH DISPARITIES

Chronic diseases such as diabetes, cancer, and cardiovascular disease including heart disease and stroke, are common causes of illness and death. Many factors can be involved in the presence and impact of these conditions, including genetic (inherited) factors; lifestyle, such as smoking and obesity; infection; and environmental factors, such as air or water pollution. In some cases, the precipitating factor is unknown. Those who live in areas where exposure to toxins occurs are at higher risk of certain conditions, especially respiratory illness and certain cancers. People of color who have low incomes are more likely to live in these areas.

Because of barriers to access to good health care, such as lack of insurance, distance from providers, or negative experiences with the health care system, Black people are less likely to have risk factors for chronic disease identified and modified through preventive measures, increasing the probability of disease progression and ultimate death. It has also been found that minority patients in some cases are less likely than non-minority patients to be offered potentially beneficial diagnostic procedures and treatments.



The burden of chronic disease, and associated mortality, is higher in the Black community than in the rest of the groups in the US. Deaths from cancer and heart disease, in particular, are highest for Black people. The combined cost of health inequality and premature death in the US has been calculated to be $1.24 trillion.

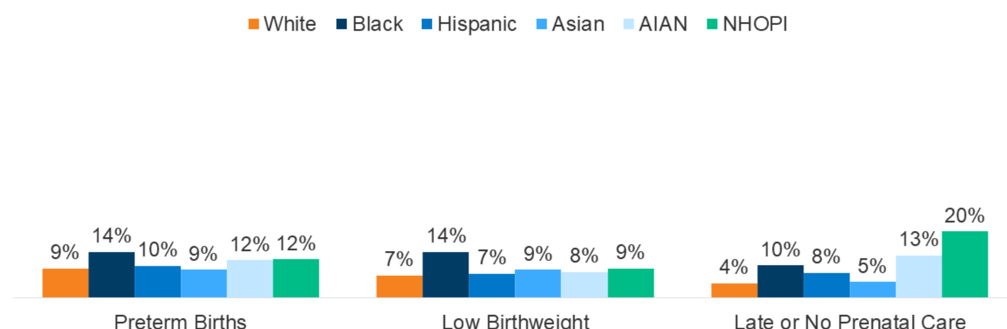


More information:
https://ncbi.nlm.gov/pmc/articles/PMC4558355/
https://www.cancer.gov/about-cancer/understanding/disparities

In 2017, Health and Human Services (HHS) reported that the death rate of Black infants in the US was more than twice as high as that of white infants. The largest drivers of this disparity were low birthweight, and complications with the health of the mother. More than twice as many mothers of Black infants received either late or no prenatal care. Interestingly, fewer Black mothers than white mothers smoked during the pregnancy (a factor that often causes low birthweight). Wisconsin has the highest infant mortality rate in the nation; the rate of death of Black infants is more than three times the rate in white infants, according to the Wisconsin Department of Health Services.

Figure 2

Percent of Births with Selected Risk Factors by Race/Ethnicity, 2018



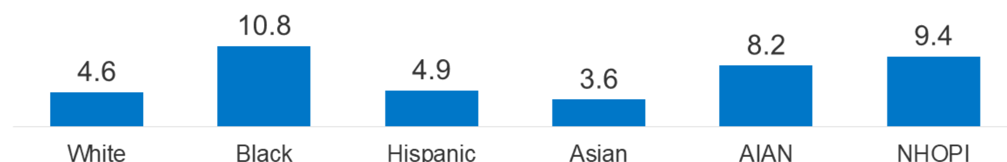
NOTE: Preterm births are those that occur prior to 37 weeks gestation; low birthweight births are those less than 2,500 grams/5.5 pounds, late or no prenatal care is pregnancy-related care that began in the third trimester or when no pregnancy-related care was received at all. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, Natality Records, 2018, WONDER Online Database.

Figure 4

Infant Mortality Rate by Maternal Race/Ethnicity, 2018

Per 1,000 live births:



NOTE: AIAN refers to American Indian and Alaska Native people. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, Linked Birth/Infant Death Records, 2018, WONDER Online Database.

More information:
https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=23
https://www.dhs.wisconsin.gov/stats/births/index.htm
(click on executive summary)

Between 2011 and 2016, the death rate of new Black mothers (from childbirth to six weeks after the birth) was more than 3 times the death rate of white mothers. An article by Orihabor et al (3) describes the significant role that systematic inequality plays in this disparity. From pre-conception to childbirth and afterwards, mothers who are limited in general health care, access to insurance, and access to high-quality, supportive, and culturally sensitive maternity care are at higher risk of death.

More information:
https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7366037/

CONCLUSION

It is clear that racial inequality in health care places a large burden on families, and mirrors the difficulties present in other aspects of daily life for minority persons. There are numerous programs that aim to improve the health of people of color. Progress will require the understanding the role of racism, of multigenerational trauma, and the implementation of practices which facilitate the empathy, respect, and empowerment, that will support those affected by it so they can heal.