Racial Health Disparities and the Impact on America's Society

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Although racial, ethnic, and cultural disparities within the health system is a flaw that is more prevalent now than ever, people of color have been victims of these issues dating back to 1855 where enslaved women were surgically experimented on (Ojangua). Systematic racism-discrimination is a thriving social and ethical topic as the world has witnessed the death of Eric Garner, Breonna Taylor, George Floyd, and many others. There is significant evidence that people of color experience unequal medical attention in comparison to people of color. The Institute of Medicine defines racial healthcare disparities as "racial or ethnic differences in health care that are not due to access-related factors or clinical needs, preferences, and means of intervention (1). Meaning, factors that include socioeconomic status, age, location and race may attribute to unequal medical care.

The death of 43-year-old Hollywood actor Chadwick Boseman took social media by storm once his battle with colon cancer was revealed. Diagnosed in 2016, Boseman kept this confidential yet still starred in 10 hit movies, including Marvels' *Black Panther*, which later would hold his legacy after this tragedy (Fisher). Although fans were shocked and grieving, this opened the narrative to a conversation that seemed almost foreign to people of color; educational awareness on the colorectal cancer risk factors within the black community. In 1994 information gathered from 8 different cardiovascular and cancer procedures showed that African American patients had higher surgical mortality rates than white people. Furthermore, a national database was used to identify 170,000+ patients who underwent coronary artery by-pass graft (CABG) (Flanders 2000). Results showed that patients who were nonwhite had a 33% higher risk mortality rate post-op CABG surgery than white patients (Yurtoğlu 2018).

According to the American Cancer Society, 1 in 41 black men will die from colon cancer, whereas the statistic for a Caucasian male is 1 in 48. The American Cancer Society also notates the disadvantages of detecting advanced-state CRC include "low socioeconomic status, black race, and young age. (American Cancer Society, 2020, p. 11).

Similarly, the topic of institutionalized racism is more prevalent than ever among black women and childbirth. As we see the bravery of women of color sharing their experiences in the media with nearly losing their life and unborn child's life due to healthcare neglect, it is

important that the message is projected, received, and understood. The CDC states, "Black, American, Indian, and Alaska Native (AI/AN) women are two to three times more likely to die from pregnancy-related causes than white women- and this disparity increases with age" (Center for Disease and Control 2019). It is important that this issue is identified and addressed in a way that allows for this issue to diminish as it is extremely detrimental for the family and communities involved.

Overall, this capstone will examine the history of inequality and disparity that has existed within the healthcare system for people of color for centuries and the impact these social issues have on society. By exploring the works of Yurtoğlu and Ojanuga, a detailed analysis will be created to highlight and raise awareness about the racial healthcare disparities that people of color have been facing for over 300 years. In addition to the exploration of academic journals, the analysis of other writings such as *The Story of My Life* an 'autobiography' by James Marion Sims, American Heart Association's and Center for Disease Control and Prevention statical annual report. These reports will serve to support and highlight the bloodlines of trauma that people of color have endured throughout the history of healthcare.

Literature Review:

American Cancer Society. "Colorectal Cancer Facts & Figures 2020-2022." American Cancer Society; 2020.

According to the American Cancer Society, the American Cancer Society is a nonprofit organization that's mission is to save and celebrate those who have been or are fighting cancer. This publication functions to summarize and analyze scientific data about colorectal cancer in Americans for the year 2020. Through the display of charts, graphs, and tables, The American Cancer Society discusses inherent risk factors for colorectal cancer, such as age, location, and gender.

Centers for Disease Control and Prevention. "Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths." 5 Sept. 2019.

This publication was created by the Center for Disease Control and Prevention to show that women of color, including Native American, Black, and Alaskan American are two-three times more likely to die from birth complications than Caucasian women. The Centers for Disease Control and Prevention states that this disparity only gets worse as natural factors such as age. The Center For Disease Control and Prevention classifies death within a year of birth as a birth complication, also stating that most of these health disparities can be avoided.

Fisher, Jenn. "Chadwick Boseman's Legacy: Colon Cancer Awareness." *Chadwick Boseman's Legacy: Colon Cancer Awareness*, 3 Sept. 2020, news.lvhn.org/chadwick-bosemans-legacy-colon-cancer-awareness/. Accessed 30 Sept. 2020.

The author Jenn Fisher discusses the impact and legacy of Hollywood star Chadwick Boseman's death that occurred in late August of 2020. Fisher discusses how shocking Boseman's death was, as he was only 43 years old, and highlights colorectal cancer risk factors such as age and race. Fisher further expands on different ways to ensure good 'cancer-fighting power,' such as getting a colonoscopy or stool screenings.

Flanders-Stephens, Mary Beth. "Birthing Briefs: Alarming Racial Differences in Maternal Mortality." *Journal of Perinatal Education*, vol. 9, no. 2, 1 Apr. 2000, pp. 50–51, 10.1624/105812400x87653.

Author Flanders-Stephans address the "maternal crisis" occurring for the woman of color. This crisis is described as African American women being two times more likely to experience life-threatening pregnancy complications. Flanders-Stephans article also displays relevant data and statistics.

J Marion Sims, and H Marion-Sims. *The Story of My Life*. La Vergne, Tn, Nabu Public Domain Reprints, 2011, pp. 234–246, archive.org/details/storyofmylif00sims/page/n5/mode/2up.

This biography styled book has been rewritten and published to reflect the original autobiography written by J. Marion Sims, also known as the father of gynecology. This biography entitles personally written chapters about specific time periods throughout Sims entire life. Chapters include his experience through school, specific conversations he had with family members, and detailed descriptions of his medical invention.

Ojanuga, Durrenda. "The Medical Ethics of the 'Father of Gynaecology''.'" *Journal of Medical Ethics*, vol. 19, no. 1, 1 Mar. 1993, pp. 28–31, jme.bmj.com/content/medethics/19/1/28.full.pdf, 10.1136/jme.19.1.28.

Author Ojangua explains the experimental technique used on African American slaved women by Dr. J. Marion Sims, later becoming known as the most successful yet controversial medical technique. Ojangua defines vaginal fistula as being very common within women of the 19th century, causing them to leak urine; and explains how Sims refused to stop experimenting on three specific women, even though their lives were nearly lost multiple times.

Yurtoğlu, Nadir. "History Studies International Journal of Perinatal Education." *History Studies Journal of History*, vol. 10, no. 7, 15 Oct. 2018, pp. 241–264, 10.9737/hist.2018.658.

Author Yurtoğlu explains statistical data on the disparities between males of color and white males during specific procedures such as coronary artery by-pass grafting. Research showed that men who were nonwhite, had a 33% higher risk mortality rates post-op CABG surgery than white patients. The article further contrasts factors such as age, race, socioeconomic status, healthcare systems/providers and more.

Gee, G. C., & Ford, C. L. (2011). Structural Racism and Health Inequities. *Du Bois Review: Social Science Research on Race*, *8*(1), 115-132. doi:10.1017/s1742058x11000130

This study conducted by Gee & Ford showed the

Trivedi, A. N., & Ayanian, J. Z. (2006). Perceived Discrimination and Use of Preventive Health services. *Journal of General Internal Medicine*, *21*(6), 553-558. doi:10.1111/j.1525-1497.2006.00413.x

People of color experience a disproportionate burden of morbidity and mortality. There are significant differences that exist in the full health potential by majority and minority racial groups. Health disparities can defined as factors such as incidence, burden of disease, prevalence, and mortality that affect ones quality of health. Health disparities are also evident in the way people of color experience health care including access to care, quality of care, and insurance coverage.

Defining Health Care Disparities

People of color are far more likely to be affected by specific health conditions such as colon cancer and heart disease; they are also more likely to die of these diseases than other majority racial group due to lesser quality of care. According to information gathered by the American Cancer Society in 2018, 1 in 41 black men will die from colon cancer, whereas the statistic for a Caucasian male is 1 in 48.

Both studies reveal that racism results in health inequities that have adverse effects on the health of people of color. The conclusions of these studies define and provide examples racial disparities exist in the healthcare system. All individuals should have equal opportunities to live the highest attainable standard of health.

Health Disparities & Systematic Racism Evidence

In 2002, the Institute of Medicine released the *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. This report was written at the request of Congress to question the validity of asking a patient their race during the health screening process. The report showed that on multiple occasions, patients that were people of color received lower quality of care than patients who were not even though aspects such as insurance, economic status. It is evident that businesses are actively discriminating against insurance status, such as the ability to pay coverages (Institution of Medicine 286).

Similarly, the American Cancer Society also notates the disadvantages of detecting advanced-stage cancer such as colorectal cancer includes "low socioeconomic status, black race, and young age (American Cancer Society).

The Impact of Healthcare Disparities

Research on structural racism and health inequities reveals that racism restricts the lives of racial minorities as it causes minority racial groups to exhibit worse health compared to people who have little- no experience with racism. A study conducted around the hypothesis that racism influences health inequalities describe structural racism as "the macro-level systems, ideologies, and processes that reinforce inequities between different racial groups. (Gee & Ford). The examples of structural racism mentioned in the research include racial segregation, immigration policy, and generational drag. These structures and processes influence health inequities. For example, racial segregation contributes to racialized patterns in the spread of infectious diseases (Gee & Ford, 2011). This study answers the research question on what causes racial health disparities. A weakness of this research is that it only covers a few issues of structural racism that are not necessarily experienced by members of racial minority groups.

Furthermore, a study on discrimination and the use of preventive health services shows that there is an association between individual experiences of discrimination and health conditions. Other studies have shown that there is an association between other things such as high blood pressure, cigarette smoking, and worsened self-assessed physical and mental health (Trivedi & Ayanian, 2006). The research also states that people who experience discrimination are less likely to seek care routine visits where preventative services are offered. The lack of preventative services results in morbidity and mortality among the racial group that lacks access to these services. The gap in this study is that it does not describe the ways in which minority races experience discrimination within the health care system yet leads off the assumption that discrimination exists.

Both studies reveal that racism itself results in health inequities that have adverse effects on the health of minority races. The implication of the studies is that they prove the need to achieve racial equality in healthcare. All individuals should have equal opportunities to live the highest attainable standard of health.

Analysis

Through the power of social media, we are exposed to nearly a new headline everyday of how a person of color has lost their life unjustifiably. Liberal Arts studies is a broad category of topics, including the study of people and communities, and the black community is a very prevalent topic right now. Now more than ever are having people have become focused on the inequalities that people of color may suffer regularly. More people are able to be addressed and educated on these topics as a community to prevent the possibility of unfair and unwarned pain to those who are innocent.

Women of color have been facing healthcare disparities as early as 1855, where Dr. Marion Sims experimented on enslaved black women. American Surgeon James Marion Sims, also controversially known as "the father of gynecology," is widely known for creating a surgical technique to cure vesicovaginal fistula, also known as VVF (Ojanuga). Lucy was the first enslaved woman to be wrongfully operated on by Dr. Sims as she underwent a number of unconsented surgeries. In 1993's medical journal *The Medical Ethics of the 'Father of Gynaecology* by Durrenda Ojanuga, Ph.D., he explains the conditions and duration of Lucy's first operation. Ultimately, Lucy spent one hour, on her hands and knees, in front of 12 other doctors, without anesthetics being cut open, and poked inhumanely.

Additionally, people of color continuously face the burden of persistent history of racial health disparities. The health status of African Americans shown in recent studies are declining due to ‘outside factors.’ Research evidence is very important in demonstrating the racial and ethnic inequalities in accessing quality healthcare treatment. Furthermore, the disparities reflect socioeconomic differences, gender bias, indirect and direct discrimination, and limited access to health care facilities contributing elements to the health disparity. The differences in population attributions and race, class, culture, and gender are the major obstacles within healthcare systems.

In regards to the racial disparities that exist among people of color, research shows that the majority group tend to have the least cancer survival rates. The observation includes the

delay within detection and screening, as well as the differences in the availability of the alternative treatments. At earlier stages, screening of cancer contributes to the differences within gene hereditability, cultural variations, and socioeconomic position (Barr 2014). Ideally, the challenges related to inadequate access to ongoing care and the treatment style. In specific kinds of cancer, racial and ethnic subgroups are likely to benefit from the early diagnosis and screening. In addition, only 52% of women of color received screening and diagnosis. This is significantly low for survival.

In comparison, an estimated 72% of American women (white women) received screening and timely diagnosis (National Center for Health Statistics US 2016). White women are far more likely to receive breast cancer screening and diagnosis at a localized stage than women of color. Conventionally, the same statistic applies to treating cervical cancer. Disparities in cancer treatment are evident through the findings; specifically, women of color are less likely to receive radiation rehabilitation in cancer treatment. Regarding race and ethnicity, the same patterns were applicable in the treatment and screening of colorectal cancer, (American Cancer Society 2020). African Americans face less concern and aggressiveness in the treatment even after securing an insurance cover.

The Cancer Surveillance system showed that people of color are more familiar with diagnosis in a remote type of cancer. Out of six African Americans, only one is likely to be diagnosed at a later stage. In comparison to white Americans, this statistic was cut in half.

Further, 40% of African Americans-people of color, were diagnosed with cancer at the uncurable stage; in comparison to the 20% of white Americans diagnosed. Furthermore, health disparities highlight the unequal treatment procedures for cancer patients of color. African Americans are statistically less likely to receive effective rehabilitation procedures for colorectal cancer. Regarding demographic factors including insurance coverage, hospital specifications, and rehabilitation complexities; male African Americans with a cancerous tumor and no diagnosis account for about 40% of all cancer patients (American Cancer Society 2020). This is vastly disproportionate in comparison to 20% of the white males who account for cancer patients with tumors and no diagnosis.

From a racial perspective, differences in viewpoints create separate group awareness, self-identities, racial narratives, stereotypes, competition, and conflicts; creating disparity and discrimination within many healthcare facilities (Gee & Ford 2011). Consequently, racial health disparities in the United States exceed the initial records for people of color (African Americans) to reveal the worst health conditions than the whites in various health conditions. Research indicates the cause of institutionalized racism; specifically in health, are due to social factors. For example, these reasons for contributing factors to health disparities may include unknown heredity disorders, increased cases of negligence of infants and mothers, low residents and dwellings by the community, poor sanitation, and miserable living conditions. Regarding the rural communities, tuberculosis was the leading cause of death among the blacks in Philadelphia. The outcome revealed the top factors were mainly environmental, (Barr 2014).

Furthermore, racial health disparities are relevant to increase residential racial discrimination as the central contributor to racism and racial difference in health. As a factor to the disparity, segregation plays a role in social disorder through increased poverty and social isolation. The research presents whites are suited to better living and health neighborhoods compared to the black communities. Residential segregation plays a distinction in quality and environmental conditions. Moreover, residential segregation by race ensures negligence and institutionalized racism. Concerning the segregation, residential requirements by the African Americans increase with little improvements in health facilities

Additionally, immigration provides further insights into the disparities in health patterns across specific groups. The position of immigrants and immigration influences the health status of individuals in minority group. Native Americans have reduced mortality rates and increased birth rates compared to other subgroups. Subsequently, immigration plays a contributing factor to mortality rates in marginalized groups. Insights on immigration observe most racial groups experience lower rates of infant and grown death rates than the native Americans. Also, among the different immigrant subgroups, exposure to the American culture compromises minority group health status'.

Immigration policies play a direct role in influencing the country's population. For example, foreigners applying for arrivals in the United States are required to pass a medical test

for specific identification of contagious diseases, mental incapability, and substance use. In addition to serving as a restraining measure for entry into the country, the screening also denies entry for individuals perceived as less healthy. Realistically, the policy contributes to immigrants having a lower disease rate compared to natives. These screening policies also fir differentiation between official and unofficial immigrants.

Furthermore because of many socioeconomic elements, undocumented immigrants are worse off compared to documented immigrants. The screening policies and practice play a complementary role, Philbin, Flake, Hatzenbuehler & Hirsch (2018). For instance, unofficial Latino immigrants are more likely to experience reduced birth-weight compared to official Latino immigrants.

On the contrary, the immigration policy known as The Deficit Reduction, initially allowed applicants to present citizenship documentation upon arrivals, due to the reduction in insurance coverage among immigrants. The policy and practice are persistent in eliminating unofficial immigrants and striking limitations on significant arrivals, Philbin, Flake, (Hatzenbuehler & Hirsch 2018). Various policies and legislation cause both indirect and direct harm to immigrants through admissibility standards.

These policies tend to generate fear even among eligible immigrants. Despite social position and status, immigrants are perceived on a fitness basis in the prevailing racial chain of command. Health disparities concerning ethnicity entail attributional proposals that evaluate individualities, such as cultural relations to a group where an individual is socially connected. Additionally, relational proportions and measures highlight a group-specific location, for instance, majority and minority position in the social hierarchy.

Discrimination in health care is a significant concern, with an extremely massive influence on health care disparities. Various reports have shown several incidences of health discrimination, especially from individuals with low health who have more healthcare barriers than others. The generalization of a particular population with little consideration to utilities and other merits provides a significant drawback in health policy. For instance, the state of California positions itself as the last state to be spending on Medicaid. The state of California also faces the highest rates of no health insurance by individuals, the National Center for Health

Statistics US (2016). In results of this, the reasons for the factors in insurance restrictions resonates with discrimination. Respectively, whites constitute less than 50% of the state's population.

In contrast, it is a contributing factor to less spending on Medicaid. The demographic pattern is responsible for reducing discrimination with other outcomes, such as insurance and income, playing a significant role. Besides, the state faces the highest immigration arrivals compared to other states. Individuals from minority groups experience the difficulties and the negative implications of discrimination in health care protection. Alternatively, racism has a direct influence on individual health through mental strain.

Moreover, unique experiences of discrimination influence personal health indirectly through character responses. The viewpoint on discrimination and the influence on health connected behaviors involves sleep, substance abuse, and diet, Trivedi & Ayanian (2006). Individuals may be reluctant to seek medical protection because of fear of discrimination. Seeking health or medical attention can be a contributing factor to extend discrimination. Besides, discrimination in health care facilities will force individuals to seek alternatives that are of lower quality services. Bias in health care influences negative experiences, and also effects the development of trust and satisfaction within the healthcare system of an institution. Individuals can choose to relinquish or suspend these health protections.

Conclusion

Stereotypes claim white people tend to constantly view people of color negatively. The viewpoint makes black people undesirable to employers and counterparts against American white people. For instance, 50% of white people perceive black people to live without welfare strategies and policies. Also, half of the white population believes that people of color prefer violence and are unintelligent. 40% of white people also perceive people of color as lazy. In comparison, white people believe only ten percent of other whites are prone to violence, five percent are unintelligent, and another five percent to be lazy. In society, black people are viewed more negatively than other subgroups. The levels of discrimination and stereotypes limit the desirability and concerns to minimize health care disparities.

Ethnic and racial minorities have little access to health facilities compared to the majority groups. Reasons for health disparities vary from discrimination, socioeconomic, gender bias, and legislative policies. Health disparities in health are relevant through insurance cover and selective treatment of diseases, for instance, cancer. Inequality is evident in screening and diagnosis at earlier stages through elective procedures and therapy to majority groups.

Discrimination in health care forces marginalized groups to seek the least favorable alternatives. The health status of African Americans is illustrated as stagnant and declining. Research evidence is critical in explaining the racial and ethnic inequalities in accessing quality health care facilities. Discrimination and racism are deeply rooted in society, limiting the social, political, and economic structures. The challenge for black individuals is unequal within health care, food, security, education, employment, and housing. The Black Lives Matter movement raises concern and awareness in addressing black individuals' plight in American society. Health disparities reflect socioeconomic differences, gender bias, indirect and direct discrimination, and limited access to health care facilities contributing elements to the health disparity.

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