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Does Twenty-Five Years Make a Difference in "Unequal Treatment"?: The Persistence of Racial Disparities in Health Care Then and Now

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In 1985, the Secretary of the U.S. Department of Health and Services (HHS) issued a landmark report that exposed the persistence of racial disparities in the U.S. healthcare system.[1] Unfortunately, twenty-five years later, racial disparities in healthcare continue to persist. For example, since 1985, more African-Americans have died from coronary disease, breast cancer, and diabetes than Caucasians, even though more Caucasians suffer from these diseases than African-Americans.[2] Notwithstanding their increased mortality rates, African Americans "have a statistically significantly lower mean number of annual ambulatory [walk-in] visits and are less likely to have seen a physician in [any given] year."[3] Studies also show that "relative to Caucasians, African Americans are less likely to receive analgesics for pain, cardiac medications, surgery for glaucoma, and referral for cardiac catheterizations."[4]

In this short essay, I briefly contrast recent history of federal government programs aimed at eliminating racial disparities in healthcare and issue an urgent challenge scholars, researchers, and federal officials to adopt a new approach to eradicate racial disparities.

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1. Office of the Director, U.S. Department of Health and Human Services, *The Report of the Secretary's Task Force on Black and Minority Health*, 35 MORBIDITY & MORTALITY WEEKLY REPORT 109 (1985).

2. Robert Weinick, et al, *Racial and Ethnic Differences in Access to and Use of Healthcare Services, 1977 to 1996*, 57 MED. CARE RES. & REV. 37, 51 (2000).

3. Robert Blendon, et al., *Access to Medical Care for Black and White Americans—A Matter of Continuing Concern*, 261 J. AM. MED. ASSOC. 278, 279 (1989).

4. Mary L. Fennell et al., *Facility Effects on Racial Differences in Nursing Home Quality of Care*, 15 AM. J. MED. QUALITY 174, 174-76 (2000).

I. GOVERNMENT INITIATIVES TO CONFRONT RACIAL DISPARITIES IN HEALTHCARE

In 1998, President Bill Clinton announced the Initiative to Eliminate Racial and Ethnic Disparities in Healthcare that was supposed to eliminate racial and ethnic health disparities in six key areas of health status, including infant mortality, by the year 2010. In 2000, elimination of racial disparities in healthcare was one of the main objectives of Healthy People 2010, initiated by HHS.

In 2002, the groundbreaking Institute of Medicine Study (IOM study) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* acknowledged continued racial disparities in healthcare and provided suggestions for the elimination of these disparities. Finally, in 2007 the National Healthcare Disparities Report (NHDR) noted that disparities in healthcare quality and access were not getting smaller and that the biggest gaps in quality and access to healthcare remain.[5]

In spite of these initiative and reports, racial disparities in healthcare have worsened over the past few decades. In 1985, researchers found that minorities suffered 60,000 excess deaths compared to Caucasians. By 2005, this number had grown to 83,570.[6] In fact, "there has been no sustained decrease in black-white disparities in age-adjusted mortality (death) or life expectancy at birth at the national level since 1945."[7] But how can this be the case twenty-five years later? I submit that the continuation of racial disparities in healthcare is due to the failure to meaningfully acknowledge and address the root cause of racial disparities: racial discrimination.

II. THE PERPETUATION OF RACIAL DISPARITIES DUE TO RACIAL DISCRIMINATION

Scholars and researchers have asserted a panoply of causes for the continuation of racial disparities in access to quality healthcare, including, cultural differences, insurance status, socioeconomic status, and education levels. Yet, innumerable research studies show that even when all these factors are controlled racial disparities in healthcare persist, leaving race as the only plausible explanation for the continuation of disparities.[8] But what

5. United States Department of Health and Human Services, Agency for Healthcare Research and Quality, *2007 National Healthcare Disparities Report*, Washington, D.C., February 2008.

6. David Satcher, et al, *What If We Were Equal? A Comparison Of The Black-White Mortality Gap In 1960 and 2000,* 24 HEALTH AFFAIRS 459 (2005).

7. Robert S. Levine et al., *Black-White Inequalities in Mortality and Life Expectancy, 1933-1999: Implications for Healthy People 2010,* 116 PUB. HEALTH REP. 474, 475, 480-482 (2001).

8. H. Jack Geiger, *Health Disparities: What Do We Know? What DO WE Need to Know? What Should We Do?, in* GENDER, RACE, CLASS, AND HEALTH 261-288 (2006).

does race have to do with it?

Some argue that race these disparities in health outcomes are explained by the biological/genetic differences between racial groups; however, biologically differences in race account for at most .03% of genetic variation, a minute fraction too small to have any negligible impact.[9] Thus, if race plays a role in racial disparities, genetic research suggests that it is due to the social construction of race, not biological differences.

Unfortunately, the significance of racial discrimination in causing racial disparities in healthcare is often ignored; however, some credible and robust research studies have suggested that racial discrimination is a chief factor in the continuation of racial disparities in healthcare. I briefly discuss this evidence below.

III. RACIAL DISCRIMINATION IN THE HEALTHCARE SYSTEM

In 1999, a study involving simulated patients found that a patient's race affected a physician's decision to recommend cardiac catheterization.[10] One year later, a survey of physicians' perceptions of patient's found that physicians rated African American patients as less intelligent, less educated, and more likely to fail to comply with medical advice physicians.[11]

That same year, Dr. Calman, a Caucasian physician serving a predominately minority area in New York, wrote about his battle to overcome his own and his colleagues' racial prejudices, which were barriers to the ability of racial minorities to access quality healthcare.[12] Most recently, a 2008 study exploring implicit and explicit attitudes about race found that physicians subconsciously favor Caucasian patients over African Americans.[13] The 2002 IOM study and 2007 NHDR noted that healthcare providers, such as physicians, are influenced by a patient's race.

Furthermore, research has shown that "experiences of discrimination in healthcare lead to delay in seeking care, an interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the healthcare system."[14] Not only has racial discrimination prevented African

9. Windsor Mak, et al, *Biological Basis of the Racial Disparities and Diseases: An Evolutionary Perspective, in* RACIAL ND ETHNIC DISPARITIES IN HEALTH AND HEALTHCARE 75 (2006).

10. Kevin Schulman, et al, *The Effect of Race and Sex on Physicians' Recommendation for Cardiac Catheterization*, 340 NEW ENG. J MED. 618, 623 (1999).

11. Michelle van Ryan and Jane Burke, *The Effect Of Patient Race And Socio-Economic Status On Physicians' Perception Of Patients*, 50 SOCIAL SCIENCE & MED. 813, 813 (2000).

12. Neil S. Calman, *Out of the Shadow: A White Inner-City Doctor Wrestles With Racial Prejudice*, 19 HEALTH AFFAIRS 170 (2000).

13. Janice Sabin, et al, *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. Healthcare Poor & Underserved 896, 907 (2009).

14. *Id.*

Americans from accessing healthcare services, but it has also caused African Americans to have poor health outcomes, such as increased rates of infant mortality.

IV. THE EFFECTS OF RACIAL DISCRIMINATION ON AFRICAN AMERICANS HEALTH STATUS

One of the main goals of both the 1998 Initiative to Eliminate Racial and Ethnic Disparities in Healthcare and Healthy People 2010 was to reduce disparities in infant mortality. Although the overall infant mortality rate reached record low levels in 2000, the rate for African Americans remains twice that of Caucasian regardless of socioeconomic status, education, and/or health insurance status.[15] The main cause of death for African American infants is preterm birth and low birth weight. Although there are several risk factors for low birth weight including, but not limited to, stress, there has been little research concerning the effects of stress caused by perceived racial discrimination.

According to a recent study, the stress from perceived racial discrimination is more predictive of racial disparities in infant birth weight than alleged biological racial differences.[16] In the study, infant birth weights of African American, Caucasian and African women were compared. The birth weight of Caucasian and African infants were almost identical, whereas the birth weight of African American infants were substantially less. Coupled with these findings was a comparison between African American women who had babies with normal weights at birth (NLBW) and African American women who had babies with very low birth weights (VLBW)—under three pounds. Researchers found that "African American mothers who delivered VLBW preterm infants were more likely to report experiencing interpersonal racial discrimination during their lifetime than African American mothers who delivered NLBW infants at term."[17] As a result of both studies, researchers suggested that one reason African American mothers have babies who weigh less at birth is that they are subject to stress caused by perceived racial discrimination.

According to the research on physician bias and infant mortality, racial discrimination not only leaves African Americans more vulnerable to stress that causes a host of illness, but it also prevents African Americans from

15. Vera Haynatzka, et al, *Racial and Ethnic Disparities in Infant Mortality Rates—60 Largest U.S. Cities, 1995-1998*, 51 MORBIDITY & MORTALITY WEEKLY REP. 329, 329 (2002).

16. Richard David and James Collins, Jr, *Disparities in Infant Mortality: What's Genetics Got to Do With It?*, 97 AM. J. PUB. HEALTH 1191 (2007).

17. James Collins, Jr., et al, *Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination,* 94 AM. J. PUBLIC HEALTH 2125, 2135-2137 (2004).

receiving the optimal care for stress-related symptoms and illnesses. Simply increasing access to health insurance will not eliminate these problems. Hence, as the nation moves closer to passing healthcare reform legislation that will increase access to health insurance, it must also include measures to eliminate racial discrimination otherwise racial disparities will persist.

V. CONCLUSION

Racial disparities persist in part because we ignore one of the root causes of the disparities: racial discrimination. To eradicate racial discrimination, I suggest that at a minimum the federal government needs to increase research to further illustrate the significance of racial discrimination in healthcare. Furthermore, because healthcare providers, such as physicians, are not covered under Title VI of the Civil Rights Act of 1964 (Title VI), which prohibits racial discrimination in the provision of healthcare, they are not punished for their failure to provide quality care to African Americans because of this discrimination. Therefore, I recommend revision of Title VI or passage of a new anti-discriminatory provision in the current healthcare reform legislation that explicitly prohibits and sanctions physicians for racially discriminating. These steps will not only lay the foundation for programs to eradicate racial discrimination, but it will force everyone participating in the healthcare system to acknowledge the continuing problem of racial discrimination in healthcare.