Health Disparities Among Black and Impoverished Communities

by

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Abstract

This study aims to research health disparities and highlight the social and economic barriers black and impoverished communities face. These barriers contribute to health outcomes where there are higher death rates and neglect of black and disadvantaged communities. Accessibility is a hindrance that affects communities in need, and many people lack resources to receive better medical treatment. People in at-risk communities are socially and economically disadvantaged and do not receive adequate services. The communities also face racial discrimination by healthcare providers. Solution-based studies suggest that community engagement, medical education, training, and fieldwork are necessary to impact and change the healthcare system. Finding solutions could also positively impact health outcomes so that there are equal rates. I related my findings to my father's experience.

Introduction to Study

I became interested in learning more about health disparities among black and poor people in a class I took last semester about health and human rights. I was able to connect the inequality black people experience in healthcare with my own. I grew concerned about the issues I could potentially face when I decide to have a child, and black women are three times more likely to die of pregnancy-related causes than white women. Liver cancer killed my father at 67 years old, and I often wonder if he received equal resources and support from his doctors. It is important to uncover the gaps in disparities and health outcomes to improve black people's quality of life.

Understanding inequalities in health outcomes is essential when looking at health disparities as a whole. We must look at the factors that contribute to health outcomes: social factors, economic disadvantage, and lack of healthcare access. Black and low-income communities are more likely to have fewer hospitals because of residential segregation. If hospitals are available, they are usually low-quality care, so people rely on community-based care, emergency rooms, and outpatient facilities instead of their primary physicians. The lack of healthcare providers in communities in need contributes to the growing disparities. People who have low income are most likely unable to afford healthcare to access a doctor or professional. Also, people that lack education face frustration when trying to understand their conditions.

I took an interest in health disparities when I realized how it could affect me and my future. I see how it has affected the lives of my loved ones. In answering these questions of why health disparities exist, it is crucial to research the social, economic, and racial factors that people often do not realize. Nonprofit and community-based programs can help raise awareness in these areas and advocate for people who lack support. That is something that I see myself doing long-term, advocating for those who need it.

My research will focus on the social, economical, and racial disadvantages people face in health care. I hope this research will answer the question of why there are health disparities among black people and people living in poverty. I think that social, economic, and racial factors explain the health outcomes and why there is a gap between black and white people. This research will benefit me in the long run when making personal decisions related to my health or someone else.

Literature Review

Healthcare accessibility, bias and environmental structures contribute to people not being able to get quality resources they need to survive. Disadvantaged communities are less likely to receive the same treatment as communities of a higher socioeconomic status (Woolf, S., & Braveman, P. 2011) This is a monumental problem because Black and impoverished people are dying at a much higher rate than other racial groups (Williams,D.R 1999) This literature review will cover 1)social factors and bias and 2)socioeconomic disadvantages black people and impoverished communities experience in healthcare. There are many other factors related to the increased morbidity and mortality. Black people and impoverished people simply are not receiving the same quality health care that their white counterparts are receiving. This issue is important because it shows the systematic racism and inequality that black and poverty-stricken communities face.

Socioeconomics prevent black and impoverished communities from getting quality medical treatment

Neighborhood segregation, food insecurity and socio-economic factors make it difficult for black and impoverished communities to receive adequate medical care. Environmental, educational and financial stressors influence health outcomes and affect health disparities. Socio-economic factors include education, income, employment, neighborhood characteristics, policies, and wealth, all of which affect health (Woolf, S., & Braveman, P. 2011). Disadvantaged racial communities receive lower medical care levels and poorer quality treatment (Williams, D.R. 1999). Segregated neighborhoods contain people in poorer environments, and housing is deficient in resources meant to enhance health and wellbeing (Williams, D.R. 1999). Poverty in

these segregated neighborhoods exposes residents to elevated stress levels and chronic health conditions (Williams, D.R. 1999). Furthermore, segregation contributes to lower access to care and poorer quality of healthcare. African American and Hispanic areas are more likely to lack health care providers and hospitals and tend to offer lower quality care (Taylor, J. 2019). The option to travel outside of their environment can be challenged due to lack of transportation for those who cannot afford it and people living in rural areas(Taylor, J. 2019). In addition to segregation, there are not many options for affordable housing in safe and resourceful neighborhoods. Racist practices hurt black people who want to own homes and put a financial strain on their families (Taylor, J. 2019).

Research shows that neighborhoods that lack access to nutritious foods experience food insecurity. This is a reality that black and impoverished communities face. In fact, 60 percent of black Americans experience food insecurity and are twice as likely to experience hunger than white Americans. This leads to chronic illness and other medical issues (Taylor, J. (2019). In supporting this, adults living in poverty are more likely to be in poor health than adults whose income is four times the poverty level (Woolf, S., & Braveman, P. 2011). Americans who earn more do not share the same health outcomes as those who earn less (Woolf, S., & Braveman, P. 2011). In fact, patterns related to mortality are evident in African Americans, American Indians, Native Hawaiians, Pacific Islanders, and economically disadvantaged Hispanics (Williams, D.R. (1999). A study showed that stress exposure affected black and U.S.-born Latinos psychologically, and stress exposure leads minorities to be at risk of toxic chemical exposure (Williams, D.R. 1999). The correlation of stress is seen in life expectancy. White males at the age of 45 have a 3.7-year longer expectancy than their black peers (Williams, D.R. 1999)

Social bias and discrimination discourage black people and impoverished people from seeking medical care.

Communication between providers and patients is important because it establishes trust and provides health knowledge. Access to media sources, health information, and processing information varies by race, ethnicity, and socio-economic status. Members of racially marginalized groups are less able to pursue and gain reliable knowledge because they lack the resources to do so (Williams, D. R., & Mohammed, S. A. 2013). Furthermore, patients who experience racism tend to underuse preventive care, delay receiving care, less likely to follow up with treatment, and receive poorer treatment outcomes (Eliacin, J., et al., 2020). Interactions between patients and providers are jointly influenced. Findings suggest that black patients might display different behaviors based on their past experiences of discrimination and express more negative feelings (Ivy W. Maina., et al.,(2018).

Providers who are unaware or aware of their racist ideas mistreat their black patients. According to a study where VA participants were interviewed, participants identified microaggressive behavior from their healthcare provider. The black patient expressed his discomfort when the provider implied he would steal when he left the room (Eliacin, J., et al., 2020). Physical appearance affects the way black men are perceived and get stereotyped, according to the same study. Negative assumptions due to appearance dictate the treatment quality they will receive (Eliacin, J., et al., 2020). There were 85 participants in this study, and 26% stated that race plays a role in the care they receive(Eliacin, J., et al., 2020). For example, a participant explained that he did not think a white provider could understand anything about black people's dynamics. Furthermore, patients who experience racism tend to underuse preventive care, delay receiving care, less likely to follow up with treatment, and receive poorer

treatment outcomes (Eliacin, J., et al., 2020). Another study showed a bias that favored white patients as more compliant than black patients (Ivy W. Maina., et al.,(2018).

Socio-economic differences affect black and impoverished communities differently by how they seek healthcare. People who earn lower wages tend to have limited resources ranging from food insecurity to inadequate medical treatment. Financial hardships force impoverished people to choose shelter over medical care to avoid expenses. Implicit racism, lack of communication from providers leave their patients feeling uneasy and untrustworthy, and less likely to complete their treatment. Socio-economic disadvantages and social bias keep black and impoverished communities from seeking the resources they need related to their health and contribute to the health disparities among black and poverty-stricken communities.

Method

Materials

This research aims to explore solutions that make healthcare access easier for black and impoverished communities. The study will also explore ways to change racial bias in healthcare providers. As mentioned in the literature review, black and impoverished communities experience racial bias and lack of accessibility in healthcare. These two issues contribute to the alarming rate of health disparities in black and poor communities. There is a lot of research conducted as this continues to be an essential issue, so it was easy to find articles and journals. The materials I used to collect data were my computer, internet access, and the online Purchase library database.

Procedure

I looked up scholarly journals and read articles based on healthcare accessibility, particularly racial bias and social-economical factors. I used keywords and phrases to narrow my search like “healthcare accessibility” and “solutions to healthcare disparities.” I chose articles that were peer-reviewed for data collection and analysis. Within the peer-reviewed journals, there were studies conducted, interviews, and data analysis that were resourceful. I examined four peer-reviewed journals that offer a variety of solutions to these issues. I chose peer-reviewed journals that provide valuable information that is crucial to changing the healthcare system. I analyzed the information by reading the journals and compared suggestions from the authors. I also thought of my suggestions for improving the healthcare system and compared them to my findings. Many of the solutions mentioned suggested healthcare professionals should change their way of communication with their patients. I found similarities in the solutions that were suggested.

Discussion

Health disparities among black and impoverished people affect health outcomes at a higher rate. This research addresses the socioeconomic and racial bias factors contributing to the gap. People in poor and black communities cannot access adequate medical treatment due to their lack of resources. Healthcare providers sometimes carry a racial bias towards people of different races. Through my research, I was able to find connections between my findings and my personal experience. My father recently passed away from liver cancer, and my family supported him. His health providers were not as supportive. My father expressed feelings of frustration up until his death with his doctor and nurses. He felt invisible. All of this points to the fact that I wanted to research this issue more to understand it better. Health disparities are a

problem that affects all of us; for example, black women die at a higher rate during childbirth than any other race. Black and impoverished people have a higher rate of dying from diseases like cancer and heart disease because of food insecurity and not following up with medical treatment. Luckily, there are solutions to decreasing the rates in health outcomes which will help change the results of health disparities.

Finally, I noticed a pattern when I read the journals and the information I analyzed shared the following themes 1)creating partnerships between businesses and the medical community that specifically help with advocacy and service 2) reducing racial bias among healthcare providers.

Community partnerships, engagement and medical education

In the literature review, my findings showed that socioeconomics prevents black and impoverished communities. In this section, I will discuss solutions for communities to get the proper healthcare they need. I wanted to dig deeper into finding programs that would help black and impoverished communities. I thought about my personal experience with my father and how he did not have the resources from his community to help when he needed it the most. I noticed that many of the findings from the research offered community-based solutions with partnerships between healthcare providers, businesses, and medical facilities. "Impacting Health Disparities in Urban Communities" provides a new framework based on educational interventions: "A graduate level community engagement course, developed within an academic medical center located in an urban setting, that demonstrates promise in effecting change in the extent to which clinicians are able to engage communities and practice "neighborhood-engaged care" with the central goal of mitigating disparities" (Alicea-Alvarez et al., 2016). The goal of this program is to end

disparities through educational engagement. Both clients and healthcare providers benefit from this program. The study mentioned students of academic medical centers are encouraged to explore how to serve the community's needs best. Clinicians provide hands-on services with the community and partner with local organizations to identify and address problems that contribute to poor health outcomes (Alicea-Alvarez et al., 2016). Clinicians can access the issues in the community to find ways to serve those in need. Utilizing clinicians has positive outcomes because they help identify and understand health-related problems that remain prominent in the community. They can provide advocacy, education, and resources to these communities.

The study also credits a program called the "Grand-Aides", which was proven to reduce emergency visits and increase drop-in clinic services: "For example, the Grand-Aides program utilizes trained health care members, under the supervision of a nurse, to conduct home visits and telephone consultations with patients to prevent emergency department visits and readmissions. The model has averted 62 % of drop-in clinic visits and eliminated 74% emergency department visits" (Alicea-Alvarez et al., 2016). Comparable to the role of social workers in schools and communities, clinicians do the same but for medical purposes. Healthcare professionals that make home visits and make telephone calls mean that healthcare information is easily accessible. As mentioned in the literature review, people with limited resources, transportation, or money would not have to worry about their health (Woolf, S., & Braveman, P. 2011). I remember when my father would drive from Albany to Manhattan to get treatment for liver cancer, and I can't help but wish he had more supportive providers. Healthcare professionals were easily accessible to help answer questions and arrange treatment suitable to his needs.

The research explains that curriculums are being created for medical students to complete and incorporate education with real-life experiences in high-risk communities. Medical

education is equally important, and academic medical centers explore different ways of integrating fieldwork with service. Research conducted by Norma Alicea-Alvarez and her team argue:

> Examples of such service learning include performing physical examinations in elementary schools and churches, conducting needs assessments of the school community, and partnering with community members to provide health education. A meta-analysis of service learning across health professions found that students who participate in service learning activities demonstrate improved attitudes, social skills, civic engagement, and academic performance (Alicea-Alvarez et al., 2016).

Medical education works in all aspects of the community, from the neighborhood, schools, and places of worship, making it easier for those who need it most. This is important because educators are learning from the community, but they can be more empathetic to the needs of the people. Accessibility is essential and is a critical issue in black and impoverished communities. An educational service engagement based curriculum was developed at Temple Universtiy's Lewis Katz School of Medicine in North Philadelphia. The school and the University Hospital border two neighborhoods with health needs, high crime statistics, and environmental barriers. Medical education is important because providers can service urban communities and practice medicine. The program provides an educational curriculum that is hands-on and enables students to provide care in all aspects of the community. This program impressed me because of the integration of service skills and medical education, both beneficial for providers and students. The program is based on the needs of the community. Students are

encouraged to create projects based on the health needs of the community. I found the program's design to be clear and organized, and courses are both lectures and fieldwork. The courses take place twice a month, intended to "gain an understanding of health care disparities in urban neighborhoods" (Alicea-Alvarez et al., 2016). Their goal is to understand and identify the threats and dangers of significant health problems in urban communities. The importance of impacting change and principles of health policy are meant to improve community-based health.

Compared to the research conducted from the literature review, this is all solution-based. When creating this curriculum, a focus group was used, and interview questions were asked regarding the community's problems, solutions that could reduce health barriers, and ages that were most affected by the issue. The questions help to identify the problems and concerns within communities that providers can address. Participants of this process were students who were enrolled at the graduate level. The experiment was conducted at different faith-based organizations, non-profit foundations, and community centers within a three-mile radius of the college. Many of these community businesses offered services to people struggling with food, housing, and employment insecurities. A survey was designed to assess skills, attitudes, and knowledge of the students about community engagement.

Reducing racial bias in health care providers

My findings in the literature review explained that health care providers have a racial bias based on their past experiences with individuals from other ethnic backgrounds. A group of veterans in my findings spoke candidly about their feelings of discrimination from their healthcare providers (Eliacin, J., et al., 2020). Black men and women from the study felt that their healthcare providers stereotype them based on their interactions, making them not want to

continue treatment. Before researching solutions to racial bias, I thought there were none. Fortunately, my findings did offer many solutions, specifically cognitive changes and training for healthcare providers. According to Diana Burgess's research in "Reducing Racial Bias Among Health Care Providers, " prejudice and negative racial stereotypes have also declined throughout the years, and providers endorse racial equality. This is not always the case. I remember my father expressing his dissatisfaction with the treatment he received from his doctors. When my father received treatment for cancer, he was often spoken to in condescending and insensitive tones. Also, I would like to mention the findings in the literature review regarding the treatment of veterans of color from providers dating back to 2017, and the solutions were based in 2007. More steps are taken in the right direction now more than ever. The study also suggested that health providers should openly acknowledge their negative and unconscious stereotypes instead of being in denial. Stereotype suppression can lead to negative consequences when servicing African-American patients. Health providers are suggested to enhance their understanding of bias instead of denying it. Provider's confidence also needs to be improved in their ability to interact with patients of other races.

According to researcher Diana Burgess, white people feel anxious when interacting because of their lack of positive experiences or encounters with black people. In a clinical meeting, white providers might show avoidance behavior and spend less time with non-white clients, which leads to poor patient-provider relationships (Burgess, D.et al., 2007). The best way to increase provider confidence is to encourage direct contact with people of other racial groups. According to the study "Reducing Racial Bias Among Health Care Providers" by Diana Burgess suggests: "interactive, facilitated discussions, particularly in which people interact in individualized ways, among colleagues of different race and ethnicity stigmatized groups,

including Blacks, and to inhibit the activation of unconscious stereotypes and prejudices. Similarly, one study found that physicians rated as "empathetic/ compassionate" by their peers had less stereotypic attitudes toward patients than physicians classified as low on empathy" (Burgess, D.et al., 2007). The more empathy healthcare providers have, the more understanding and patient they can be towards black patients. These kinds of interactions do not last forever and have to become routine training for healthcare staff. Forging partnerships with patients is another cognitive measure healthcare providers can take to change racial bias. If healthcare providers interact with patients from a collaborative place rather than a traditional role, it can help both parties feel like they are working together. Patients and providers will identify each other as partners psychologically.

We are not seeing the long-term effects of implementing these practices in black and impoverished communities. Community-based programs exist, but I do not think the results are being measured enough in hospitals or in black and disadvantaged neighborhoods. There are plenty of educational medical facilities that do not prioritize community necessities and focus more on scientific methods than social service. My father received treatment at Albany Medical Center, a hospital known for educating medical students on real-life emergencies. From what I know, many of these students were awkward and cold when communicating with my father. My father had no shame in asking questions related to his treatment, and he would not stop until he understood, even when the providers seemed annoyed. My father did a better job advocating for himself than anyone who worked at Albany medical center.

There were limitations in my study, and I noticed that there were not many studies that showed the progress of implementing these programs and training into the healthcare system. I found that many medical education programs exist but have not seen the qualitative information

to back the claim. The medical education program in Philadelphia seems to be in the beginning stages of tracking the implementation process. The program laid out the core curriculum and still seems to be adjusting to the community and medical facility. I would also like to mention that only students needed to take the course twice a month, and for long-term implementation, more education should be provided, not just twice a month.

Conclusion

There is an abundance of information about health disparities because the issue is affecting black and impoverished communities at higher rates. Socioeconomic and racial bias do deter black and disadvantaged communities from seeking and receiving quality treatment. This issue shows the drastic difference in health outcomes between black and poor people compared to white and middle-class neighborhoods. After all, people should receive medical treatment suitable to their needs, even if there are financial or environmental barriers. Black and impoverished communities in urban settings deserve the same medical treatment as suburban middle-class communities.

The divide is apparent, and research conducted to find solutions to the problem moves in the right direction. The United States healthcare system does not always value the lives of all individuals, but there is light at the end of the tunnel. Healthcare providers are taking awareness and accountability, and they are proactive in making a significant change. Intersectionality between medical providers and community-based programs shows positive effects of advocacy by providers. Conversations to bring awareness to the problem seem to be taking place among professionals. Community engagement, medical education, fieldwork, advocacy, and communication effectively change the system. Healthcare professionals who truly understand the

community's needs are crucial to advocate and provide resources to individuals with limited access. I think that there should be more efforts in encouraging black and impoverished individuals to seek medical attention, and I think that should come from professionals.

People need to feel trust and sincerity from healthcare providers, which is not always a priority to those in the medical field. I started to research health disparities, and I made the mistake of generalizing the problem. There are many other essential attributes to health disparities, and it is not black and white. Understanding and researching the components is a step towards solving the problem. I hope that the healthcare system can continue to make significant changes so that black and disadvantaged people feel protected and included. More research should be done to capture the effectiveness of medical education. Interviewing medical providers, people in the community, and tracking their process could be a good way of conducting research. I wish, more than anything, that my father could have received more support in his treatment. My inspiration for this research is my father and seeing the similarities with the information and his experience.

References

Alicea-Alvarez, N., Reeves, K., Lucas, M., Huang, D., Ortiz, M., Burroughs, T., & Jones, N. (2016). Impacting Health Disparities in Urban Communities: Preparing Future Healthcare Providers for “Neighborhood-Engaged Care” Through a Community Engagement Course Intervention. Journal of Urban Health, 93(4), 732–743. https://doi.org/10.1007/s11524-016-0057-6

Burgess, D., van Ryn, M., Dovidio, J., & Saha, S. (2007). Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology. Journal of General Internal Medicine : JGIM, 22(6), 882–887. https://doi.org/10.1007/s11606-007-0160-1

Eliacin, J., Matthias, M., Cunningham, B., & Burgess, D. (2020). Veterans’ perceptions of racial bias in VA mental healthcare and their impacts on patient engagement and patient-provider communication. *Patient Education and Counseling*, *103*(9), 1798–1804. https://doi.org/10.1016/j.pec.2020.03.017

Hagiwara, N., Elston Lafata, J., Mezuk, B., Vrana, S., & Fetters, M. (2019). Detecting implicit racial bias in provider communication behaviors to reduce disparities in healthcare: Challenges, solutions, and future directions for provider communication training. Patient Education and Counseling, 102(9), 1738–1743. https://doi.org/10.1016/j.pec.2019.04.023

Ivy W. Maina, Tanisha D. Belton, Sara Ginzberg, Ajit Singh, Tiffani J. Johnson (2018) A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. Retrieved from Social Science & Medicinehttps://doi.org/10.1016/j.pec.2020.03.017. Volume 19ISSN0277-9536https://doi.org/10.1016/j.socscimed.2017.05.009. (https://www.sciencedirect.com/science/article/pii/S0277953617303039)

Taylor, J. (2019). Racism, Inequality, and Health Care for African Americans. Retrieved 4 March 2021, retrieved from https://tcf.org/content/report/racism-inequality-health-care-african-americans/

WILLIAMS, D.R. (1999), Race, Socioeconomic Status, and Health The Added Effects of Racism and Discrimination. Annals of the New York Academy of Sciences, 896: 173-188. https://doi.org/10.1111/j.1749-6632.1999.tb08114.x

Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist, 57*(8), 1152-1173. doi:http://dx.doi.org.ezproxy.purchase.edu/10.1177/0002764213487340

Woolf, S., & Braveman, P. (2011). Where health disparities begin: the role of social and economic determinants--and why current policies may make matters worse. *Health Affairs (Project Hope)*, *30*(10), 1852–1859. https://doi.org/10.1377/hlthaff.2011.0685