Systemic Racial Bias in Health Care Delivery to Women

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Abstract

Introduction: The main hypothesis is that racial bias towards minority women perpetuates systemic racism in the U.S., health care system resulting in negative health outcomes and detrimental incidences.

Methods: In this semi-systematic and literature review, an informational web-based search was used from the U.S. National Library of Medicine at the National Institutes of Health, Elsevier, the Centers for Disease Control and Prevention, and ResearchGate. Inclusion criteria were adult women over the age of eighteen, women of color restricted to the United States only, and different areas of health care delivery.

Results: This review found that women of color, especially black women, faced substantially more systemic racial bias in the United States health care delivery system and felt more excluded from adequate health care from clinicians due to racial discrimination.

Discussion: There is very little literature on how to combat racial bias in health care delivery in the U.S. The mainframe of this stereotypical behavior from health care workers is conventional conscious and subconscious biases. Change needed for this type of behavior needs to start at the cognitive level.

Keywords: Health care delivery, minority women, racial bias, implicit racial bias, gender bias

Introduction

Minorities face societal biases in the United States health care system that are a result of prejudicial and discriminatory acts and behaviors yielding depraved health outcomes (Lewis et al., 2016). Women, especially minority women, are often subjected to these experiences, leaving them feeling marginalized, avoiding wellness visits, and scheduled physician appointments because of these racially bias incidences (Lewis et al., 2016; Gary, et al., 2015). Minority women face racial disparities in many aspects in health care delivery in the U.S. health care system as in the United States, African American women represented 60% of new HIV infections and had a 2.8-3.7 times higher likelihood of dying from pregnancy-related deaths (Prather, et a., 2016). The aim of this study was to identify documented incidents of systemic racism in health care delivery against minority women in the U.S. health care system. The overall goal of the present review was to investigate racial biases towards minority women, which perpetuates systemic racism in the U.S. health care system resulting in negative health outcomes and detrimental incidences.

Methods

For this study, a semi-systematic review was conducted following the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) guidelines (Snyder, 2019; Moher et al., 2009). In addition, a literature review was conducted when PRMISA guidelines were not met (Snyder, 2009). The review included quantitative and qualitative, English only published studies. The timeframe of this study was conducted within the last 18 years from 2002 to 2020, in order to capture the more recent data. This research review was conducted using the National Center for Biotechnology Information (NCIB/PubMed), and U.S. National Library of Medicine databases. The following search terms, “racial bias”, “gender bias”, “health care delivery, and the “United States” were used for the review. Additional research sources included

Elsevier, the Centers for Disease Control and Prevention (CDC), ResearchGate, and Google search engine to locate additional articles, using the same search terms. The study's semi-systematic and literature review was conducted during the months of October and November 2020.

The study reviewed qualitative and quantitative research articles that studied the impacts of racial and gender bias in health care delivery in the U.S. for women of color. Research articles included in this search were adult women over the age of eighteen, women of color, restricted to the U.S. only, and different areas of health care delivery. Research articles excluded from this search were women under the age of eighteen, men regardless of race, Caucasian women, and racial and gender bias in health care delivery outside of the United States.

Data extraction was conducted based on the area of health care delivery, the aim and/or objective of the study, methodological study and data collection methods, and the research study design (CASP, 2018; Moher et al., 2009). This data extraction resolved the issue of duplications. A total of 33 references were considered for this research review based on the title and abstract. Of the 33 references considered, 15 articles were excluded that did not meet the inclusion criteria based on their aims and/or objectives. A total of 18 articles were considered to have met the inclusion criteria.

Findings

Areas of racial bias identified in the U.S health care delivery system were maternal mortality and pregnancy-related mortality rates, health care provider interactions, insurance-based discrimination in health care delivery, and racial and gender bias in labor pain management. These topics were chosen due to the high rates of racial disparities, unconscious

racial bias impacting health care delivery, and the unique perspective of the victim's point of view.

Racial Bias Impacting Maternal Mortality and Pregnancy-Related Mortality Rates

Maternal mortality in the U.S. exhibits one of the most notable racial disparities in women's health outcomes (Maternal Health Task Force, n.d.). Despite the significant increase in financial support in hospital-based maternity care and its participation in the Millennium Development Goals (MDGs), the maternal mortality ratio, as of 2018, was 17.4 deaths per 100,000 live births (CDC, 2019a; Maternal Health Task Force, n.d.). The National Center for Health Statistics reported disproportionate rates of racial and ethnic maternal deaths in 2018; 37.3 deaths per 100,000 live births were reported for non-Hispanic black women, 14.9 deaths per 100,000 live births for non-Hispanic white women, and 11.8 deaths per 100,000 live births for Hispanic women (CDC, 2019a). African American women were three to four times more likely to have a higher maternal mortality rate (Maternal Health Task Force, n.d.). Conversely, African American women also experienced higher pregnancy-related mortality deaths (PRMRs) with 40.8 deaths per 100,000 live births as compared to their white counterparts, (Maternal Health Task Force, n.d.).

From 2007-2016, PRMR's increased from 15.0 to 17.0 per 100,000 live births from 2007–2016 (CDC, 2019b). The CDC's implementation of the Pregnancy Mortality Surveillance System, that tracked pregnancy-related deaths from 1987 to 2017, saw an increase from 7.2 deaths per 100,000 births to 17.3 deaths per 100,000 live births, respectively in the U.S. (CDC, 2020a). Black, American Indian, and Alaska Native women were found to be two to three times more likely to die from pregnancy-related deaths, with disparities increasing over the age of 30 and PRMRs four to five times higher in this group than their white counterparts (CDC, 2019b).

Non-communicable diseases, such as cardiomyopathy, thrombotic pulmonary embolism, and hypertensive disorders, contributed to more pregnancy-related deaths in black women than their white counterparts (CDC, 2019b; Maternal Health Task Force, n.d.). Delayed prenatal care visits also contributed to pregnancy-related deaths, with 25% of women in the U.S. not receiving the recommended prenatal visits (Maternal Health Task Force, n.d.). This decline in prenatal care visits was found to occur in 34% of African American women and 41% of American Indian and Alaska Native women (Maternal Health Task Force, n.d.). From 2000 to 2017, while the world saw a reduction in maternal mortality deaths by 38%, the U.S failed to not only meet its national goals of a reduction in MMR by 10% between 2007 and 2020, but also the Healthy People 2020 goal of decreasing the MMR from 12.7 maternal deaths per 100,000 live births in 2007 to 11.4 maternal deaths per 100,000 live births (Maternal Health Task Force, n.d., USHHS, 2014).

Interactions with Health Care Providers

Unconscious, implicit cultural, and stereotypical characterization has led to racial and gender biases which have inadvertently socially grouped individuals into a categorically accepted minority of social norm(s) (Burgess et al., 2016; Burgess et al., 2007). This, in turn, has influenced the interpretation of behaviors and symptoms, under the assumption that it is typical conduct for an individual's race, ethnicity, and sex (Burgess et al., 2016; Burgess et al., 2007). These unconscious biases have led to poor health care delivery for women of color, often leading to prolonged undiagnosed health problems or poor treatment of a diagnosed issue (Burgess et al., 2016; Gary et al., 2015; Burgess et al., 2007). Gary et al., (2015) stated that the lack of communication and poor clinician-to-patient interactions often led to incomplete diagnostic information and curative recommendations for women, particularly for black women. As cited in one patient's experience:

> *When the doctor come in he'd cross his leg, and say "How you doing; you doing fine? Well, is there anything bothering you?" "Well," I'd say, "my back is still bothering me." He'd say, "Well, it'll get better. Sign this paper. Take this." That doctor did not put his hands on me. Never touched me*! (Gary et al., 2015, p. 7).

Clinicians' aversion to performing proper physical assessments of their patient's issues can create an unwelcoming environment, furnished with racial undertones, sending an implicit, yet strong message, that the patient is to the clinician, subhuman, disgusting, or dirty in some way (Gary et al., 2015). Okoro et al., (2020) reported one participant's experience with a health care provider:

> *They treat you different, even with the way they greet you. - ...because you African American. You do get treated a little bit different, because they don't even have the compassion a lot of times to Afro Americans. They don't consider that a lot of things is serious with us when it is* – (Participant #2) (p. 4).

Insufficient time spent with patients by clinicians and other health care providers has jaded many black women, knowing they have been unheard and underserved. This type of behavior from clinicians can influence women of color's perception of clinicians, often delaying them in scheduling or not scheduling follow-up appointments at all as reported in one participant's experience by Okoro et al.(2020):

> *I thought about not going to that dentist office anymore because when we go there I feel we're stared at. It's super uncomfortable in there. I called it, "We're ink on paper." We are the spot on paper, ink on paper. That's how I feel when I go in there with all the white people around. 'I was gonna stop going because of the stares, because of the feeling I have because I'm in there telling my kids, "Be still. Don't do anything." Even*

> *though all these little white kids are running around. "Don't you stand up, don't move because we will be look at. You will destroy it. If something is broke, it will be because of you. If you are there and it's over there, it'll be because of you." I do that with my kids. That's not right, so I stopped.* (Participant #4) (p.4).

Insurance-Based Discrimination in Health Care Delivery:

Insurance-based discrimination can have negative health outcomes for women of color and can impact their perceptions of care from clinicians and other health care providers (Weech-Maldonado et al., 2012). Research by Weech-Maldonado et al., (2012) reported that Medicaid enrolls roughly 60 million Americans, providing health insurance coverage to an estimated 27% of all blacks or African Americans. This same study also reported that women of color were three times more likely to experience insurance-based and racial and ethnic discrimination when enrolled in the Medicaid program. Medicaid and Medicare beneficiaries also expressed grievances about their hospital experiences, reporting a lack of quality of care and a more hostile environment because due to their type of insurance (Gary et al., 2015; Weech-Maldonado et al., 2012). Women of color, especially African American women who are economically disadvantaged and living in low-income areas, have significantly wider health gaps and lower health statuses compared to their white counterparts living in suburban areas (Okoro et al., 2020).

Racial and Gender Bias in Labor Pain Management

The Institute of Medicine (IOM) determined that implicit racial bias, stereotyping, and prejudice exist in health care providers' conscious and subconscious thinking contributing to discriminatory behaviors in health care practice (Dehon et al., 2017). As reported by the 2012 National Healthcare Disparities, black patients received poorer health care service than white

patients for 40% of the quality and disparity measures (Dehon et al., 2017). For example, patients of color were 22% to 30% less likely to receive analgesic medication and 17% to 30% were less likely to receive narcotic analgesics (Dehon et al, 2017). Patients of color also had an increased chance of experiencing longer wait times and were less likely to be admitted to the hospital as compared to their white counterparts (Dehon et al, 2017).

In women of color, labor pain has been found to be interpreted differently by clinicians based on the perceptions of the individuals' culture, race, and ethnicity (Mathur et al., 2020). A study by Mathur et al., (2020) suggested that prior evidence has shown that clinicians show racial maternal bias in childbirth pain, contributing to the unequal distribution of pain management for women of color. According to Mathur et al., (2020), White American women were perceived to have experienced more significant labor pain than all women of color and Hispanic American women were perceived to experience less significant labor pain. The same study noted that women overall in the U.S. did report variations in pain sensitivity according to different races; however, African Americans reported greater pain sensitivity compared to both Hispanic and White women (Mathur et al., 2020).

During childbirth, women of color's opinion about their pain management were commonly not sought after, with the stigmatization of being uncooperative if they requested or declined the same treatment as white patients (Mathur et al., 2020). The lack of understanding and the inaccurate understanding of how labor affects women of all cultures can influence maternal racial bias resulting in the inequitable treatment of labor pain management (Mathur et al., 2020). Conversely, the dehumanization of women of color by clinicians who presumed that they experience less pain during childbirth also suggests the inequitable management of labor pain (Mathur et al., 2020). Conversely, the cultural super humanization of the African American

woman as a “Strong Black Woman/Superwoman,” who is resilient in the face of adversity, may lead to undermining labor pain and inappropriate health care treatment (Mathur et al., 2020, p. 8). This type of stereotyping can lead to decreased reasons to help women of color and a decline in the welfare of women during labor pain (Mathur et al., 2020). This same study found that socio-demographic and -geographic factors did not influence presumptive stereotypes, but rather stereotypical cultural constructs held by clinicians significantly influenced their application of pain management for women of color (Mathur et al., 2020).

Summary

Women of color, especially black or African American women, face more racial bias in health care delivery as compared to Caucasian women. The IOM found that clinicians stereotyping, and prejudicial behaviors have led to the inequitable distribution of health care delivery to women of color in the U.S. Women of color also experienced diminished health care delivery in hospital settings, especially those insured with Medicare and Medicaid, as some reported being met with hostile and dismissive attitudes from health care providers. The presumptive stereotypical constructs held by providers have also led to the bias and mismanagement of labor pain sensitivity for women of color. The mainframe of this stereotypical behavior from providers is the conventional conscious and subconscious biases, which infects and becomes relevant in the health care delivery system. The change needed for this type of behavior needs to start at the cognitive level, with health care providers being made aware of their prejudices and learning how to correct their behaviors.

Discussion

Despite the racial biases that plague health care delivery to women of color, there is extraordinarily little literature on direct interventions to improve health care delivery in the U.S.

The social determinants of health constructs of race/ethnicity, socioeconomic status, and gender are stereotypically reinforced by both individuals and society, altering the psychosocial behaviors of how women of color are perceived individually, versus how they are stereotypically perceived socially (Okoro et al., 2020). Advocating for a social medicine curriculum that includes the social determinants of health in medical school education, may also afford health care providers with a more complete understanding of the social constructs surrounding the various minority populations they serve (Axelson et al., 2017). Incorporating the Social-Ecological Model in health care will help clinicians to better understand how the influential and overlapping complexities of each level can address and prevent racism in health care on a multilevel system (CDC, 2020b).

Further, literature and systematic reviews of cognitive-behavioral therapies on racial biases could be helpful to clinicians' psychological thinking in overcoming racial prejudices (Zeidan et al., 2018; Burgess et al., 2016; Burgess et al., 2007). Health care facilities could also incorporate cognitive-behavioral and mindful-based therapies that address behavioral biases towards systemic racism in health care delivery (Zeidan et al., 2018; Burgess et al., 2016). Implicit racial bias training programs should be introduced into health care settings to see if implicit racial bias does contribute to the reduction in the quality of care delivered to women of color (Zeidan et al., 2017). Tracking racial disparities in health care delivery at the government and non-profit levels, while at the same time addressing racial biases through structural competency, can help to access the inequalities in institutionalized social conditions that determine health-related resources (CDC, 2019; Metzl and Hansen, 2014).

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