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Structural Racism Key in Health Care Disparity

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The death of George Floyd in May of 2020 at the hands of police shocked the nation as video footage of the event was played on every channel during every newscast.

Millions watched in horror as George pled with Derek Chauvin for his life, called out for his dead mother, and cried, "Please, I can't breathe!" Thousands of people in Minneapolis and other metropolitan cities across the United States took to the streets in protest of the systemic racism present in our police departments and the targeting and murder of people of Color by those who are sworn to serve and protect them.

We watched, feeling saddened, shocked, and awakened, as Minneapolis was looted and burned. We weren't horrified because systemic racism is a new problem that we had just become aware of. We were horrified because when we saw it with our own eyes, we could no longer ignore it. Structural and systematic racism does not just exist in our police departments, but influences our healthcare system as well. The COVID-19 pandemic was the catalyst, the George Floyd (if you will), that has brought this racism and discrimination to the forefront and demanded that we take notice. The pandemic has shed a bright light on disparities along racial and ethnic lines, revealing life-threatening consequences that cannot be denied, ignored, or explained away any longer.

The proof of structural racism is in the numbers when looking at the impact of COVID –19 on the Non-Hispanic Black population versus Non-Hispanic Whites. According to the Centers for Disease Control and Prevention (CDC), of the COVID-19 tests performed on Black Americans, 13.8% of tests were positive compared to 7% for White Americans, reflecting the higher rate of infection. In addition, Black Americans are 4.7 times more likely to be hospitalized and are 3.5 times more likely to die due to COVID-19 compared to Whites.[1]

These figures are even more astounding when referencing the American Indian or Alaska Native population and are similar to those of the Hispanic or Latino population.[2] Large disparities also exist in the percent of Black Americans that are getting vaccinated compared to vaccination rates for Whites. While it is acknowledged by the CDC and other institutions that preexisting health conditions, living conditions, work-related exposures, and lack of education factor into the racial disparities in infection rates and outcomes, it's important to be clear and honest about the structural racism that is at the heart of these factors.[3]

It is true that Black Americans have higher rates of some health conditions that put them at greater risk for poorer health outcomes such as hypertension, cardiovascular disease, diabetes, chronic respiratory disease, liver disease, and autoimmune disease—but there is increased risk of

[1] Sophie Lewis, "Black Doctor in Indiana Dies of COVID-19 After Publicly Complaining of Racist Treatment at Hospital," *CBS News*, December 25, 2020, https://www.cbsnews.com/news/black-doctor-susan-moore-indiana-dies-covid-19-facebook-video-racist-treatment-iu-hospital/. Mathieu Rees, "Racism in Healthcare: What You Need to Know," *Medical News Today*, September 17, 2020, https://www.medicalnewstoday.com/articles/racism-in-healthcare.

[2] Centers for Disease Control and Prevention (CDC). "COVID-19: Community, Work, and School," *Centers for Disease Control and Prevention*, February 11, 2020.

[3] Crista E. Johnson-Agbakwu, Nyima S. Ali, Corrina M. Oxford, Shana Wingo, Emily Manin, and Dean V. Coonrod, "Racism, COVID-19, and Health Inequity in the USA: A Call to Action," *Journal of Racial and Ethnic Health Disparities* 9, no. 1 (2022), 52–58.

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these conditions when poverty, historical trauma, and being discriminated against are present.[4] If we are to see better health outcomes overall, the underlying contributors of racist policies and biases need to be uncovered and addressed.

For generations, policies have perpetuated racial segregation and discrimination and have promoted the economic and education disparities between Black and White Americans. Redlining, which forced Black Americans who were escaping the horrific conditions in the South into poor, segregated neighborhoods in the North, had ramifications that persist to this day. Black Americans continue to be overrepresented in low-wage jobs with many living in segregated, overpopulated, and impoverished communities with increased pollution levels and limited transportation.[5] Since schools are funded by property taxes, another system that discriminates, the schools in these communities don't provide the same level of education as schools in wealthier, predominantly White neighborhoods. This impacts future income as well and perpetuates the cycle into future generations.

Poverty, homelessness, and unemployment, conditions that disproportionately affect Black Americans, make them more prone to poor health, increase their risk of severe disease, and cause them to be more likely to die from COVID-19. Access to healthcare plays a pivotal role, with a lack of quality health insurance taking center stage. Black Americans are consistently overrepresented in lower-paying occupations and make less money than their White counterparts at all job levels, resulting in a disproportionate number of Black Americans either having inferior health insurance or none at all.[6] Without adequate health insurance, Black Americans are less likely to see a provider for preventative measures and are more likely not to be treated for existing conditions, only seeking medical care in cases of emergency, and sometimes, not even then due to financial constraints.[7]

It is not just financial constraints and lack of health insurance that influence Black Americans not to seek treatment or preventative measures, but also a distrust in the medical community due to decades of racist policies and actions that negatively impacted marginalized groups. The medical community has a long history of mistreating Black Americans, including conducting gruesome experiments on enslaved people, forced sterilizations, and the infamous Tuskegee study where treatment for syphilis was withheld from hundreds of Black men. These men were misinformed about their diagnosis, were given placebos instead of treatment, and were coerced into having unnecessary and painful tests done, all to track the progression of the disease.[8]

Many Black Americans today have had their own experiences with discrimination at the hands of medical professionals. A 2016 study showed that 73% of medical students and residents held one or more false beliefs about biological differences between Black patients and White patients. Some of these centuries-old

[4] Elizabeth Ann Andraska, Olamide Alabi, Chelsea Dorsey, Young Erben, Gabriela Velazquez, Camila Franco-Mesa, and Ulka Sachdev, "Health Care Disparities During the COVID-19 Pandemic," *Seminars in Vascular Surgery* 34, no. 3, (September 2021), 82-88.

[5] Utibe R Essien and Atheendar Venkataramani, "Data and Policy Solutions to Address Racial and Ethnic Disparities in the COVID-19 Pandemic." *JAMA Health Forum* 28 (April 2020).

[6] Algernon Austin, "Why Do Blacks Earn Less?," *HuffPost* (May 26, 2011).

[7] Johnson et al, "Racism, COVID-19, and Health Inequity in the USA."

[8] Martha Hostetter and Sarah Klein, "Understanding and Ameliorating Medical Mistrust Among Black Americans," *Commonwealth Fund* (January 14, 2021), https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans.

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beliefs about Black people—ones created by doctors to justify the inhumane treatment of slaves—include the assumptions that Black people have thicker skin, that they have less sensitive nerve endings, and that they have stronger immune systems. These beliefs by medical professionals result in sub-standard care such as not receiving appropriate pain management, not being classified as needing emergency care, not being admitted to the hospital, and not having needed tests ordered.

These biases transcend income and education as was the recent case of Dr. Susan Moore who documented her treatment after being diagnosed with COVID-19, claiming that she wasn't getting sufficient care from White doctors and nurses because she was Black. Dr. Moore reported that she had to beg for the antiviral treatment, Remdesivir, that she had to wait hours for pain medication, and that she had to demand a CT scan to prove her pain was real. Even after the test confirmed the source of her pain, Moore said that the doctor "made me feel like I was a drug addict, and he knew I was a physician."

Dr. Moore spoke with a patient advocate and asked to be transferred to another hospital, but instead she was sent home. At this she said, "This is how Black people get killed. When you send them home and they don't know how to fight for themselves." Dr. Moore went home, only to be admitted to a different hospital less than twelve hours later when she spiked a fever and her blood pressure plummeted. On December 22, 2020, COVID-19, and, likely, racism that resulted in poor care, took Dr. Moore's life.[9]

In the past few years, a bright light has been shown on the systemic and structural racism that is, and has been, negatively impacting the lives of Black Americans and other marginalized communities. This racism impacts our justice systems, police departments, employment agencies, education systems, housing policies, healthcare system, and a multitude of other policies, programs, and institutions. Actionable steps need to be taken at the federal, state, and local levels. Lawmakers need to enact policies that address ongoing discrimination in labor and housing markets, in the justice system, and they need to create universal healthcare, raise wages, and invest in marginalized communities.

Current policies that promote discrimination and segregation, such as education funding, need to be challenged and reformed. We need training that starts at the student level and progresses throughout an institution's hierarchy that acknowledges, validates, and addresses the existence of structural racism, that promotes self-reflection and educates on implicit bias, microaggression, and culturally competent care and interaction.[10] We need to strengthen public health departments and social service organizations with deeper relationships in minority communities and improve health literacy.

There need to be more Black Americans and others from marginalized groups being accepted into medical school and other programs that create more diversity in the occupations that they are currently underrepresented in. There needs to be an overall improvement in infrastructure and resources for vulnerable communities and hospitals.

Seeing and acknowledging the problem isn't going to change it. To protect the health and lives of minorities, we need to take action or the race disparities that have existed for centuries will only continue.

[9] Lewis, "Black Doctor in Indiana Dies of COVID-19 After Publicly Complaining of Racist Treatment at Hospital."

[10] Rees, "Racism in Healthcare."