STRUCTURAL FACTORS OF HEALTHCARE AND HEALTH DISPARITIES IN RACIAL AND ETHNIC MINORITIES IN THE UNITED STATES

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INTRODUCTION

It is widely accepted that the infant mortality rate and average life expectancy are two critical indicators of a country's healthcare system and its population's health. Additionally, understanding the distribution of chronic health conditions helps to provide a clearer picture of public and societal health. In the United States there have been reported health and healthcare disparities for decades and despite attempts to narrow the gap in healthcare and health disparities they continue to persist and are observed on multiple fronts.

In a time where the population in the United States continues to become more diverse, not just in race and ethnicity but also in age, gender identification, sexual orientation and other categories it is concerning to see that healthcare and health disparities which were brought to light in the mid 1980's documented in the "Report of the Secretary's Task Force on Black and Minority Health" (the Heckler Report) but have existed throughout the history of the United States have yet to be resolved. Increased focus and attention has been directed toward various health inequalities in the United States most notably since 2000 by multiple levels of government. The increased focus has led to the United States government creating an ever-expanding list of health dimensions of disparities and offices directed toward establishing health equality. Yet, this approach appears to only lead to bureaucratic delays, drilled-down data that lacks impact and meaning, and often skewed results as the creation of multiple data points may show improvement in certain dimensions but the disparities as a whole still exist.

The purpose of this thesis is to broaden the scope of inquiry to capture a more accurate view of the ever-present and persistent causes for and experiences of healthcare and health disparities by racial and ethnic minorities in the United States. To develop an effective approach to eliminating the health and healthcare disparities in this country we must first understand the big picture before we drill down into the minutia of the data. The healthcare and health disparities in the United States do not only impact racial and ethnic groups; they impact every dimension in which there is diversity (age, gender identification, sexual orientation, etc.). This high-level view brings into focus three primary structural factors of society which are intertwined and are the foundation or root of the healthcare and health disparities demonstrated in the United States.

If we think about the history of medical advances that we've seen in each of our lifetimes we may easily be amazed. There have been vaccinations that have nearly eradicated certain diseases that plagued societies not much more than 50-60 years ago but are now almost all but forgotten. There have been advances in medical treatments, devices, technology and pharmaceuticals which have helped to globally extend the lifespan of humankind. Innovation in the practice of medicine, health and healthcare has and promises to produce continued amazing results. Yet, despite the widely seen and known scientific advances individual minority groups continue to lag behind the White majority population in equal impact of these advances in the United States.

We must first understand the big picture of what is going on in the United States. These disparities do not just affect racial and ethnic groups but every dimension of difference (age, gender, etc.). There are additional nuances and biases that may come into play when discussing these differences, including social factors. The top three overarching factors that lead to a majority of disparities are intertwined with economic, education and

cultural competence. If one is not well educated one cannot achieve a good economic status. Low socioeconomic status affects racial and ethnic minorities at a higher rate. This reduces the prevalence of certain races and ethnicities in various professions and then the cultural competence will only be that of the dominant class, adversely impacting experiences and gaps in health and healthcare.

The Heckler report, mentioned above, objectively detailed the wide disparity in the excess burden of death and illness experienced by Blacks and other minority Americans as compared with the nation's population as a whole. It also put forth that such disparities had been in existence for as long as federal health statistics were routinely collected. The report further emphasized the fact that six medical conditions between Blacks and Whites accounted for 86% of excess Black mortality and the fact that close to 45% of deaths up to the age of 70 years (58,000 of 138,000) in the Black population would have been avoidable if better evaluation, detection, and treatment had been available. The six conditions were: cancer (3.8%), heart disease and stroke (14.4%), diabetes (1.0%), infant mortality (26.9%), cirrhosis (4.9%), and homicide and accidents (35.1%) (Riley 2012).

In the United States Blacks, Hispanics and other racial and ethnic minorities are paying the price for a system with pervasive healthcare disparities in access to care, healthcare coverage, utilization of care, and quality of care. These healthcare disparities and their outcomes which impact racial and ethnic minorities are rooted in structural causes which reinforce segregation by education and economic class and at a point-of-care level lack culturally competent healthcare workers and maybe a lack of a culturally aware society. More effort needs to be put forward in point the structural issues and their resultant health and healthcare disparities.

Most Americans from all racial and ethnic groups are still unaware of the existence of health disparities. Although these issues have been discussed for years, even most Blacks are unaware of the disparities in rates of infant mortality and life expectancy between Blacks and Whites. Thus, the issue of first raising awareness is critical.

The disparities in health outcomes (i.e. health disparities such as differences in infant mortality rate) coupled with observed healthcare disparities (such as access to care and coverage) which are caused by the structural differences have continued to develop into an underlying feeling of mistrust of the medical system among racial and ethnic populations. This lack of trust can be seen in multiple dimensions of healthcare (access to, coverage, utilization of and quality of) as well as multiple dimensions of health such as chronic health conditions, infant mortality and life expectancy. The skepticism that has manifested among racial and ethnic minority populations threatens the possibility of narrowing the gap in these disparities and continues to prevent the achievement of health and healthcare equality in the United States. Although there has been attention focused and efforts made to address the health and healthcare disparities in the United States there has been a limited amount of attention paid to address the structural reasons contributing to such disparities resulting in relatively poor results in the current efforts being made.

Positive trends from the health care sector are reductions in mortality rates and some increases in access to preventive services and other clinical services for disadvantaged populations. Unfortunately, ongoing racial and ethnic tensions under the current presidential administration do not bode well for the continuation of these positive trends. As one of the most powerful and wealthiest countries in the world, one would expect the population of the United States to reap the benefits of such economic superiority and prosperity. However, despite efforts and initiatives to correct health and healthcare

disparities in the United States, such an expectation may be premature. The state of global healthcare indicators show that the United States is nowhere near where it could be especially when comparing racial and ethnic minorities and more importantly the structural dimensions which contribute to the cycle of systematic health and healthcare disparities in this country. These obstacles include difficulty in accessing health insurance and quality health care, as well as differential access to high-quality education, employment, housing, and income—factors known as the social determinants of health (World Health Organization, Social determinants of health 2014). These social determinants of health are often the underlying causes of health disparities (HHS Disparities Action Plan 2015).

To begin I should define the difference that is meant by the terms healthcare disparity and health disparity for the purposes of this thesis. I will use the National Institutes of Health's (NIH) definition for healthcare disparities and the Center for Disease Control and Prevention's (CDC) definition of health disparities. The NIH defines healthcare disparities as the differences in access to or availability of facilities and services. The CDC defines health disparities as preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic and other population groups or communities. These definitions are essentially the cause (healthcare disparity) and effect (health disparity) demonstrated in different racial and ethnic groups in the United States. However, at a deeper level I will also examine the structural issues, the cause of the healthcare disparities that leads to these differences in health.

For the purposes of this thesis, I will be discussing disparities based on racial and ethnic differences, but it is extremely important to note that disparities occur across multiple dimensions including gender identification, age, sexual orientation and many other

diversity dimensions not just race and ethnic differences. Although these other dimensions are not in the scope of this project, it is important to note that they are as crucial to understand and study. As racial and ethnic differences have been a primary and underlying cause for disparities it is important to discuss these and understand the fundamental healthcare disparities, experienced health disparities and their causes as there have been multiple and failed attempts to correct these for decades.

The United States is moving away from the idea of the melting pot that it once was and is instead becoming ever more diverse in race, ethnic, cultural, religious, sex and gender identity and sexual orientation. It appears the mentality is no longer a melting pot but that each citizen is a unique snowflake and to understand the health and healthcare disparities that currently exist in this country and identify their causes provides the opportunity to reduce and eventually equalize the distribution of health and healthcare. This will not only benefit the racial and ethnic groups that experience these disparities but it will set the ground work to address the structural causes of disparities which impact all socially disadvantaged groups in the United States which is fundamentally important as the United States continues to become increasingly more diverse with additional dimensions of diversity continuing to emerge.

HEALTHCARE DISPARITIES: ACCESS TO HEALTHCARE

Differences in access to healthcare contribute to the healthcare disparities seen in the United States. Successful health outcomes cannot be achieved without timely use of personal health services. Poor access comes at both a personal and a societal cost. For example, the inability to receive needed vaccinations may cause the spread of disease thus burdening the population in addition to the individual carrier. There are several ways to measure access such as: presence of specific resources (i.e. health insurance, source of care, etc.), healthcare utilization metrics, and assessment by patients on the ease of access to healthcare. To improve access to healthcare there a few steps that can be taken such as: assisting patients with the ability to gain entry into the health system, gaining access to sites where patients can receive needed health services and access to providers who meet the patient's needs and can develop a successful patient-provider relationship built on mutual trust.

The problems with access to appropriate healthcare are not simply rooted in racial and ethnic densely populated urban areas but also the rural areas inhabited by Black and Hispanic populations. In rural areas Blacks and Hispanics have lower medical service utilization rates mostly because poor and minority populations in the rural areas tend to receive care at public clinics or emergency rooms where utilization is limited due to long travel and wait times (Yelin et al., 1983). It has been demonstrated that there is a discrepancy in service at urban treatment centers which can be associated with access and cultural sensitivity. Blacks and Hispanics reportedly receive lower quality healthcare than the majority White population. Lack of insurance and access issues explain only part of the

differences. Minority satisfaction with physician interaction appears to be influenced by the physician's race and ethnicity. Minorities, particularly Blacks, tend to prefer physicians of their own racial and ethnic background and rate them as providing better care (Saha et al., 2003).

Uninsured rates decreased from 2000 to 2016. Most access measures did not demonstrate significant improvement from 2000 to 2014. Overall quality of healthcare improved from 2000-2015 but the pace varied by priority area. The overall trend is that disparities are getting smaller over that time period but they do persist especially for the poor/low income and uninsured groups. Still, there is 66% worse care between the uninsured and privately insured. Groups with poor or low income levels have worse health outcomes than their counterparts in high income groups. Three leading causes of years of potential life lost from 2000 to 2015 remain unchanged and are unintentional injury, cancer and heart disease (Agency for Healthcare Research and Quality 2017). Heart disease, cancer, cerebrovascular disease, chronic lower respiratory diseases, unintentional injuries and diabetes were among the leading causes of death for the overall United States population (Agency for Healthcare Research and Quality 2017). Hispanics experience worse access to care compared to Whites for 75% of measures, Blacks experienced worse access to care compared to Whites for 50% of measures and Asians experienced worse access to care compared to Whites for 28% of measures (Agency for Healthcare Research and Quality 2017).

Not surprisingly, large differences in access to health care also exist between Whites and people of color. Both Latinos and Native Americans have low levels of health insurance coverage. Among all people with some form of health insurance, Hispanics, Blacks, and Native Americans are more likely to have some form of public health insurance, such as

Medicaid, rather than private insurance. Health insurance is designed to protect individuals from the burden of high healthcare costs. However, even with health insurance, the financial burden of healthcare can be high and is increasing (Banthin & Bernard, 2006). High premiums and out-of-pocket payments can be a significant barrier to accessing needed medical treatment, resulting in higher comorbidity and lower quality of life (Henrikson, et al., 2017). In addition, the advent of high-deductible health plans is placing a financial burden on many people, especially those with chronic conditions (Reed, et al., 2012; Zimmerman, 2011). Ensuring health care is affordable remains an important factor in achieving access to high-quality health care.

Racial and ethnic minority populations continue to face major barriers in accessing health care (Agency for Healthcare Research and Quality 2012). Although having a regular provider or "medical home" as defined by the Center for Disease Control increases the chance that people receive the preventive and other services they need to stay healthy, approximately 23 percent of Hispanic or Latino adults do not have a usual source of medical care, as compared to less than 12 percent of non-Hispanic or Latino adults (Centers for Disease Control and Prevention 2012). Moreover, even as access to insurance increases, many parts of the country still lack the provider capacity to offer needed primary health care services. The Health Resources and Services Administration (HRSA) is addressing this issue by increasing the number of providers offering care in health professional shortage areas, as well as expanding the ability of health centers to care for more patients. Of the 21.7 million patients served by community health centers in 2013, nearly two out of three patients were members of racial and ethnic minority populations (Health Resources and Services Administration 2014).

HEALTHCARE DISPARITIES: HEALTHCARE COVERAGE

Under the Affordable Care Act (ACA) which remains threatened under the current Trump presidential administration the gap in healthcare coverage has narrowed. Despite these gains disparities continue to persist for some ethnic minority groups, specifically the Hispanic population. The gains by the ACA are only minimal and are at risk of being undone. Over the past 3 decades disparities continue to remain with very few successful steps in mitigating these differences. As political debates and other social issues such as race and gender equality continue to cause division for our society even the minor advances that have been gained over these thirty years may collapse.

Under the Affordable Care Act (ACA) people of color had larger gains in coverage compared to Whites. For example, the Hispanic uninsured rate dropped from 26% to 17% (4 million), the Black uninsured rate dropped from 17% to 12% (1.8 million), the Asian uninsured rate dropped from 15% to 8% (0.9 million) and White uninsured rate dropped from 12% to 8% (6.8 million) (Artiga, et al. 2018). Despite gains made from the affordable care act disparities in coverage still remain and of note Hispanics are more than two-fold as likely to be uninsured than Whites (22& to 9%) (Artiga et al. 2018). Ineligibility in the healthcare marketplace also disproportionately affects people of color more than Whites. Blacks tend to experience higher ineligibility rates due to coverage gaps from states that have not implemented Medicaid expansion and Hispanic and Asian populations tend to experience decreased eligibility due to a higher rate of non-citizen and immigration status (Artiga et al. 2018).

Any gains that people of color benefited from currently face a threat by the new Trump presidential administration's efforts to repeal key portions of the Affordable Care Act mandate. Should this occur, people of color would be disproportionately impacted and risk throwing away a decade of progress which has been slow to achieve. Cuts to outreach providing enrollment assistance and shorter open enrollment periods may also limit progress reaching the remaining eligible uninsured population (Artiga et al. 2018) It's already been reported that insurance markets are looking to increase premiums in response to the uncertainty caused by the efforts to alter the Affordable Care Act.

There were additional benefits in the Affordable Care Act that were slated to begin in 2014 which could help ease the healthcare disparities in coverage. The benefit is two-fold in that it requires certain health insurance plans to cover "Essential Health Benefits Categories" services such as outpatient surgery, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services (including behavioral treatment and prescription drugs), rehabilitative and facilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services that include oral and vision care. In addition to the added coverage, the Affordable Cara Act also required that all plans were to phase out annual dollar cost spending limits for the previously mentioned services as well. When one considers the health disparities discussed later in this paper the impact of this additional coverage in reducing health differences can be more easily understood. One challenge to the 2014 implementation of this additional coverage is that each has significant latitude in establishing the benefits to healthcare plans. This has led to a reduced realization in the potential benefit and these additional coverages are also in jeopardy by the current presidential administration.

HEALTHCARE DISPARITIES: QUALITY OF HEALTHCARE

The Institute of Medicine defines health care quality as the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. It is widely known that racial and ethnic minorities (Black, Hispanic and Asian) are the recipients of lower quality of care when compared to Whites. This is one of the primary reasons that the Center for Medicare and Medicaid Services (CMS) Disparities National Coordinating Council (DNCC) has offered assistance to improving the quality of care received by minority Medicare beneficiaries. Reports demonstrate disparities in the quality of care provided to different populations, even when access to care is ensured through adequate health insurance coverage (HHS Disparities Action Plan 2015). It is widely reported through numerous outlets that even when racial and ethnic minorities have the same health insurance coverage that the quality of care they receive is lower than that of Whites.

Though quality of care for racial and ethnic minority populations is slowly improving, significant disparities persist between the quality of care received by Whites and that received by many racial and ethnic minorities (Agency for Healthcare Research and Quality 2012). For example, African Americans are far more likely than non-Hispanic Whites to be hospitalized for heart failure. Although some hospitalizations for heart failure are considered unavoidable, rates of hospitalization can be linked to the quality of outpatient care received (Agency for Healthcare Research and Quality 2012). Other disparities exist in the quality of care received; for example, Asian Americans are less likely than Whites to receive recommended hospital care for pneumonia (Agency for Healthcare

Research and Quality 2012). In another example, African American mothers are less likely than White mothers to receive adequate prenatal care (Agency for Healthcare Research and Quality 2012). The quality and quantity of prenatal care pregnant women receive may influence a range of birth outcomes, including low birth weight and preterm birth.

HEALTH DISPARITIES: AVERAGE LIFE EXPECTANCY

The average life expectancy in the United States has continued to increase over the decades. This increase in average life expectancy is due to a number of factors and one of the most important has been the advancement in healthcare and medical treatment. One does not need to look far to see that how the disparities in healthcare manifest in noticeable and significant disparities in average life expectancy among racial and ethnic minorities. When we take a deeper look we can see how healthcare disparities have impacted the average life expectancy by race and ethnicity and how they magnified when stratified by wealth (of which Whites hold the advantage).

Another way to document health disparities is to look at life expectancies for Blacks and Whites, as life expectancy rates serve as a widely used indicator of health. In 1950, the life expectancy for Whites was 69.1 years. However, it was not until 1990 that the life expectancy for African Americans reached 69.1 years, four decades later. In other words, it took African Americans 40 years to catch up to the life expectancy of White Americans in 1950.

By 1980, average life expectancy in America had reached 74 years old which was almost 25 years longer than at the beginning of the 20th century and as of 2015 average life expectancy in the United States had reached 78.8 years old. However, Black Americans, Hispanic Americans, Asian Americans, and other minorities who represented about one third of the U.S. population, continue to experience significant health disparities, including shorter life expectancy and higher rates of diabetes, cancer, heart disease, stroke, substance

abuse, infant mortality, and low birth weight (National Institute of Health: Health Disparities 2010).

Significant disparities in health outcomes between White and most other racial and ethnic minorities are not only evident in the infant mortality rate but in average life expectancy as well. Average life expectancy factors include socioeconomic status (low wages and poverty), racial and ethnic minority population concentration, healthcare quality and access and association with risk factors contributing to poorer health. Life expectancy for Blacks has been substantially lower than White Americans for as long as records have been available (Kunitz and Pesis-Katz, 2005). Although life expectancy had generally increased since the 19th century for both White and Blacks a disparity continues to exist due to such factors as slower declines in heart disease for Blacks and more rapid increases in homicide and HIV (Harper et al., 2007).

One of the structural contributions to the poorer health outcome of average life expectancy is geographic location. Many of the minority racial and ethnic groups find themselves grouped into the urban centers of the United States where too many people live in segregated ethnic ghettos (Dennis, 2005). Many of these urban areas are poor and economically strained. There is a lack of quality housing and quality dietary products. Along with members of racial and ethnic minorities there are many people with mental illness who are disproportionately concentrated in high poverty areas and these areas generally lack the resources needed to maintain community services at a minimum level (Chow et al., 2003).

The lack of opportunity in these neighborhoods all but guarantees the same outcome for younger generations. The impact of living in such districts with high concentrations of the

poor are higher crime rates, higher unemployment rates, homelessness, substance abuse, and high residential turnover. These factors create unfavorable social conditions that individuals cannot control individually and that exacerbate the impact of personal vulnerabilities and problems in living (Chow et al., 2003). One of the ways crime has a high impact on Black mortality rates is that there tends to more than five times of a chance for a Black person to die by homicide, a preventable mortality, than Whites and socioeconomics like geographic factors can explain most of this disparity (Rogers et al., 2001). With racial and ethnic minorities trapped into the social structure of impoverished neighborhoods they are stuck in a cycle of poor health outcomes which are destined to continue.

Neighborhood concentration alone is not the structural cause of such disparities but a combination of the concentration of Blacks in the neighborhood of residence as well as individual socioeconomic status account for the disparities in mortality outcomes between Blacks and Whites (LeClere et al., 1997). Socioeconomic status is a combination of factors which can lead to negative health outcomes. Minority groups such as Blacks and Hispanics are more than twice as likely to live below the poverty level (which in 2015 was just under $30,000 per year for a family of four) putting potential pressure to make difficult financial choices that can impact health. There is the associated lack of medical coverage, poor quality of care and higher incidence of risk factors associated with low socioeconomic status. Ethnic and racial minorities are more likely to be subject to living in low socioeconomic areas because social selection theory postulates that Whites have a greater propensity to avoid living in high poverty areas because they are more likely to enjoy social and economic advantages (Chow et al., 2003). We can see that a combination of factors impact average life expectancy in the United States which is closely tied to the healthcare disparities such as access and coverage but are rooted in structural dimensions such as

economics that continue to perpetuate the gap that exists between Whites and racial and ethnic minorities in average life expectancy.

HEALTH DISPARITIES: INFANT MORTALITY

Evidence garnered over the past three to four decades is compelling when we examine the disproportionate rates of infant mortality in the United States when stratified by race and ethnicity. There are many facts that demonstrate that health and disease states are unevenly visited upon various population groups. One illustrative example is infant mortality which for Black babies remains nearly 2.5 times higher than for White babies (Riley 2012). Racial and ethnic minorities are not given a chance when one considers the impact that infant survival has to influence the future landscape on health and healthcare disparities.

Between 2013 and 2015, infant mortality rates in the United States ranged from a low of 4.28 per 1,000 live births in Massachusetts to a high of 9.08 in Mississippi. For infants of non-Hispanic White women, the rates ranged from 2.52 in D.C. to 7.04 in Arkansas, and for infants of Hispanic women, the range was from 3.94 in Iowa to 7.28 in Michigan. For infants of non-Hispanic Black women, the lowest mortality rate of 8.27 in Massachusetts was higher than the highest state rates for infants of non-Hispanic White (7.04) and Hispanic (7.28) women. The highest mortality rate for infants of non-Hispanic Black women was in Wisconsin (14.28) (Mathews et al. 2018). Some factors correlated with a higher infant mortality rate are low birth weight, quality and timing of prenatal care, maternal age, and maternal educational level (Mathews and MacDorman, 2007). Interestingly most of these factors are tied to socioeconomic status which leads to a cycle incidence of higher infant mortality rates among Black and other racial population.

Millions of Americans are underinsured and disproportionate number of these underinsured people are racial and ethnic minorities and this leads to a lack of access which correlates highly with the quality of healthcare they receive (Kennedy et al., 2007). Racial and ethnic disparities exist in the use of pregnancy related care (initiation and adequacy of prenatal care visits, prescriptions for multiple vitamin and iron supplements; and claims for complete blood cell counts, blood type and RH status, hepatitis B surface antigen, ultrasound, maternal serum alpha-fetoprotein, drug screening and HIV test) (Gavin et al., 2004). Patients of lower socioeconomic status typically lack the insurance coverage which allows access to better prenatal care and correlates highly with pregnancy outcomes.

Since 1980 prenatal care use increased for all groups but is highest among Whites. From 1980 to 2004 use of prenatal care has increase from 79.2% to 85.4% for White women, 62.4% to 76.4% for Black women, and 60.2% to 77.5% for Hispanic women (National Center for Health Statistics 2015). It is again evident that Black women and Hispanic women do not enjoy the same access to prenatal care in 2015 as their White counterparts did more than twenty years ago. However even when some researchers controlled for economic access the disparities in prenatal care continued to persist supporting that there is more than just one factor in the infant mortality outcomes among minorities (Gavin et al., 2004).

Maternal age is also a significant component in infant mortality outcomes. Teenage mothers are likely to be unemployed and lack adequate health coverage for appropriate prenatal care. In 2000 Black and Hispanic women were more than 50% as likely to bear a child when compared with White women. Teenage (age 19 and under) Whites made up 9.4% of all live births in 2000 when compared with 17.1% for Blacks and 14.3% for Hispanics (National Center for Health Statistics 2016).

The disproportionate number of teenage mothers can be correlated with maternal educational attainment which is another risk factor for infant mortality. The gap between White and Black women was not as noticeable (22.7% and 23.8% of live births in 2004 respectively); however Hispanic women were more than twice as likely (48.4%) to have completed less than a high school education (National Center for Health Statistics 2106). The lack of appropriate education (especially sexual education) can have a severe impact on pregnancy prevention, prenatal care, maternal income potential, and future educational achievements. It has similarly been shown that White females have a distinct advantage when it comes to advanced educational attainment. White women (28%) are more than twice as likely as Black women (13.7%) and more than three times as likely as Hispanic women (8.0%) to complete more than 16 years of education (National Center for Health Statistics 2016). It is widely accepted that a more advanced education can lead to a better career. Research has demonstrated that there are substantial differences in earnings in women between ethnic groups across metropolitan areas (Reid et al., 2007). These earning disparities easily translate into lack of appropriate medical coverage which is a barrier to better prenatal care.

Data showing the relationship between the mother's level of education (which is closely related to socioeconomic status) and infant mortality illustrate this linkage. Even White mothers who are high school dropouts have lower infant mortality rates than college-educated African American mothers. The best-off African American mothers had worse health outcomes than all other racial/ethnic.

Racial and ethnic status is associated with behaviors that potentially influence pregnancy outcomes including, cigarette smoking, prenatal care utilization, and use of multivitamin supplements and socioeconomic status is usually intertwined with discussions

of ethnic and racial disparities in fetal mortality (Price, 2006). As was previously mentioned that when financial access to prenatal care is controlled for infant mortality outcomes between racial and ethnic groups continued to persist supporting that there is more than just one factor in the infant mortality outcomes among minorities (Gavin et al., 2004). The lack of proper education which can be associated to maternal age as younger mothers are destined to leave their education to care for a child can also lead to behaviors with high risk factors as well. It is widely known by reading any package of cigarettes of the influence on pregnancy and the incidence. Cigarette smoking, drug and alcohol use, and poor nutrition can all be factors in low birth weight which is a risk factor for a higher rate of infant mortality. It is also noticed that pregnant racial and ethnic minorities who typically receive less prenatal care are more likely to receive tests related to high-risk behavior (Gavin et al., 2004).

Not one of these issues sits alone as the sole reason for the disparity in infant mortality rates between racial and ethnic groups in the United States as it is a combination and induced cycle which is the culprit. Educational differences can be manifest in the disparity in risk factors such as age of pregnancy, substance abuse, employment opportunity, and medical care. On the other hand, age of pregnancy can significantly determine educational level, employment opportunity, and healthcare access in addition to being a family behavior which may be repeated by the younger generation. Many of these issues are part of the social constructs which serve as evidence of unequal healthcare in the United States medical system.

HEALTH DISPARITIES: CHRONIC HEALTH CONDITIONS

Heart disease continues to be the leading cause of death in the U.S., and racial and ethnic minorities and individuals with low socioeconomic status are strongly affected. The AIDS epidemic disproportionately affects racial and ethnic minorities. In 2007, Blacks comprised 13% of the U.S. population, but accounted for nearly half of persons living with HIV/AIDS. HIV/AIDS rates (cases per 100,000) were 77 among Black/Blacks, 35 among Native Hawaiians/Other Pacific Islanders, 28 among Hispanics, 13 among American Indians/Alaska Natives, 9.2 among Whites and 7.7 among Asian Americans (National Institute of Health: Health Disparities 2010). Racial and ethnic health disparities exist in every major chronic disease category impacting the population such as cancer, diabetes and heart disease serving as further evidence of the inequality experienced by these groups in the United States.

In 1950, no disparity in rates of death from heart disease existed between Blacks and Whites. However, even though rates of death from heart disease for both groups have steadily declined, since 1980, a gap in rates between Whites and Blacks that was not present in 1950 has appeared. A similar pattern exists for rates of death from cancer, which began increasing for both groups. In 1970, however, the rate for Blacks began to show a steeper increase than that for Whites. Although by 1990 cancer death rates began to decline for both groups, a gap remains between Blacks and Whites (Williams, et. Al 2007).

Even worse, Black women are more likely than White women to be diagnosed with cancer when the cancer is at a more advanced stage, to have more aggressive forms of the cancer that are resistant to treatment, and to have what are called “triple-negative tumors”

(tumors that grow more quickly, recur more quickly, and kill more frequently). Black women also have higher rates of mortality from breast cancer than White women. In short, although Black women have a lower overall incidence of breast cancer than White women, their health outcomes after breast cancer are worse for every indicator.

Major depression provides another example of "first and worst." National-level data indicate a lower overall prevalence of current and lifetime rates of major depression for Blacks than Whites. However, those Blacks who are depressed are more likely than Whites to be chronically depressed, to have higher levels of impairment, to have more severe symptoms, and to not receive treatment. Again, although the overall incidence of major depression is lower for Blacks than for Whites, on every measure of severity, Blacks do more poorly (Williams & Mohammed 2009).

Ethnic and racial groups are also subject to higher incidences of chronic disease which given the overall average life expectancy outcome for these groups is not surprising. Blacks and Hispanics are more likely to have elevated risks for adult mortality and this can be seen in the incidence of certain disease conditions (Hummer et al., 2000). Some of the leading causes of death which have a higher association with Blacks and Hispanics are heart disease, hypertension, diabetes, and AIDS. The problem with many of these conditions it the inequality in treatment and care of these chronic diseases at the clinical level. The clinical level problems in quality of care are stemmed from the underlying predisposition of mistrust in the medical and government establishment which has lead the higher infant mortality rates and lower average life expectancy. The lack of faith in the system which has perpetuated low socioeconomic standing, marketed high risk behavior to high poverty areas (cigarettes and alcohol), segregated racial groups into poor urban centers, limited

access to equal education, employment, and healthcare access is at the root of the medical disparities seen in the United States.

In 2015 Blacks were nearly twice as likely to be diagnosed with serious heart conditions, 8.3% and 9.0% respectively when compared with Whites at 4.2% and also disproportionately represented in hypertension a known risk factor for serious heart conditions (National Center for Health Statistics 2015). When considering the disproportionate number of ethnic and racial minorities afflicted with serious heart conditions one might expect the medical system to be well prepared in treating patients of the various races equally. However, this is not the case and ethnic and racial minorities also experience a disparity in care for serious heart conditions such as myocardial infarction even though they are nearly twice as likely to be affected by such a condition. Non-White patients (Black, Hispanic and Asian/Pacific Islander) experience significantly longer times to fibrinolytic therapy (door-to-drug times) and percutaneous coronary intervention (door-to-balloon times) than White patients, raising concerns of serious healthcare disparities in the United States (Bradley et al. 2004). A substantial portion of the treatment disparities were accounted for by the hospital in which the patient was treated further supporting the underlying issue of appropriate access to care as a rudimentary link to gaps in health status (Bradley et al., 2004; Chow et al., 2003).

Diabetes is another chronic disease which has a higher rate of occurrence in ethnic and racial minority populations. Again, Blacks and Hispanics represent a significantly higher percentage of the diabetes population especially in the age group 45-64 when compared with Whites (National Center for Health Statistics, 2015). Diabetes, especially type-2 diabetes, tends to be a disease associated with those in lower socioeconomic standing and is likely associated with poor access to preventative care and appropriate nutrition. The

Center for Disease Prevention indicates that Black, Mexican American and Puerto Ricans are twice as likely to have diabetes and type-2 diabetes tends to affect residents of urban areas and persons of lower socioeconomic status at a higher rate (Liburd and Vinicor, 2003). It has already been demonstrated how Blacks and Hispanic groups tend to represent the majority of residents in poverty stricken urban areas and the already lengthy list of health outcomes which develop in such areas. A significant issue with diabetes for Blacks and Hispanics revolves around treatment. There is a significant deficit in healthcare treatment of ethnic and racial minorities in urban areas due to socioeconomic status and access problems, but also due to cultural competence of physicians. Blacks and Hispanics experience a higher hospitalization rate for treatable diabetes complications when compared to Whites. The major differences are in treatment and self-management, patient education and health status (for example poor glycemic control which is one of the most significant predictors of hospitalization) (Jiang et al., 2005). This ties the lack of cultural sensitivity by the physician to the patient's health outcomes. Simply put if you do not understand your patient's needs and conditions other than the physical manifestation of the disease then you cannot effectively treat them and if you do not feel the treatment is effective then can lead to a lack of trust in the healthcare provider and the greater medical system.

Illness is not simply the presence of a disease it transcends mere physical manifestation as it incorporates mental well-being. It is easy to see the simple connection of the mind and the body to experience complete health. Unfortunately, the surgeon general's mental health report noted that the needs of minority racial and ethnic groups remain largely unmet and is yet another contributing factor to poorer health (Chow et al., 2003). It has already been discussed how mental stresses can lead to more risk-taking behavior and

the influence which risk taking behaviors have on health outcomes such as cigarette smoking leading to higher death rate (through association of chronic disease) and higher infant mortality rate (through lower birth weight and other associated pregnancy complications). Some of the factors explaining the disparity in mental health are lack of adequate insurance coverage, religious and other culturally sanctioned belief systems, and lack of access to receptive and culturally compatible providers (Chow et al., 2003). There are also significant barriers to seeking treatment based on trust issues between medical professionals and the healthcare system. The racial and ethnic differences in perceptions about the etiological causes of mental illness are at the core of the differences Blacks have toward professional mental health seeking (Schnittker et al., 2000). Barriers to effective treatment of mental and physical illness are contributing factors in the negative health outcomes for racial and ethnic minority groups.

The barriers to healthcare use and utilization which lead to the disparity in physical and mental treatment causing the disparities in health outcomes are rooted in trust issues of healthcare system and its healthcare professionals. These issues of mistrust function at a basal level and are a direct cause of the social injustices imparted on ethnic and racial minorities, especially Blacks, in the past and the current disproportionate treatment of these groups. Many Blacks feel receiving medical care is degrading and feel they are viewed as beneath Whites by White healthcare providers and reports by Blacks indicate that their mistrust stems from healthcare provider bias, prejudice and stereotyping (Kennedy et al., 2007).

When we look back at chronic diseases we can see that in some cases such as heart disease the disparities have grown worse over time for racial and ethnic minorities. There are a number of factors that contribute to chronic conditions such as cancer, diabetes and

heart disease (diet, economic status and utilization of medical care) which all demonstrate levels of inequality for Blacks and Hispanics when compared to Whites. It is hard to ignore the link between structural factors and the demonstrated chronic disease health disparities between racial and ethnic minorities in the United States.

CAUSES OF HEALTHCARE DISPARITIES: EDUCATION

Up to this point we have discussed the differences in access, coverage and quality of healthcare and the resultant preventable difference in burden of disease as evidenced by the disparities in average life expectancy, chronic health conditions and infant mortality experienced by racial and ethnic population groups and communities. One can see that many of the healthcare and health disparities are closely intertwined and that pressure in one area has the potential to impact another area of the healthcare spectrum. We have examined some of the persistent healthcare disparities (access, coverage, and quality) in the United States which despite government focus continue to impact socially disadvantaged racial and ethnic groups. We looked at the resulting impact that healthcare disparities have on some of the primary indicators of a population's health such as average life expectancy, infant mortality and chronic health conditions. The themes of economic, education and cultural competence have been in the background related to the healthcare and health disparities described thus far. Now I turn to focus more on the structural causes of healthcare and health disparities in the United States so that we will have the opportunity to better influence the outcomes and close the inequality gap.

Educational attainment can be a powerful predictor of health status. Education disparities in the United States contribute to some of the underlying causes of healthcare disparities. The difference in education are typically understood as contributing factors to economic disparities which in turn have the ability impact health insurance, time off of work to receive needed treatment, work hours and other issues which may affect basic access (such as health insurance and a source of care).

It is clear that low levels of education mean worse health outcomes. It is also clear that stark disparities in educational attainment exist among racial and ethnic groups. In a second study, Woolf and his colleagues (Woolf et al., 2007) again compared the number of potential lives saved by biomedical advances with the number of potential lives saved if every person over the age of 25 years had the mortality rate of people with some college education. They found that for each single life saved by biomedical advances, eight would be saved by addressing educational disparities

CAUSES OF HEALTHCARE DISPARITIES: ECONOMIC

The divide between economic classes is ever widening and the disparity in health outcomes between the United States richest and poorest is among one of the largest in the world. Without the ability to access a center for treatment many financially strained patients are left with little options. One resource is presenting at a local hospital emergency room to receive what would be basic care for patients who are not impacted by disparities. This is a drain on the hospital resources and increases the cost of care universally. Healthcare and health disparities affect not only the individual but they also have an impact on society as well. Even those that are financially comfortable or better-off have seen the cost of their healthcare increase significantly over time. These increases, much like the financial divide, are keeping a rift open between having the ability to afford healthcare and not having the ability to afford healthcare.

There are worsening trends over time (from 2008 to 2014) for the rate of poor adults who visited the emergency room for asthma and mental health related issues (Agency for Healthcare Research and Quality 2017). There were persistent significant disparities in delays in getting medical care due to financial or insurance reasons between poor people and high-income people and uninsured versus privately insured (Agency for Healthcare Research and Quality 2017).

An additional link can be drawn between residential segregation and the percentage of people of color who live in communities with highly concentrated poverty (defined as 30 percent or more of the population living below the federal poverty line). A large body of research shows that living in these communities is harmful to people's health. This is

because health-enhancing resources (access to physician care, for example) are generally harder to find in these communities. At the same time, conditions that present health risks (for example, environmental degradation, lack of access to healthy food, and lack of access to appropriate outdoor spaces that encourage physical activity) are generally more prevalent in these communities.

The National Center for Health Statistics for 2017 reported that Blacks (24.9%) and Hispanics (21.8%) were significantly more likely to live under the poverty level when compared with Whites (10.6%). This is extremely troubling. As minority populations continue to grow, there continues to be a significantly disproportionate amount of racial and ethnic minorities stricken by poverty. Whites are avoiding the pitfalls of poverty by enjoying the socioeconomic advantages of their situation. The divergence between groups continued to grow further when the United States had fallen upon difficult financial times after the 2008-2009 financial crises. There is already a severe difference in earning potential of ethnic and racial minority groups and the gap between the rich and the poor continues to widen. Hispanic (30%) and Black (24.5%) populations represent a disproportionate percentage of low income earners in the United States when compared with Whites (14.8%) (National Center for Health Statistics 2017). Healthcare disparities may continue to grow for Hispanics in lower socioeconomic classes especially since the Hispanic population, although not subject to the history of inequality as Blacks, is currently the largest minority population in the United States (Burchard et al., 2005).

Over the past decade, the United States has seen a widening gap between the rich and the poor. The cycle of poverty continues to repeat itself among the minority populations as they lack the social and economic advantages which allow Whites to avoid such pitfalls. However even Whites in high poverty areas are subject to worse health outcomes than their

wealthier counterparts. Mortality rates and risk factors are higher for those of lower socioeconomic status (Steenland et al., 2004). It is however more common for Blacks and Hispanic populations to be concentrated in the high poverty areas of the United States and it is these groups that suffer the most from the lack of community resources. The low social circumstance for Blacks and Hispanics directly contributes to their higher mortality rate (Nazroo, 2003).

CAUSES OF HEALTHCARE DISPARITIES: CULTURAL COMPETENCE

Cultural competency training has increased clinician awareness of ethnic disparities in accessing care; however, it has not improved the clinical outcomes of patients (Sequist et al. 2010). The requirement for cultural competency training emerged from the recognition that culturally diverse patient populations generally have low-quality care experiences and potentially poorer clinical outcomes (Sequist et al. 2010). Cultural competency can be described as a professional understanding of the manner in which people of diverse cultural backgrounds and belief systems perceive health and illness, and respond to various symptoms, diseases, and treatments (Crandall et al. 2003). Part of the problem for this lies with the models of culture employed in training and clinical practice, which are often simplistic and facilitate stereotyping. There is a need to re-examine educational curricula and the models of cultural competency employed in the healthcare settings. It has been well documented (Waldram et al. 2006) that culturally appropriate care is pivotal to the overall "success" of the administration of healthcare services. This knowledge is derived through an understanding of what constitutes a successful consultation, diagnosis, and treatment, and varies with every person who seeks care within a medical system. Minorities, particularly Blacks, tend to prefer physicians of their own racial and ethnic background and rate them as providing better care (Saha et al., 2003).

There is an obvious disproportionate amount of White healthcare workers when compared with racial and ethnic minority healthcare workers. This is likely a result of the structural systems which keep Blacks in poor urban and suburban areas which afford less access to educational or employment advantages seen in their White counterparts. With

fewer minority healthcare professionals, the control of the healthcare system lies almost exclusively in the hands of White Americans who are often likely to overlook issues that are most prevalent to the minority population (Kennedy et al., 2007). It can be extremely difficult to treat a patient if one cannot understand their needs as seen in the case of diabetes and other chronic disease condition or in the use of prenatal care when financial access is controlled for. Many healthcare providers, unless they are of the same ethnic background, know very little about how to interact with the Black and Hispanic client population (Kennedy et al., 2007). The lack of cultural competence and sensitivity of Whites toward other ethnic and racial groups exposes a tremendous flaw in medical training in the United States and one that affects the quality of care that patients receive. Patients that see physicians of their own race, rate the care that they receive higher than when they see a physician of another race which is most likely due to the lack of cultural competence and sensitivity by White healthcare workers (Kennedy et al., 2007). The missing component of White healthcare workers is the knowledge and understanding how the past social and political conditions have left their brand on the Black population and that these fundamental events are at the very heart of healthcare disparities, trust, and participation in medical research.

A glimpse into the not so distant past gives us tremendous insight into what contributes to the doubt which minorities, especially Blacks, have in the United States healthcare system and its practitioners. It is important to focus on the Black population as they have been subject to some of the harshest treatment in United States history. Although slavery has been abolished since 1865 the wounds have left their scars on the Black population and the generations of their offspring in these contemporary times. For hundreds of years Blacks were systematically denied full citizenship and rights in the

United States. Since the end of legalized segregation, they have continued to be marginalized in our society, with unequal access to education, jobs, and housing through myriad forms of racism (Brown et al., 2008). Unequal access to education is preventative to promoting more ethnic and racial minorities in the healthcare field and differences in employment opportunity all but assure poorer quality of care and a healthcare workforce the does not represent the patient population that they serve.

Mistrust of the United States healthcare institution is understandably justified when past events are taken into consideration. The abuses directed toward Blacks have created a primitive tension between themselves and Whites which is present in society today. Suspicion of the medical community by Blacks can be justified by a long history of exploitation in the name of research that is rooted in slavery and continues to the present day (Corbie-Smith et al., 1999). One need not look further than the infamous Tuskegee Syphilis Study. Blacks were subjected to unethical research practices which not only reinforce their past mistreatment but have direct effects on their current believe in medical and scientific research and the government. In addition to Tuskegee Blacks believe that HIV infection, Agent Orange exposure, and the Central Intelligence Agency distribution crack cocaine in Black communities are contemporary evidence that the legacy of abuse continues (Corbie-Smith et al., 1999). Although, there may not be the same unethical treatment in medical research there is a resurgence of racial tensions in the United States in recent years and more so under the current Trump presidency that seems to be reinforced by the number of unarmed Blacks who have been killed by police officers. These injustices help reinforce racial and ethnic tensions and biases and prevent closing the gap of cultural sensitivity.

The issue with prior unethical practices against Blacks is the structural system which it now contributes to. Blacks continue to distrust their physicians who are not culturally competent because they are not properly educated in cultural sensitivity however there is a barrier to becoming culturally competent when there is a lack of participation in medical research. To put it blatantly Blacks, believe clinical trials are dangerous and their beliefs that the government conducted unethical research such as administering risky vaccines to prison populations are not without merit (Achter et al., 2005). Although there is evidence to support that Blacks find that the government is protective when it comes to medical research they certainly believe that this protection is selective (Achter et al., 2005). The skepticism is certainly comprehensible and unfortunately leads to the absence of ethnic and racial minorities, especially Blacks, in clinical research which can provide valuable insight into cultural barriers and lead to beneficial treatments and therapies.

Scientific and medical researchers are highly aware that there are subtle and significant differences between individuals which lead to a variety of outcomes when conducting research on human subjects. It is extremely important to have a large and heterogeneous mix of research subjects to truly understand the effects of any research. Lack of Black participation in clinical trials raises concerns about how well findings from clinical trials can be generalized, as well as how beneficial they can be to Blacks (Corbie-Smith, et al. 1999). This is particularly disconcerting when the average life expectancy, infant mortality rate and incidence of certain chronic illnesses are analyzed in the racial and ethnic minority populations.

Diseases such as diabetes, cancer and HIV, which disproportionately affects the Black population, continue to be underrepresented by racial and ethnic minorities in clinical trials (Corbie-Smith et al., 1999). As the average human life expectancy continues to expand,

chronic disease such as serious heart conditions (a higher disease rate in Blacks and Hispanics) and cancers are destined to increase. Although there is sufficient cause to be doubtful of healthcare practitioner's ethical motives it cannot be overlooked that vast improvements have been made in the treatment of many illnesses and diseases including cancer over the last several decades and these advances are due primarily to clinical trials research that test the effectiveness of treatments (Paskett et al., 2002).

To close the gap in health outcomes due to treatment variation from new and novel medicines more racial and ethnic populations must be represented. For example, take into consideration that breast cancer is the leading cause of cancer death among Hispanic women, yet this population is not appropriately represented in clinical trials. It is also noted that the perceived physician satisfaction rating has affected the use of diagnostic resolution for breast abnormalities among Hispanic and Latina females. (Mojica et al., 2007). If there were trust in medical research, clinicians would be able to learn the necessary cultural competency skills required to effectively satisfy their patient base and improve health outcomes. There is also the essential need to understand presentation of cancer illness in all ethnicities and due to past and ongoing discrimination has resulted in decreased trust in the healthcare system among minorities. There is a lack of Hispanic and Black participation in cancer clinical trials which is of significant importance because specific patient subpopulations are necessary for further understanding of race and ethnic based differences in prognosis, presentation and response to therapy (Murthy et al., 2004).

Due to past mistreatment of human subjects in medical research, in particular minority groups such as Blacks, numerous regulations have been instituted to protect all human subjects in research and what are considered vulnerable populations from further ethical violations. Informed consent has been one such development to provide research

participants with disclosure to the research procedures, risks and benefits. However, without the proper understanding of the research population the difficulty of informed consent is magnified when cultural differences exist between the participant and the study team (Corbie-Smith et al., 1999). These difficulties can be due to a variety of factors which are part of the structural system leading to healthcare disparities. In patients form varying ethnic backgrounds, with different levels of English fluency or limited formal education, written consent documents often outstrip their comprehension of the intended content. In addition to literacy, cultural and linguistic barriers may further complicate comprehension of written material (Corbie-Smith et al., 1999). Similarly, many ethnic and racial minorities believe that informed consent removes any obligation or responsibility from medical researchers in the event of abuse.

Recently, the National Institute on Minority Health and Health Disparities launched a new resource for stakeholders who work with populations with limited English proficiency: The Language Access Portal (LAP). The LAP contains information in multiple languages on diseases for which major health disparities have been identified in non-English-speaking populations, including cancer, diabetes, and cardiovascular disease. New disease areas will continue to be included and additional resources will be incorporated as they become available (Agency for Healthcare Research and Quality 2017). Fortunately, patient-centered care, care defined by successful resolution of clinical symptoms and whether patients achieve their overall desired outcome, showed improvement in about 80% of the measures (improving overall). One example of significant improvement was in provider-patient communication (Agency for Healthcare Research and Quality 2017). This is certainly a step in the right direction but again disparities continue to exist.

Patient-provider relationships are shaped by the experiences, culture, values, and expectations of both the provider and the patient. Racial and ethnic minority patients tend to have more mistrust of healthcare professionals and perceive more discrimination in the healthcare system than do non-Hispanic Whites (Institute of Medicine 2002). Further, a lack in providers' knowledge about the culture and language of their patients can lead to misunderstandings in patient and provider interactions. Patients from racial and ethnic minority populations often report greater satisfaction with healthcare from providers of the same race, ethnicity, or culture. The commonality of the same racial or ethnic background makes a provider more successful at gaining patients' trust and improves the ability to communicate in a more culturally and linguistically competent manner (Ngo-Metzger et. Al.). This evidence underscores the need for health professionals with diverse backgrounds and improved cultural competencies to care for and serve racial and ethnic minority populations. Currently, the racial and ethnic makeup of the health care workforce lags behind that of the U.S. population. For example, although 13 percent of Americans are Black and 16 percent are Latino, only 6 percent of physicians are Black and 5 percent Latino (Association of American Medical Colleges 2010). Increasing the number of health professionals from racial and ethnic minority populations may help increase the quality and satisfaction of patient-provider interactions, thereby helping to improve these populations' patient experiences.

Racial and ethnic diversity in the health care workforce has shown to be associated with improved access to care. Providers who are culturally competent provide care directly related to greater consumer satisfaction among racial and ethnic minorities (Institute of Medicine 2004). The diversity of the public health and healthcare workforces, however, continues to lag behind the growing racial and ethnic diversity of the United States

population (Agency for Healthcare Research and Quality 2011). As mentioned, Hispanics and Blacks comprise nearly one-third of the nation's population, but they account for only slightly more than one-tenth of U.S. physicians (Association of American Medical Colleges 2010). Further, physician shortages in underserved areas often inhabited by racial and ethnic minority populations can also contribute to inequities in health care (HHS Disparities Action Plan 2015).

Although there are programs and initiatives such as the HRSA New Access Point awards in 2012 and 2013 to improve the cultural competency and racial and ethnic diversity in the healthcare workforce there is still an extreme challenge here. First there is an ever increasing amount of diversity and as mentioned earlier Blacks, Asians, Hispanics and Whites and the other races and ethnicities from the United States census also exist and we should caution leaving them out. Additionally there are subdivisions within races as White and Black can represent a large variety of nations and cultures and there are additional dimensions such as age, gender identity and sexual orientation. This adds a significant amount of complexity to cultural competency in the United States however this may be one of the most important factors to improving the nation's healthcare system aside from the economic and education factors that lead to the healthcare and health disparities in the United States. The primary reason the cultural competency serves as a key factor to improving health outcomes among minority populations is the fact that being able to understand the patient and the patient's needs are paramount to improved health outcomes and as we become an ever diverse society on not just the racial and ethnic dimensions but also those of age, sexual orientation, gender identity and others having a healthcare workforce that understands its patient population will serve as a foundation for the health of the United States.

The many initiatives undertaken by the United States government are commendable on the part that they recognize that health and healthcare disparities exist in the United States and that the inequality gap needs to be addressed. However when we focus only on addressing the healthcare disparities such as access, coverage and quality it is equivalent of the common expression of putting a bandage on a bullet wound. Addressing the healthcare differences among racial and ethnic minorities will have an impact on health disparities but as we've seen by the evidence this impact is slow to be realized if realized at all. It is the structural factors such as education, economic and cultural competency which need to be addressed to influence the greatest impact. The structural factors of inequality in the United States are the gun to which we are bandaging the bullet holes and if we address the source it stands to postulate that we will affect equality in healthcare and health.

CONCLUSION

The conditions which make disparities in healthcare and health so troubling are the increase in racial and ethnic minorities in the United States coupled with the ever-growing gap between the wealthy and the poor. It is commonly reported that the percentage of non-Whites in the United States is expected to increase to nearly 50% by 2050 however ethnic minorities are significantly underrepresented in clinical trials due to the legacy of the Tuskegee Syphilis study, personal negative experiences with medical research, cultural based beliefs of determinism or fatalism, concerns about conspiracies against minority groups, and contradictory media coverage about research trials contribute to minority skepticism and mistrust (Harris et al., 2003). It is paramount to repair the relationship between racial and ethnic minorities to work toward reversing the trend of low participation rate that will ultimately benefit the populations which are excluded by research policy and skepticism of the medical research establishment.

Racial categories, a powerful organizing feature of American social life, both reflect and reinforce group differences in access to economic, political, and social resources. For example, institutional or structural forms of systematic discrimination can limit educational, employment, and housing opportunities as well as solidify the underlying mistrust in the very systems which perpetuate such disparities (Schulz et al., 2002). These structural components are direct causes of the differences between Black and Whites in social practices with respect to factors such as drug consumption, income generation (lower socioeconomic status), social and institutional relationships (satisfaction level and mistrust of the medical and healthcare community), and even personal health and hygiene (Bourgois

et al., 2006). These problems are cyclical as they feedback into the loop which facilitates more of the same and it is necessary to understand this to take the appropriate corrective action.

Physicians and scientific medical researchers are in desperate need of cultural competence and sensitivity training to help narrow the gap in treatment discrepancies and medical research. A trusting relationship is important for research participants to feel comfortable in clinical trials and with medical care (Corbie-Smith et al., 1999). The United States healthcare institution needs to make significant changes in its system of practice to help facilitate better trusting relationships between physicians and patients of various racial and ethnic backgrounds. This is especially important now as fewer patients are able to use their social network to choose a provider, and as time constraints increasingly limit the clinical interaction, a trusting relationship may take longer to develop if it develops at all in our current system (Corbie-Smith et al., 1999).

To further ease the mistrust, it will be necessary to recruit more racial and ethnic minorities into the healthcare field. This will be significantly important for Blacks who have experienced the unique combination of slavery, segregation and racism which has caused them to have different behavioral patterns, values and beliefs. These disparities are still seen in the continuing inequality in income level, education, and treatment decisions (Kennedy et al., 2007). Social inequalities exist throughout life and interact longitudinally to increase the risks of morbidity and mortality (Goodman, 1999).

Efforts to reduce or eliminate well established racial disparities in health must consider the complex relationship between race and socioeconomic status, including the political, social and economic processes that create and maintain racial differences in access

to social and economic resources (Schulz et al., 2002). It will be necessary to influence a positive change in healthcare outcomes through a multiple factor approach, one which attempts to close the gap in socioeconomic status in education and economics, better educates the healthcare community in cultural competence and promotes more ethnic and racial minorities in the healthcare field. Only through a collaborative effort can the United States erase the mistakes of its past and stop the repetitious patterns of structural inequality to improve the health of its future.

As mentioned in the beginning this paper is only focusing on and highlighting the continued health and healthcare disparities experienced by racial and ethnic minorities and not disparities experienced by other vulnerable populations. The United States continues to become a more diverse society with the percentage of racial and ethnic minorities continuing to increase and at the same time additional dimensions of diversity continue to emerge. As each of us look to identify ourselves as a unique and special individual. This continued diversification across multiple dimensions exposes our society toward additional avenues with which disparities in healthcare and health can emerge. Understanding the structural elements such as education, economic and cultural competence of inequality and working to correct them for racial and ethnic disparities will provide the society of the United States the opportunity to achieve the health equality it seeks.

Good health, however, is about more than just having access to care. It is critical to consider what happens before an individual needs to go to a doctor's office and to consider what is happening in the community where that individual lives. Where people live, work, worship, and play, said Williams, has a greater impact on health outcomes than having access to a physician. This means that it is essential to look at ways to reduce inequalities in the nonmedical social determinants of health.

The focus needs to be on the root causes of healthcare and health disparities, such as the education and economic conditions in the communities where people live. These factors play a larger part in healthcare and health disparities in the United States along with the cultural competence that is experienced in clinical care. One might think that in a time when medical advances and technology have continued to extend the average life expectancy of the population and the number of insured individuals continue to grow that on the surface healthcare and health disparities are not as prevalent as they were in the past but as we've seen especially with the marginalized racial and ethnic groups such as Blacks and Hispanics that these disparities continue to persist in American society. Although there have been improvements, these improvements have been universal to all people of the United States and while there have been a number of government actions the gap is still there. Now, more than ever, it is important not just to measure multiple metrics of healthcare and health disparities but to work to take action to address the intertwined structural components which lead to the differences so that all may benefit and true equality, not just in healthcare and health can be attained.

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