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**Racial Inequality of United States Health Care**

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Biology and Psychology

University of Wyoming

Honors Program Senior Thesis

## Introduction

Categories or labels including race, religion, socioeconomic class, and gender are ascribed, often without implicit intent, to well-known people and strangers alike. People have placed others in categories for centuries. Race is one category that is so deeply ingrained in our worldviews that it enters nearly every aspect of human life. As a construct, it is judged by the physical characteristics of a person, especially skin color. Race impacts personal interactions, education and occupational opportunities, and health care access. One of the most alarming impacts of race is in the health care system. Patients of different races are treated differently by medical professionals, and therefore, often have different medical outcomes (Golash-Boza, 2015). But race is not a biological or scientific construct, it is a social one. A social construct is a set of views or beliefs maintained by culture. Race is not a biological construct. There are more differences within people of the same race than there are between different races, on average. The difference in DNA between one human to any other human on the planet, is only half of a percent (Berg et al., 2015). While humans are more similar than they are different, major health disparities do exist between races. This issue will be identified in scope and magnitude, as well as addressing solutions to bring about health equality in the future.

To begin, several definitions will be clarified. Health *disparity* is a broad term, that can be used to define a discrepancy or gap that occurs in health status or health care. Health *status* describes how healthy an individual is and what diseases he or she may potentially suffer from

during a lifetime. The treatment an individual receives in the health system, by doctors, nurses, or other providers is known as health *care* (Geiger, 2005). Health *disparity* and health *inequality* refer to the same problem, which is different groups of people having different levels of health status and receiving different levels of health care. In the United States, a group of people who suffers the most from severe health inequality and disparities are racial minorities.

**Historical Context of U.S. Health Care**

To fully understand racial health disparity today, the history of the American health system must be understood. For centuries, health inequality attributes the most severe differences to race. The health of racial minorities has suffered due to unethical treatment and negligence of medical personnel for centuries since the country was founded. This unethical treatment can be traced back to the time of slavery, when African Americans were not treated but rather medically experimented upon without consent (Golash-Boza, 2015). These medical treatments were often painful, as anesthesia was not used. In the beginning of slavery in the U.S., anesthesia had not been invented yet. But even when it was invented, it was not used in the case of these medical experiments. Unfortunately, there are cases of this medical experimentation until the time when slavery was abolished in 1865. Since enslaved people were considered subhuman, the record keeping is not conclusive. The number of African Americans experimented on is unknown. Much of the knowledge comes from autobiographies that were written by literate slaves who escaped. Obviously, this data represents only a small proportion of the experiments that occurred during this time, as the number of escaped slaves was low and the number of those who could read and write to tell the story was even lower. To make matters worse, often, the enslaved people never even received the treatment they were used to develop, but it was instead given to white people who could pay for the treatment (Washington, 2006). In terms of mental health

during this time, African American diseases were vastly misrepresented in the census. In reviews of the census, it was found that in some towns the census would report double the mentally ill African Americans than the number of African Americans that even lived in the town (Washington, 2006). Even after the reviews, it was said to be free of errors; the misrepresentation and lying that occurred about the population was written into history and never fixed in the government records. The next well recorded violation of rights was when many bodies were traded to medical schools for dissection. Most of these bodies were removed from cemeteries, without prior consent of the person or the posthumous consent of the family. However medical schools kept excellent records of the deceased that were exhumed and used as unwilling cadavers. This practice was often done disproportionally to African Americans. At the Medical College of Georgia, 75 percent of the bodies recovered were of African Americans, even though the minority represented less than 50 percent of the population (Golash-Boza, 2015). With less power in society, the bodies of African Americans were less protected. If a person of affluence died, the body was often guarded until it had decomposed enough that it could not be used for dissection. For African Americans, this was not the case. Thus, the bodies of African Americans were more often used against their knowledge or familial consent to be dissected by medical schools.

Another well known, shockingly relatively recent, example of exploitation of the health care gap in people of color is the Tuskegee syphilis experiment. In this study, hundreds of African American men were told they were being treated for a disease. Instead, scientists were observing how untreated syphilis affected the human body (Reverby, 2000). Untreated syphilis is a painful disease that causes lesions, appetite changes, headaches, visual disturbances, and organ failure followed by death (Chapel, 1980). This disease can be passed between people through

sexual contact. Therefore, not only did the men have the disease, they were likely also passing it to other people without being aware. The Tuskegee Study did not end until 1972. Another startling practice that is disproportionately preformed on people of color is that of sterilization. It is easier to think of sterilization as something of the past. Yet, practice is still occurring today. Only 19 percent of white women have undergone the procedure to be permanently unable to carry a child. In contrast, 30 percent of African American women had been sterilized in 2004 (Golash-Boza, 2015). This is because African American women are often not thought to be capable of deciding how to care for their own reproductive health, and therefore are often convinced to undergo sterilization to prevent further pregnancies. This is true even when looking at women of similar statuses, including martial and income status (Golash-Boza, 2015).

These examples demonstrate that racial inequality is not a new phenomenon and has been occurring for many centuries. And racial inequality is still present within the US medical system. The treatment of people of color in the United States remains a cause for great concern. While laws now prevent extreme mistreatment, they have not eliminated health disparity.

**Current Health Disparity in U.S.**

There has never been a time, in the history of the country, that the health status of minorities has been equal to that of white Americans (Geiger, 2003; Byrd and Clayton, 2000; National Center of Health Statistics, 2003). Today, a person's race will have a significant impact on the health care through a given lifespan. In the United States, a person from a racial minority is more likely to live with more illnesses and have a shorter lifespan than a Caucasian person. This is especially true of African Americans, though it is certainly true of other racial minorities, such as Hispanics, Native Americans, and Asian Americans as well. For African Americans, a six-year shorter life is expected than a white American born at the same time (National Center

for Health Statistics, 2003). Black Americans are more likely to die from a startling variety of disease including pneumonia, cancer, HIV or AIDS, influenza, diabetes, and cardiovascular disease. The disparity between races is so severe that if the disease death rate for African Americans was adjusted to be the same as Caucasian Americans, 866,000 African American deaths could have been prevented in a single decade (National Center for Health Statistics, 2001; Woolf, 2004). These are all diseases that are treatable and largely preventable with education and a healthy lifestyle; these are not diseases that vast amounts of people should be dying from in an industrialized country with adequate health care available. The fact that 866,000 African American individuals lost their lives, and 866,000 families had to grieve a premature death caused by racial inequality in health care should be a wakeup call. While African Americans do experience the worst health disparity, when compared to white Americans, racial inequality also extends to Hispanic Americans, Native Americans, and Asian Americans.

A specific case of health disparity can be found in blood pressure differences between African Americans, white Americans, and citizens of West Africa, which is where many African Americans can trace their ancestry. The average blood pressure of African Americans is much higher than that of Caucasian Americans of similar age and health, putting them at higher risk for a variety of diseases. African Americans have been recorded having some of the highest blood pressure found anywhere in the world. However, West Africans have some of the lowest blood pressure found anywhere in the world, lower than both African Americans and white Americans (Cooper et al., 1999). Clearly, the issue of blood pressure is not genetic. If the recent ancestors of African Americans come from West Africa, and the blood pressure is vastly different in the two populations, genetics and race cannot explain this difference in health. It is puzzling that the two extremes, highest blood pressure and lowest blood pressure found anywhere on the planet, are

found in a similar genetic population with the same ancestor. The explanation can most likely be found in the racialized society that African Americans live in that lead to the first part of health disparity which is health status.

The second piece of health disparity, treatment, can also be demonstrated with a specific example. Hemophilia and sickle cell anemia are two deadly blood disorders. Each of these are hereditary diseases that can be passed from parents to children depending on the combination of genes that occurs during formation of the zygote. In relation to racial difference, hemophilia affects mostly white men, while sickle cell anemia disproportionally affects African Americans. This is because of the prevalence of the disease-causing genes present in these populations which raises the chance that two parents will pass the disease to children. Hemophilia occurs in approximately 20,000 people in America. Sickle cell occurs in five times as many people or 100,000 people. In fact, one in twelve people with African descent carry the alleles for this disorder (American University Radio, 2018). Sickle cell disease can cause pain, stroke, organ failure, and early death (American University Radio, 2018), while hemophilia results from a blood clotting factor deficiency that causes joint pain and can cause severe blood loss when injured (National Heart, Lung, and Blood Institute, 2016). While far fewer people suffer from hemophilia, there are 28 separate drugs to treat this disorder. There are only two medications to treat sickle cell; and the second one was released in 2017. Before that drug's release people only had one treatment option for the disease. Clearly, funding has gone to find a treatment to improve quality of life for those suffering with hemophilia. But sickle cell disease has largely been ignored, and treatment has lagged the treatment for other blood disorders. This health treatment disparity is stratified by race.

**Compounding Factors**

As with most huge, national scale issues health disparities interact on multiple levels. Individual factors such a gender and socioeconomic status interact with race to determine the health care inequality that an individual may face throughout a lifetime. While it is crucial to understand that the main cause of health disparity is race, there are factors that can exacerbate the disparity. Two factors that can widen the gap in health care are socioeconomic status and gender of the person receiving health care in the United States. But even when controlling for these factors, health outcomes for racial minorities is still far worse.

Socioeconomic status has long been given as a reason that people have differing levels of health care in the United States, and for good reason. A poorer person is less likely to have access to quality care in the area they live, is more likely to suffer from poor nutrition and inadequate or unsafe housing, and obviously, have lower income to be able to pay for health care (Willians, 2004; Berkman & Kawachi, 2000; Hofrichter, 2003; Kawachi, Kennedy, & Wilkinson, 1999). These differences, between people of lower and higher socioeconomic status are problematic on their own but can also cause long term health problems. For example, not being able to afford nutritious food can cause hunger in the short term. It can also result in obesity and/or malnutrition in the long term, because the food that is being consumed does not have proper nutritious value. This requires the person to seek medical care, where further issues are encountered. For poor patients, and especially when the person is both poor and racial minority, it has been found that even simple medical procedures are not completed properly. Clinical history, physical examination, and routine blood and laboratory work are likely not completed well; minority patients are also far less likely than white patients to be given

medication to control pain even for acute medical problems such as bone fractures (Kahn et al., 1994; Todd, Samarov, & Hoffmam, 1993). This may be because of inattention by providers or because health professionals believe the medication will be used recreationally. Thus, while poor people of all races deal with issues such as lack of access to health care and poor nutrition, poor people of color must also deal with problems such as increased pain and decreased attentiveness of providers once the decision is made to access medical care. The trend of poorer health and healthcare for minorities also continues into the middle class of America. African Americans of middle class socioeconomic status rate themselves as sicker and have more chronic illnesses than do white middle-class Americans (Farmer and Ferraro, 2005). So, while middle class Americans have more access to care and face fewer difficulties in accessing heath care, minorities are still facing more illness in their lives than their white counterparts solely due to race. And while people of low socioeconomic status certainly have health disparity from those with higher socioeconomic status, the larger factor at play is racial identity.

Another factor that will determine how healthy a person is through a lifetime is gender. Someone's gender will also contribute to sickness and health care treatment; the gender who experiences inequality and poorer health is women. From puberty onward, women are more physically and mentally ill than men are, even when reproductive health problems are excluded (Lorber & Moore, 2002; Sweeting, 1995). Many illnesses, such as anorexia nervosa and depression can be related to gender norms of society (Hill, 2009). Women are expected to conform to a certain body shape and personality type to be attractive, which puts unnecessary pressure on women of all ages. This can lead to a less healthy life, overall, for women than men.

One health problem that disproportionately affects women is breast cancer. This is not a social or cultural issue, women being more affected by breast cancer than men is biological.

While men can develop breast cancer, women are far more likely to; for every man diagnosed with the disease, there will be 100 women diagnosed (American Cancer Society). Women being diagnosed more than men is a biological factor of the disease. Equally alarming is the social factor of race in the diagnosis and treatment of the disease. A white woman in America is more likely to get breast cancer than an African American woman; this could be do lifestyle choices or hereditary influences. But the African American woman will more likely die from the disease (Hennessey-Fiske, 2010). Even an issue that begins biologically, breast cancer ends up having disparities in which ethnicities are less likely to survive the devastating diagnosis and disease.

**Explanations of Health Disparities**

The question remains, what institutional or other biases cause people of racial minorities to suffer from health disparities through life and die younger than their white counterparts. There are numerous explanations for health disparities in the United States. A single cause cannot directly explain the inequality that exists in health care. But a combination factors can illuminate institutional problems that perpetuate racial inequality. The disparity of health status and health care exists for minorities is exacerbated by exposure to environmental hazards, lack of cultural competency of health care providers, and implicit bias.

Racial minorities in American face environmental hazards far more often than do Caucasians. These environmental hazards often come in the form of increased pollution and toxic waste that are disproportionately located in neighborhoods where people of color reside. The strongest predictor of where a dangerous waste facility is located is the neighborhood's racial makeup. Race can predict the location more closely than household income, value of homes in the area, and the amount of waste that is produced in the area that must be treated in a facility (Bullard et al., 2007). People of color, no matter where they live in the country, how

much their home is worth, or how high their socioeconomic status is, are more likely to live close to or have a hazardous waste facility built in the area they live in. Minorities in the United States are also more likely to suffer from air pollution than are whites, as the standards set by the Environmental Protection Agency for air quality are less likely to be met if the area is one in which many racial minorities live. This can cause short-term and long-term health consequences. In the short-term people who live in areas with high pollution, such as by a hazardous waste facility, can be diagnosed with upper respiratory infections, headaches, and nausea; in the long-term diagnoses may include asthma, lung cancer, or heart disease (Morton et al., 2014). This nation has over 400 waste facilities, and nearly ten million people live within two miles of one (Morton et al., 2014), while not all these millions of people are racial minorities, clearly many are. More people of color are adversely affected by the hazardous waste and air pollution; once exposed to these dangerous chemicals it causes health problems for the rest of a lifetime.

Another explanation for extreme health disparities for people of color is lack of cultural competency by health care providers. Cultural competency refers to awareness of and respecting cultures that are not your own and being able to effectively communicate with people of differing backgrounds (Brach & Fraserirector, 2000). In a health care situation, this refers to the relationship between the patient and health care provider, such as a doctor, nurse, or other provider. This can be a result of a mismatch between health beliefs in different communities, lack of minority workers in health care, language barriers, patient distrust in the health system, and location and hours of operation of health services (Brach & Fraserirector, 2000). Providers and health institutions may not be aware of the differences in culture, and thus, do not interact effectively with minority groups. Patients may already distrust the medical system from previous experience or because of cultural beliefs about the importance of alternative medicine, and when

health care providers do not address these concerns it can perpetuate the issue and cause more health inequality. Health providers who are not part of the cultural group are not aware of the differences, but these differences can be glaringly obvious to the minority patient being treated.

Implicit bias on the part of health care providers is another explanation for health inequality of racial minorities. Implicit bias is unconscious, and often unintentional differential treatment of people with different races than self. In contrast to explicit bias in which someone will outwardly say and express dislike for a race, implicit bias is often never outwardly expressed and can go unnoticed. An example of an implicit bias, in general terms, would be sitting closer to a white person than an African American on a bus, even though one had to walk further to sit closer to the white person. The average clinician has been shown to have a moderate bias against African Americans as opposed to Caucasian Americans (Blair et al., 2011). The bias can manifest in treatment and doctor visits with the African American in a variety of ways. An example, to demonstrate how implicit bias may work in a clinic setting, is a white physician treating an African American who is receiving treatment for hypertension. The woman comes in for treatment, and her blood pressure is higher than her previous treatment. The physician decides that she is not following her treatment regimen, he assumes that she cannot afford the more extensive medication to treat the problem and decides to continue current treatment even though it is not working. A Caucasian American comes in for the same problem, and the same clinician assumes the medication is not strong enough, instead of the regimen not being followed, and prescribes a stronger treatment. The conceptual model given is one example, of countless, of a way that an implicit bias which is never stated, and likely not even known by the physician, can negatively impact a person receiving treatment (Blair et al., 2011). While the physician did not intentionally treat the African and Caucasian patients differently, implicit bias

outside of conscious awareness left the two patients with far different treatments and likely two different health outcomes.

**Solutions to Lower Health Inequality**

Men and women of color living sicker and shorter lives, because of their race, is a clear and startling issue. While there are countless explanations as to why minorities experience health disparity in the health system, environmental discrimination, lack of cultural competency, and implicit bias are three factors that greatly impact the experience of people of color when receiving health care. The medical system has begun to recognize it as such and implemented programs to combat the issue. While some of the programs have helped educate doctors on ways to combat health care inequality, not all are effective. Programs to combat inequality have begun to work towards ending the health care gap in America, but there are still many steps that must be taken to allow every person a chance at living a healthy life, regardless of race. A starting place for this to change is within medical schools. Before these future doctors practice medicine, steps can be taken to combat racial inequality in health care and make future health care providers aware of the problem.

One step that has been taken, by many medical schools across the country, is to implement courses aimed at helping doctors understand the significance of alternative and complementary medicine. It is important for students who will eventually practice medicine to understand this because many races and cultures have differing ideas of medicine and health. These often include treatments from traditional sources as opposed to exclusively mainstream, Western medicine. This is not only true of racial minorities, it is true of one third or Americans. It has been found that about 33 percent of adult American use some form of alternative or complementary medicine, which could include acupuncture, homeopathic medicine, or

chiropractors (Wetzel et al., 1998). While this solution is not race specific, it does help racial minorities because it allows future physicians to understand how complementary and alternative medicine can be used in conjunction with modern medicine to treat and cure patients. At the time of the study, 64 percent of the 125 medical schools in the United States reported having at least one class in the curriculum relating to complementary or alternative medicine, while 41 percent of the schools had the topics covered in a required course (Wetzel et al., 1998). At first glance, this seems like a hopeful number, with 41 percent of schools requiring learning about this and another 23 percent giving the option to students. But this still leaves up to 59 percent of future practicing doctors with no formal education about the topic. As 33 percent of Americans, including many racial minorities, use complementary or alternative medicine, nearly all doctors will encounter patients who will use this in conjunction with the treatment they are receiving. Doctors must be aware of this and ensure the treatments are compatible and safe. Thus, the more medical schools require this kind of formal preparation, the better prepared doctors will be to treat patients from many different racial, ethnic, and economic backgrounds. The use of courses, required or elective, by medical schools to teach future physicians about the importance and utility of alternative and complementary medicine is a step in the right directions towards lowering racial inequality in healthcare.

An interesting and promising approach that has been implemented by medical schools is to open clinics in underserved communities. These underserved communities are often those with mostly racial minorities and require extra care to adequately treat patients. An example of a great program, though there are many similar ones, is the Chicago Medical School at Rosalind Franklin University of Medicine and Science (Gallegos, 2017). The clinic opened by this medical school is in an area of Chicago that is mainly composed of people of color. This

program has partnered with pharmacology, nursing, and other colleges who train health care providers. It also recognizes that patients may experience difficulties in accessing care that are not seen in the majority white population. These may include language barriers or lacking access to transportation to and from medical appointments. The program initiated by the Chicago Medical School addressed these issues with language interpreters and by partnering with Uber to help patients make it to the clinic and access the care needed (Gallegos, 2017). This clinic is an example of lowering health disparity because it offers access to care that was not seen in this area of Chicago before. It offers patients better ways to connect with engaged physicians by language barriers and transportation needs being alleviated. This program, and ones like it, are ways that medical schools are working to lower health care inequality. When patients form relationships with physicians and other care providers in their area, patients are more likely to access care in the future and live an overall healthier life. It also shows trainee physicians that they can make a difference in a racial minority, underserved community.

The medical system does have existing standards that accredited medical schools are required to follow to combat racial disparity in health care. An accredited medical school must provide a class that covers intercultural communication or cultural competency (Friar, 2017). While all schools require this, most of the courses focus on the needs of the patient and how to effectively communicate with patients depending on their racial or ethnic backgrounds. The idea behind this approach is positive. But there are issues with it, as it can increase stereotypes associated with race and perpetuate racial health inequality (Friar, 2017). Harvard Medical School has implemented a unique training in cultural competency, called *cultural humility*. The course guided students through looking into their own background, identifying biases, and how those biases came to be. By becoming aware of their internal, implicit bias, it allowed them to

confront the bias and find ways to lower their own biases. The class was welcomed to discuss all biases and was also guaranteed to be confidential so that students felt open to discussing implicit bias towards groups of people (Friar, 2017). Courses on cultural competency bring awareness to the issue and allows physicians the understanding to lower their own biases. The model of identifying biases within the physician treats the core of the problem. It helps to stop health inequality before it can even begin by creating self-awareness in physicians. Racial concordance is the patient and provider being of the same race. This can increase the rate at which minorities receive preventative care, all medical care needed at the time, and self-report to have a better overall experience in the health care system (Saha et al., 1999). Since racial concordance is not always possible within the health care setting, the best option for physicians is to become aware of cultural differences through classes and discussions. Some may argue that racial concordance is a solution to health disparity, however a true solution lies in identifying and eradicating biases. The display of cultural humility, for cultures other than one's own, can allow for the positive benefits to be received and the display of negative stereotypes to decrease. And with time and practice on the part of the physician, health disparities would decrease.

Within the health care system, where doctors and other health care providers are already providing care, there are also options that can lower the health disparity gap in health care. These options largely center on education, much like options within medical schools. There are also institutional options that can be implemented to combat the problem of health inequality that hospitals and clinics can implement to track the health disparity gap within specific institutions or systems. Many of the options for health care providers who are already practicing are voluntary and as such, the providers must be aware of the problem and accept further education on ways to combat it.

The first effort being made within institutions, though not uniformly, is to document medical encounters and associate these with race. Documenting the race of patients, and outcomes with professionals, is essential to be aware of racial disparities within an institution. The Department of Health and Human Services does keep data regarding the medical treatment of people regarding race, but this is not always institution specific (Williams et al., 2000). This is a great first step, to identify the problem and specific institutions that are causing a disproportional widening of the gap in health care equality. It is promising that government entities do keep track of data of this sort, but it is critical that hospitals and private health care institutions also take steps to document this data to provide better health care. This data could give benchmarks for what hospitals should be achieving and allow for antidiscrimination policies to be put in place to avoid health disparities (Williams et al., 2000). While some hospitals do implement this to provide better quality of care to all patients, it would have to be government mandated to require all hospitals to follow suit. The Department of Health and Human Services having the data is a respectable start to keeping data on the problem of health disparity. And more must be done in order to combat the problem on the level of individual institutions and health care providers. While some may object the thought of directly asking for race, as many Americans think this causes more issues that it solves, it is essential to bring about solutions for health care. It has been stated that, "… but it is necessary - in medical care as in multiple other areas of American life – to count race until it no longer counts" (Geiger, 2003). Race still affects the lives of people in America, in how healthy they will be in a lifetime and the care they will receive from the health care system. As such, it must be accounted for within health care institutions until there is no longer a health care inequality gap.

Environmental justice, a movement aimed at giving citizens a healthier community to live in, is another institutional solution to one cause of health disparity in America. As previously discussed, race of occupants of an area is the biggest predictor of where a waste facility will be located (Bullard et al., 2007). This suggests environmental racism. Environmental justice is the response to this issue. The movement largely began and still depends on individual communities insisting on change to the pollution and other health hazards that exist within their area (Golash-Boza, 2015). In order for health to be improved, and environmental justice to be a reality, residents must often bring the health concerns to the attention of researchers, scientists, and lawyers who are willing to take up the cases. Once residents have brought the problem to the attention of scientists, the contaminant must be found and proven to be present. Then, lawyers are brought in to bring a lawsuit against the company that is releasing the waste into the community. Ideally, the company is then forced to ensure the safety of residents by safely disposing of toxins. There have been many recent examples of this, such as the Flint water crisis in which the residents drinking water was laced with toxic lead or Hype Park in Georgia with air and soil contamination in which residents suffered from abnormally high disease and death rates (Kennedy, 2016; Golash-Boza, 2015). This solution is often not properly efficient, as decades can pass with very little progress towards a cleaner environment (Bravender, 2015). While this solution can be viewed on an institutional level, as the legal system is the eventual place where companies are required to remove the facility or lower the pollution that is being emitted, it requires the outrage of a community first. The citizens, who have suffered from health issues for years, must be the first step in beginning to call for environmental justice to protect the health of themselves, the families, and their community.

Within a hospital environment, the first option is to provide physicians and care professionals with education opportunities and support services that increase cultural competency. The lack of cultural competency has been identified as a large contributor to health disparity and dealing with this can help minority patients be better served within the health care system and increase overall health. There are many ways a hospital can accomplish this. One solution is to provide interpreter services to patients experiencing a language barrier with providers; this allows the patient and doctor to effectively discuss health issues and treatment options. Another option is to offer training aimed at helping physicians better understand other cultures, and perhaps display cultural humility that has been previously discussed. This can be offered as part of an orientation training for incoming health care providers and as ongoing education for doctors as they work at the hospital. Doctors can also include family in health care as appropriate. If families are aware of the treatment, it can make adherence to a regimen easier for the patient. Hospital administration can also help accommodate minority patients with a variety of option such as working hours to fit a subculture's needs, brochures in language and technicality levels commonly understood, and the physical environments patients are in (Brach & Fraserirector, 2000). Cultural competency or humility is a difficult concept to learn and understand well. It takes commitment by both the hospital administration and health care providers for this to be effective. But, the drastic benefits that minority patients can reap from the improvement of cultural knowledge on the part of health care providers, is worth the additional effort.

A similar method can be used to identify and change implicit bias within physicians and other providers. Since doctors have demonstrated a similar bias as the general population, (Blair et al., 2011), education can offer solutions. Implicit bias can often be unconscious, in any person,

when interacting with people of different races. Education about this can bring implicit bias from the unconscious to the conscious and allow for change of thought patterns relating to races. To begin, there are simple tests than can be performed to identify bias in people, such as associating words with a set of people. Such test might ask someone to associate "black" and "white" with "good" and "bad", if a doctor takes longer to associate black with good and white with bad, then black with bad and white with good, it may suggest an implicit bias of some size (Teal et al., 2012). Once the bias is identified, and no longer an unconscious function, the provider can work to correct this issue. One way to do this would be to conduct small group discussion following the test or reflection writing (Teal et al., 2012). While this exercise is certainly uncomfortable, it brings an important issue to the forefront of consciousness and allows it to be addressed to lower health disparities. The process could be a one-time event or could be repeated within the workplace to determine if the bias has been lowered by the educational opportunity. It is also noteworthy that the process is relatively quick, it can be done in less than a day as opposed to taking a whole class in series, and can have obvious benefits. Lowering implicit bias in physicians can help minority patients to be healthier, because the doctor is aware when a patient walks in the room if some implicit bias needs to be corrected for before offering diagnosis or treatment options.

Another suggestion of how to reduce health disparity, this one made by the Surgeon General, is to focus on preventative care in racial minorities (U.S. Department of Health and Human Services). Preventative care is aimed at helping a healthy person stay that way and avoid developing a preventable disease. The process of effective preventative care can be achieved in a stepwise fashion, addressing the most pressing and dangerous issue first (Katz, 2015). Whether the largest health issue a person is facing is physical, social, or psychological, the addressing of

the problem will help subsequent issues to be solved more easily. Since many dangerous behaviors can compound on themselves, it is most effective to treat all. But this must be done one step at a time to increase overall health. Some examples of preventive medicine could be cessation of smoking, implementing a healthy diet to lower obesity risk, mental health assistance, or addressing substance abuse (Katz, 2015). Even addressing one of these problems could give a patient a much higher chance of living a healthy life. Thus, when all of these are addressed in a preventative care model, the quality of life can drastically increase. This is especially important for racial minorities who are often overlooked in the health care system. When a physician makes the effort to prevent a dangerous disease from developing in a minority patient, it can allow the patient to trust the provider, creating a better doctor-patient dynamic. Preventative care gives racial minorities a better health care experience and an overall healthier existence.

A final solution to the health disparities minorities face is to increase care coordination with other providers. If physicians increase care coordination with alternative care providers, complementary care providers, and traditional healers, which many racial minorities access in coordination with Western medicine, it could improve outcomes for racial minorities health (Brach & Fraserirector, 2000). This can help to ensure that the treatments being given are compatible, as there are often cases in which vitamins, herbs, or other natural supplements can interfere or have potentially dangerous side effects when used in conjunction with modern medicine. Doctors should treat a traditional healer as they would any other complementary or alternative practice provider, such as a chiropractor, acupuncturist, or other supplemental treatment. When the treatments that a patient wishes to use are coordinated, it allows for the best outcomes for the patient. A physician should be aware of the possibility that a patient may wish to use a treatment that is not part of modern medicine, present the question of whether they are or

plan to use this treatment, and proceed to coordinate treatment plans if the patient is using this type of medicine. Coordination of care, with any alternative medicine, gives a safer treatment protocol for the patient. This increase in continuity of care gives a higher quality of life and peace of mind for the patient in knowing that all aspects of health are being taken into consideration.

## Conclusion

Racial inequality in the United States health care system has caused health disparities between races, resulting in differing levels of health status and health care. There has never been a time in the United States when the health of minorities equals health of Caucasian Americans. Currently, African Americans can expect to live six years less than a Caucasian American born at the same time in the same place (Geiger, 2003; Byrd and Clayton, 2000; National Center of Health Statistics, 2003). But disparity in health care is not attributed to physical or putative biological differences between races. They are due to social, cultural, and racialized barriers. Through the history of the health care system in America, minorities, African Americans in particular have been treated with shocking dehumanization. Such as described medical tests were used on enslaved people, use of bodies for medical school anatomy without consent, and the Tuskegee syphilis study illustrate this unethical treatment (Golash-Boza, 2015; Reverby, 2000). Given the historical context in which the current health system came to be, the scope of the current health disparities people of color experience can be fully understood. Two specific examples, of blood pressure health status and blood disorder health treatment, illuminate the health disparities that people of color will deal with throughout a lifetime. While certain characteristics, such as socioeconomic status and gender, can compound and make the health disparity more drastic, it is important to note that even when these are controlled for, people of

color will experience a lower health status and worse health care (Hennessey-Fiske, 2010; Farmer and Ferraro, 2005). Health disparities that minorities experience in the United States can begin to be explained by a combination of environmental hazards, lack of cultural competency of health care providers, and implicit bias (Bullard et al., 2007; Brach & Fraserirector, 2000; Blair et al., 2011). These explanations give rise to solutions that can attempt to remedy health inequality and health disparity for minorities in health care. These solutions include medical school efforts such as classes on alternative or complementary medicine and implicit bias discussion-based classes, (Wetzel et al., 1998; Friar, 2017), and opening clinic to serve communities which lacked access to health care previously (Gallegos, 2017). Institutions, such as health care networks and the legal system, can lower health disparities through environmental justice to give a healthy living space and tracking health encounters by race to ensure all races are being treated appropriately for illness (Golash-Boza, 2015; Williams et al., 2000). Finally, hospitals and providers can lower health inequality, mainly with education and implementing what is learned. Physicians can learn cultural competency and how to avoid bias (Teal et al., 2012; Brach & Fraserirector, 2000), as well gaining knowledge of how to focus on preventive care in minorities and enhance care coordination between all health care providers a patient chooses to visit (Katz, 2015; Brach & Fraserirector, 2000). Indeed, all individuals within the health care system can take steps to ensure that people of all races are treated fairly and well. Providers can seek training to gain cultural competency and lower implicit bias, communities can call for unpolluted living space, and medical schools can offer more formal education on health disparity. With the collective efforts of health care professionals and patients alike, progress can be made towards future health equality. This will lead to patients of all races having longer and healthier lives who can contribute fully to the society they are a part of. Everyone benefits when

there is equality of health care. After all, humans of all races are infinitely more similar than they are different. Thus, health status and health care must reflect this biological fact.

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