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Our Inalienable Right to [Health] Care: Blacks,
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Introduction

For people of color, especially blacks, major disparities in healthcare access and health outcomes exist. In Tavis Smiley's book titled "The Covenant with Black America", he argues that differential access to health resources is determined by a number of factors: "...health insurance status, living in an underserved [poor and "colored"] community, being underrepresented in the healthcare professions, being uninformed about healthcare services and need, and feeling insecure about or trusting of the healthcare system" (Smiley 2003: 3). While I agree with this list, I choose to supplement his list with a number of other relevant factors that help determine access to quality health care services and positive health care outcomes for people of color. These factors include dealing with everyday racism, recognizing and often protesting white privilege as well as having to psychologically cope with social structures that act as white public spaces, namely all the places where racism and white privilege is reproduced for the benefit of whites and a "whitened" buffer class who is given limited access to the resources of the dominant white power.

While new research continues to document the racialized health outcomes of non-white populations in the United States, little research has been done on how the systemic racial oppression impacts these underserved populations and influences their health outcomes. Yet the studies that do exist focus primarily on the exclusionary aspects of racism. Understood as racial discrimination, such a focus can miss new forms of subtle racism that do not exclude people, but include them in racial ways. This subtle and often overlooked form of racial

subordination must be analyzed in order to create strategies to combat this type of oppression. As a social institution, the American health industry functions from within the same societal rules and regulations instilled formally and informally since the inception of the United States of America. In this paper, I aim to explore how whiteness operates in tandem with racism in the U.S. health care system, using historical and contemporary institutionalized policy examples. I will also try to demonstrate how such inclusionary white cultural practices foster white privilege in health care even in the absence of exclusionary racism. According to my advisor Enoch Page, white cultural practices are observable and normalized behaviors “to which all who identify as white (or behave as whitened) are expected to adhere” (Page Definition of Racism).

In 1997, a national effort to eliminate racial health disparities was initiated. Six main areas where racial minorities experience serious health disparities were identified: infant mortality, heart disease, diabetes, HIV/AIDS, cancer screening and immunizations (CDC: Office of Minority Health 2007). This governmental effort to eliminate racial health disparities has been largely unsuccessful, with people of color still suffering from diseases and dying at a disproportionately higher rate than whites. If this is the case, wouldn't it stand to reason that scholars and researchers might want to analyze the factors that impact why whites continually have better health, even when we look across class lines?

Understanding White Public Space

Racism versus Whiteness

The prevalent racism model used most often by antiracist academics construes acts of exclusionary discrimination as the primary barrier to people of color health care access (Page). In essence, discrimination theory is a necessary but limited analysis that easily slips into blaming the victims while social systems appear to be blameless. My research using Whiteness theory focuses on the far more benign practices of inclusionary structuring of access which tend to secure white privilege for some populations while omitting many others for factors that ostensibly appear not be racial ones. In essence, whiteness is racist behavior predicated on white supremacy, even where no overt discrimination can be found.

With an understanding that racial discrimination is less acceptable today, whiteness theory recognizes and eventually aims to make structural changes to eliminate institutionalized racism. In order for this project to succeed institutional agents of whiteness must admit that even where it can be shown that overt racial discrimination has been eradicated,

...whiteness *does* have content in as much it generates norms, ways of understanding history, ways of thinking about self and other[s], and even ways of thinking about the notion of culture itself... We need to look more closely at the content of the normative and attempt to analyze both its history and its consequences (Frankenberg 1993: 231).

Frankenburg's quote directs us to analyze what is considered the natural and normal attitudes, beliefs and values of the powerful racial majority group. For instance, research has found that whites often believe themselves successful based

on their ability to work hard while stereotyping blacks as having an inferior work ethic and therefore to blame for their status in American society (Feagin and McKinney 2003). This white racial ideology allows whites to ignore their own racial privilege which has been systematically protected for several hundred years.

The Past Shapes the Present

Often, medical and social science research focuses on teaching people of color to change certain cultural behaviors deemed problematic by white America while ignoring the systemic oppression tied to centuries of racial injustice in America, and the world at large. Through military force, the spread of “new” diseases, and hundreds of broken promises and treaties with the indigenous population, the United States was forged as a white settler nation (Mills 2008). Native Americans were considered expendable and blacks were enjoyed as cheap labor. This history shows how American policy has been to consider only whites as full and equal citizens while non-whites were considered inferior and often sub-human. Colonization, internment camps, reservations, slavery, Jim Crow, segregation, anti-miscegnation laws, citizenship requirements, and immigration laws have all impacted the economic viability of non-whites and resulted in resources being distributed along the color line. For example, after enslaved blacks were freed, they were still considered second-class citizens and not given equal access to resources such as education, political representation or financial reparations in order to put them at the same power and status of white Americans.

Within the U.S. medical industry, health care professionals, acting as agents of whiteness, have had a large role, from colonial times to the present, in what resources were given to blacks and how they were perceived by the masses. The narrative of scientific racism defined slaves as biologically inferior. It was, therefore health care professionals who provided social meaning to perceived biological and genetic differences of blacks and whites (Randall 2006). Along with physician attitudes affecting black health outcomes, institutional policies, practices and procedures must be analyzed. These policies include issues like the disproportionate number of people of color affected by environmental racism where pollutants are a daily life struggle, the poor response time of government officials to Hurricane Katrina given that it struck a predominantly black and poor region, and current urban housing renewal programs that have actually decreased the amount of low income housing available forcing communities to struggle harder to survive.

The Health Care System as White Public Space

Historical Racial [Medical] Exploitation

Harriet Washington, in her book titled *Medical Apartheid: The Dark History of Medical Experimentation of Black Americans from Colonial Times to the Present*, provides a comprehensive historical documentation of the atrocities perpetuated by the U.S. health care system on blacks from slavery to the present day. This research is crucial to an understanding of the hostile relationship blacks have with the American health care system. Washington lays out the various

ways the medical system has exploited black Americans including, but not limited to, the disproportionate number of blacks used for medical experimentation on infectious disease and radiation, the horrific often inhumane displays of black bodies, and the hypersexualization and sterilization of black women (2006).

Historically, being considered property and not human beings, blacks were used by scientists for experiments without their informed consent. This did not end with slavery as is noted by the most publicized unethical and racist Tuskegee experiment that took place on 399 black men with syphilis from Tuskegee, Alabama between 1932 and 1972. This 40 year experiment on black men shows how beneficiary agents of whiteness (health care professionals of the Public Health Service) set out to study people of color in a way that caused them harm. While Tuskegee remains one of the most widely known medical experiments done on blacks it is neither the first nor the last racial experiment done on blacks.

Better Care for All U.S. Citizens?

After the Civil Rights Movement of the 1960's, we saw health care facilities that had refused to treat blacks open their doors as well as an increase of black health care professionals due to the desegregation policies enacted in schools. Compared to the segregated past, policies of forced integration provided blacks and other people of color with greater access to economic and social resources. Why then, do we still see that from the 1960's to the present time, social indicators like the SAT's, infant mortality rates, and AIDS and TB

infectious rates (among others) have continued to show a strong white advantage and POC disadvantage (Olson 2004)?

IoM & National Healthcare Disparities Reports

Two recent studies important to this conversation-- The Institute of Medicine's study titled "*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*" and the National Healthcare Disparities Report -- discuss health care access for people of color and found race, not class, to be the determining factor in who receives access to quality health care. This research is ground-breaking in that it acknowledges the "racial" factor without placing the blame on historically oppressed groups. According to both studies, non-whites receive less access to preventative and curative services as well as a lower standard of care. They both state that when you "control" for other social factors, race plays a significant role in differential access to health care which demonstrates the adverse racial effect of institutionalized and interpersonal racism in health care.

The Angry Heart

The failure of the health care system to deliver care in a non-racialized way that does not privilege whites more than non-whites has been best illustrated in the powerful documentary *The Angry Heart*. This film aims to document the racialization of health care provision for blacks with heart disease by arguing for a need to acknowledge the racialized distribution of medical resources. For black

heart patients this includes the lack of early diagnosis and treatment options. Both Nancy Krieger and Camara Phyllis Jones, who are interviewed in the film, state that health disparities organized along the color line are not issues of socioeconomic status, but rather are a direct outcome of our historical and contemporary socio-political system (Krieger 2003; Jones 2000).

Despite their higher prevalence of hypertension [a type of cardiovascular disease], medical professionals have historically considered African Americans to be at a low risk for cardiovascular disease (Dressler 1993). Medical professionals who therefore operate as the agents of whiteness in their authority to diagnose or to allocate medical resources are thereby able to shield their own actions from racial scrutiny by maintaining deniability. This deniability is possible when they can ignore their own participation in the racial allocation of resources but at the same time keep themselves out of the equation. This deniability also heightens their propensity to inaccurately assess black health risk. For instance, medical professionals who are working with black patients who have hypertensive symptoms, but who are not presumed to have the same cardiovascular symptoms that are usually associated with their white cohort, are far less likely than whites to get referrals to coronary artery bypass graft surgery. African Americans need these referrals to provide them with the necessary treatment to prevent and manage their cardiovascular health. Due to this combined effect, agents of whiteness learn how to mask the systemic factors that privilege the dominant group in the name of helping to determine individual and group health.

AIDS

“In the United States, survival after a diagnosis of AIDS varies enormously, with women and people of color having shorter life expectancies than white men...Indeed, the best empirical research suggests... [that] regardless of cultural and psychological factors, patients with poor outcomes – those living in poverty, by and large, with minorities and women overrepresented- had them because of barriers in access to effective care” (Farmer 1999: 265-266). While some information holds that whites still remain the majority of AIDS cases, there is evidence to suggest that blacks and Latinos are contracting AIDS at an alarming rate with people of color being 70% of reported AIDS cases in 2004, according to the Center for Disease Control and Prevention. These statistics show that AIDS remains a serious problem to the health of our growing non-white populations and that American society’s blaming the victim obscures the true reasons for being at “higher” risk for disease and dying from it.

New Orleans Health Report

Another tragic example of the racialized health care service and access received by people of color, more specifically black Americans, can be found in the May 2007 conference report titled “After Katrina: Rebuilding a Healthy New Orleans”. On August 29, 2005, Hurricane Katrina hit New Orleans, flooding the city as the levys failed and leaving thousands homeless. Katrina, while opening our eyes to the Third World poverty rates in New Orleans, “...also confronted us [with] the costs to all of us when we choose not to invest in our most vulnerable

and marginalized communities, too often communities of color”(Gillam et al 2007:3). This divestment in people of color can be explained by looking at New Orleans as functioning within white public space. When evaluating government responses to natural disasters, research has shown that black victims have suffered racial discrimination.

Clearly, race matters in terms of swiftness of response, allocation of post disaster assistance, and reconstruction assistance. Emergency response often reflects the pre-existing social and political stratification structure with black communities receiving less priority than white communities. Race and class dynamics play out in disaster survivors’ ability to rebuild, replace infrastructure, obtain loans, and locate temporary and permanent housing (Gillam et al 2007:8).

This quote inextricably explains how whites are given a higher priority and differential access to emergency resources in the event of disasters. The rebuilding of New Orleans is a reformation of white public space but in order to do this several issues must be ignored. First, there must continue to be little discussion about the institutionalized racism in housing and land use planning that privileges whites with securing higher ground and environmentally safe neighborhoods. Second, the discussion regarding the racial inequities found in what waste gets cleaned and where it is disposed must be censored. Third, any conversation on the health disparities facing Hurricane Katrina survivors must remain absent from national, state and local policies to rebuild. These three actions have been taken and almost guarantee that the reinvestment in New Orleans will continue to replicate the poverty and racial discrimination that existed prior to Katrina. Another example of New Orleans having to survive

within white public space is evident when we know that “local, state and federal emergency planners [had] ...known for years the risks facing New Orleans’ transit-dependent residents [and created no emergency contingency plans for this potential crisis]” (Bullard 2007: 10).

This New Orleans report also documents the collective impact of racism, poverty, geographical location and social isolation on the health outcomes of black Americans, especially in Louisiana. Almost two years after this storm, we are still finding that the New Orleans health delivery system remains greatly fractured and that providing quality health care is a great challenge (Gilliam et al 2007). As a nation, we must learn to recognize the racial divisions we have created and recreated to maintain privilege and public space in the hands of powerful whites. Failing to address these disparities on the local, state and national level is another example of American society maintaining white public space as white and ignoring the racialized experiences of people of color from within the system.

Conclusion

Understanding the historical and contemporary manifestations of racial privilege provide a foundation with which to understand how the United States health care system through the lens of ideological whiteness. This macro level analysis has attempted to shift conversations of racial health disparities away from the usual dialogue of behavior modifications to a systemic understanding of the problem of racially differential access and services. With such large percentages

of the non-white community being afflicted by these health disparities, it is important to grasp how these health conditions are racially construed in ways that foster attitudes and practices among agents of whiteness that precipitate unequal access and subsequent outcomes in our health care system.

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