OVERVIEW

Health Care and Systemic Racism

By Yonette F. Thomas

Introduction

Systemic racism affects virtually every facet of US society, including the provision and quality of health care in the United States. Studies have consistently shown that Black, Latino, Indigenous, and Asian Americans face considerable disparities in health care compared to the White population. For example, the American Medical Association (AMA) reports that even with overall improvements in public health over the decades, people of color tend to receive lower quality health care, including a lower likelihood of routine care and higher mortality and morbidity rates. Furthermore, such disparities do not affect all people of color in the same way but are mediated by additional factors, including gender and socioeconomic class. These findings have generated further sociological and medical research, as well as political debate and various policy proposals. Advocates of equality in health care seek to design and implement policies that serve to erode racial and ethnic disparities and improve intergroup relations.

Life Expectancy at Birth in the United States, 1970–2015

Year of Birth	Black Men	Black Women	White Men	White Women
1970	60.0	68.3	68.0	75.6
1980	63.8	72.5	70.7	78.1
1990	64.5	73.6	72.7	79.4
2000	68.2	75.1	74.7	79.9
2010	71.8	78.0	76.5	81.3
2015	72.2	78.5	76.6	81.3

Data adapted from *Health*, United States, 2019, National Center for Health Statistics (US), 2020.

Understanding the Discussion

- **Centers for Disease Control and Prevention (CDC):** US national health protection agency.
- **Cultural competency:** Behaviors, attitudes, and policies that enable effective collaboration among people from diverse racial, ethnic, and linguistic backgrounds.
- **Implicit bias:** Attitudes, beliefs, or stereotypes that are held unconsciously and affect an individual's understanding, actions, and decisions.
- **Institutional racism:** The manner in which a society's institutions operate systematically, both directly and indirectly, to favor some racial and ethnic groups over others regarding access to opportunities and valued resources; also sometimes called "institutional discrimination."
- **Patient Protection and Affordable Care Act (ACA):** A 2010 US health care bill created by the administration of President Barack Obama; also known as Obamacare.
- **Systemic racism:** Racist beliefs, actions, policies, and institutions that are embedded within an entire society or culture.

History

Racial disparities in health care have been noted throughout US history, but by the 1990s there was increasing attention to the issue. The 1998 government report *One America in the Twenty-First Century: Forging a New Future*

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noted that gaps in longevity and health care access for people of color were well documented. The report also noted that the continuing gap in health care access undermined the vision of one America. The authors proclaimed that “America should not be a society where babies of different racial backgrounds have significantly different life expectancies. If our Nation is committed to the proposition that all people are created equal, our most basic indicators of life and health should reflect this principle.”

In discussing the issues of race and health, *One America in the Twenty-First Century* made conclusions about three critical areas in health care in the context of race. The report identifies structural inequities, discrimination by providers, and the cultural competency of providers as key factors that contribute to continuing inequity in health care delivery.

Structural inequities are difficulties in accessing the health care system that stem from disparities in employment, income, and wealth. For instance, more than half of insured US residents obtained health insurance through their employers in 2020, but more than one-third of employers did not offer plans to their employees and fewer workers were eligible for employer-provided insurance plans in certain lower-wage industries, such as retail. Among those who are insured, limited pools of approved providers and difficulty securing appointment times can also contribute to delayed care. Such inequities in access affect rates of sickness, disease, suffering, life expectancy, and mortality among racial groups. Furthermore, studies indicate that racial disparities in health and health care are interrelated and sustained in various socioeconomic groups.

The structural inequities of systemic racism are compounded by the explicit or implicit biases that may be held by health care providers of any racial or ethnic background. These biases have been shown to also affect relationships between health care providers and patients of color and the quality of the care delivered. The health care establishment is disproportionately White. Health care providers of any racial or ethnic background who are unaware of systemic racism and their own implicit biases often discriminate against Black patients and other patients of color on the basis of stereotypes without even realizing it. Such discrimination can result in differences in care such as inadequate, denied, or delayed medical treatment, unnecessarily prescribed treatment, or cursory care. The statistics show that, on average, Black patients receive medical treatment, including pain medication, less frequently and in later stages of disease than White patients. When Black patients do receive treatments, the medications or procedures are often less effective, less expensive, outdated, and more conservative than those prescribed to White patients.

Researchers continue to investigate the complex connections between race or ethnicity and health care, including the social and economic implications of various policies.

Photo courtesy Pexels.

In addition to structural inequities and provider discrimination, racial disparities in health care access may be affected by differences in language or culture between the provider and patient. Providers need to be culturally competent in order to deliver effective medical care to people from different cultural backgrounds. Often, a lack of cultural competency undermines the necessary cooperation between providers and clients, which in turn results in less effective medical services.

Wayne Winborne and Renae Cohen, editors of *Intergroup Relations in the United States: Research Perspectives* (1998), observed that “advocates of race consciousness in public policy believe that race functions so powerfully in American society that to ignore it is to perpetuate institutionalized inequalities and marginalization of certain groups.” Furthermore, they concluded that “race-cognizant

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One America initiative staff with President Bill Clinton in June 1998.

Photo: White House Photographer, public domain, via Wikimedia Commons.

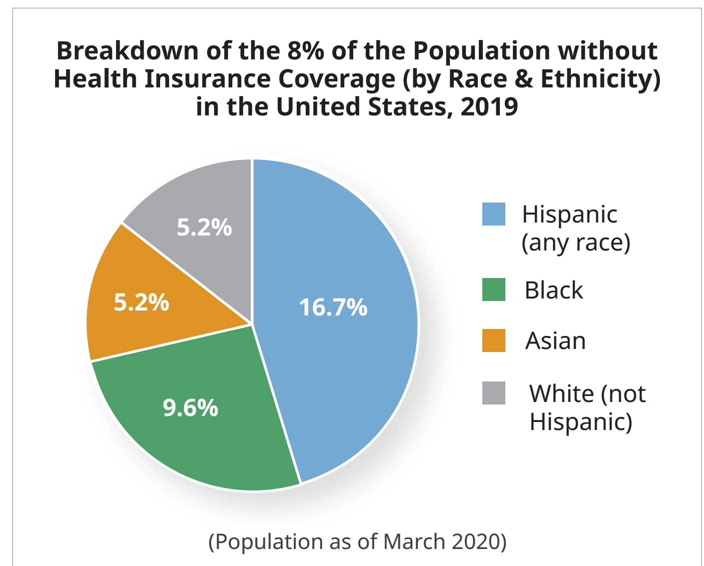
public policies may be seen as improving race relations by fostering equality and recognition of marginalized groups, despite causing backlash against groups benefiting from them." This perspective supports the view that in order to realize improvements in overall health care in the United States, it is necessary to design and implement policies that serve to erode racial inequalities and improve intergroup relations.

The authors of *One America in the Twenty-First Century* outlined a range of steps to eliminate disparities in key areas of health care and access. These recommendations included continued advocacy for broad-based expansions in health-insurance coverage; continued advocacy for increased health care access for underserved groups; increased funding for existing programs targeted to underserved and minority populations; enhanced financial and regulatory mechanisms to promote culturally competent care; and increased emphasis on the importance of cultural competency to institutions training health care providers.

At times the US government has taken concrete steps toward addressing racial and ethnic disparities in health care. In the late 1990s, President Bill Clinton announced efforts to eliminate long-standing racial disparities in infant mortality, cancer screening and management, heart disease, AIDS, and immunizations by the year 2010. While these goals were not met across the board, advocates of health care equity were encouraged by official acknowledgement of the systemic problems in the US health care system. Racial disparities in health insurance coverage were one such unmet goal. The Henry J. Kaiser Family Foundation 2010 report *Health Reform and Communities of Color: Implications for Racial and Ethnic Health Disparities* noted that "although people of color represent one-third of the US population, they comprise more than half of the uninsured." One of the primary objectives of the Patient Protection and Affordable Care Act (ACA), signed by President Barack Obama in 2010, was to close the gap in health care disparity between people of color and White people. For example, one of the provisions expanded Medicare benefits to individuals who are below 133 percent of the federal poverty level. Another provision allowed for affordable care for those who are either not granted insurance through an employer or cannot afford their employer's plan; this provision applies to those whose incomes fall between 133 and 400 percent of the federal poverty level. At the time of the law's passage, 80 percent of Hispanic Americans, Black Americans, American Indians, and Alaska Natives fit into these parameters. According to a Kaiser Family Foundation report, by 2017 the ACA was credited with overall improved health care coverage, access, and utilization for all racial and ethnic groups and a narrowing of some disparities, though gaps remained.

Health Care and Systemic Racism Today

In 2020 the Centers for Disease Control and Prevention (CDC) recognized that "though health indicators such as life expectancy and infant mortality have improved for most Americans, some minorities experience a dispro-



Data from US Census Bureau, Current Population Survey, 2020 Annual Social and Economic Supplement (CPS ASEC).

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Tamara Jones gives antibiotics to James Davis as he recovers from COVID-19 in the intensive care unit at Roseland Community Hospital on December 16, 2020, in Chicago, Illinois. The Roseland neighborhood, on the city's South Side, is 95 percent Black. The COVID-19 death rate among Black Chicagoans is nearly double that of the city's White residents.

Photo: Scott Olson, Getty Images.

portionate burden of preventable disease, death, and disability compared with non-minorities." Yet, despite an increasing awareness of institutional racism in health care, statistics show that disparities in health care, delivery, and outcomes continue to exist and even to grow in certain areas into the twenty-first century. According to a September 2021 US Census Bureau report, while 8.6 percent of the US population overall was uninsured in 2020, the percentage uninsured varied when broken down by race and ethnicity. That year, 5.4 percent of White, non-Hispanic Americans were uninsured, compared to 10.4 percent of Black Americans, 18.3 percent of Hispanic Americans of any race, and 5.9 percent of Asian Americans.

Researchers continue to investigate the complex connections between race or ethnicity and health care, including the social and economic implications of various policies. New challenges also continue to emerge. For example, CDC data from November 2021 show Black or African Americans were about twice as likely as White Americans to die of the coronavirus disease 2019 (COVID-19) during the global pandemic—even after researchers accounted for higher rates of preexisting conditions that increase the mortality risk of COVID-19, such as obesity, hypertension, and diabetes among the Black population. American Indians or Alaska Natives and Hispanics or Latinos also had COVID-19 death rates more than twice than White Americans. Black Americans' and Latinos or Hispanics' risk of hospitalization from COVID-19 was also about two and a half times that of White Americans, while American Indians and Alaska Natives were more than three times more likely to be hospitalized.

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