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## The Impact of Racism on US Healthcare

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# The Impact of Racism on US Healthcare

by

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An Honors Capstone

submitted in partial fulfillment of the requirements

for the Honors Diploma

to

The Honors College

of

The University of Alabama in Huntsville

December 2, 2023

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## **Abstract**

This paper discusses the structural racism that pervades the United States healthcare system, resulting in unequal healthcare treatment for several racial minority groups. In particular, the paper focuses on racial inequities in four different areas of healthcare: pain treatment, health insurance, maternal and infant care, and mental health. In addition to focusing on current inequities in these specific areas, historically racist policies and practices that resulted in these health disparities are discussed. Following this discussion, the enactment of policies that require education on diversity and the racist origins of the healthcare system is suggested as a solution to minimizing the medical mistreatment that minorities face.

*Keywords:* structural racism, healthcare

## Introduction

The United States is often regarded as a country that prioritizes freedom. This is demonstrated by several popular phrases about the country, including “liberty and justice for all,” the last words of the Pledge of Allegiance. However, despite this portrayal of freedom and justice for all people, extensive research supports that racial inequity in the US healthcare system is prevalent. Racism pervades several different areas and components of healthcare, including pain treatment, access to hospitals and/or doctor’s offices, health insurance, maternal and infant care, and mental health. Hill, Ndugga, and Artiga (2023) provide statistics for several of these areas, performing a 2021 data analysis which found that Black and Indigenous people had a shorter life expectancy than White people (65.2 and 70.8 years, respectively, compared to 76.4 years for White people), higher rates of uninsurance among Indigenous and Hispanic people (21% and 19%, respectively, compared to 7% for White people), higher rates of death among Black and Indigenous infants (10.4 and 7.7 per every 1000 infants, respectively, compared to 4.4 per 1000 for White infants), and decreased rates of mental health treatment for Black, Hispanic, and Asian adults with a mental illness.

Several factors contribute to racial inequities in healthcare, including implicit bias, which occurs when a person positively or negatively evaluates someone else without knowing they have evaluated them (Gopal et. al, 2021). It is negative implicit bias that results in worse medical outcomes for racial minorities. While implicit racial bias is a significant contributing factor to racial inequities in healthcare, there is another factor that contributes to these inequities on a much larger scale: structural racism. Perez-Stable (2021) defines structural racism as macro-level

conditions, such as government policies, that decrease and hinder the opportunities and resources of racial minorities.

In this paper, I will focus on the impact structural racism has on four of the areas of healthcare that were previously mentioned: pain treatment, health insurance, maternal and infant care, and mental health. Following my discussion of these areas of healthcare and their connection to structural racism, I will offer some recommendations to improve the medical treatment of minorities.

### **Pain Treatment**

There are a number of research studies that demonstrate the racial disparity in pain treatment. For example, Todd et. al's (2000) research found that only 57% of Black people who went to the emergency room for a bone fracture received pain relief medication, compared to 74% of White patients who had bone fractures. In fact, a significant amount of research finds that healthcare professionals are less likely to give Black people any type of pain medication and, if they do prescribe medication, administer lower dosages to Black people (Hoffman, Trawalter, and Oliver, 2016).

This difference in the perception of a patient's pain, the decision to prescribe medication, and the administration of dosage amounts is rooted in structural racism. In Hoffman, Trawalter, and Oliver's (2016) study, the researchers highlight the history of myths in the United States regarding Black people's bodies and the perception of Black people's pain. Several of these myths were perpetuated by medical professionals and slave owners in the 1800s in an attempt to depict American slavery as a logical and moral system (Hoffman, Trawalter, and Oliver, 2016). For example, Samuel Cartwright--a physician who practiced in pre-Civil War Mississippi and Louisiana--penned several articles regarding differences between Black and White bodies. Some of Cartwright's false medical claims include that in comparison to White people, Black

people have darker internal organs and fluids (a result of the increased pigmentation of their skin), harder, thicker bones, a stronger sense of smell, sharper vision, and better hearing (Guillory, 1968). Hoffman, Trawalter, and Oliver (2016) studied the prevalence of these myths about Black bodies by presenting two mock medical cases, one with a White patient and the other with a Black patient, to White medical students and residents. The study found that approximately 50 percent of the medical students surveyed held some false beliefs about Black people's bodies (e.g, Black people's bones are stronger, Black people's nerve endings are less sensitive, etc.), and that the presence of these beliefs was directly correlated with rating the Black patient's pain as less severe than that of the White patient and prescribing inadequate medication to the Black patient (Hoffman, Trawalter, and Oliver, 2016).

The presence of Cartwright's 19th century false medical statements in the 21st century illustrates the impact of structural racism on the way that medical professionals currently treat the pain of Black patients. Cartwright's beliefs stemmed from the desire to preserve and justify slavery in the American South, which is why many of them revolve around Black people being physically superior in comparison to White people (Guillory, 1968). If, according to Cartwright, Black people have better eyesight, sharper hearing, and thicker bones, then it is logical for them to spend their lives laboring as slaves instead of White people, who do not have these physical attributes, doing so. The persistence of these false claims well into the 21st century, as illustrated by Hoffman, Trawalter, and Oliver's (2016) study, highlights how the attempt to preserve the US slavery system continues to influence the scientific beliefs and decisions of medical professionals today, resulting in the unequal and inadequate treatment of Black people's pain and injuries in medical settings.

## **Health Insurance**

The implementation of the 2010 Affordable Care Act and policies that expanded healthcare coverage during the Covid-19 pandemic helped increase the possession of health insurance for the majority of races in the US (Artiga and Hill, 2022). Nonetheless, racial disparities in health insurance still exist. Artiga and Hill (2022) report that in 2021, the uninsurance rate for White people in the US was 7.2%, while the uninsurance rates for American Indian and Alaska Natives (AIAN), Hispanic people, Black people, and Native Hawaiian and other Pacific Islanders (NHOPI) were 21.2%, 19.0%, 10.9%, and 10.8%, respectively. Sohn (2017) found that Black and Hispanic people have a greater likelihood of losing their health insurance when they first enter adulthood and, again when they enter middle adulthood.

This increased likelihood of health insurance loss contributes to racial gaps in health insurance and is connected to poverty (Sohn, 2017). According to the 2018 census, Native Americans had the highest poverty rate of any race at 25%, followed by Black and Hispanic people, who had poverty rates of 20.8% and 17.6%, respectively (Poverty USA, n.d.). The increased poverty rate for racial minorities is a product of structural racism, dating back to the abolition of slavery. While slavery was abolished in the 19th century, the US government implemented several policies and practices that made it nearly impossible for Black people to accumulate wealth once free, including sharecropping (providing a crop for rent), laws enforcing segregation, and making it difficult for Black people to vote (National Alliance to End Homelessness, 2021). As a result of these government-enforced practices, several Black people fell into poverty in the 20th century and had no wealth or assets to leave their descendants, thus contributing to the racial gaps in poverty today. Extensive research supports that poverty is directly correlated with education. The vast majority of schools in the US rely on property taxes for funding, meaning that poorer communities often receive less money for educational resources (Dynarski, 2017). Because of the higher poverty rates for racial minorities, children of color



often live in lower-income communities and, thus, receive an inadequate education due to poorly funded schools, making it more difficult for them to achieve higher education. Sohn (2017) notes that individuals with higher income and education are more likely to gain and maintain health insurance, meaning that minorities, who are disproportionately affected by poverty and educational obstacles, are more likely to lose health insurance, often because they cannot afford to pay for coverage due to poverty and do not have the higher education needed to acquire jobs that provide adequate coverage. Therefore, government policies implemented in the 19th century have resulted in generational poverty for racial minorities, leading to them being forced to live in lower-income communities, attending lower-income schools, and ultimately impacting their ability to obtain higher education and higher-paying jobs, which directly affects their ability to gain health insurance and receive quality healthcare (Sohn, 2017).

### **Maternal and Infant Health**

Pregnant people of color are affected by a number of disparities in maternal and infant care. According to Hill, Artiga, and Ranji (2022), Black and AIAN women have a significantly higher likelihood of dying during pregnancy (41.4 and 26.2 deaths per every 100,000 women, respectively) than White women do (13.7 deaths per every 100,000 women). In addition, Black, AIAN, and NHOPI women suffer from a greater number of preterm births and a lack of prenatal care in comparison to White women, while Black, AIAN, and NHOPI infants are more likely to die than White infants (Hill, Artiga, and Ranji, 2022).

These statistics can be attributed to some of the aforementioned products of structural racism, including incorrect beliefs about Black people's bodies and pain perception. Urban (2021) discusses the historical mistreatment of black women's bodies, noting that several physicians used black women to perform reproductive experiments, including Dr. J. Marion Sims, who conducted unmedicated surgery on 11 different slaves' genitalia in search of a

solution for vesico-vaginal fistulas. Dr. Sims ascribed to the false belief that Black people were less sensitive to pain than White people are, which is thought to have influenced his decision to not use anesthesia for the enslaved women but administer anesthesia to the White women he operated on in New York (Wall, 2006). As mentioned, these illogical beliefs about Black pain perception are still prevalent among medical students and residents well into the 21st century (Hoffman, Trawalter, and Oliver, 2016), which may contribute to the lack of prenatal care and increased death rates of mothers and infants of color.

In addition to falsehoods about Black people's pain sensitivity, income level also impacts maternal and infant healthcare. Studies indicate that racial income disparities are positively correlated with racial infant mortality disparities (Owens-Young and Bell, 2020). While women of all races fall victim to the wage gap in the US, White women make more than several racial minorities, bringing home about 83% of a White man's earnings, while Black and Hispanic women bring home 70% and 65% of what a White man makes, respectively (Kochhar, 2023). Indigenous women also earn less than White women do, making approximately 59 cents for every dollar a White man makes (AAUW, 2023). Because Black, Hispanic, and Indigenous earn less money than White women do on average, it is generally more difficult for them to afford adequate healthcare coverage and services, which can result in them poorer medical treatment when pregnant.

### **Mental Health**

As mentioned in the introduction of this paper, Black, Hispanic, and Asian people with mental illnesses are less likely to receive mental health treatment than White people with mental illnesses are (Hill, Ndugga, and Artiga, 2022). Similar to the other areas of healthcare discussed, several components of structural racism play a role in this racial disparity in mental health treatment. For example, extensive research illustrates that poverty can make people more

susceptible to depression or depressive symptoms (Mossakowski, 2008). Therefore, because minorities endure increased rates of poverty (Poverty USA, n.d.), they have a higher likelihood of experiencing depression due to socioeconomic factors. Despite experiencing factors that trigger depression and depressive symptoms at a higher rate, many minority groups have decreased access to mental health treatment and are more susceptible to poorer treatment when they do receive mental health services (McGuire and Miranda, 2008). One contributing factor to this limited treatment access is health insurance disparities, as many minority races have a greater likelihood of losing health insurance due to increased poverty rates (Sohn, 2017) and, therefore, cannot afford mental health services.

### **Recommendations**

To combat the impact structural racism exerts on the healthcare, the US must implement policies that require its citizens to be educated on historically racist systems and policies and how they continue to oppress people of color today. One of the first components that children should be taught about throughout school is diversity and its importance. Knowledge of diversity increases the inclusion that students of color feel at their schools, and helps all students learn how to accept and appreciate people who differ from them (Drexel University School of Education, n.d.). If children learn how to celebrate other's differences, they will be more likely to grow into adults who accept people of various backgrounds and walks of life.

Another action that must be taken is requiring those who want to be doctors to learn about the structural racism that the US healthcare system was built upon. Calhoun (2021) states that medical professionals should be taught the "full truth" (p. 145), and I fully agree with this statement. Instead of telling the partial truth or lying by omission, inform medical students of the origins and history of the procedures they are learning about, which are often rooted in racism. For example, students should not simply learn that Dr. J. Marion Sims created a procedure that

repaired vesico-vascular fistulas; they should learn that the procedure exists because he carelessly experimented on the bodies of several different enslaved women, operating on them with no anesthesia (Wall, 2006). They should learn that Black people do not have thicker bones, sharper vision, superior hearing, that Black people can and do feel pain, and that these beliefs stemmed from the desire to preserve slavery, an institution that dehumanized and exploited Black bodies. If medical students are never informed of the true history of medical procedures, practices, and ideas, then we will continue to produce generations of ignorant doctors whose treatment of minority patients is influenced by racist, centuries-old beliefs, resulting in people of color continuing to suffer from inferior health care.

### **Conclusion**

There is no question that racial disparities in US healthcare are present, as the sources discussed in this paper and a plethora of others illustrate these health disparities. However, what is lesser known to many people, including some who want to pursue medicine, is the connection between these racial health disparities and historic policies and practices that were created to oppress minorities. The policies and practices are interconnected, compounding each other. For example, policies that created generational poverty for some minority groups (e.g., sharecropping, voter disenfranchisement), resulted in an increased likelihood of minorities living in impoverished areas, which results in them attending schools that are poorly funded and decreases the likelihood of them receiving an adequate education, which results in an increased likelihood of minorities working lower-paying jobs and, thus, maintaining a lower-income status, which makes it more difficult for minorities to gain and afford adequate healthcare. This example highlights the effect of racist policies and practices on several different areas of life, including income, education, and healthcare, illustrating that these systems were designed in a way that hinders the ability of minorities to live comfortable, successful, and healthy lives.

To make it easier for minorities to receive the healthcare that they deserve, the US must start by enacting policies that call for teaching students about diversity and educating those who want to pursue medicine on how structural racism continues to influence the medical treatment of minorities today. Change begins with education. If people are never educated on how US institutions were designed to oppress minorities and, unfortunately, have succeeded in doing so, then people of color will continue to receive unequal treatment from the healthcare system.

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