

Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism

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ABSTRACT. During the Jim Crow era of 1877 to 1954, the federal government sponsored and supported the racially separate and unequal distribution of resources, including, but not limited to, education, housing, employment, and healthcare. On May 14, 1954, the Supreme Court ruled in *Brown v. Board of Education* that separate and unequal education violated the Constitution because separate is inherently unequal. Many believed that this ruling, the Civil Rights Acts of 1957, 1960, 1964, 1968, and the Voting Rights Act of 1965 would put an end to the unequal treatment of African Americans in the United States. However, inequalities still exist today because the ruling and the laws did not change the structures of the United States. Specifically, structural racism prevents African Americans from obtaining equal access to resources such as wealth, employment, income, and healthcare, resulting in racial disparities in health. Because racial disparities between African Americans and Caucasians are the most studied in the United States, this article will focus exclusively on how structural racism continues and causes racial inequalities between African Americans and Caucasians in wealth, employment, income, and healthcare, which lead to racial disparities in access to healthcare and health status.

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Introduction

Structural racism operates at the societal level in the United States and is the power used by the dominant group to provide members of the group with advantages, while disadvantaging the non-dominant group (Mullings and Schulz 2005: 3, 12). The dominant group uses structural racism not only to obtain resources, such as wealth, employment, income, and healthcare, but also to limit the non-dominant group's access to these resources. During the Jim Crow era, structural racism sponsored by the federal and state governments explicitly created advantages for Caucasians and disadvantages for African Americans. Structural racism still exists after the Jim Crow era.

This article will focus on the federal government's failure to enforce the civil rights laws, which has given advantages to Caucasians in the obtainment of wealth, employment, income, and healthcare, while creating disadvantages for African Americans. In the past, I have written about the failure of the government to enforce civil rights laws in healthcare and its impact on health status and outcomes (Yearby 2007: 462–470; 2012: 1281, 1288; 2014: 287, 289). Recently, Hahn, Truman, and Williams (2018) have shown that the enforcement or lack thereof of civil rights laws concerning healthcare, education, employment, and housing can impact racial health disparities. This article builds on prior work by arguing that the lack of enforcement of civil rights laws is an example of structural racism, which causes racial disparities in health status and access to healthcare.

I. Structural Racism: Wealth

There are racial inequalities in net worth and wealth. Net worth is the difference between what a household owns and what it owes. Based on a recent Pew Research Center Report, the net worth of Caucasian households was \$144,200 in 2013, approximately 13 times the net worth of African American households, which was \$11,200 (Pew Research Center 2016). The net worth of Caucasian households was \$98,700 in 1983, compared to \$12,200 for African American households. Thus, in 30 years, the net worth of African American households *decreased* by \$1,000 in comparison to the \$45,500 increase of Caucasian households.

Wealth is money in the bank that allows families to buy a home, obtain a college degree, and/or retire. Research suggests that racial wealth inequalities have grown over the last 30 years because of racism (Asante-Muhammad et al. 2016). The average wealth of Caucasian families has grown by 84 percent—three times the rate of growth for the African American population. In 1983 the average wealth for African American households was \$67,000 compared to \$355,000 for Caucasian households. By 2013, the average wealth for African American households was \$85,000 compared to \$656,000 for Caucasian households. If the average wealth of African American families continues to grow at the same pace that it has for the last 30 years, it will take African American families 228 years to amass the same amount of wealth Caucasian families have today, which is 17 years shorter than the 245-year span of slavery in the United States.

The Institute on Assets and Social Policy at Brandeis University conducted a study that followed the same households for over 25 years (1984–2009) and found that the total wealth gap between Caucasian and African American families nearly tripled, increasing from \$85,000 in 1984 to \$236,500 in 2009, a difference of \$152,000 (Shapiro et al. 2013). The study also showed that in 2009 the median wealth of Caucasian families was \$113,149 compared with \$5,677 for African American families, a difference of almost \$108,000. Researchers found that approximately 66 percent of the wealth gap between African Americans and Caucasians was a result of racism, which caused racial inequalities in homeownership, income, employment, education, and inheritance.

During the Jim Crow era, structural racism provided Caucasians, the dominant group, with support and money to obtain net worth and wealth through home ownership, while preventing African Americans, the non-dominant group, from obtaining net worth and wealth through homeownership. This is significant because home ownership is the central way that Americans build net worth and wealth, which is often passed from generation to generation.

A. Homeownership: Jim Crow and Beyond

With the enactment of the National Housing Act of 1934, which created the Federal Housing Administration (FHA), housing builders were

subsidized, but only as long as none of the homes were sold to African Americans, a practice that was called redlining (Rothstein 2017). The subsidies received exclusively by Caucasians were used to create the suburbs. The FHA also published an underwriting manual that stated that housing loans to African Americans would not be insured by the federal government. Private lenders followed suit, providing conventional mortgages to Caucasians, while drastically limiting the number of conventional mortgages to African Americans.

The FHA policies are an example of structural racism because Caucasians wrote the policies giving them an advantage in buying homes, while disadvantaging African Americans. Due to the FHA and its policies, only 2.3 percent of FHA-insured mortgages outstanding in 1950 were for non-Caucasians, while 5.0 percent of conventional mortgages were for non-Caucasians (Gordon 2005: 209). That means federal policy was more racist than the behavior of private lenders. As a result, African Americans were relegated to inner-city housing projects. African Americans were prevented from buying homes in the suburbs from 1934 until 1968. President Kennedy ended these FHA redlining policies with an Executive Order in 1962, but conventional mortgages remained discriminatory until the passage of the Fair Housing Act in 1968.

Even though the laws were changed in 1968, African Americans were never compensated for the harm they suffered in wealth attainment when they were prevented for three decades from owning a home, and thus, they have never overcome the loss of net worth and wealth. In 1976, the homeownership rate was 44 percent for African Americans and 69 percent for Caucasians (Pew Research Center 2016). In 2014, the rate of African American homeownership was 43 percent compared to 72 percent of Caucasians. This inequality in homeownership is present even when African Americans have a high income or a college education. The rate of homeownership among high-income African Americans is 68 percent compared to 84 percent for upper-income Caucasians. Homeownership for college-educated African Americans is 58 percent compared to 76 percent for college-educated Caucasians. This inequality is a legacy of government-sponsored structural racism during the Jim Crow era and the continuation of racially discriminatory practices by private lenders after the Jim Crow era.

The 1975 Home Mortgage Disclosure Act required banks to report racial data in order to track racial discrimination in lending. From 2004 to

Figure 1. Racial discrimination in housing. Whether racism is overt, as in this 1942 poster, or revealed in subtler forms of steering, the health effects are measurable. African Americans who experience racism are far more likely than Caucasians to be afflicted with hypertension, which can lead to heart disease, stroke, and premature death.

Source: Siegel (1942). (Lib. of Congress, LC-DIG-fsa-8d13572, public domain)



2007, Countrywide charged 200,000 African American and Hispanic borrowers more than similarly qualified Caucasian borrowers for their loans (Havard 2014: 177). From 2004 to 2009, Wells Fargo also charged 34,000 African American and Hispanic borrowers more than similarly qualified Caucasian borrowers for their loans (Reckard 2012). Both companies steered African Americans into subprime loans when they qualified for conventional loans. Subprime loans generally carried higher-cost terms, such as prepayment penalties and adjustable interest rates that started with low initial rates, which significantly increased after two to three years, making the loan payments unaffordable and leaving borrowers at

high risk for default or foreclosure. Both lenders were fined by the U.S. Department of Justice, but the fines were a pittance compared to all the money they made from African American borrowers. Furthermore, African Americans were not fully compensated for the harm of paying more or losing their homes. Thus, even when the laws prohibit racial discrimination, lenders still give advantages to the dominant group and disadvantage the non-dominant group.

These practices will seemingly continue as the U.S. Department of Housing and Urban Development (HUD) announced on March 7, 2018 that it would remove anti-discrimination language from its mission statement, which is significant because it is the agency tasked with preventing racial discrimination in homeownership (Watkins 2018). Furthermore, Congress passed legislation in 2018 that cancels the requirement of credit unions and mid-size and small banks to report racial data related to home mortgages. These data are used to determine whether credit unions and banks are racially discriminating. That is important because a 2018 report by the Center for Investigative Reporting showed that “redlining persists in 61 metro areas—from Detroit and Philadelphia to Little Rock and Tacoma, Washington—even when controlling for applicants’ income, loan amount and neighborhood, according to its analysis of Home Mortgage Disclosure Act records” (Jan 2018). As a result of these discriminatory practices that have not been stopped by the federal government, many American neighborhoods are racially segregated, which negatively impacts African Americans’ health status and access to healthcare.

B. Impact of Racial Segregation on Health Status and Access to Healthcare

One way racial segregation affects health status is related to the quality of food available in different neighborhoods. Lang and Bird (2015: 131) note that food choices available to people living in racially segregated neighborhoods are extremely limited:

Residents do not have access to healthy food due to a lack of supermarkets and a preponderance of convenience stores and fast food restaurants as the primary food outlets.

The nutritional quality of what is for sale in these “food deserts” has been shown to lead to obesity, a risk factor for cancer and

cardiovascular disease (Walker et al. 2010: 881; Larson et al. 2009: 74; Lewis et al. 2005: 672).

Racial segregation also affects where African Americans receive care. In racially segregated neighborhoods, African Americans are disproportionately likely to undergo surgery in low-quality hospitals, whereas in areas with low degrees of racial segregation, African Americans and Caucasians are likely to undergo surgery at low-quality hospitals at the same rate. This is significant because among Medicare patients, most of the racial disparities in risk-adjusted death rates for major surgery are a result of the site of care (Dimick et al. 2013: 1050–1051). Research has also shown that residential segregation is associated with an increase in lung cancer mortality rates for African Americans (Hayanaga et al. 2013: 37).

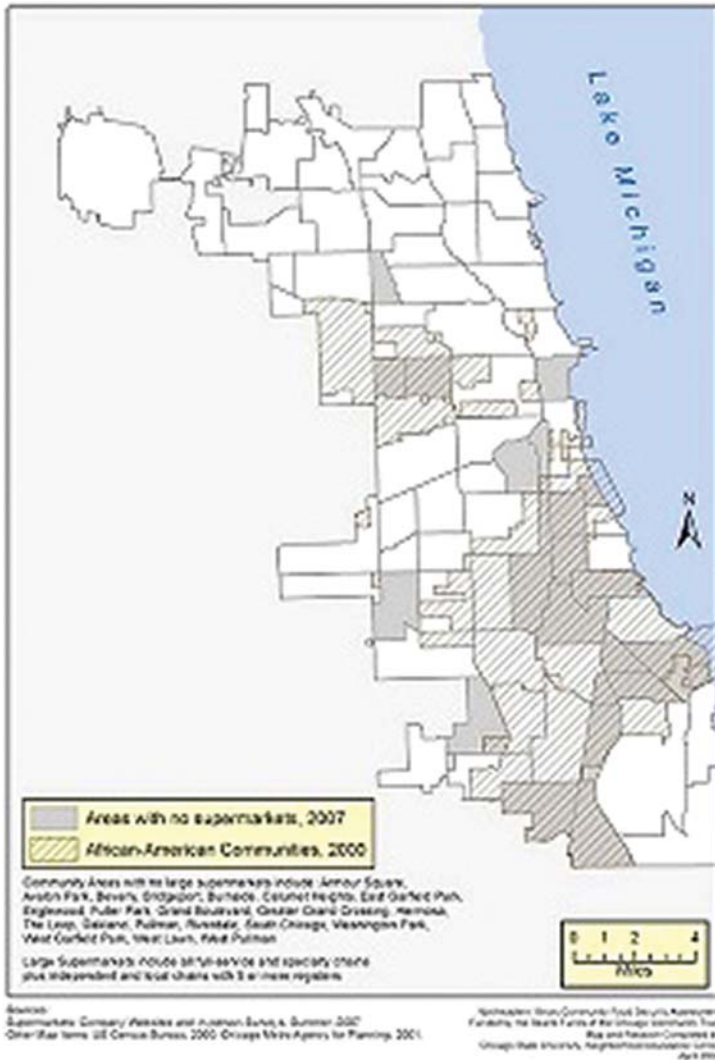
Furthermore, the racially segregated neighborhoods that are predominately African American usually have less economic investment, but they have more stressors such as pollution, noise, overcrowded housing stock, and high rates of crime (Ellen et al. 2001: 393; Diez Roux 2001: 1786). These neighborhoods also have fewer resources such as places to exercise or play, which increases African Americans' rates of disease and disability. For instance, researchers have found that the presence of one or more health clubs as well as lower crime rates were both directly associated with lower cardiovascular disease risk for the African American women in their study (Mobley et al. 2006: 327). In addition to the indirect effects of residential segregation on African Americans' rates of disease and disability, residential segregation affects access to healthcare.

In 1992, a report of 190 urban community hospitals found that the percentage of African American residents in the neighborhood was the most significant factor in hospital closures between 1980 and 1987. As the percentage of African American residents increased in the neighborhood, hospital closures increased (Whiteis 1992, cited in Smith 1999). Sager and Socolar (2006: 27–31) report that, as the African American population in a neighborhood increased, the closure and relocation of hospital services increased for every period between 1980 to 2003, except between 1990 and 1997.

In fact, Sager (2014: 28) showed that 45 percent of hospitals open in 1970 had closed by 2010, and of these hospitals 60 percent

Figure 2. Food deserts are a cause of poor health. A healthy diet is hard to maintain if there are no stores in a neighborhood that sell fresh fruits and vegetables. This map of Chicago shows considerable overlap between areas with no supermarkets (dark shading) and areas inhabited predominately by African Americans (hatched areas). In this way, racial segregation in housing contributes directly to poor health for African Americans.

Source: Illinois Advisory Committee (2011: 8).



were in neighborhoods that were predominately African American. St. Louis and Detroit are poignant examples of these race-based hospital closures. St. Louis had 18 hospitals in predominately African American neighborhoods. By 2010, all but one had closed. In 1960, Detroit had 42 hospitals open in predominately African American neighborhoods; by 2010 only four were open (Sager 2014: 30, 31).

This reduction of hospital beds in African American communities, which generally have the greatest need for care, further compromises African Americans' health by decreasing their access to healthcare (Clark 2005: 1023, 1034–1035). As hospitals leave predominately African American neighborhoods, the remaining hospitals are left to fill the void. This often strains the remaining hospitals' resources and their ability to provide quality care. Consequently, the hospitals that do remain to provide care to African Americans gradually deteriorate and provide substandard care.

Not only is access to healthcare diminished because of a reduction of hospital services, but care also suffers because of physician departures (Clark 2005: 1033–1034). "Physician flight" is an important consequence of disruptions in primary care services, and particularly hospital closures. Once a hospital has closed or relocated, the physicians practicing in the area often follow the hospital to more affluent neighborhoods, thereby further disrupting the healthcare services in predominately African American neighborhoods. Evidence shows that primary care physicians often leave after the closure of a neighborhood hospital because the hospital provides a critical base for their practice. This disruption in care is significant because many predominately African American neighborhoods already suffer from physician shortages prior to hospital closures and physician flight (Majette 2003: 130). Additionally, as the number of primary care physicians decreases, African Americans are forced to seek care in emergency rooms and public hospitals, which are often understaffed and not adequately maintained (Clark 2005: 1034–1035). Because healthcare in the United States is distributed based on ability to pay, African Americans' access to healthcare is also limited by structural racism in employment, wealth, and income, which provide resources for individuals to purchase health insurance.

Figure 3. The health of African Americans has been disadvantaged in numerous ways as a result of historic patterns of racism. First, racism directly causes illness, as described in Figure 2. Second, chronic illness or work-related injuries reduce income, making healthcare unaffordable. Third, a high percentage of hospitals in predominantly African American neighborhoods have been closed, leading to an exodus of primary care physicians as well. Fourth, underinvestment in hospitals in predominantly African American neighborhoods causes them to be overcrowded and substandard in the quality of service.

Source: Jack Delano (1942). (U.S. Farm Security Administration, public domain)



II. Structural Racism: Employment and Income

Minorities have higher poverty rates than Caucasians, and thus, disproportionately live in poverty. In 2011, the U.S. Census Bureau reported that 42.7 million people, about 14.3 percent of the U.S. population, were below the poverty level. The poverty rate for African Americans was 25.8 percent compared to 11.6 percent for Caucasians. There were 43 states and Washington, DC that had poverty rates above 20 percent

for African Americans compared to only seven states that had poverty rates above 14 percent for Caucasians (Macartney et al. 2013). The difference in poverty rates is in part due to racism that prevents African Americans from obtaining the same employment opportunities as Caucasians, limiting their ability to earn income.

The unemployment rate for African Americans has been at least twice as high as Caucasian unemployment for all but seven years during the 53-year period between 1962 and 2015 (Pew Research Center 2016: 26). For instance, studies show that African Americans seeking employment have a harder time obtaining employment because non-African American managers tend to hire more Caucasians (Giuliano, Levin, and Leonard 2009: 589). Moreover, African Americans with non-Caucasian-sounding names received 50 percent fewer callbacks than African Americans with Caucasian sounding names (Bertrand and Mullainathan 2004). If applicants “whiten” their resumes, the amount of callbacks they receive doubles. For example, 25.5 percent of resumes received callbacks if African American candidates’ names and experiences were “whitened,” while only 10 percent received callbacks if they left their name and experience unaltered (Kang 2016).

This is true even for low-wage jobs, as evidenced by a field study conducted in New York City that used African American, Latino, and Caucasian testers to answer classified job ads (Pager et al. 2009). The study found three categories of behavior: categorical exclusion, shifting standards, and race-coded job channeling. Although the African American testers did not face racial animus or hostility, they were often told that there were no jobs available, while the Latino and Caucasian testers were offered the position. In one test, the African American tester filled out an application and was told that his references would need to be checked before he could be interviewed, while the Latino and Caucasian testers were interviewed without reference checks, and the Caucasian tester was hired. In terms of shifting standards, African American testers were not allowed to apply for sales positions due to the lack of direct experience on their resume; however, Latino and Caucasian testers with the same level of experience were allowed to apply and were even offered the jobs. In other cases, employers perceived real skill or experience differences between the African

American testers and the Latino and Caucasian testers, even though the resumes conveyed identical qualifications.

Finally, employers encouraged African American testers to apply for different jobs than the ones initially advertised (Pager et al. 2009). For instance, one store advertised a salesperson position, but the African American tester was steered into applying for a stock position, while the Latino and Caucasian testers were able to apply for the sales position. In restaurants, the African American tester was channeled into a busboy position, instead of the advertised server position. Similar to hiring, job placement was linked to race, where African American testers were channeled into lower positions than advertised and Caucasian testers were allowed to apply for the advertised position or channeled into higher-level jobs. Furthermore, the Caucasian testers were channeled into jobs with more consumer contact even if they had limited experience. The authors argue that the discriminatory hiring practices were a result of employers applying different hiring criteria based on race: African American testers were held to a higher standard than Latino and Caucasian testers. Additionally, the authors asserted that employers' assumptions about competence and customer preferences, which were linked to stereotypical beliefs that African Americans were not competent or lacked necessary social and cognitive skills, resulted in race-based job channeling. Even if African Americans are hired, there are racial inequalities in income.

Income is defined as money necessary to meet daily expenses and is usually derived from wages. Few African Americans are in the top 5 percent of earners and most experience slow wage growth (Wilson and Rogers 2016: 7). Since 1967, when the U.S. Census Bureau began collecting data on household income, African Americans' median household income has been less than Caucasian's median household income, measured in constant 2014 dollars (Pew Research Center 2016: 21). In 1967, the median African American household income was \$24,700 compared to \$44,700 for Caucasian households, a difference of \$20,000. In 1987, the median African American household income was \$37,800 compared to \$63,600 for Caucasian households, a difference of \$25,800. By 2014, median African American household income was \$43,300 compared to \$71,300 for Caucasian households, a difference of \$28,000. From 1967 to 1987, the median Caucasian household income increased by \$18,900,

compared to an increase of \$13,100 for the median African American household income. From 1967 to 2014, the median Caucasian household income increased by \$26,600, compared to an increase of \$18,600 for the median African American household income. Thus, in 47 years (1967–2014) the African American household has *almost* achieved the same median household income as Caucasians had in 1967. This disparity in household income is largely a result of unequal wages.

Research shows that in several industries African Americans are paid less than Caucasians doing equal work. For example, African Americans are seldom hired by most of the well-known high-tech firms; however, when they are hired they receive less pay and are passed over for promotions and pay raises. In fact, African Americans make \$3,656 less than Caucasians working in the high-tech industry (Guynn 2014). African American women also experience racial inequalities in pay.

Since 1967, the earliest year in which the U.S. Census Bureau collected wage information by race and gender, African American women have made less than Caucasian males (Temple and Tucker 2017: 2, 3). In 1967, African American women made on average \$0.43 for every \$1 paid to a Caucasian man. By 2012, African American women made on average \$0.63 for every \$1 paid to a Caucasian man. The pay gap between African American women and Caucasian men is wider among older women, with the two biggest pay gaps being in women 25–44 (67 percent of male Caucasian pay) and 45–64 (59 percent).

Because the widest gap is among older women, it should not be surprising that even when African American women have some postsecondary education they are still paid less than Caucasian men (Wilson et al. 2017). African American women with some college get paid \$15.58 an hour compared to \$22.51 an hour for Caucasian men with some college. In fact, African American women with some college get paid only \$0.42 more an hour than Caucasian men *without* a high school diploma. African American women with an advanced degree, such as a master's degree, make \$7 *less* per hour than Caucasian men with a bachelor's degree and \$17 *less* per hour than Caucasian men with an advanced degree.

In terms of annual pay, African American women with a bachelor's degree or more made \$50,200, about the same as a Caucasian man with some college. A Caucasian man with a bachelor's degree or more made

\$76,708 annually, almost \$27,000 more than an African American woman with a bachelor's degree or more. African American women with a bachelor's degree make \$46,000 annually, only \$3,500 more than a Caucasian man with only a high school diploma. African American women with a master's degree make \$55,843 compared to \$86,330 for Caucasian men with a master's degree (Wilson et al. 2017).

This wage gap is true for almost every occupation. In fact, Caucasian male physicians and surgeons earn, on average, \$18 more per hour than African American women physicians and surgeons (Wilson et al. 2017). Thus, among surgeons and physicians, for every \$1 a Caucasian male makes, an African American woman makes \$0.54 (Temple and Tucker 2017). Overall, African American women had to work seven months into 2017 to be paid the same as Caucasian men in 2016 (Wilson et al. 2017). Over a 40-year career, African American women will lose \$840,040 in wages and need to work a total of 63 years to earn what a Caucasian man would earn in 40 years (Temple and Tucker 2017).

There are also disparities in pay between African American women and Caucasian women. Currently, African American women make \$0.67 for every \$0.76 paid to Caucasian women. However, from 1967 until 1979, wages for African American women and Caucasian women were nearly the same (Wilson et al. 2017). The current inequality is important not only because of the wage difference, but also because of the difference in hours worked. Since 1979, African American women's working hours for low-wage workers has increased by 30.1 percent (from 1,162 hours/year to 1,511 hours/year) compared to a 27.6 percent increase for Caucasian women (from 1,086 hours/years to 1,386 hours/year). In fact, married African American women work 200 *more* hours per year, two *more* weeks per year, three *more* hours per week, and make \$3.00 *less* per hour than married Caucasian women (Wilson et al. 2017: Table 1).

A. The Laws

The racial inequalities in employment and pay are a result of structural racism because African American men and women are hired less frequently than similarly qualified Caucasians. Even if African Americans are hired, they are paid less. Racial discrimination in hiring persists, and research shows that there has been no change in racial discrimination

in hiring for the last 25 years (Quillian et al. 2017). This violates Title VII of the Civil Rights Act of 1964. Yet, companies are still allowed to do it.

Research shows that more than one-third of jobs are filled through referrals, which has not changed for the last 26 years (Frank 2018). For example, Ezorsky (1991: 14–18) found that in the 1980s and 1990s, over 80 percent of executives found their jobs through networking and 86 percent of available jobs did not appear in classified advertisements. As a result of racially segregated neighborhoods, Caucasians do not interact with African Americans at work, home, or other places and thus do not refer them for jobs. As a result, they use their power at work to refer more Caucasians for jobs, which disadvantages African Americans. This practice is an example of structural racism, which has a disparate impact on minorities. Under Title VII, the government prohibits employers from using seemingly neutral employment policies and practices that have a disproportionately negative impact on applicants or employees of a particular race, color, age, religion, sex (including pregnancy), national origin, or disability. Current job referral practices do have a disparate impact on minorities and women, yet the practices continue unfettered by the government.

Regardless of job title, industry, or location, female and minority applicants were much less likely to report receiving an employee referral than their Caucasian male counterparts. More specifically, Caucasian women were 12 percent less likely, men of color were 26 percent less likely, and women of color were 35 percent less likely to receive a job referral (Frank 2018). Furthermore, U.S. organizations pay out employee referral bonuses. In fact, 42 percent of U.S. organizations pay out referral bonuses, and it is even higher for the technology industry, where 58 percent provided employee bonuses for referrals. Hence, those who make the referrals are being rewarded for it, even though it has a disparate impact on minorities.

Parker and Funk (2017) report that 53 percent of African American women have experienced discrimination at work compared to 40 percent of Caucasian women and 22 percent of men. Of all the women who reported experiencing discrimination, 25 percent said that they earned less than men doing the same job, 23 percent said they were treated as if they were not competent, and 7 percent said they were denied a promotion or turned down for the job.

Despite the strong evidence that racial discrimination plays a persistent role in hiring and promotion, discrimination lawsuits are rarely won and thus do not show the full picture of workplace discrimination. Even when minorities file discrimination lawsuits only 1 percent win on the merits because racial discrimination lawsuits are hard to prove. Discriminatory hiring patterns are often hard to prove because the data are not available, making it hard for those alleging discrimination to win because they have the burden of proof. Even when a plaintiff can prove discrimination, he or she also has to show that racial bias was the motivating factor in the decision. However, businesses argue that discrimination was just one factor among many, often winning because no employee is perfect. Moreover, minorities filing racial discrimination lawsuits often face considerable backlash from the industry, including being denied hiring by all the other companies in the industry, even when the allegations are found to be true (E. J. Smith 2004).

Additionally, Title VII of the Civil Rights Act of 1964 and the Equal Pay Act of 1963 prohibit wage discrimination based on race and gender. In 2016, the government created a data collection system to identify trends in wage discrimination based on gender and race to support claims of gender and race-based discrimination in wages. However, this system has not been implemented. As a result, it is difficult to prove racial and gender discrimination in wages.

The government has failed to enforce Title VII of the Civil Rights Act of 1964 and the Equal Pay Act of 1963 by allowing the continuation of employee referral programs that have a disparate impact on minorities, by not protecting workers who bring racial discrimination cases, and by not collecting data related to discrimination in hiring and pay. These failures are compounded by the high standard that the courts have set to prove racial discrimination in hiring. As a result, African Americans have been exposed to racism without recourse, which directly impacts African Americans' health status and access to healthcare because healthcare is delivered based on ability to pay or on the ability to find a job with health insurance benefits.

B. Impact of Racism on Health Status and Access to Healthcare

Experiencing racism has direct biological effects that cause increased rates of disease and disability in African Americans. Specifically, racism results in increased stress for African Americans that impairs their health status. Studies have shown that both U.S.-born and foreign-born African American women who have experienced racism were more likely to have chronic hypertension or hypertension events (Cozier et al. 2006: 681–683; Krieger 1990: 1276–1277). In fact, African American women who had experienced racism and had chosen not to object to it were 4.4 times more likely to have hypertension than those who stated that they took action or talked to somebody.

Research suggests that there is a higher positive correlation between perceived racial prejudice and increased cigarette and alcohol use among African Americans as compared to Caucasians (Williams et al. 2003: 200, 201). Three studies have found a positive correlation between discrimination and cigarette smoking, two studies a similar correlation between discrimination and alcohol use, and two studies showed that perceptions of discrimination made an “incremental contribution” to differences in health between blacks and whites. Specifically, the odds of the following behaviors increased with the level of racism experienced by people of color compared to Caucasians (Shariff-Malco et al. 2010: Table 4):

Percent increase in behavior related
to frequency of experience of general racism

	Sometimes	Often or always
Smoking	24	95
Binge drinking	9	31
Obesity	18	33

Therefore, racism makes people sick through these intervening variables. The health of people subjected to racism at work or elsewhere is being damaged, and the damage increases according to the frequency according to which a person experiences racism.

The increased stress from perceived racism also affects birth outcomes by increasing African Americans’ rates of infant mortality. African

American mothers who delivered preterm infants of “very low birth weight” (VLBW) were more likely to experience and report interpersonal racial discrimination during their lifetimes than were African American mothers who delivered infants at term. That is of great significance because VLBW “accounts for more than half of the neonatal deaths and 63 percent of the black–white gap in infant mortality in the United States” (Collins et al. 2004: 2132, 2135).

Finally, research has shown that experiencing racism accelerates the biological aging of African American men, which may lead to their lower life expectancy (Chae et al. 2014: 103, 107–108). Life expectancy for African American men in 2015 was 72.2 years. Caucasian men passed that milestone before 1990, at least 25 years earlier (US-NCHS 2017: 116, Table 15).

Moreover, as a result of structural racism in employment and income, Caucasians obtain the best quality healthcare available because they have health insurance from their jobs or are able to pay for healthcare not covered by insurance. African Americans have limited access to healthcare because they do not have health insurance from their jobs, or they cannot afford to pay for healthcare (Thomas and James 2009: 1, 2, 5–6). “[O]f the 45.7 million non-elderly Americans who were uninsured in 2008, more than half (55 percent) [were minorities].” Specifically, 32 percent of Latinos are uninsured, 28 percent of Native Americans are uninsured, and 21 percent of African Americans are uninsured, compared to 13 percent of Caucasians. Additionally, public healthcare programs like Medicaid disproportionately serve minorities.

African Americans and [Latinos] are more likely than [Caucasians] to work in low-wage jobs, and tend to have reduced access to employer-sponsored coverage relative to their higher-wage counterparts.

Consequently, low-income minority workers are more likely than Caucasians to be uninsured or covered by Medicaid.

Individuals who have low-wage jobs are less likely to be offered coverage through their employers and less likely to take up coverage when offered.

As a result of their lack of employer-sponsored healthcare insurance and their poverty, these minority families are disproportionately unable to afford to pay for healthcare. Thus, compared to the insured, a larger share of the uninsured are unable to pay their medical bills (Thomas and James 2009: 7; Foutz et al. 2017).

Data from a report of the U.S. Institute of Medicine (US-IOM), *Caring Without Coverage: Too Little, Too Late*, showed that the uninsured received a fraction of the health services and access to healthcare that privately insured patients regularly received, and that the uninsured tended to wait longer and to become sicker before seeing a doctor (US-IOM 2002: 1, 3–5). The report compared the care received by the insured and uninsured for illnesses such as, cancer, diabetes, and cardiovascular disease:

The quality and length of life are distinctly different for insured and uninsured populations, with worse health status and shortened lives among uninsured adults. (US-IOM 2002: 7).

Moreover, lack of health insurance created other problems:

The uninsured [were] less likely to receive recommended preventive and primary care services, face[d] significant barriers to care, and ultimately face[d] worse health outcomes. . . . Compared to the insured, a larger share of the uninsured report problems paying medical bills, relying on home remedies rather than seeking the care of a doctor, skipping dental care, and not filling a prescription due to cost. (Thomas and James 2009: 1, 7)

A lack of insurance leads to the under-treatment of those who are unable to pay, which results in unnecessary deaths (Yearby 2011: 82–83).

In a paper by Dietrich Jehle and his colleagues, delivered at the annual meeting of the Society for Academic Emergency Medicine, uninsured trauma patients were found to be 1.8 times more likely to die from their injuries from auto accidents and were 2.6 times more likely to die from gunshot wounds, as compared to privately insured patients (Davis 2010: B1; Yearby 2011: 84). Jehle explains that “uninsured adult patients in general have a 25 percent greater mortality rate than insured adults for all medical conditions” (Baker 2010). In addition, several previous research studies reached similar conclusions (Rosen et al. 2009:

1010). That is, “the uninsured have a higher death rate from trauma injuries due to treatment delays, different care due to receipt of fewer diagnostic tests, and decreased health literacy” (Yearby 2011: 84–85).

Being uninsured translates into a higher than average mortality rate through various channels:

Lack of medical insurance is most often associated with worse baseline health status, with increased and poorly recognized co-morbidities. It is known that preexisting medical conditions are associated with poor outcomes after trauma, suggesting that an uninsured patient would do worse after traumatic injury. (Haider et al. 2008: 948, footnote omitted).

Disparities in health outcomes by race remain similar regardless of insurance status. Nevertheless, lack of health insurance is an important co-factor in predicting mortality:

The highest adjusted odds of death were for *uninsured* Hispanic patients . . . followed by *uninsured* African American patients . . . when compared with insured white patients, suggesting that insurance status has a stronger association with mortality after trauma. (Haider et al. 2008: 947)

According to a study conducted by National Public Radio, the Robert Wood Johnson Foundation, and the Harvard T. H. Chan School of Public Health (2017: 13), 52 percent of African Americans say they have avoided seeking healthcare because of cost. The study also found that between 2005 and 2006, “[t]he largest difference in doctor visits between insured and uninsured populations was seen among African Americans and individuals of two or more races.” This racial difference in physician visits is not new; in 1986, for example, a national survey of the use of healthcare services produced similar findings:

Even after taking into account persons’ income, health status, age, sex, and whether they had one or more chronic or serious illnesses, 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 a year. (Blendon et al. 1989: 279)

Thus, unequal access to health insurance, due in part to structural racism in employment and income, is a significant factor in African

Americans' access to healthcare, which is compounded by structural racism in healthcare (Haider et al. 2008: 948).

III. Structural Racism: Healthcare

Throughout the 1960s, African Americans waged national and international battles to obtain the rights of full citizenship in the United States (Bell 1980). The civil rights movement focused on equality of rights in every area of life, including the right to quality healthcare. The disenfranchisement of African Americans seeking healthcare did not change until African Americans forced the government to comply with the constitutional mandates of the Equal Protection Clause of the Fourteenth Amendment (D. B. Smith 1999: 29). In 1962, a group of African American physicians, dentists, and patients filed a lawsuit against two hospitals in North Carolina receiving federal funding because the hospitals denied admission to African Americans on the basis of race (*Simpson v. Cone Hospital* 1963). Not only did the federal government intervene on behalf of the plaintiffs, but it also enacted Title VI of the Civil Rights Act of 1964 to put an end to “separate but equal” access to healthcare (D. B. Smith 1999: 115–116).

A. The Laws

When Title VI of the Civil Rights Act of 1964 was enacted, federal funding to healthcare entities was limited. However, the enactment of Medicare and Medicaid in 1965 significantly increased federal funding to all healthcare entities, including hospitals and nursing homes. In fact, Congress made compliance with Title VI “mandatory” before healthcare entities could receive any Medicare and Medicaid funding. The government focused its initial efforts on hospitals. Because hospitals relied on federal funding, the federal government was able to force most hospitals to integrate without much resistance from the hospital industry. Faced with the loss of a substantial source of revenue, most hospitals integrated overnight, putting an end to separate and unequal hospital care (D. B. Smith 1999: 100–102, 143–161, 191–195). The desegregation of most hospitals has been linked to a decrease in infant mortality rates among African American women from 1965 to 1971 (Hahn et al. 2018). Unfortunately, the desegregation of most hospitals was the main victory

of Title VI. The federal government has failed to apply Title VI to healthcare providers. That failure has resulted in racial disparities in African Americans' health status and access to healthcare. A loophole in the law was created by the determination that physicians receiving payments under Medicare Part B are exempted from compliance with Title VI because these payments are not defined as federal financial assistance. Thus, physicians can continue to discriminate based on race (D. B. Smith 1999: 164). However, the governmental funding of physicians who racially discriminate is a violation of domestic and international law (Randall 2002: 47–65).

B. Impact on Health Status and Access to Healthcare

Persistent racism in the healthcare system leads 22 percent of African Americans to avoid seeking healthcare (NPR et al. 2017: 12). An even larger number, 32 percent, say they have personally been discriminated against when going to a physician or health clinic (NPR et al. 2018: 13). Empirical evidence of healthcare providers' racial prejudice was first published almost two decades ago in a study that investigated primary care physicians' perceptions of patients and found that a patient's race and sex affected the physician's decision to recommend medically appropriate cardiac catheterization (Schulman 1999: 622–624). Specifically, African Americans were less likely to be referred for cardiac catheterizations than Caucasians, while African American women were significantly less likely to be referred for treatment compared to Caucasian males.

Summarizing a number of previous studies, Smedley, Stith, and Nelson (2002: 5) conclude that race plays a role in disparities of treatment:

[R]acial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors. Studies of racial and ethnic differences in cardiovascular care provide some of the most convincing evidence of healthcare disparities . . . These studies have demonstrated that differences in treatment are not due to clinical factors such as racial differences in the severity of coronary disease or overuse of services by whites. Further, racial disparities in receipt of coronary revascularization procedures are associated with higher mortality among African Americans. (footnotes omitted)

Ayanian et al. (1999a: 1661, 1663) also found that African Americans were less likely than Caucasians to be evaluated for renal transplantation, and that African Americans were less likely to be placed on a waiting list for transplantation after controlling for patient preferences, socioeconomic status, the type of dialysis facility patients used, perceptions of care, health status, the cause of renal failure, and the presence or absence of coexisting illnesses.

Calman (2000: 172–174), a Caucasian physician serving African American patients in New York, wrote about his battle to overcome his own and his colleagues' racial prejudices, which often prevented African Americans from accessing quality healthcare. Based on a survey of physicians' perceptions of patients, van Ryn and Burke (2000: 813–814) showed that physicians rated African American patients as less intelligent, less educated, and more likely than Caucasian patients to fail to comply with physicians' medical advice. Physicians' perceptions of African Americans were negative even when there was individual evidence that contradicted the physicians' prejudicial beliefs.

In 2006, Dr. van Ryn repeated this study using candidates for coronary bypass surgery. Again, the physicians who were surveyed exhibited prejudicial beliefs about African Americans' intelligence and ability to comply with medical advice. The physicians acted upon these prejudicial beliefs by recommending medically necessary coronary bypass surgery for male African Americans less often than for male Caucasians (van Ryn et al. 2006: 351–354).

More recently, a study found that physicians subconsciously favor Caucasian patients over African American patients (Green et al. 2007: 1234 (Table 1), 1235–1236). In this study, physicians' racial attitudes and stereotypes were assessed and then physicians were presented with descriptions of hypothetical cardiology patients differing only in race. Although physicians reported not being explicitly racially biased, most physicians *regardless of race or ethnicity* held implicit negative attitudes about African Americans, and thus were aversive racists. This is significant because research has shown that the stronger the implicit bias, the less likely the physician was to recommend the appropriate medical treatment for African American patients for heart attacks.

A patient's race can affect physicians' "question-asking in clinical interview, diagnostic decision-making, referral to specialty care,

symptom management, and treatment recommendations” (van Ryn 2014: 7).¹ For example, contrary to evidence showing that African Americans are intelligent and compliant, some healthcare providers believe that African Americans are unable to adhere to treatment regimens, and thus providers give less than the medically recommended healthcare services to African Americans (van Ryn et al 2006: 354). African Americans often sense this bias against them, which results in delays seeking care, an interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the healthcare system (Sabin et al. 2009: 907). As a result, many African Americans die unnecessarily (Green et al. 2007: 1235–1236; van Ryn et al. 2006: 351–354; van Ryn and Burke 2000: 813–814; Schulman et al. 1999: 622–624; Ayanian et al. 1999a: 1661, 1663).

In 1950, before the end of legalized racial segregation, the life expectancy rates of 65-year-old male African Americans and Caucasians were the same (Cohen 2004: 3; US-NCHS 2017: 116, Table 15). By 1995, African American mortality rates—when compared to Caucasians for cancer, diabetes, suicide, cirrhosis of the liver, and homicide—were higher than they were in 1950 (Williams 1999: 175–176).

Satcher et al. (2005: 459) observed that, as of 1985, 60,000 excess deaths were occurring annually in African American and minority populations:

Health disparities are observed across a broad range of racial, ethnic, socioeconomic, and geographic subgroups in America, but the history of African Americans, rooted in slavery and postslavery segregation, motivates our focused analysis of black-white health disparities.

By 2002, an estimated 83,570 African Americans had died each year who would not have died if African American death rates were equivalent to those of Caucasians.

The disparity in death rates has persisted over time. Levine (2001: 475, 480–482) noted: “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.” Referring to the U.S. Census data from 1940 to 1998 on the estimated excess deaths in the African American population compared to the Caucasian population, Levine (2001: 480–82) concluded:

No matter how much racial equality in access is introduced into such a system, black people can be expected to continue to have higher mortality rates than white people, because the higher occurrence of preventable risk among blacks will continue to produce higher risks of becoming ill or injured in the first place.

These disparities in mortality are a result of structural racism in healthcare, where healthcare providers of all races and ethnicities give an advantage to Caucasians by providing appropriate medical care, while providing less than the appropriate care to African Americans, giving them a disadvantage.

Using Census data to analyze the effects of race and socioeconomic status on the use of services among Medicare beneficiaries, Gornick et al. (1996: 791–794) found racial disparities in the provision of services. Even after controlling for income, the study showed that physicians provided less comprehensive or recommended treatment to African American Medicare patients than to Caucasians, resulting in African Americans having fewer physician visits, mammograms, and immunizations for influenza and more hospitalizations and higher mortality rates. Likewise, Bach et al. (1999: 1198–1202) found that African Americans were less likely than Caucasians to receive curative surgery for early-stage lung cancer, which is linked to increased mortality rates of African Americans. In fact, the study showed that if African American patients had undergone surgery at a rate equal to Caucasians, their survival rate would have approached that of Caucasian patients.

According to a study conducted by Harvard researchers, African American Medicare patients received poorer basic care than Caucasians who were treated for the same illnesses (Ayanian et al. 1999b: 1260–1261, 1265). The study showed that only 32 percent of African American pneumonia patients with Medicare were given antibiotics within six hours of admission, compared with 53 percent of other pneumonia patients with Medicare. Also, African Americans with pneumonia were less likely to have blood cultures done during the first two days of hospitalization. Other studies have shown that lower death rates are associated with prompt administration of antibiotics and collection of blood cultures. For example, Kanwar et al. (2007: 1865) show that timely antibiotic therapy can improve health outcomes in patients with

community-acquired pneumonia. Metersky et al. (2004: 342) conclude: “[P]erformance of blood cultures on Medicare patients hospitalized with pneumonia has been associated with a lower mortality rate.” Yet, these life-saving therapies are often withheld from elderly African Americans.

Additionally, African Americans are more likely to die from coronary artery bypass grafting, abdominal aortic aneurysm repair, and resection for lung cancer than Caucasian patients (Dimick 2013: 1046–1048). This disparity in medical treatment and survival rates is due to the separate and unequal access to quality hospitals. For example, even though African Americans live closer to high-quality hospitals than Caucasians, they are more likely to undergo surgery at low-quality hospitals.

This disparity in death rates from surgery is in part due to physician referral patterns based on race. The provision of primary care is racially separate and unequal, which determines where patients have surgery. A plethora of “decisions about where to go for major surgery [such as coronary artery bypass grafting, abdominal aortic aneurysm repair, and resection for lung cancer] are made by referring physicians, not by patients and their families” (Dimick 2013: 1046, 1051).

According to Bach et al. (2004: 582): “There is still a high degree of segregation in primary care.” Most African American patients are served by a relatively small number (22 percent) of physicians who were not board certified and who had problems gaining access to high-quality services for their patients, including high-quality specialist surgeons and high-quality hospitals. Thus, the failure of the federal government to enforce Title VI has advantaged Caucasian patients, while disadvantaging African Americans, resulting in their poorer health status.

IV. Solutions

Racism is the root cause of the many health problems that result in African Americans dying at a younger age than Caucasians. Certainly, discrimination by healthcare providers and in healthcare institutions is a major part of that disparity, but the conditions that lead to racial health disparities are not limited to healthcare. Racism is endemic in the United States, and a part of all the structures of the United States, even when the structures appear neutral. The health of African Americans will only reach parity with Caucasians when all aspects of structural

racism have been eradicated. Since structural racism is a multifaceted problem, it can only be addressed by adopting multifaceted solutions.

To address structural racism in wealth, the government needs to enforce the civil rights laws concerning mortgage lending and housing discrimination. To try to neutralize decades of discrimination, the government needs to provide grants for African Americans to move into middle-class, upper-middle-class, and upper-class neighborhoods. Furthermore, federal grants for neighborhood revitalization need to go primarily to predominately African American neighborhoods to decrease pollution, noise, overcrowded housing stock, and high rates of crime. One way to address the high rates of crime is to invest in job and skills development for African American adults and young adults. Additionally, the investment should provide the residents with safe places to exercise and play. As the community is revitalized, the government needs to ensure that the benefits go to the current residents, not to those who will move in once the community is better, which is a problem with gentrification. Finally, banks and lenders who have been found to racially discriminate against African Americans should be required to put money in a fund to pay for down payments for African American homebuyers.

To address structural racism in employment and income, the government needs to enforce the civil rights laws concerning hiring and wage discrimination and track hiring and wage data. All companies should be required to publicly report hiring and pay information based on race and gender. Any disparities that cannot be explained by length of employment should be corrected with a monetary payout that includes interest. If a company is found to violate the laws, it should be required to pay treble damages, three times the amount of damages that it causes. Finally, companies should be required to provide additional healthcare resources to African Americans to cope with experiencing racial discrimination.

To address structural racism in healthcare, the government needs to stop funding and supporting racial discrimination within the healthcare system and hold everyone in that system responsible for racial disparities in treatment.² This means that everyone receiving federal funding under the Medicare and Medicaid Acts must comply with Title VI, and when they do not, then the government must impose penalties on them, such as fines. For example, healthcare professionals need to be

targeted for civil rights violations. This problem can be corrected by including physicians in the definition of healthcare entities or by defining their payments as federal financial assistance. This is already done under some laws. For example, under the Affordable Care Act (42 U.S.C.A. § 18113), (West 2003 & Supp. 2011), physicians and all healthcare professionals are defined as healthcare entities as it relates to assisted suicide. Thus, Title VI regulations could define physicians as a healthcare entity, which would make Title VI apply to them. If that occurred, physicians could be held legally liable for providing less adequate care to African Americans than to Caucasians.

In addition to addressing structural racism, the federal government needs to implement policies that improve African Americans' health status and access to healthcare. First, the government needs to put an end to racially based hospital closures by using Title VI. Specifically, both state and federal regulators must review institutional plans to close or relocate high-quality healthcare facilities for the disproportionate harm such plans have on African American communities. This review will force hospitals to balance the benefits of closing, relocating, and over-concentrating high-quality facilities in predominately Caucasian neighborhoods against the detrimental effects on African American communities that will result because of the disruptions in care. By instituting this review, the racial link will become clearer, and owners will have to mitigate the harmful effects of closing, relocating, and over-concentrating quality facilities in predominately Caucasian neighborhoods.

Dr. Sager (2014: 28), whose work showed that hospital closures were linked to race, suggests that states need to identify hospitals in time to intervene if such is needed to protect the public's health and are likely to close. Then, the state must make the public aware of the risk of the closing of those hospitals. To prevent the closure of hospitals needed by under-served communities, Sager (2014: 42) argues that states should allow "officials or citizens to petition a court to take control of a hospital and stabilize its finances under state receivership law or urge the governor to declare that closing the hospital constitutes a 'public health emergency,' allowing the State to seize control of [a] needed hospital and stabilize it." For permanent protection, "states can use short-term financial relief through a state trust fund financed by 0.25 percent of each hospital's revenue, which is about \$500 million yearly."

After ensuring that hospitals remain open, the government needs to mandate that hospitals adopt policies and practices that make the elimination of racial discrimination in healthcare a priority. According to Dr. van Ryn (2014: 12), racism or subtle tolerance of racial discrimination is widespread in the organizational climate of many medical care institutions. These informal organizational norms are supportive of racial discrimination and encourage the expression of implicit and explicit racial prejudice by healthcare providers within these healthcare institutions. Van Ryn (2014: 12) reports the finding of a national survey that demonstrated this problem:

Over 70 percent of Black physicians report experiencing racial discrimination in their workplace. In another study, 62 percent of physicians reported that they had witnessed a patient receive poor quality healthcare because of the patient's race or ethnicity.

Thus, in order to put an end to structural racism in healthcare and overcome the slow response to racial disparities in health status, both state and federal regulators should require healthcare facilities to conduct strategic diversity planning (Dreaschlin et al. 2013). The planning should include mandatory diversity courses for all hospital staff—including senior management staff—in which the policies and practices of the healthcare institution are reviewed for racial prejudice and discrimination. It should also require the adoption of policies that have a zero tolerance for racial prejudice and discrimination that includes an automatic punishment for any infraction of the policy regardless of accidental mistakes, ignorance, or extenuating circumstances.

Furthermore, van Ryn (2014: 25) proposes several reeducation practices that can reduce the use of racial discrimination by physicians, such as self-awareness, intergroup contact, seeking counter-stereotypic images and imagery, developing emotional regulation skills by increasing positive emotions, empathy, and partnership building skills. Psychology research studies have shown that implicit racial bias can be changed through reeducation methods. Dasgupta and Greenwald (2001: 800) tested participants' implicit associations with admired and disliked people who were either African American or Caucasian. Blair (2002: 242, 247) showed pictures of African Americans associated with

good things and pictures of infamous Caucasians: “A Black doctor, for example, can be alternatively associated with negative race stereotypes or positive professional stereotypes.” Rudman et al. (2001) enrolled participants in a prejudice and conflict seminar to help them unlearn some of their automatic biases or implicit prejudices.

Furthermore, according to Dr. Sana Loue (2015: 1417, 1418), healthcare providers should be taught cultural humility. The basic assumption of cultural humility training is that in every interaction with a patient, there is something healthcare providers neither know nor understand that cannot be answered through stereotyping. It can only be answered by expressing humility in each encounter with a patient to learn about that specific patient’s needs and desires. Additionally, the explicit and implicit negative attitudes and behaviors that healthcare providers hold against African Americans can only be addressed through a development of critical consciousness, which requires “lifelong self-reflection, self-critique, and learning” (van Ryn 2014: 12). Rather than being a promise of mastery like cultural competency, cultural humility training tries to transform healthcare providers into enlightened change agents who are actively engaged in trying to put aside their biases to do the best for their patient. No longer would training emphasize differences between individuals and ignore the similarities; instead, it would train healthcare providers to view all patients as unique individuals, both similar and different from themselves.

Moreover, all healthcare provider training, including, but not limited to, state continuing medical education, medical school education, residency training, nursing school education, social worker education, hospital administrator education, education in business administration in healthcare, and premedical education, must include implicit and explicit racial prejudice reeducation practices, cultural humility training, and Title VI training. In order to ensure that all physicians undergo training, the federal government needs to make the training a mandatory requirement in order for physicians to receive Medicare or Medicaid payments or staff privileges at a Medicare or Medicaid certified healthcare facility.

Finally, Professor Vernellia Randall (2014: 12–16), a racial health disparities expert, proposes adopting a new anti-discrimination law that would hold institutions and healthcare providers responsible for

intentional, reckless, and negligent racial prejudice that affects African Americans' access to healthcare. The law would authorize and fund the use of medical testers and provide a private right of action both for individuals who are victims of racial prejudice and discrimination and for organizations that represent these individuals. Furthermore, each healthcare institution and healthcare provider would be responsible for submitting a racial equity report card that would be available online and in print to patients seeking care. When a healthcare institution or a healthcare provider was sued and found guilty of violating the law, then that person or entity would be fined, subject to punitive damages, and required to pay attorney's fees.

Adopting all of the solutions discussed above would not only put an end to structural racism in wealth, employment, income, and healthcare, but it would also begin to decrease racial disparities in health status and access to healthcare, saving at least 835,700 African American lives and \$337 billion over the next 10 years (Satcher et al. 2005: 459; Waidmann 2009). However, none of these recommendations will fix the problem until the government enforces the civil rights laws. Then and only then will the United States begin to fulfill the promise of equality it made to African Americans in the 1950s and 1960s.

Notes

1. Research summarized by van Ryn (2014: 12) shows that 80 percent of Caucasian Americans show a significant implicit preference for Caucasians over African Americans.

2. Yearby (2010: 57) examines the successes and failures of federal programs aimed at elimination of racial discrimination in healthcare and emphasizes the critical role that scholars, researchers, and federal officials will play in the adoption of new approaches aimed at eradicating racial disparities.

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