

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (with CD)

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Racial and Ethnic Disparities in Healthcare: A Background and History

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INTRODUCTION

Despite steady improvement in the overall health of the United States' population, the health of America's racial and ethnic minorities varies from the *mainstream*. For example, the health status of African Americans—a racial-ethnic group already burdened with deep and persistent history-based health disparities—has been recently characterized as stagnant or deteriorating (Byrd and Clayton, 2000, 2002; Collins, Hall, and Neuhaus, 1999; National Center for Health Statistics, 1998a; Sullivan, 2000; Williams, 1999). A body of nearly 600 scientific publications documenting racial and ethnic disparities in healthcare provides ample evidence of this problem (Geiger, 2000; Mayberry, Mili, and Ofili, 2000). Though it is well known that these disparities reflect socioeconomic differences and inadequate access to quality healthcare, contemporary evidence suggests that in addition to racial, ethnic, class, and gender *bias*, direct and indirect *discrimination* are also important factors (Geiger, 2000; Mayberry, Mili, and Ofili, 2000; U.S. Commission on Civil Rights, 1999a, 1999b; Williams, 1999).

Following the lead of the legislation and committee reports, this Institute of Medicine (IOM) study is one part of a multifaceted effort by the United States Congress to understand and eliminate racial and ethnic disparities in healthcare. The IOM report explores, analyzes, and offers corrective action for factors linked to racial and ethnic health and healthcare

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disparities, including American racial, ethnic, and immigrant relations; “racism;” “historic racial discrimination” and bias; biased clinical decision-making; a health system structured on the basis of race, *ethnicity*, and class; and access barriers caused by shortages of racial and ethnic *minority* providers (Byrd and Clayton, 2000, 2002; Section of House Committee Report to Accompany H.R. 3064, 2000; Sullivan, 2000).

Differences in population characteristics such as race, ethnicity, *class*, *culture*, and gender are at the root of many of the present health and health system problems in the United States. From the perspective of racial and ethnic relations, such differences have generated group identities and self-awareness, racial mythology, group interaction, stereotyping, competition, conflict, a corpus of critical theory, accommodation, and in some instances, *assimilation* and integration. A number of academic disciplines and formidable bodies of scientific literature have grown around each of these subjects and in many instances African Americans serve as surrogates for racial and ethnic minority groups in the United States. This is not only by design, but based on the fact the overwhelming majority of the research, published literature, and data on racial and ethnic disparities before 1985 was focused on that group. Moreover, the chronicle of African Americans, alongside Native Americans, epitomizes the depth, breadth, and intensity of the American racial and ethnic minority experience (Burns and Ades, 1995; Byrd and Clayton, 2000, 2001a, 2002; Feagin and Feagin, 1999; Outlaw, 1990; Smedley, 1999; Stuart, 1987).

Though viewed by many as recent occurrences, racial- and ethnic-based health disparities are centuries-old phenomena. They are outcomes that reflect medical-social values and policies in Western (and later U.S.) medicine and healthcare, which paralleled the values and policies in the larger societies. Could it be that these differences, and the biases and discrimination they both generated and reflected, have dictated or even distorted how the U.S. health system functions? If so, what are the characteristics and profile of this dysfunction? What are the origins, bases, and evolution of the biases and inequities that contribute to persistent racial and ethnic health and healthcare disparities? Their persistence represents a major challenge and an affront to the genius of the American health system, while serving as the driving force behind this IOM study. As we acquire the knowledge to begin answering these questions, we can start to understand the nature of the problems, to perform objective analyses, and, eventually, to craft fact-based, logical interventions and solutions for the problems (Byrd and Clayton, 2000, 2001a, 2002; Feagin and Feagin, 1999; Section of House Committee Report to Accompany H.R. 3064, 2000; Smedley, 1999; *The Healthcare Fairness Act of 1999*, 1999; U.S. Department of Health and Human Services, 1985a).

It is clear that health and healthcare in the United States are multi-racial, multi-ethnic, immigrant stories. A brief examination of racial and ethnic relations in this country from its colonial past to the present provides the context for the larger examination of health and healthcare as social processes and problems. And since virtually all modern health policy decisions are based on the collection of accurate demographic, health, and health-related data, it is essential to have a better understanding as to how data regarding America's various racial and ethnic groups are collected. An examination of the intricacies of the process, its standardization, and its evolutionary phases is both a prerequisite and a necessity, especially as it has related to health and healthcare. A factual chronology about data and its collection is provided in order to appreciate and learn from the past experiences, to dispel assumptions and mythologies, and as a preparation for future fact-based policy-making.

America is a nation of immigrants. A discussion built around appreciating the nation's health experience as an immigrant story, thus, provides a window on the present racial and ethnic health disparities. Following is an examination of the major U.S. racial and ethnic groups, both European and people of color, focusing on their health and the variables that affect their health. This lends a broader and much needed health policy perspective on where we have been and where we need to go.

Recurrent themes resonate throughout the document. For example, as racial and ethnic minorities become larger percentages of our total population, the health and healthcare of minority Americans become national public policy issues of the first rank—in both relative and absolute terms. Another theme is that healthcare is presently conceptualized as a human right.

Obtaining a background regarding the roles of race, ethnicity, gender, culture, and class in U.S. society and healthcare is requisite to deciphering the message inherent in the racial and ethnic health and healthcare disparities. In order to acquire a deeper understanding of the present racial and ethnic health and healthcare disparities, one must gain an understanding of the origins, evolution, and perpetuation of racial and ethnic bias, inequities, and disparities in health and healthcare in the United States and its earlier Western predecessor cultures. Because of the variation in opinions and usage of certain terms emanating from this wide range of disciplines, a glossary has been included that contains terms the IOM Committee thought would be useful to readers (Byrd and Clayton, 2000, 2001a; Feagin and Feagin, 1999; Fee, 1997; Fluss, 1997; Section of House Committee Report to Accompany H.R. 3064, 2000; *The Healthcare Fairness Act of 1999*, 1999).

American Racial and Ethnic Relations: The Context

Racial and ethnic diversity is a basic tenet in the evolution of this society. Neither health nor healthcare is an exception. “The development of social and economic inequalities based on race and ethnicity has been a central theme—and a central dilemma—of the history of the United States [and the Western World], shaped over many generations by the European conquest of indigenous peoples and by massive waves of both coerced and uncoerced immigration from all over the world” (Pedraza and Rumbaut, 1996, xvi). Moreover, racial and ethnic relations have always been tumultuous in the United States. The use of terms such as *dominant group* and *subordinate group* in the study of American racial and ethnic relations suggest—and has often been linked to—racial and ethnic hierarchy, stratification and substantial inequality among groups. Disparate outcomes between European Americans and racial and ethnic minority Americans in many spheres of social life, health, and healthcare—as all are viewed as social processes—are not new and should not be unexpected (Byrd and Clayton, 2000, 2001a, 2002; Feagin and Feagin, 1999; Jaco, 1979; Kosa and Zola, 1975; Pedraza and Rumbaut, 1996; Smedley, 1999). Founded more than 200 years ago after a revolution that cut colonial ties with Europe, the creation of the United States was based on Enlightenment principles of freedom and equality. A vigorous nation of great racial and ethnic diversity emerged. However, racial and ethnic *prejudices*, biases, oppression, and conflict were embedded in the colonial antecedents, the founding period, and central documents of the new republic (Brinkley, 1993; Feagin, 2000; Omi and Winant, 1994). Further, as Rumbaut notes, “[I]mmigration and conquest—by hook or by crook—have been the originating processes by which American ethnic groups have been formed and through which, over time, the United States itself has been transformed into arguably the world’s most ethnically diverse society” (Pedraza and Rumbaut, 1996, xvi). The European (predominantly English) colonists often took land from Native Americans (American Indians) by force or collusion. By the late-seventeenth century, the colonists had established an economy strongly based in African-American chattel slavery in the South and on the slave trade in the North. Moreover, throughout succeeding centuries a tradition of oppressing non-English (e.g., Irish and Italian) and non-European (e.g., Chinese, Japanese, and Mexican American) immigrants was also established (Brinkley, 1993; Burns and Ades, 1995; Feagin, 2000; Feagin and Feagin, 1999; Stuart, 1987). At first, liberty and justice were provided only for males of British descent, and inequality in life chances along racial, gender and ethnic lines became a fundamental fact of the new nation’s institutions. As Flexner observed, “Whatever their social station,

under English common law, which became increasingly predominant in the colonies . . . women had many duties, but few rights" (1975, 7). Conflict between Anglo-Protestant Americans and Indians varied from outright warfare to separate coexistence. Though the promotion of non-English immigration had coincided with English mercantile and colonial aims and intensified in the nineteenth century, new white immigrants ("foreigners") often met hostility and found themselves less than equal socially or under law. Women struggled continuously for their rights (Flexner, 1975). Racial tension and conflict was a constant between Anglo-Protestant Americans and African Americans under 246 years of brutal and exploitive chattel slavery, followed by 100 years of social segregation, physical oppression, political subjugation, and economic exploitation. As English domination was modified over the next two centuries by the challenges and occasional ascendancy of other northern Europeans, southern, and eastern Europeans as well as other non-European groups trying to move up socially, economically, and politically, the United States became an unprecedented and uneasy mix of diverse peoples (Brinkley, 1993; Burns and Ades, 1995; Feagin, 2000; Feagin and Feagin, 1999; Omi and Winant, 1994; Shipler, 1997; Stuart, 1987).

Basic documents of the new republic reflect its patterns of racial subordination, ethnic discrimination, and gender difference. Neither the Articles of Confederation, nor the Declaration of Independence, nor the Naturalization Law of 1790 extended the doctrines of freedom and equality to African Americans (Brinkley, 1993; Feagin and Feagin, 1999; Omi and Winant, 1994). One provision of the Naturalization Law of 1790 was that only "white" persons could become citizens (Takaki, 1993, 273). After a failed campaign by southern slaveholders to count black slaves for apportioning states' legislative representation though not for direct taxation (Brinkley, 1993, 150), enslaved Americans were counted as three-fifths of a person in the U.S. Constitution. Women were not allowed suffrage until 1920, Native Americans until 1924, and most African Americans until 1965. First-generation Asian Americans could not become U.S. citizens until 1952 (Brinkley, 1993, 576-577, 816; Feagin and Feagin, 1999, 209, 391; Office of Research on Women's Health, 1998, 17). Slavery was not only legal with blacks designated as chattel, the slave trade was allowed to continue until 1808, and a fugitive slave provision was incorporated by the 1850s that required the return of runaways to their owners. Neither the Declaration of Independence's famous statement that "all men are created equal" nor the Constitution's Bill of Rights applied to African Americans (Higginbotham, 1978, 1996). The Alien, Sedition, and Naturalization Acts compromised the rights and citizenship status of immigrants as early as the late 1700s and early 1800s. The Page Act of 1875 restricted the immigration of Chinese women, while the Chinese Exclusion Act of 1882 pro-

hibited the group as a whole (Brinkley, 1993; Feagin, 2000; Feagin and Feagin, 1999; Takaki, 1993).

By adopting the English language and accommodating to English-oriented institutions, white non-British immigrant groups have gained substantial power and status in the United States. However, voluntary and involuntary immigrants from Africa, Asia, and Latin America, as well as Native Americans have remained subordinate to white Americans in political, cultural, and in most instances, economic terms. For example, despite their arrival as agricultural laborers recruited in the 1880s, Japanese Americans could not become naturalized citizens until the passage of the McCarran-Walter Act of 1952 (Omi and Winant, 1994, 81). Though racial and ethnic diversity, inequality, and oppression continue to be part of the foundation of U.S. society, Americans of color continue to challenge their subordinate status (Feagin and Feagin, 1999; Omi and Winant, 1994). In many ways, the continuing story of racial, ethnic, class, and gender biases and conflicts in the United States is evidence of the system's dynamism—the promises and sorrows of the American dream. America's troubled past has profoundly affected its health system. Likewise, the poor health status and outcomes of African American and other minority populations are inextricably linked to historical racial and ethnic discrimination (Byrd and Clayton, 2000, 2001b, 2002; Stuart, 1987; Williams, 1999). If current demographic trends continue and people of color become the majority of the U.S. population by the middle of the twenty-first century, dramatic institutional changes will be necessary—including changes within the nation's health system (Brinkley, 1993; Byrd and Clayton, 2000, 2001a, 2002; Collins, Hall, and Neuhaus, 1999; Feagin, 2000; Feagin and Feagin, 1999).

Racial and Ethnic Data Collection and Definitions

Racial and ethnic minority groups are among the more difficult demographic categories to categorize because there is no simple scheme for defining these groups or classifying the categories' subgroups (U.S. Department of Health and Human Services, 1985a). As will be discussed later, attempts at categorization are further complicated by the complex histories and chronologic layers of definitions and classifications related to racial and ethnic concepts in Western culture (Byrd and Clayton, 2000, 2002; Smedley, 1999). Imprecise and changing definitions of race and ethnicity emanating from the federal government, anthropologists and other social scientists further complicate the issue of definitive categories or classifications (American Anthropological Association, 1997; Thernstrom, Orlov, and Handlin, 1980; Zenner, 1996). Nevertheless, in order to assess the health status, outcomes, and services utilization of vari-

ous racial and ethnic groups in the United States, data must be collected with some type of category system. Although current data collection systems are both imprecise and do not adequately collect data for all the important U.S. racial or ethnic minority groups, the federal government does attempt to perform this task in a systematic manner (U.S. Office of Management and Budget, 1997).

The U.S. government provides a standard classification system for record keeping, collection, and presentation of data on race and ethnicity in federal program administrative reporting and statistical activities. The five racial and two ethnic categories are: American Indian or Alaskan Native, Asian, Native Hawaiian or Pacific Islander, Black, White, Hispanic or Latino, Not Hispanic or Latino [Box 1-1, Introduction, this volume], and originate from a 1977 Office of Management report (Haynes and Smedley, 1999). Depending on the data source, these racial or ethnic classifications are based on self-classification or on observation by an interviewer or other person filling out the questionnaire (National Center for Health Statistics, 2000).

Before 1980, the National Vital Statistics System for newborn infants and fetal deaths tabulated the race of the fetus or newborn according to the race of both parents. If the parents were of different races and one parent was White, the child was classified according to the race of the other parent. When neither parent was White, the child was classified according to the father's race, with one exception: if either parent was Hawaiian, the child was classified as Hawaiian. Since 1989, newborn infants and fetal deaths are tabulated according to the race of the mother (National Center for Health Statistics, 1998a). In spite of these efforts, most existing sources of health data, with the exception of those derived from the census and from the vital registration system (birth and death certificates), permit examination of only the three largest racial and ethnic categories: non-Hispanic White persons, non-Hispanic Black persons, and persons of Hispanic or Mexican origin (National Center for Health Statistics, 2000).

The gathering of racial data by the U.S. Census Bureau is symbolic of its centrality in the nation's culture (Omi and Winant, 1994). As the U.S. health system developed, these data sets profoundly affected health policy and health services delivery. Race has been such an important characteristic in this country that census takers have tallied the racial composition of the population since the first U.S. Census taken in 1790: "[T]he U.S. Census has always included a question about race. Whites were normally distinguished from nonwhites" (Thernstrom, Orlov, and Handlin, 1980, 869). However, "[t]he racial categories used in census enumeration have varied widely from decade to decade" (Omi and Winant, 1994, 3). Until the 1850 census, African Americans were tabulated as either "Slave" or

"Free Colored," with the latter term sometimes including detribalized Native Americans. Though the 1850 and 1860 censuses collected data for free persons in "White," "Black," or "Mulatto" categories, the main tables continued to designate the overall population as "White," "Slave," and "Free Colored." The 1860 census also counted "Civilized Indians" (who were required to pay taxes because they did not live on reservations) and Chinese. In 1870, Japanese were added, and the "Civilized Indian" category was divided into "Pure Indians" and "Half-breeds" designations. The first reliable statistics tabulated for Native Americans "are those for 1890, the year in which the Bureau of the Census and Bureau of Indian Affairs made a concerted effort to report accurately the Indian population and the occurrence of vital events" (Stuart, 1987, 96). Census Bureau officials grouped mulattos with Negroes under "Colored" in 1880, but made finer distinctions in 1890, counting 6.3 million Negroes, 957,000 mulattos, 105,000 quadroons, and 70,000 octoroons. Finally admitting these divisions were valueless for analytical purposes, they grouped them all together with the Chinese, Japanese, and Indians under the general heading "Colored" (Thernstrom, Orlov, and Handlin, 1980).

In 1900, under the growing influence of anthropological notions of race, census officers were determined to assess the U.S. population in terms of the then-presumed four great races: Caucasian or White, Negro or Black, Mongolian or Yellow, and Indian or Red. Chinese and Japanese were designated subdivisions of Mongolian, and it was finally decided to use the term Negro and abandon the ambiguous term "Colored." By 1910 census officials reverted to "Black" and "Mulatto" but avoided the term "Colored." The main divisions were "White," "Negro," "Indian," "Chinese," "Japanese," and "All Other" (including subdivisions for Hawaiians, part-Hawaiians, and other races). The Indian population was treated separately in a special census recording both the "civilized" and those residing on reservations, and provided details on tribes, languages and geographic areas. This set many precedents for modern censuses. Mexicans were put in the "Other Races" category in 1930 but were later counted as Whites. Other Asian and Pacific Islander subgroups were tabulated, but appeared only in general tables. Enumerators in 1960 were instructed to consider how the person or family identified itself, and in 1970 self-identification was introduced into racial and ethnic tabulations (Thernstrom, Orlov, and Handlin, 1980).

Ethnicity is a much more recent concept. As a response to the general movement toward self-identification and the modern notions of a plural-

* While the 1890 Census had used the term "Colored" to mean all nonwhite persons, in the West Indies it meant part-European, part-Negro, and in the earlier censuses, in some southern states, and in some other countries it meant anyone with a Negro ancestor.

istic democratic society, the ethnic-origin category was introduced in the Current Population Survey in 1969 and included in the U.S. Census in 1980. However, there are difficulties with this mode of distinguishing races and ethnic origin, including sampling variation, changes in respondent fashion, and the difficulties of handling racial and ethnic mixtures. These issues are yet to be resolved (Haynes and Smedley, 1999; National Center for Health Statistics, 2000; Thernstrom, Orlov, and Handlin, 1980). The 1997 standards have five *racial groups*: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, and White, all of which continue to offer possibilities for confusion and complexity. Respondents are able to select more than one of the five groups, which sometimes diminishes sample size, creates ambiguous results, and increases the likelihood of not meeting the standards for statistical reliability or confidentiality. All federal data systems are required to be compliant with this system by 2003 (National Center for Health Statistics, 2000). Whether or not one is of Hispanic origin reflects another dimension, because the U.S. Census Bureau reiterates, "Hispanics are classified as an ethnicity, not as a race. People of Hispanic origin, therefore, may be of any race" (U.S. Census Bureau, 2001a). Therefore, the Office of Management and Budget outlines a more complex "combined format" whose minimum acceptable categories are: American Indian or Alaskan [sic] Native; Asian or Pacific Islander; Black, not of Hispanic origin; Hispanic; or White, not of Hispanic origin (Haynes and Smedley, 1999).

Distinguishing racial and ethnic groups from one another is useful in medical, health services, and epidemiologic research, provided that researchers are clear on the nature and source of human variation (e.g., cultural and behavioral patterns, environmental influences) and their relationship to health outcomes. Race and ethnicity affect factors as varied as disease rates, health behaviors, conceptions of well-being and attitudes toward health maintenance and home treatment, illness behavior, utilizations patterns, concepts of disease and illness, interactions with mainstream health professionals and organizations, and ethnic interest groups and medical delivery (Harwood, 1981). Using such information applicable to distinct groups could direct appropriate and efficient biomedical and health services research, focus health promotion disease prevention efforts, objectively redirect health services and restructure components of the health system, and guide diversity and cultural competence programs. However, if the "boundaries" of ethnic identity remain unclear, continue to be perceived as more flexible rather than rigid, become agents to defocus and fragment the nation's health policy and political mechanisms, all compounded by increased numbers of mixed ethnicity families in this country (where individuals claim two or more ethnicities), the challenge of pluralistic ethnic-oriented data collection, analysis, research, and program creation remains daunting. As we develop the methodology and

science of tracking racial and ethnic health and healthcare outcomes, urgent efforts should be directed toward eliminating racial and ethnic bias in the caregivers and re-educating both caregivers and patients to eliminate stereotyping, conscious, and unconscious biases. In the interim, there can be no delay in making recommendations leading to: 1) patient and provider education to understand the existence and dynamics of racial and ethnic bias in the healthcare arena; 2) programs at all levels teaching the dynamics of the stereotyping and the bias-producing processes and how they affect healthcare; and 3) the development of measures to teach patients and providers the specific cultural competence, diversity and cross-cultural skills to maximize the benefits of the doctor-patient relationship (Haynes and Smedley, 1999; White, Rutledge, and Brown, 2000; Zenner, 1996).

Immigration, Racial and Ethnic Groups, Health and Healthcare

Racial and ethnic groups are viewed today as by-products of social processes such as immigration, group interaction and conflict, group hierarchies and dominance, *acculturation*, and assimilation (Feagin and Feagin, 1999; Pedraza and Rumbaut, 1996). Acknowledgment of the effects of racial and ethnic problems on health and disease, the health professions, and, finally, the health system is new and indicative of an ongoing contemporary cultural movement among liberal democratic governments worldwide. These social dimensions of health and healthcare delivery serve as markers of a growing awareness, critique, examination, and redirection that is finally committed to the notion of embracing all of the nation's diversity (Byrd and Clayton, 2000, 2001a, 2002; Glazer, 1997; *The Healthcare Fairness Act of 1999*, 1999; Section of House Committee Report to Accompany H.R. 3064; Taylor et al., 1994). The World Health Organization has defined health as ". . . a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity" (Sutchfield and Keck, 1997, 3), and has proclaimed that "health [without qualification] is a human right" (Fluss, 1997, 377). These declarations, which are evidence of the fact that health is viewed as a universal human need—a "primary good," along with income, education, religious freedom, freedom of conscience, speech, press, and association, due process, the right to vote, and the right to hold office—are givens (Taylor et al., 1994, 4). Another corollary of this ongoing reassessment is that American health and healthcare are increasingly being viewed as immigrant, multicultural, racial, and ethnic minority stories with biomedical, medical historical, sociocultural and political, public health, health policy, and medical-social dimensions (Table 1).

This is why a brief overview of North American health and healthcare from racial, ethnic, and immigration perspectives is germane to this dis-

cussion (Byrd and Clayton, 2000, 2001a, 2002; Fluss, 1997; Garrett, 2000; Malone and Johnson, 1986; U.S. Commission on Civil Rights, 1999a, 1999b).

Native Americans, North America's original racial/ethnic group, are the indigenous people of the land now occupied by the United States. Scholarship concerning their fifteenth through twenty-first century interface with European explorers and invaders, the backdrop for America's racial and ethnic immigrant saga, is growing exponentially. It is becoming clear that health factors such as disease transmission, epidemics, and exposures of non-immune populations to new diseases had as much to do with early group interaction and eventual European dominance of New World, pre-Columbian (North, Central, and South American) people as to political and military activity (Burns and Ades, 1995; Byrd and Clayton, 2000, 2002; Diamond, 1999; Stannard, 1992; Watts, 1997).

We know that the 105 years between Columbus's landfall in the Caribbean and English colonization in 1607 had profound health effects in North America. Sixteenth-century Spanish colonies spreading from the Caribbean, South America, Mesoamerica (central and southern Mexico and adjacent areas of Central America), Mexico, and St. Augustine, Florida, bolstered by expeditions deep into North America itself, facilitated the spread of Old World diseases that greatly reduced American Indian populations. The resulting depopulation may have contributed to the myth of an "empty" American continent ripe for European settlement (Byrd and Clayton, 2000; Diamond, 1999; Watts, 1997). Not only does the Native American health experience serve as the opening chapter of the North American chronicle of racial and ethnic health, American Indian health and healthcare have been major factors shaping both their *demography* and their contact with Europeans. Prior to 1492, native people in the New World had few serious diseases compared with people of the Old World (Diamond, 1999; Pedraza and Rumbaut, 1996; Watts, 1997). Isolated from the Old World's domesticated animals* and diseases such as smallpox, influenza, measles, typhus, malaria, leprosy, cholera, bubonic plague, gonorrhea, and chancroid—even New World exposure to virulent forms of tuberculosis or syphilis is questionable—95 percent of the 8 to 12 million Native Americans inhabiting the North American continent at that time succumbed to European conquests, politics, and diseases (Diamond, 1999; Pedraza and Rumbaut, 1996; Stannard, 1992; Watts, 1997). By

* Though it is not fully understood, the origins of the germs (bacteria, viruses, etc.) causing many human diseases can be traced to many animals domesticated in the Old World, such as pigs, cows, horses, sheep, and goats. SOURCES: Diamond J. *Guns, Germs, and Steel: The Fates of Human Societies*. Paperback Edition. New York: W.W. Norton and Company, Inc., 1999; Pedraza S, Rumbaut RG. *Origins and Destinies: Immigration, Race, and Ethnicity in America*. Belmont, California: Wadsworth Publishing Company, 1996.

TABLE 1. Race, Ethnicity, and Immigration: North American Health and Health Care

Selected Indigenous and Immigrant Groups: An Overview of Race, Ethnicity, and Immigration in Relationship to Health and Health Care in North America			
Indigenous and Immigrant Group	Time of Entry	Economic Conditions in North America	Governments and Actions
Phase One: Pre-Columbian and North American Development: Prehistory-1600s			
Native Americans– Indigenous Group	Prehistory-1600– 2002	Land-based, self-sufficient, local economies with some regional trade; Ranged from Pueblo agriculturalists of Southwest, hunting societies on the Plains, to mixed agricultural-hunting societies elsewhere; Autonomous bands and tribes of geographically isolated, discrete, hunter gatherer, and farming communities. Dysfunctional relationships with social and economic system result in persistent poverty and isolation.	
Phase Two: Commercial Capitalism and the Slave Society: 1600–1865			
English	1600s-1800s	Mercantilism; land taken from Native Americans; English entrepreneurs and commercial capitalism emerges.	
Africans	1600s-1800s	Enslaved as property; became major source of labor for plantation capitalism.	
Irish Catholics	1830s-1860s	Driven out of Ireland by oppression and famine; labor recruited for low-wage jobs in transport, construction.	
Phase Three: Industrial Capitalism: 1865–1920			
Chinese	1850s-1870s	Contract labor and low-wage work in mining, railroads, construction; menial service work for White settlers.	
Italians	1880s-1910s	Moved as peasants into industrial capitalism; overseas recruitment for low-wage industrial and construction jobs in the cities.	

Health and

Government Conditions and Actions	Some Health and Health Care Considerations
Autonomous tribal units based on chiefdoms, common land-ownership, and mutually supportive living conditions. Government participation in land take-overs, broken treaties, and traumatic relocations. Paternalistic, shifting, and conflicting relationship with government persists.	Benign New World health environment: virtually no exposure to infectious crowd diseases; Slower pace of city development; and high levels of population isolation compared with Old World. Traditional healers practicing archaic medicine with strong religious and magical overtones. In lieu of Indian Health Service, persistent poor health status and outcomes.
English state creates land companies; colonial governments define individualized property and protect property. Capitalism promoted by: Commercial agriculture and plantation oligarchy; Legal race-based slavery established.	From rustic and deficient health and health system beginnings, establish race- and class-based health system based on English models. Separate and unequal tiers of "health" and health system for blacks, the poor, Native Americans.
Colonial governments establish slave codes; U.S. Constitution legitimates slave trade; U.S. government substantially controlled by plantation oligarchy.	"Slave health subsystem" established, and "slave health deficit" perpetuated, medical abuse and exploitation for blacks (246 years). Racial inferiority myth backed up by medical/scientific community. Legal health system segregation and discrimination (100 years), with de facto segregation and discrimination to present.
U.S. government opens up western lands; Irish take urban political machines from British Americans.	Initially assigned to lower tiers of health system (public hospitals, dispensaries, charity care) as immigrants; Early poor health status and outcomes.
Local governments help recruit Chinese labor; later, anti-Chinese laws passed in California; 1882 Exclusion Act.	Health and health system discrimination and segregation reflect social, political, economic, and legal status.
Government backing for labor recruitment; U.S. treaties with Europe; intervention in European affairs (World War I); incoming numbers reduced by 1924 Immigration Act.	Initially assigned to lower tiers of health system (public hospitals, dispensaries, charity care) as immigrants; Early poor health status and outcomes.

TABLE 1. (Continued)

Selected Indigenous and Immigrant Groups: An Overview of Race, Ethnicity, and Immigration in Relationship to Health and Health Care in North America			
Indigenous and Immigrant Group	Time of Entry	Economic Conditions in North America	Governments and Actions
Eastern European Jews	1880s-1910s	Industrial capitalism utilized their skilled and unskilled labor; small entrepreneurs re-established themselves; much anti-Semitic discrimination.	
Japanese	1880s-1900s	Recruited as agricultural laborers for Hawaii; later migrated to West Coast as laborers; served in domestic work; created small businesses and farms.	
Phase Four: Advanced Industrial (Multinational) Capitalism: 1920s–2002			
Mexicans	1910s-2002	With Asian/European labor cut off, Mexicans recruited for farms and industry; low-wage jobs in new urban industries. Now biggest component of the largest racial/ethnic minority group (Hispanic).	
Puerto Ricans	1940s-2002	Early farm labor migration; U.S. corporations recruit labor; blue-collar work in service economy. Second component of the largest racial/ethnic minority group (Hispanic).	
Recent Asian and Caribbean Groups	1950s-2002	Many political and economic refugees; create economic niches, make use of expanding service economy.	

SOURCES: Byrd WM, Clayton LA. *An American Health Dilemma*. Volume 1. *A Medical History of African Americans and the Problem of Race: Beginnings to 1900*. New York: Routledge, 2000; Byrd WM, Clayton LA. *An American Health Dilemma*. Volume 2. *Race, Medicine, and Health Care in the United States: 1900-2000*. New York: Routledge, 2001; Burns R, Ades L. *The Way West: The Way the West Was Lost and Won, 1845-1893*. A six hour documentary series [videotape] for *The American Experience*, Boston: WGBH Educational Foundation, WGBH, Boston, 1995; Diamond J. *Guns, Germs, and Steel: The Fates of Human Societies*. New York: W.W. Norton and Company, 1997; Dowling HF. *City Hospitals: The Undercare of the Underprivileged*. Cambridge, Massachusetts: Harvard University Press, 1982; Feagin JR, Feagin CB. *Racial and Ethnic Relations*. Sixth Edition. Upper Saddle River, New Jersey: Prentice Hall, 1999; Feagin JR. *Racist America: Roots, Current Realities, and Future Reparations*. New York: Routledge, 2000; Frost, Richard H. The Pueblo Indian smallpox epidemic in New Mexico,

Government Conditions and Actions	Some Health and Health Care Considerations
Government backing for labor recruitment; U.S. treaties with Europe; incoming numbers reduced by 1924 Immigration Act.	Initially assigned to lower tiers of health system (public hospitals, dispensaries, charity care) as immigrants; Early poor health status and outcomes.
Government backing for labor recruiting; U.S. imperialism in Asia; conquest of Philippines and Hawaii; government laws exclude Asians.	Health and health system discrimination and segregation reflect social, political, economic, and legal status.
U.S. government provides labor recruitment programs and fosters U.S. agri-business in Mexico, stimulating out-migration; U.S. Border Patrol monitors immigration; new law regulates immigration.	Initial assignment to lower tiers of health system (public hospitals, dispensaries, charity care) as immigration continues. Hispanic uninsured rate now the highest of any racial or ethnic group and culturally and linguistically incompetent health system represents continuing problems.
Conquest of Puerto Rico in 1898; U.S. government-supported agribusiness takes over economy, creates surplus labor, stimulates migration to U.S.	Initial assignment to lower tiers of health system (public hospitals, dispensaries, charity care) as immigrants continues. Hispanic uninsured rate now the highest of any racial or ethnic group and culturally and linguistically incompetent health system represents continuing problems.
U.S. intervention in Asia from 1853 to 1990s; government action in South Korea, Vietnam, Taiwan, Philippines stimulates out-migration; Cubans and Haitians flee repression.	Initial assignment to lower tiers of health system (public hospitals, dispensaries, charity care) as immigrants continues. High uninsured rates and culturally and linguistically incompetent health system represent continuing problems.

1898-1899. *Bull Hist Med* 1990; 64:417-445; Garrett L. *Betrayal of Trust: The Collapse of Global Public Health*. New York: Hyperion, 2000; Office of Research on Women's Health. *Women of Color Health Data Book: Adolescents to Seniors*. Washington, DC: U.S. Department of Health and Human Services. NIH Publication No. 98-4247, 1998; Pedraza S. Rumbaut RG. *Origins and Destinies: Immigration, Race, and Ethnicity in America*. Belmont, California: Wadsworth Publishing Company, 1996; Trennert RA. *White Man's Medicine: Government Doctors and the Navajo, 1863-1955*. Albuquerque: University of New Mexico Press, 1998; U.S. Commission on Civil Rights. *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality*. Vol. 1. *The Role of Governmental and private Health Care Programs and Initiatives*. Washington, DC: U.S. Commission on Civil Rights, 1999; U.S. Department of Health and Human Services. *Report of the Secretary's Task Force on Black and Minority Health*. Vol. 1. *Executive Summary*. Washington, DC: U.S. Government Printing Office, 1985.

1900, only about 250,000 Native Americans remained in the United States (Pedraza and Rumbaut, 1996). Though much of this toll was directly related to health-related causes such as smallpox epidemics, other causes included warfare with Europeans and Americans, mortality related to the Amerindian slave trade, and massive forced population relocations (Pedraza and Rumbaut, 1996; Stannard, 1992). Since the nineteenth century, Native American health and healthcare have been poor. Today the health of Native Americans is characterized as being isolated from the mainstream health system; administered by a government that is often culturally insensitive; inadequately funded and understaffed; paternalistic; disparate from health status and outcomes perspectives; and has been allowed to spread communicable diseases such as smallpox and tuberculosis (Frost, 1990; Garrett, 2000; Stuart, 1987; Trennert, 1998).

In contrast to relatively well-organized, Iberian-run health systems (Risse, 1987), early North American colonial health systems were rudimentary. The environment, poisoned by ongoing conflict with Native Americans, was dangerous. Moreover, as Leavitt and Numbers (1985, 3) noted, "Early settlers in America often suffered from malnutrition, which increased their vulnerability to infectious diseases. . . . The gravest threats to life and health were malaria and dysentery in summer and respiratory ailments, like influenza and pneumonia, in winter." Thus, for the early English and Dutch settlers, these *endemic* (always present), and *epidemic* (appearing from time to time with great intensity) threats—most of which were infectious and transmitted from one person to another—brought basic human survival into question. By the eighteenth century, English commitment to a plantation economy and black chattel slavery had combined with Protestant and Puritan elements of the culture to implement legal racial slavery and a race- and class-based health system. Poorhouses and almshouses, based on English models, served as the first hospitals in the colonies. There was a dearth of scientifically trained physicians, and a separate and unequal *slave health subsystem* serviced African Americans. A *slave health deficit* whose origins can be traced back to the African continental and Atlantic slave trade was institutionalized (Blanton, 1930, 1931; Byrd and Clayton, 1992, 2000; Ewbank, 1987; Higginbotham, 1978; Leavitt and Numbers, 1985; Numbers, 1987; Trennert, 1998).

Territorial growth fueled by the elimination or displacement of Native Americans, as well as economic success spurred by commercial plantation agriculture and black chattel slavery, and the political freedom spawned by a successful Revolutionary War that liberated the colonies from England all served to foster the institutionalization (founding of medical schools, private hospitals, and a formally trained branch of the medical profession) and complexity of the health system. At that time, home care or self-care were the health delivery norms for all but poor or

marginal populations (Byrd and Clayton, 2000; Feagin, 2000; Vogel, 1980, 1985).

Late eighteenth and early nineteenth century Anglo-Protestant affluence and sophistication only added to the race- and class-based stratification of the health system. Adding to the squalor and crowding in America's rapidly growing eighteenth and nineteenth century cities and "dual" health system were waves of immigrants, many of whom arrived "half starved, half sick, and often barely alive" (Dowling, 1982, 9). By the Jacksonian and Antebellum periods, white immigrants (e.g., Germans, Scottish, Irish, Scandinavians) were assigned to the lower tiers of the mainstream system (public hospitals, dispensaries, and health charities) present in the East, the slave health subsystem burgeoned, and all Americans in frontier areas in the West, both slave and free, suffered deficient and primitive health conditions and services. The South, where most African Americans resided as slaves, was the most backward region with regard to public health policies and institutions. As a result, there were mid-nineteenth century increases in mortality affecting urban ethnic immigrants, black slaves, and free blacks (Breedon, 1989; Byrd and Clayton, 2000; Duffy, 1990; Leavitt and Numbers, 1985; Rosenberg, 1974, 1987, 1989; Savitt, 1978, 1985; Vogel, 1980, 1985). Between 10 and 15 percent of American doctors had medical degrees, while the rest were either apprentice-trained or pretenders (Barzun, 2000, 405; Garrett, 2000, 285; Trennert, 1998, 11). Native Americans in the throes of displacement or elimination had little contact with the health system until the latter half of the nineteenth century (Trennert, 1998).

The Civil War, in addition to being a turning point in the nation's political and economic affairs, was a watershed event in American health. It highlighted the weakness in U.S. public health, medical education, and health delivery systems. However, the Civil War convinced average European Americans of the importance of biomedicine and public health and paved the way for major medical educational and professional, sanitary, and health reforms—simultaneously spurring a national hospital movement (Byrd and Clayton, 2000; Duffy, 1990; Rosenberg, 1987, 1989). Black health plummeted due to Civil War collapse of the slave health subsystem. Deleterious effects were compounded by the preexisting slave health deficit, abandonment of African Americans by the mainstream health system, and continuation of racially discriminatory health policies and treatment. In lieu of emancipation, the war and its aftermath represented a health catastrophe for African Americans as their health status fluctuated wildly until 1910. This led influential biostatisticians such as Frederick Hoffmann, as well as many in the medical profession to confidently predict black extinction by year 2000 (Byrd and Clayton, 1992, 2000; Duffy, 1990; Jones, 1993; Morais, 1967; Tucker, 1994).

On one level, the late nineteenth century represented an era of reconciliation and progress for white European American ethnic groups—both the North and South—as the United States emerged as a world power. However, traditional patterns of racial and ethnic oppression and conflict between dominant White, Anglo-Saxon, Protestant groups, and non-European as well as more recent immigrant groups (e.g., Italians and Jews) continued (Feagin and Feagin, 1999). Improvements in biomedical education and science, medical practice, and a burgeoning hospital movement were evident. However, based on the evidence they do not explain the decline in infectious diseases and mortality and the general increase in life expectancy (which did not occur among blacks) (Byrd and Clayton, 2000, 2002; Duffy, 1990; Leavitt and Numbers, 1985). Instead, it is more likely that improvements in public health measures such as sanitation, water and milk supplies augmented by improvements in diet, housing, and personal hygiene are responsible for the decline in mortality (Leavitt and Numbers, 1985; Ewbank, 1987). Nevertheless, groups on the margins of, or sometimes excluded from, social progress or the health system such as African Americans, Native Americans, Asian Americans, Mexican Americans, other ethnic and religious minority groups, and large blocs of the poor, were not full beneficiaries of these positive results. Members of these groups, along with women, were segregated and isolated from the mainstream health system and systematically excluded from health professions training (Byrd and Clayton, 2000, 2002; Leavitt and Numbers, 1985; Trennert, 1998; Walsh, 1977).

After World War I, the Great Depression, and World War II it became clear to all the nation's racial and ethnic groups that medicine and medical care could make a difference in reducing infectious disease morbidity and mortality, increasing life spans, and improving health outcomes and quality-of-life in America (Byrd and Clayton, 1992, 2000, 2002; Fee, 1997a, 1997b; Leavitt and Numbers, 1985). As the efficacy of health interventions, therapies, and technologies increases, the equitable distribution of medical care and health services becomes even more important. As Byrd observed, "American medicine is now devastatingly effective, corrective, preventive, and selective. Doing without health care these days spells doom or defectiveness" (Byrd, 1986, 1026). For a plethora of reasons,* race, class-, and ethnic-based health status, outcome, and services disparities

* Reasons for overall health improvement and convergence of health and healthcare for all Americans can be attributed to scientific (e.g., vaccinations, antibiotics), social (e.g., improved nutrition, housing, and sanitation), political (e.g., movement toward egalitarianism and the welfare state), economic, medical-social (e.g., acceptance of public health goals), and health policy (e.g., policies promoting a healthy population and good health) factors, all of which are detailed in the references.

between America's racial and ethnic minorities and the European American majority narrowed over the first three-fourths of the twentieth century. Though overall U.S. health status and outcomes continued to slowly improve, these history-based disparities have either stagnated or worsened during the past two decades for racial and ethnic minorities. *Understanding* the character, causation, mediators, and mechanisms of the racial and ethnic disparities in health and healthcare could eventually lead to recommendations and interventions to *eliminate* them (Byrd and Clayton, 2000, 2002; Clayton and Byrd, 2001; Collins, Hall, and Neuhaus, 1999; Garrett, 2000; Haynes, 1975; Malone and Johnson, 1986; Mayberry, Mili, and Ofili, 1986, 2000; U.S. Commission on Civil Rights, 1999a, 1999b; Williams, 1999).

An Uneasy Mix of Diverse Peoples: The Dynamics of the United States' Racial and Ethnic Group Interaction

Other than Native Americans, all Americans are immigrants who arrived on the North American continent within the last 500 years (see Figure 1 for distribution of ancestry groups). Of the varying races and ethnicities, some entered English North America (later the United States), voluntarily, some were recruited, and others were brought in involuntarily. American immigration took place in waves during various socio-economic and political periods of our nation's history, with various groups dominating particular periods. Examining these immigrant waves from a racial-ethnic relations perspective (including group characteris-

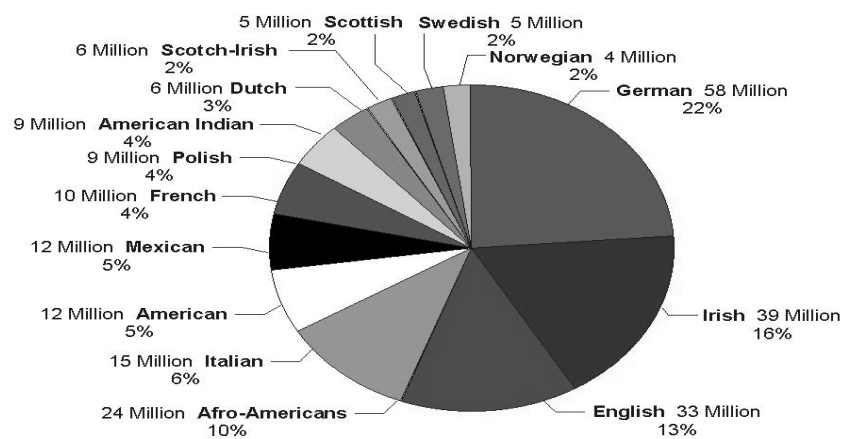


FIGURE 1 The top 15 ancestry groups, 1990 U.S. Census. SOURCE: U.S. Census Bureau, 1990 Census Report, CP-S-1-2, Detailed Ancestry Groups for States.

tics, group interactions, power relationships and experiences juxtaposed with a changing capitalistic economy and expanding political and governmental framework—Table 1) provides a backdrop that clarifies the immigrants' health status and outcomes and evolving relationships with and within the health system (Byrd and Clayton, 2000, 2001a, 2002; Diamond, 1999; Feagin, 2000; Feagin and Feagin, 1999; Garrett, 2000).

Shared culture and national origin are prime characteristics of both indigenous- and immigrant-Americans. Thus, all can be considered members of ethnic groups (Feagin and Feagin, 1999). Scientists who study race consider it a socially determined category based on shared physical characteristics (most often skin color and appearance) most commonly dividing the human family into three to five major "racial" groups. The dominant racial types as previously noted are Asian (sometimes referred to as Mongoloid or Yellow), White (sometimes referred to as Caucasoid or Indo-European), and Black (sometimes referred to as Negroid) with some authorities adding American Indian (sometimes referred to as Red) and Australian Aboriginal (sometimes referred to as Malay) types (Omi and Winant, 1994; Stringer and McKie, 1997; Thernstrom, Orlov, and Handlin 1980; Van den Berghe, 1967). Of the 2 to more than 60 arbitrary "racial" types that science has created over the centuries, the U.S. government has adopted the first 4, with Hispanic reserved as an ethnic category (Cavalli-Sforza, 2000; Cavalli-Sforza, Menozzi, and Piazza, 1994; Haynes and Smedley, 1999; National Center for Health Statistics, 2000). While virtually none of the authorities still believe in "pure" races, all concede that many groups overlap the various racial classification systems and that there are a few that cannot be classified at all. Further confusion is introduced when all attempts at definition are confounded by the belief that *race* is just one aspect of *ethnicity*.

The United States is still highly stratified on the basis of race, ethnicity and class, and growing income inequality over the past decades may be accentuating these trends (Feagin and Feagin, 1999; U.S. Census Bureau, 2001f; Wolff, 1995). Though they are analytically separable, race, socioeconomic status (SES), ethnicity, and class phenomena are closely interrelated in the United States. They are also health and healthcare variables. From the nation's seventeenth century beginnings, English Americans have had much greater power and resources than other groups, and such power and resource inequality has tended to persist from one generation to the next. Other factors facilitating white, European American groups in becoming members of the mainstream have been *identificational assimilation* and their progressive acceptance as "White Americans" between the mid-nineteenth century and World War II (Feagin and Feagin, 1999; Jacobson, 1998; Lipsitz, 1998; Steinberg, 1989). Historically, some groups are confined to lower-class positions because of lack of access to both

power and economic means that are built into the status system by formal and informal, structural, and to some extent, legal norms. The fact that individual class system mobility is also limited and that experiences differ markedly for certain groups is also based on understanding that there are two very different patterns of ethnic incorporation—*discrimination* versus *exclusion*.

Among those who suffered from discrimination were the Irish, Italians, Greeks, Jews, and Poles—the European immigrants, mostly from southern and eastern Europe, that came to America voluntarily in the mid-nineteenth to early twentieth centuries. Among those who suffered from social exclusion were Blacks, Native Americans, Mexican Americans, and Puerto Ricans—those whose history began as the product of involuntary conquest, annexation, and colonialism, as a result of which they were not allowed to become integrated into the major institutions of the society (Pedraza and Rumbaut, 1996, 16).

Few deny that African Americans, Native Americans, and Hispanics disproportionately occupy the lowest strata of the class system and have been traditionally restrained within these strata by political, ideological, legal and economic mechanisms. Traditionally, groups under Anglo-Protestant political or economic dominance, especially when compounded by racial worldview-caste considerations and *stereotyping*—Native Americans, Hispanics, African Americans, or Asians, or immigrants who arrived as indentured servants or laborers—have moved into and circulated within the lower rungs of the social hierarchy. However, in the ensuing racial and ethnic *acculturation* and *assimilation*, competition, and struggles that have evolved over time, individuals and groups, even of the less-favored races and ethnicities, have moved into positions of power (e.g., African-American and Italian Supreme Court justices; Mexican, African-American, Jewish, and Italian mayors). The various groups' distinctive health and healthcare profiles largely reflect these factors along with their demographics, sociocultural, and racial and ethnic experiences (Feagin, 2000; Feagin and Feagin, 1999; Harwood, 1981; Smedley, 1999; Takaki, 1993; Terry, 1992; Williams, 1999).

Black or African American [Black, not of Hispanic origin]

Presently America's oldest, largest, non-indigenous racial group,* the black population was projected by the U.S. Census Bureau to number

* Release of 2001 census data indicated Hispanics were tied with Blacks as America's largest racial/ethnic minority group. SOURCE: Canedy D. Troubling label for Hispanics: 'Girls most likely to drop out.' *New York Times*, Sunday, March 25, 2001, p. 1.

35,470,000 as of January 2, 2001, or 12.8 percent of the U.S. population (Bohannon and Curtin, 1995; U.S. Census Bureau, 2001b). Erroneously considered an homogenous population, the categories “Black” or “African American” include the descendants of the original seventeenth-through nineteenth-century slave population, as well as immigrants from Jamaica, Haiti, Trinidad, Barbados, and other Caribbean nations along with more recent immigrants from Ghana, Nigeria, Egypt, Ethiopia, Somalia, Sudan, the Cape Verde Islands, Liberia, and other African countries. Although viewing this group monolithically makes it easier to perform tasks related to health policy and health status indicators, it masks dramatic linguistic and cultural diversity issues, varied illness behavior, and preferences among these individuals and groups (Office of Research on Women’s Health, 1998; U.S. Commission on Civil Rights, 1999a).

Demographically, the black population remains younger (median age 30.4 years) than the general (median age 35.9 years) and white non-Hispanic population (median age 38.6 years), has less affluence and higher poverty levels (23.6% in poverty) than the general (9.8% in poverty) or white (7.7% in poverty) populations, suffers higher unemployment rates than the general or white populations, and exhibits lower educational levels (13% of blacks are college graduates) than the white (25% of whites are college graduates) population. Eighty-seven percent of African Americans live in cities and they reside in all 50 states. However, over half live in 13 Southern states—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia. Though subpopulations vary, people are usually assigned to the black or African-American category based on appearance—characteristics such as skin color, hair texture, and facial features. African Americans generally experience higher unemployment rates and employment in lower paying jobs, which helps explain their high rates of uninsuredness in a largely employment-based health system (Byrd and Clayton, 2000, 2002; Office of Research on Women’s Health, 1998; U.S. Census Bureau, 2001c, 2001d, 2001e).

Mired in corrosive sociocultural, health and biomedical system legacies of 2000 years of being portrayed as being biologically and intellectually inferior; 246 years of chattel slavery, including a slave health deficit and a slave health subsystem; 100 years of legal segregation and discrimination and a “Negro medical ghetto;” and contemporary social, political, and economic isolation, oppression, exploitation, and a “dual” and unequal health system (Byrd and Clayton, 2000, 2002), “African Americans experience healthcare differently from [W]hites and other populations within the nation” (U.S. Commission on Civil Rights, 1999a, 23). For a plethora of reasons, African Americans have experienced the worst health status, suffered the worst health outcomes, and been forced to utilize the worst health services of any racial or ethnic group.

Based on the latest available data as the new millennium began, African Americans are faced with persistent or worsening, wide and deep, race-based health disparities compared with either the white or the general population (Byrd and Clayton, 2000, 2001a, 2002; Clayton and Byrd, 2001; Collins, Hall, and Neuhaus, 1999; Mayberry, Mili, and Ofili, 2000; Williams, 1999).

American Indian or Alaskan [sic] Native

Projected by the U.S. Census Bureau in 2001 to number 2,448,000, or 0.9 percent of the U.S. population, American Indians, Eskimos, and Aleuts* are the smallest of the major racial and ethnic groups discussed in this report. However, their numbers are growing three times more rapidly than the white population. Comprising culturally diverse, complex, and distinctive groups of people speaking more than 300 languages, the American Indian or Alaskan Native population is made up of 535 federally recognized (plus 100 that are not officially recognized) tribes in seven nations (e.g., Navajo, Iroquois) on nearly 300 reservations in the lower 48 states, and approximately 500 government units in Alaska (Office of Research on Women's Health, 1998; U.S. Census Bureau, 2001b).

The commonality of their poor health experience, while obscuring their diversity, mirrors their shared sociocultural experience, which includes, but is not limited to:

- the rapid and forced change from a cooperative, clan-based society to a capitalistic and nuclear family-based system;
- the outlawing of language and spiritual practices [reminiscent of the black slavery experience];
- the death of generations of elders to infectious diseases or war; and
- the loss of the ability to use the land walked by their ancestors for thousands of years (Office of Research on Women's Health, 1998, 2).

For much of the twentieth century, the observations of the 1928 Meriam Report that the health of the Indian population was characterized by "a high birth rate and high death rate with excessively high infant mortality and a large proportion of deaths from tuberculosis" (Stuart, 1987, 1996), held true. Health-seeking behavior and responses to healthcare services such as being strongly autonomous, being non-linear thinkers (especially regarding time), using indirect communication and styles, and having a historical suspicion of authority reflects these experiences (Kingfisher, 1996).

* A Native American people inhabiting the Aleutian Islands and coastal areas of southwest Alaska.

Moreover, “Health care for the Amerindian population had been poorly provided by the Bureau of Indian Affairs since 1849” (Porter, 1999, 288). Their health and demographic profile—including poverty, lower education levels, and disease profiles often compounded by substance abuse—reflects the residue of this legacy. Due to treaty obligations, Native Americans largely receive their health services via the federal government, and “[T]he Indian Health Service (IHS)—since 1955 a part of the United States Public Health Service—provides healthcare through its clinic and hospitals to all American Indian/Alaska Natives who belong to federally recognized tribes and live on or near the reservations in its 12 service areas” (Office of Research on Women’s Health, 1998, 2). Though “[t]he health status of American Indians has improved dramatically during the twentieth century, particularly after the transfer of Indian health to the Public Health Service in 1955” (Stuart, 1987, 95), their diversity—compounded by their many small population groups scattered throughout the country—has made it difficult to provide consistent, quality, readily accessible healthcare. Their health status and outcomes are reflections of these circumstances (Burns and Ades, 1995; Office of Research on Women’s Health, 1998; Trennert, 1998; U.S. Commission on Civil Rights, 1999a).

Asian American [Asian or Pacific Islander]

Numbering less than one million until the Supreme Court ruled against immigration quotas in 1965, Asians and Pacific Islanders are the fastest growing minority group in the United States—representing 3 percent of the total population and around 13 percent of all people of color. Asian American immigrants to the United States have come from more than 20 countries. Having emigrated from countries such as China, Japan, India, the Philippines, Korea, Laos, Cambodia, Vietnam, and Thailand, Asians and Pacific Islanders represent more than 60 different ethnic groups and speak more than 100 different languages. Though only the largest subpopulations are detailed here—Filipino, Chinese, Japanese, Asian Indian, Korean, and Southeast Asian—that in no way lessens the importance of smaller groups such as the Laotians, Belauans, Micronesians from Nauru, Thai, Melanesians on Fiji, Cambodians, Tongans, or Hmong (Feagin and Feagin, 1999; Office of Research on Women’s Health, 1998). Under Title VIII of the 1975 Native American Programs Act, Pacific Islanders—who are not all immigrants to the United States as are many other Asians—along with American Indians, Alaska Natives (Eskimos and Aleutians), Native Hawaiians, and Samoans, are defined as “Native Americans.” Representing only 5 percent of the total Asian American and Pacific Islander (AAPI) category, they present bipolar health and social profiles of artificially aggregated groups, and their health outcomes are

akin to those of American Indians/Alaska natives rather than to other Asian subpopulations. Disaggregating their health status and outcomes from other Asian subpopulations whenever possible would seem to lend clarity to any health assessments or analyses of such arbitrarily combined groups (Feagin and Feagin, 1999; Office of Research on Women's Health, 1998; U.S. Commission on Civil Rights, 1999a).

U.S. Census Bureau projections of the AAPI population at 11,279,000, or 4.1 percent of the population, by November 1, 2000, reflect a population growth rate of 37 percent between 1990 and 1998, the highest in the nation. The AAPI population is young, with a median age of 32.1 years—3.8 years younger than the general population and 6.5 years younger than non-Hispanic whites. Fifty-six percent of Asian and Pacific Islanders live in the Western United States with the highest concentrations residing in Hawaii (63% of the total population), California (12%), Washington (6%), and New York and New Jersey (5% each). Asian and Pacific Islander Americans are more likely to reside in metropolitan areas (95% compared with 75% overall). In the late-1990s, 24 percent of the nation's foreign-born residents were AAPIs, with 6 of 10 being foreign-born. Only Mexico produced more foreign-born residents than the Philippines or China (including Hong Kong) (U.S. Census Bureau, 2001b; U.S. Commission on Civil Rights, 1999a).

Despite projections as a privileged and prosperous minority—now a part of their "*model minority*" image—many subgroups of Asian Americans are economically disadvantaged. While college graduation rates were the highest in the country for Asian and Pacific Islander Americans (42%) and the median income for Asian and Pacific Islander households as of 1998 was over \$46,000—the highest of all major racial and ethnic groups—some 14 percent of AAPIs have incomes below the poverty level, almost twice the rates of non-Hispanic whites (7.7%). Vietnamese Americans, for example, have an average family income that is about half that of AAPI populations as a whole. Moreover, AAPI families tend to be larger (3.15 persons compared with 2.23 persons in metropolitan white households), which translates into a lowered estimated income per member. There are more than 365,000 Pacific Islander Americans residing on more than 22 islands—including Polynesia (Hawaii, Samoa, and Tonga), Micronesia (Guam, Belau, and the Carolines, Marianas, Marshalls, and Gilberts), or Melanesia (e.g., Fiji). Their health profiles are distinct from other Asian groups. Half the Pacific Islander Americans live in Hawaii, 30 percent live in California, 4 percent in Washington, and 2 percent each in Texas and Utah. These islands represent autonomous governments with varied political relationships with the United States, and have varying levels of health and healthcare. The health system in Guam is relatively advanced, while the Commonwealth of the Northern Marianas offers a lesser level of care to its residents, and

the Republic of Belau and the Federated States of Micronesia have older hospitals and provide a generally poorer level of care. Though the health problems of the Native Hawaiians and other Pacific Islander groups today largely reflect their poor socioeconomic and educational status, whether in island or urban settings, barriers to health and healthcare such as linguistic isolation, cultural differences (e.g., obesity is acceptable in Polynesian culture and large body size is equated with power and respect), traditions, and health beliefs and practices remain problematic (Office of Research on Women's Health, 1998; U.S. Census Bureau, 2001c, 2001e, 2001g; U.S. Commission on Civil Rights, 1999a).

Educational attainment differs among Asian and Pacific Islander Americans, ranging from high school graduation rates of 31 percent among the Hmong, 64 percent for Tongans, 80 percent for Hawaiians, and 88 percent for Japanese. High AAPI college graduation rates vary from the very high rate for Asian Indians of 58 percent to Tongan, Cambodian, Laotian, and Hmong rates of 6 percent or less. As in other groups, educational levels are strongly correlated with health status and outcomes (Office of Research on Women's Health, 1998; U.S. Commission on Civil Rights, 1999a).

Based on the economic and educational progress some AAPI groups had made by the late-1960s, the "model minority" image replaced many of the negative stereotypes applied to Chinese and other Asian Americans. Some viewed this as an attempt, after several years of civil unrest and urban riots, to prove that the U.S. social system does work for minorities. "However, Asians often are pitted against other minority groups and are made scapegoats by low-income [W]hites and other minorities who indirectly blame Asians for their failure to succeed and claim that Asians take away their educational and job opportunities" (Office of Research on Women's Health, 1998, 18). Moreover, the "model minority" image tends to trivialize the health problems of Asians and suggests that they can take care of the problems themselves, while overlooking the diversity among Asian populations and the health and health system problems faced by the newest AAPI refugees (Office of Research on Women's Health, 1998; Steinberg, 1989; U.S. Commission on Civil Rights, 1999a).

Hispanic

Hispanic has been a widely used term that was eventually designated by the government to identify persons of Mexican, Puerto Rican, Dominican, Cuban, and Central and South American ancestry and heritage. *Hispanic* is an English-language word derived from *Hispania*, the Roman name for Spain—emphasizing the Spanish heritage of these groups while ignoring the other (e.g., Native American, Mestizo, and African) geo-

graphical and cultural components. Although their origins are predominantly Native American (Indian), they also have significant infusions of blacks, whites, or Asians, which explains why Hispanics can be of any race. An alternative Spanish-language word and collective designation, *Latino*, recognizes the Latin American origins of these groups and is, therefore, more acceptable to many Spanish-speaking Americans (Feagin and Feagin, 1999, 291; Office of Research on Women's Health, 1998).

Projected by the U.S. Census Bureau to number at least 32,832,000 by November 1, 2000, Hispanics were reportedly tied with African Americans numerically as of March 2001 as constituting between 11.9 and 12.8 percent of the U.S. population (Canedy, 2001; U.S. Census Bureau, 2001b). The major subgroups are Mexican Americans (64%), Central and South Americans (14%), Puerto Ricans (10%), "other Hispanics" (7%), and Cuban Americans (4%).

More than one-third of Hispanic Americans are foreign-born, and approximately one-half the women giving birth to Hispanic infants were born outside the 50 states and Washington, D.C. Ninety percent of the nation's Hispanic population is urban and 70 percent reside in six of the most populous states (California, Texas, New York, Florida, New Jersey, and Illinois). The largest concentrations are in four cities (New York City, Los Angeles, Chicago, and San Antonio) and the South and West (three-fourths of all Hispanics) regions of the nation (Office of Research on Women's Health, 1998; U.S. Census Bureau, 2001b).

The diversity of the Hispanic population is remarkable. Comprising virtually all races, that group diversity includes 75% of all United States farm workers, which is important because Hispanic farm workers have a life expectancy of only 49 years. The Hispanic population also has infant mortality rates 25% higher than the United States average and higher cancer rates. Occupations and living conditions range from university professors and executives to people living in colonias, which are unincorporated areas lacking septic tanks, sewers, and running water. The median age of the Hispanic population is much younger (26.6 years) than the general (35.9 years) or white (37.0 years) population; educational levels are lower and they suffer higher poverty rates (22.8%) compared with the white non-Hispanic population (7.7%). Though subpopulations vary, Hispanics generally experience higher unemployment rates and are employed in lower-paying jobs, which helps explain their high rates of the lack of employer-based health insurance (Office of Research on Women's Health, 1998; U.S. Census Bureau, 2001b, 2001c, 2001e).

Hispanic subpopulations, especially Mexican Americans, appear to enjoy better health than would be predicted given their low socioeconomic status and their low utilization rates for healthcare services. Some groups, such as Mexican-American women, despite their greater poverty, have

lower rates of hypertension than Cuban, white, or African-American women. Among Hispanics, Puerto Rican and Cuban Americans use health facilities at rates comparable with whites while overall group utilization rates are lower. Moreover, prevalence rates for certain diseases like cancer and low birth weight infants favor new immigrant, less acculturated Hispanics. For poorly understood reasons, the risks for these health problems increase as these immigrants become more “American.” The unfortunate tendency to use such data to minify Latino health problems must be acknowledged and ameliorated. There is so much variation in the health of Hispanic-American subgroups that looking at aggregated measures can obscure meaningful intragroup differences. This requires the collection of more focused and analyzed health data and statistics for these groups, along with more research to understand the patterns, forge health policy, and improve outcomes (Office of Research on Women’s Health, 1998; U.S. Commission on Civil Rights, 1999a).

Among the original occupants of the New World—from Cape Horn to Alaska and the Caribbean, to California, the Southwestern United States, and Texas—the ancestors of Latinos were dominated by Spaniards and Portuguese in the 1500s. After generations of intermingling between the dominant groups (Spaniards and Portuguese, Native Americans, black African slaves) and a complex series of political events and territorial wars, various Latino groups were either colonized (e.g., Cuba and Puerto Rico) or annexed (large parts of Mexico) by European minorities, which sometimes grew into majorities—while Latinos became second-class citizens in the process (Feagin and Feagin, 1999; Numbers, 1987; Takaki, 1993). Heavily recruited by the United States for agricultural and low-wage labor in the 20th century, these groups have acculturated and grown numerically while struggling against racism, prejudice and *stereotypes*, discrimination, poverty, being politically marginalized, and being looked upon as having a “foreign” language and culture. Their health experience reflects their social, economic, and political realities, which is a distinct theme of healthcare disparities in the United States (Canedy, 2001; Feagin and Feagin, 1999; Office of Research on Women’s Health, 1998; U.S. Commission on Civil Rights, 1999a).

White Non-Hispanic Ethnic Groups

White non-Hispanic people, who number 196,929,000 (71.3 percent of the population), constitute the largest bloc of the U.S. population. These white ethnic groups are dominant players in American society, controlling the mainstream culturally, socially, economically, politically, and institutionally. This also applies to the U.S. health system: its professions, its politics, its policies, and its institutions (Byrd and Clayton, 2000, 2002;

Feagin, 2000; Feagin and Feagin, 1999; Starr, 1982; U.S. Census Bureau, 2001b). Often thought of in monolithic terms, brief descriptions of some of these European ethnic groups from ethnic and healthcare perspectives reveal that they are quite variegated. These “White American” ethnic groups are the major determinants at both the production phase and receiving ends of what constitutes “normal” health and healthcare in the United States. Although other specific white ethnic groups are not mentioned here—such as the French, Dutch, Scottish, Scotch-Irish, Swedish, Norwegian, or Slovak—this in no way lessens their importance in the health system or contribution to American society (Feagin and Feagin, 1999; Pedraza and Rumbaut, 1996; Starr, 1982; Stevens, 1971, 1999; U.S. Census Bureau, 2001a).

English Americans and Anglo-Protestant Culture

Having led in the domination and settling of English North America, the Anglo-Protestant (sometimes referred to as White Anglo-Saxon Protestant [WASP]) transported the core “American” values of achievement, conscience, industry, antisensuality, and civic-mindedness to the new culture. However, at times they also brought a caste-like exclusivity, bigotry, and hierarchical views on matters of culture and race. As much a high status-power group as an ethnic group, until recently they dominated the presidency, cabinet, governmental, judicial, financial, educational, and corporate positions, established the nation’s institutional infrastructure and administered and managed its institutions. With 33 million claiming partial or total English ancestry, they rank numerically among the three largest white groups (Germans and Irish) and although currently being challenged culturally and politically, remain the most powerful group in America.

Most significantly, “of America’s many groups . . . the English immigrants and their descendants require attention, for they possessed inordinate power to define American culture and make public policy” (Takaki, 1993, 7). They have been the determiners and the purveyors of the “overall American culture which serves as a reference point for immigrants and their children” (Feagin and Feagin, 1999, 76). In short, they set the tone for American political, business, and cultural life. The current U.S. health system is a by-product of these forces (Byrd and Clayton, 2000, 2001a; Domhoff, 1983; Feagin and Feagin, 1999; Jordan, 1968; Pedraza and Rumbaut, 1996; Schlesinger, 1998; Smedley, 1999).

The presence of the English Americans and their culture is so pervasive that they are taken for granted and few references are made to their existence. Many allege they have lost much of their authority and power in the past five decades, especially after the 1960s when the Anglo-Protestant establishment was brought into question. Neverthe-

less, they are the leading edge of medical and health establishments and are a strong determinant of the “norms” for health and healthcare in America (Byrd and Clayton, 2000, 2002; Dowling, 1982; Starr, 1982; Stevens, 1971).

German Americans (1840s forward)

At 58 million, German Americans are the largest American ancestry group. They have blended into the white majority so well that they are sometimes portrayed as a “model minority.” Their early health experience was shaped by the typical European immigrant health experience. The largest immigrant group of the mid-nineteenth century and unusually concentrated in urban areas of the Eastern seaboard, most early German immigrants were poor and dependent upon the public, dispensary, and charity care upon which other poor populations depended. Although squalor and overcrowding seemingly bred rampant disease rates, contributions by outstanding academic and practicing immigrant physicians eventually made a mark on American academic medicine (Lyons and Petrucelli, 1978; Pedraza and Rumbaut, 1996; Shryock, 1974; Viner, 1998).

For example, the heavy infant and childhood death toll suffered by German immigrant children living in New York tenements spurred immigrant physicians Abraham Jacobi and Maximilian Herzog to establish the German Dispensary and the Department for the Diseases of Children in the 1850s, the first of its type in America. From there they conducted research, studied, published scientific articles, and trained practitioners who influenced not only the New York medical community but also established the scientific basis of pediatric pathology, physiology, and therapeutic practice. Physician Emil Noeggerath made significant scientific contributions to pathology, obstetrics, and gynecology while headquartered at the German Dispensary. Such efforts not only led to medical school faculty appointments at the New York Medical College but “served to build a reputation for the Germans in the wider American profession, and to encourage the introduction of German science to American audiences” (Viner, 1998, 453). Moreover, institutions such as Philadelphia’s German Hospital (founded 1860-1861) and New York City’s German (now Lenox Hill) Hospital (founded 1869) appealed to ethnic and language-centered identity. These phenomena, along with a strong and influential nineteenth century transatlantic biomedical and scientific exchange with Germany and Austria, led to a strong German influence on the health system and facilitated German acculturation and blending into the mass of white American health, medicine, and healthcare just as they blended into larger white America (Lyons and Petrucelli, 1978; Pedraza and Rumbaut, 1996; Rosenberg, 1987; Shryock, 1974; Viner, 1998).

Irish Americans

Separate branches of the same nationality, Irish Catholic and Scotch-Irish Americans total about 11 percent of the population. They represent the second (39 million) and twelfth (6 million) largest ancestral groups, respectively. The earlier Protestant Irish groups had settled disproportionately in the South and frontier areas, and acculturated and blended into white America by the nineteenth century while until recently, the much more numerous Catholic faction suffered significant amounts of racial stereotyping, discrimination, and religious bigotry. "Targets of nativist hatred toward them as outsiders, or foreigners, they sought to become insiders, or Americans, by claiming their membership as whites. A powerful way to transform their own identity from 'Irish' to 'American' was to attack blacks. Thus, blacks as the 'other' served to facilitate the assimilation of Irish foreigners" (Takaki, 1993, 151). Moreover, the Catholic group made significant contributions defining urban, ethnic politics, and forcing religious tolerance through their allegiance to the Roman Catholic church (Feagin and Feagin, 1999; O'Connor, 1995; Pedraza and Rumbaut, 1996; U.S. Census Bureau, 2001a).

Their early health experience was a stormy immigrant one. As Paul Starr observed, ". . . the Massachusetts General Hospital initially refused to admit Irish patients on the grounds that their presence would deter other people from entering the hospital" (Starr, 1982, 173). Such discrimination struck fear in ethnic and religious minority members already disadvantaged in the health system by their immigrant, cultural and SES circumstance. "Discrimination was a principal reason for the formation of separate religious and ethnic hospitals" (Starr, 1982, 173). As signs of ethnic progress, New York's Catholics founded St. Vincent's Hospital in 1849 and St. Francis Hospital in 1865. "By 1885, the Catholic community had opened 154 hospitals throughout the United States, more than had existed in the United States *in toto* in the late 1860s" (Rosenberg, 1987, 111). This not only assuaged Catholic religious concerns (e.g., being assured last rites), but also offered professional training and staff opportunities for Irish and other Catholic health professionals who would otherwise have been passed over. Recent indicators are that Irish Americans now rank at or above the national average for all whites on the educational, occupational distribution, and income levels (Feagin and Feagin, 1999; O'Connor, 1995; Pedraza and Rumbaut, 1996; Rosenberg, 1987; Starr, 1982; U.S. Census Bureau, 2001a).

Italian Americans

Making up 6 percent of the U.S. population and the fifth largest ancestry group, Italian Americans have been less rapidly assimilated and

slower to yield their distinctive ethnic identity. Having endured poverty, difficult working conditions, anti-Catholic prejudice, and intense nativist attacks along with the poor health status and outcomes associated with those conditions, Italian Americans finally shrugged off the “inferior race” imagery and have made rapid progress up the political, social, and economic ladder, especially after World War II. Italian Americans are now one of the major groups in the American tapestry of blending and ethnic pluralism (Feagin and Feagin, 1999; Pedraza and Rumbaut, 1996; Rosenberg, 1974; U.S. Census Bureau, 2001a).

Jewish Americans

Jews could be regarded as the most widely persecuted ethnic group in world history. They now constitute some 6 million persons or 2.5 percent of the population. Present in the Atlantic Coast colonies since at least 1654, Jewish Americans face and have endured the most severe and persistent levels of discrimination and anti-Semitism of all “White American” ethnic groups. Establishing unique niches in U.S. society, they have utilized educational and cultural means to become an economically prosperous group. Healthcare and the medical profession have been major vehicles for Jewish advancement, despite being early victims of hospital discrimination. “Jews feared they would have to eat non-kosher food and face ridicule for their appearance and rituals” (Starr, 1982, 173). Despite this and their hard-scrabble immigrant experience within the health system, the name change of “Jews Hospital” in New York City to Mt. Sinai was to signify that it served the community at large. Participation in the health system at the institutional and professional levels offered immigrant Jews another stepping stone into mainstream America. Through their struggles against nativist stereotyping and discrimination, they have also led the way in creating an environment of religious tolerance and diversity in America, while simultaneously spreading values of justice, tolerance, and fairness throughout the culture (Feagin and Feagin, 1999; Pedraza and Rumbaut, 1996; Rosenberg, 1974; Starr, 1982; Steinberg, 1989; Viner, 1998).

Polish Americans

Polish Americans as an ancestral group make up approximately 4 percent of the U.S. population. Other than being of Eastern European origin and being subjected to a more intense nativist reaction in the early-twentieth century than some other “White American” ethnic groups, their racial and ethnic experience could be viewed as typical. Even the more privileged Northern European immigrant groups, including the French,

Dutch, Scottish, Swedish, and Norwegians sometimes experienced acculturation trauma and discrimination barriers to their entry into American society and the health system. In the 1960s, President John F. Kennedy appointed the first Polish American cabinet officer. "By the third generation, Polish Americans were entering universities in large numbers and joining the professional middle class" (Pedraza and Rumbaut, 1996, 204). Their health system experiences were similar to other immigrants modulated by what regions of the country they settled in, their religious affiliation, whether they were urban or rural, and if they migrated to the suburbs after World War II (Feagin and Feagin, 1999; Pedraza and Rumbaut, 1996; Starr, 1982; Steinberg, 1989; Stevens, 1999).

Racial and Ethnic Health and Healthcare Disparities and Their Documentation in the United States

The black experience of poor health status, poor health outcomes, and limited access to the worst health services for the 366 years before 1985—well-known to African Americans, a small group of government officials, and a tiny cadre of academics—was not appreciated by the general public until relatively recently. Shock waves were generated throughout the health system by the release of then Secretary of Health and Human Services Margaret Heckler's 1985-1986 report on minority health and its acknowledgment that "*there was a continuing disparity in the burden of death and illness experienced by blacks and other minority Americans as compared with our nation's population as a whole [Heckler's emphasis]*" (U.S. Department of Health and Human Services, 1985b). The response was characteristic of the high unawareness levels regarding disparate health and healthcare for the nation's racial and ethnic minorities. The broadened focus on *all* of the nation's racial and ethnic minority groups marked a new era in racial and ethnic health and healthcare in the United States. The *Report of the Secretary's Task Force on Black and Minority Health* (also known as the Malone-Heckler report) noted the health disparity had existed "ever since accurate federal record keeping began" and that it "was the first time . . . a common effort [has been attempted] to carry out a comprehensive and coordinated study to investigate the longstanding disparity in the health status of blacks, Hispanics, Asian/Pacific Islanders, and Native Americans compared to the non-minority population" (U.S. Department of Health and Human Services, 1985b, ix, 2). Despite the Malone-Heckler Report findings that "Although tremendous strides have been made in improving the health and longevity of the American people, statistical trends show a persistent, distressing disparity in key health indicators among certain subgroups in the population" (U.S. Department of Health and Human Services, 1985b, 2), and "[t]hese disparities in health status

persist . . . 15 years later" (U.S. Commission on Civil Rights, 1999a, 16). *As well, major impediments to understanding and eliminating racial and ethnic health and healthcare disparities have been in areas related to inadequate data collection and analysis* (Byrd and Clayton, 2000, 2001b, 2002; Clayton and Byrd, 2001; Collins, Hall, and Neuhaus, 1999; U.S. Commission on Civil Rights, 1999a; U.S. Department of Health and Human Services, 1985a).

Before 1985 requisite record keeping on black and minority health and healthcare was totally inadequate to the task of correcting the history-based disparities and sharing the beneficence of the health system and medical progress equitably across America's increasingly diverse racial and ethnic population. Even though some health data on African Americans had been collected over time, it is only recently that specific efforts are underway to collect adequate health data for Native Americans, Hispanics, and Asian Pacific Island Americans. However, shortfalls in these areas remain (U.S. Commission on Civil Rights, 1999a; U.S. Department of Health and Human Services, 1985b). Characteristic of the difficulties inherent in racial and ethnic data collection that reflected the health status and outcomes of various population groups, "The first survey and tabulation of deaths by disease and race was taken by the U.S. Census Bureau in 1850" (Byrd and Clayton, 2000, 284). Moreover, before the implementation of a nationalized system for registering deaths in 1933, when all states registered as least 90 percent of their deaths and, thus, were qualified for inclusion in the Death Registration Area (DRA)* system, it was difficult to describe mortality trends for any U.S. group before 1940 (Byrd and Clayton, 2002; U.S. Commission on Civil Rights, 1999a; U.S. Department of Health and Human Services, 1985b).

Some of the earliest records documenting racial and ethnic health disparities germane to the North American colonies and, later, the United States were embedded in slave trade data, race-based census data, *Annual Reports* from the Commissioner of Indian Affairs, insurance company data, and isolated instances of record keeping of racially comparative mortality rates and infant death rates. As well, records of epidemic diseases were kept by the mercantile slave traders, plantations, government agencies, insurance companies, cities and towns, and some states. A representative survey of available data sources from major historical periods are con-

* Death Registration Areas is a geographic area for which mortality data are published. SOURCE: Last JA, ed. *A Dictionary of Epidemiology*. Second Edition. New York: Oxford University Press, 1988, 35.

tained in Byrd and Clayton's database at the Harvard School of Public Health and their book, *An American Health Dilemma*.*

Virtually all of the data suggest that from the United States' beginnings, even before the Revolutionary War, black, poor, Native American, and immigrant populations suffered the worst health status, outcomes, and healthcare. This reflected an evolving health system rigidly structured on the basis of race, ethnicity, class, gender, moralistic judgements, and indentured servitude-racial slavery. As the modern U.S. health system evolved during the twentieth century, it has made impressive medical and scientific progress. Despite changes in politics, health policy and administration; reforms in health professions education and research; restructuring of old along with the addition of new delivery systems; and major healthcare and health system financing changes, the U.S. healthcare system has had great difficulty shedding its racial-, ethnic-, class-, and gender-based tiering, hierarchies, and almost reflexively discriminatory medical-social culture (Byrd and Clayton, 2000, 2002; Farley, 1970; Farley and Allen, 1989; Garrett, 2000; Morais, 1967; Smith, 1999; Stuart, 1987; U.S. Commission on Civil Rights, 1999a).

* They include the African continental and Atlantic slave trade period (Curtin, 1969; Davidson, 1961; Kiple and King, 1981; Klein, 1978; Lewis, 1942; Ransford, 1983; Savitt, 1978; Sheridan, 1985), the North American colonial era (Blanton, 1930, 1931; Klein, 1978; Savitt, 1978, 1985; Sheridan, 1985), the Republican era (Boles, 1984; David et al., 1976; Ewbank, 1987; Fogel, 1989; Owens, 1976; Reuter, 1970; Steckel, 1979), the Jacksonian and Antebellum periods (Curry, 1981; Ewbank, 1987; Farley and Allen, 1989; Lewis, 1942; Savitt, 1978, 1985), the Civil War era (Barbeau and Henri, 1974; Bremner, 1980; Cobb, 1952; Mohr, 1986; Shryock, 1966), the Reconstruction era (Blassingame, 1973; Farley and Allen, 1989; Morais, 1967; White, 1970), the Gilded Age and Progressive eras (Du Bois, 1967; Manning, 1983; Rabinowitz, 1978; Stuart, 1987; Summerville, 1983), the Early 20th century from 1901-1929 (Du Bois, 1896, 1906; Ewbank, 1987; Farley, 1970; Farley and Allen, 1989; Stuart, 1987), the Great Depression and World War II eras from 1930-1945 (Ewbank, 1987; Farley and Allen, 1989; Hart, 1991; Lewis, 1942; Morais, 1967; Myrdal, 1944; Reuter, 1970; Stuart, 1987), the post-war and Civil Rights eras from 1945-1965 (Beardsley, 1987; Ewbank, 1987; Farley, 1970; Farley and Allen, 1989; Jaynes and Williams, 1989; Morais, 1967; Pettigrew, 1964; Rosenbaum, Layton, and Liu, 1991; Smith, 1999; Stuart, 1987; U.S. Bureau of the Census, 1975), the Civil Rights era in healthcare from 1965-1980 (American Cancer Society, 1988; Baquet et al., 1986; Clayton and Byrd, 1993a; Davis and Schoen, 1978; Davis et al., 1989; Haynes, 1975; Henschke et al., 1973; Leffall Jr., 1974, 1979; National Center for Health Statistics, 1991, 1992; René, 1987; Stuart, 1987; U.S. Department of Health and Human Services, 1985b, 1986), and the era of the Black Health Crisis of the 1980s and 1990s (American Cancer Society, 1997, 1998; Braithwaite and Taylor, 1992; Clayton and Byrd, 1993a, 2001; Collins, Hall, and Neuhaus, 1999; Jaynes and Williams, 1989; Livingston, 1994; National Center for Health Statistics, 1992a, 1992b, 1996, 1997, 1998a, 1998b, 2000; René, 1987; Singh and Yu, 1995; U.S. Department of Health and Human Services, 1985a, 1986, 1986a).

CHANGING CONCEPTS OF RACE AND ETHNICITY

On Racial Groups and Hierarchies

In contrast to *ethnicity*, race is a concept with roots stretching back to antiquity. The Feagins' (1999, 6) observation that, "This singling out of people within the human species in terms of a biologized 'race' hierarchy is a distinctively European and Euro-American idea," highlights the Western origins of today's pervasive racial *worldview*. The origins of the word "race" are disputed and may be derived from Arabic, Latin, Spanish, or German sources, and predate the sixteenth and seventeenth century beginnings of modern Western science. Initial English use of the word may have been in a 1508 poem by William Dunbar in which he referred to "bakbyttaris of sindry racis" (backbiters of sundry races) (Banton and Harwood, 1975, 13). The word "race" appeared in the formal English literature in 1580 according to *Webster's Dictionary* and other sources. The *Webster's Dictionary* definitions of race are so broad and variegated that they seem somewhat nebulous. *Webster's* first definition of race is "a breeding stock of animals," alluding to current biological definitions. It also defines race as "a family, tribe, people, or nation belonging to the same stock," and further describes race as "a class or kind of people unified by community of interests." Moreover, the destructive potential embodied in race—the Western cultural concept strongly grounded in human inequality with its bias producing capabilities that Jordan began documenting several decades ago (Jordan, 1968)—began to surface long before its sixteenth-century English language usage. Therefore, race serves as a biological term, a descriptive term for people sharing certain physical characteristics, and a culturally determined hierarchical human ranking system embodied in the Western *worldview* (Banton and Harwood, 1975; Byrd and Clayton, 2000; Smedley, 1999).

As recently as the early part of the twentieth century, laymen and some scientists used the word "race" to describe human groups that shared particular cultural characteristics such as religion or language (e.g., the "Jewish race" or the "French race"). Earlier, "[p]hysical anthropologists have called races the various sub-species of *Homo sapiens* characterized by certain phenotypical and genotypical traits (e.g., the 'Mongoloid race' or the 'Negroid race')" (Van den Berghe, 1967, 9). Some modern zoologists refer to subspecies or varieties as synonymous with a race—a partially isolated breeding population with some differences in gene frequencies from other related populations. Recent conceptualizations of race have reinforced movement away from the biological to the sociological sphere. Audrey Smedley noted "of fifty-eight introductory textbooks in physical anthropology published between 1932 and 1979 there has been a

progressive elimination of the term and concept of race from textbooks...in the United States . . . when either the term was no longer mentioned in the texts or the authors argued that races do not exist or are not ‘real’” (Smedley, 1999, 2). Such a paradigm shift has undermined the scientific standing of race as a purely biological or physical concept. Van den Berghe offers a precise and simple sociological definition of race referring “to a group that is *socially* defined but on the basis of *physical* criteria” (Van den Berghe, 1967, 9). Since there are virtually no biologically significant or inherent differences within the species *Homo sapiens*, understanding what happens to people after the social selection process takes place is paramount to understanding what’s important about race (Byrd and Clayton, 2000, 2001b, 2002; Smedley, 1999; Mayr, 1982; Van den Berghe, 1967).

Ancient founders of medicine and science’s precursors began a hierarchical, discriminatory, and bias-producing cycle as they started using race and ethnicity as means of classifying mankind. Driven since ancient times by folk beliefs, religious teachings, and social customs based on differences in physical appearances of various geographic populations, race became the subject of formal theoretical speculation and scientific investigation by the eighteenth century (Byrd and Clayton, 2000; Levi-Strauss, 1951; Smedley, 1999). *As an extension of Western culture’s intellectual preoccupation with human inequality, race became a focus of empiric and scientific inquiry for the next three centuries, codifying a color-coded, racial hierarchy of man—white, yellow, red, and black in descending order—in the process* (Banton, 1986; Byrd and Clayton, 2000; Smedley, 1999). By the middle third of the twentieth century, traditional biology- and anthropology-based ideas of race and “races of man” that had become dominant during the nineteenth-century rise of science began breaking down. This occurred as more objective anthropologic, genetic, paleontologic, archeologic, linguistic, biogeographic, and DNA and other molecular biologic studies proved: 1) the unity of the human species, 2) the common African origins of all racial groups, and 3) the biologic insignificance of the old parameters of racial classification such as skin and eye color, hair texture, physical features, and skull size and shape (Banton, 1986; Banton and Harwood, 1975; Cavalli-Sforza, Menozzi and Piazza, 1994; Cavalli-Sforza, 2000; Smedley, 1999). *Yielding to a deluge of scientific evidence, race has come to be more objectively considered a sociocultural concept wherein groups of people sharing certain physical characteristics are treated differently—often on the basis of stereotypical thinking, discriminatory institutions and social structures, a shared worldview and social myths* (Byrd and Clayton, 2000, 2001b; Diamond, 1999; Feagin, 2000; Feagin and Feagin, 1999; Smedley, 1999).

After briefly surveying the broad range of ideas about race, *racism*—the nefarious by-product that produces negative results and outcomes for the persecuted race—requires definition.

Racism is any set of beliefs that organic, genetically transmitted differences (whether real or imagined) between human groups are intrinsically associated with the presence or the absence of certain socially relevant abilities or characteristics, hence that such differences are a legitimate basis of invidious distinctions between groups socially defined as races (Van den Berghe, 1967, 11).

Race and racism are closely related and interdependent. As Van den Berghe points out:

The existence of races in a given society presupposes the presence of racism, for without racism physical characteristics are devoid of social significance. It is not the presence of objective physical differences between groups that creates races, but the social recognition of such differences as socially significant or relevant (Van den Berghe, 1967, 11).

Racism translates into *actions* that are both overt and covert.

It takes two, closely related forms: individual whites acting against individual blacks, and acts by the total white community against the black community. We call these *individual racism* and *institutional racism*. The first consists of overt acts by individuals, which cause death, injury or the violent destruction of property . . . the second type . . . originates in the operation of established and respected forces in the society, and thus receives far less public condemnation than the first type (Carmichael and Hamilton, 1967:4).

We must now turn our attention to understanding how racism—which usually has strong class overtones—works (the mechanisms) and creates its outcomes (through mediators) in health and the health system. This approach should also be useful in understanding the impact on health and healthcare of other bias-producing mechanisms such as ethnicity, culture, class, gender, disability, sexual preference, and age. We now know that:

1. The racial experience has been, and remains, the most intense in discriminatory levels and differential outcomes, especially with regard to health and healthcare;
2. As it is one of the oldest bias-producing concepts that simultaneously produced high interest levels, more is known about race and racism;
3. As critical theory, psychology, and the sociologic study of racism have revealed, it is an excellent surrogate and is often a fellow traveler with most other major types of bias, prejudice, and discrimination;
4. Race and racism embody virtually all of the moral, egalitarian,

medical ethical, and American creed issues that burden our society and health system as we enter the twenty-first century;

5. Understanding the basic human psychological mechanisms, regardless of who the perpetrators or victims may be, that produce racism, bias, stereotyping, discrimination, and group hatreds that might affect clinical decision-making is critical to crafting strategies and interventions for solving the problems; and

6. Finally, if the racial bias and discriminatory aspects of the U.S. health system are solved, America will have gone a long way toward achieving justice and equity in health and healthcare for all its citizens (Byrd and Clayton, 2000, 2002).

America's racial health problem should be at the leading edge of all our efforts to ameliorate racial and ethnic health disparities through cultural competence, multicultural medicine, anti-bias, and diversity training efforts. There are several archetypes we have found useful in understanding how race operates. These are genesis points of principles applicable to the health system and comprehending how some other types of bias operate (Byrd and Clayton, 2000; Smedley, 1999; Van den Berghe, 1967).

Racial Models as Tools for Analysis and Understanding

Van den Berghe summarized some of the differences between the old-fashioned form of racism associated with slavery—*paternalistic racism* and the more modern variety, *competitive racism*. In the former type, blacks were viewed as immature, irresponsible, improvident, fun loving, child-adults—inferior, but lovable as long as they did not deviate from clearly defined roles. This paternalistic racism allowed for extreme intimacy because it maintained social distance. The prejudiced white superior loved and was committed to the dependent black who was loyal and loved the master in return. Resistance or rebellion by the slave triggered extreme brutality. With the abolition of slavery, poor and working class whites, who were the majority (and demanded control), no longer accepted the slaveowner's paternalistic image of blacks as good children or pets. To them, blacks were seen as clannish, uppity, insolent, aggressive, dishonest competitors for scarce resources. Therefore, *competitive racism* became the dominant racist mechanism of modern U.S. society (Van den Berghe, 1967).

Robert W. Terry's investigations on racism have evolved over the past three decades. His most recent efforts have crystallized on the concepts of *societal* and *individual* racism. Bias also operates at these levels. Incorporating many of his original theories, Terry also focuses on social and institutional mediators of racism defined through power relationships. These

mediators include: 1) *Power*, the unfair distribution or disproportionate capacity by the dominant white/Anglo group to make and enforce decisions; 2) differentially controlling *Resources* such as money, education, information, and political influence by the dominant racial group; 3) establishing societal *Standards* according to dominant white/Anglo definitions, automatically marginalizing other group norms; and 4) incorrectly defining *Problems* by the dominant white/Anglo group such that perceptions and solutions are distorted, inappropriate, manipulable, and dysfunctional. These four points are major contributors to what Feagin and others describe as “white privilege.” Terry’s work could also be viewed as the groundwork suggesting the application of some of these principles and concepts to public health as embodied in the work of Camara Phyllis Jones. Presenting a theory based on three levels of racism—*institutionalized racism*, *personally mediated racism*, and *internalized racism*—as explanatory and analytic tools for understanding race-associated differences in health outcomes, Jones posits a new paradigm that can be used for crafting interventions to mitigate the impacts of racism on health and health-care, and expand the national conversation on racism (Jones, 2000). In the health arena, all of these principles can be applied in both historical and contemporary configurations, and also lend themselves to understanding the European American dominance of the health system (Feagin, 2000; Feagin and Feagin, 1999; Feagin and Vera, 1995; Jones, 2000; Terry, 1992).

Psychiatrist Joel Kovel devised a psychological archetype of racism focusing on European Americans as the source of the race problem. His *dominative racism* was based on direct physical oppression and sexual obsession, while his more modern *aversive racism* is characterized by avoidance of the dominant group (whites) based on isolation of the subordinate group (blacks). Grounded in complex and infantile psychological mechanisms, it explains the white flight to the suburbs and the creation of inner-city black ghettos with all the attendant problems of segregation, isolation, and inequality. The most subtle, modern, and malignant form of racism is Kovel’s *metaracism*. It pervasively represents pure racism because it is systematic and independent of individual factors representing the last stage of racism that remains when racial passions have been washed away. *Metaracism* is “. . . the racism of technocracy, i.e., one without psychological mediation as such, in which racist oppression is carried out directly through economic and technocratic means” (Kovel, 1984, *xi*). It is the racism of differential taxation schemes wherein unequal, inner-city, public schools are produced; the racism wherein African Americans who have more kidney and heart disease than any other population subgroup receive fewer transplants and other highly desired invasive therapeutic procedures; discrimination and selection for education and jobs based on white culture-based “aptitude” and “achievement tests”; the racism of

police profiling wherein African Americans are automatically criminal suspects; the racism of “reverse discrimination” whereby white males are “protected” by Civil Rights laws that were designed to help blacks who were previously denied participation in American society; and the racism of computerized arrest record files for job screening in neighborhoods where most of the black adolescent males experience police encounters (whether convicted of crimes or not). Because it incorporates the most advanced forms of domination, mutates into multiple chameleon-like configurations (whatever forms are necessary to carry out its racist mission), and is the most detached from the older, hate-filled, odious forms of racism leading to discrimination and overt and covert violence, *metaracism* is the dominant mode of racism in postmodern, * late capitalist, U.S. society. Applying and building upon what has been learned in these areas to other aspects of bias and discrimination in the health system represents the future of cultural competence, cross cultural training, diversity, and multicultural medicine (Byrd and Clayton, 2000, 2002; Feagin and Spikes, 1994; Kovel, 1984; Kozol, 1991; Lemann, 1999; Massey and Denton, 1993; Meyer, 2000).

On Ethnic Groups

In contrast to *race* as a group designation, *ethnic group*—a group socially distinguished or set apart, by others or by itself, primarily on the basis of cultural or national-origin characteristics—is a much more recent concept and has been considered a more indefinite category (Feagin and Feagin, 1999; Thernstrom, Orlov, and Handlin, 1980). The preeminent paradigm in an attempt to subsume race since the end of World War II, deficiencies inherent in applying a model based on white ethnic history to non-white groups and its failures to explain or illuminate America’s lived racial realities have repeatedly undercut the concept’s utility (Feagin, 2000; Feagin and Feagin, 1999; Omi and Winant, 1994).

Aside from the difficulties in defining ethnicity, the term has been the focus of a long-standing academic controversy between scholars who choose to define the term narrowly and another group who want to use it broadly, subsuming previous racial, cultural, religious, national-origin, or linguistic categories (Feagin and Feagin, 1999; Sollers, 1989; Sowell, 1981; Steinberg, 1989, 1995; Van den Berghe, 1967). As Takaki noted “Race . . . has been a social construction that has historically set apart racial minorities from European immigrant groups. Contrary to the notions of

* Postmodern is a family resemblance term (often relating to art, architecture, or literature) that reacts against earlier modernist principles, as by reintroducing traditional or classical elements of style or by carrying modernist styles or practices to extremes.

scholars like Nathan Glazer and Thomas Sowell, race in America has not been the same as ethnicity" (1993, 10). Furthermore, many race relations authorities argue that such a strategy ignores the day-to-day realities of American bias, racism, and discrimination (Cose, 1993, 1997; Feagin, 2000; Feagin and Spikes, 1994; Feagin and Vera, 1995; Omi and Winant, 1994; Van Ausdale and Feagin, 2001; West, 1994); the country's racial history (Feagin, 2000); its systematic inequalities (Feagin, 2000; Feagin and Spikes, 1994; Feagin and Vera, 1995; Hacker, 1995; Steinberg, 1989, 1995); and the *ideological racism* encompassed in the worldview on race that is an integral part of Western and U.S. culture (Feagin, 2000; Feagin and Feagin, 1999; Feagin and Vera, 1995; Smedley, 1999). The stark differences in health status, services, and outcomes evidenced by African Americans, especially, and other racially identifiable non-white groups certainly seem to suggest the soundness of these principles. Whether the nation's racial and ethnic minorities are to be allowed adequate health status and outcome to fulfill their human capital and social potential—necessary prerequisites to be competitive in the twenty-first century—is the issue with which our system, ultimately, must grapple (Byrd and Clayton, 2000, 2002; Mayberry, Mili, and Ofili, 2000; U.S. Commission on Civil Rights, 1999a; Williams, 1999). Failure of our health system to successfully cope with increasing healthcare costs, increasing race- and ethnic-based health inequities and disparities, and increasing disability, cuts our nation's competitive edge, compromises overall quality-of-life, and poses a threat to the national good from a public health standpoint (Byrd and Clayton, 2000, 2002; Garrett, 2000; Haynes and Broder, 1996; Skocpol, 1997).

ORIGINS AND EVOLUTION OF INEQUITIES AND BIAS IN WESTERN AND U.S. HEALTHCARE AND HEALTH SYSTEMS

Introduction to a Historical Perspective on Inequities and Bias

Examining the origins, bases and evolution of health and healthcare inequities, inequalities, and biased thinking in Western *life sciences*, whether they are framed in racial, ethnic, class, gender, or cultural terms is a necessary foundation for understanding and eliminating racial and ethnic health disparities. For many readers, examining racial and ethnic bias and discrimination from the perspective of health professions, medical-sociology, and health systems requires a different mode of thinking—sociocultural, historical, *constructionist*, and *structural*, instead of *reductionist*, purely disease-oriented paradigms framed in public health, medical model, or quantitative terms. Such an exercise has certain drawbacks. For example, focusing on racial and ethnic biases, inequities, and inequalities may overlook the effects of other problems such as gender or class, which

are longstanding foci of bias, inequity, and inequality. In addition, only brief allusions to the broader historical or social contexts are possible; our examination will be limited to Western and, later, American medicine, health, and healthcare; and class dimensions will automatically creep in. With these caveats in mind, we will proceed.

Ancient Origins

The Classical period of Western scientific dominance beginning around 500 BC was pivotal, as the Greeks brought the gifts of objectivity, empiricism, and logic to the world and began separating the natural world from the religious one. However, along with their ethnocentrism and hierarchical cultural antecedents, their early efforts at taxonomy, which was a developmental stage of the scientific method, seemed to be preoccupied with human inequality (Byrd and Clayton, 2000; Drake, 1987, 1990; Finley, 1983; Goldberg, 1990). Greek philosophers—including Plato and Aristotle, often considered the fathers of modern science and medicine—began arbitrarily assigning slaves to lower categories within the human family, along with blacks and Asians (Harris, 1972, 13-28; Jordan, 1968, 11-12, 60; Wasserman, 1974, 13-20). For example, Plato's Great Chain of Being and Aristotle's modification, the Scala natura, which according to Lovejoy (1964) was "one of the half-dozen most potent and persistent pre-suppositions in Western thought," ranked everything:

Peasants at the bottom, then servants to the gentry, then various grades of nobility and the monarch at top. Racism is embedded in the Chain of Being; the idea was used to rank the various races into "higher" and "lower." Of course, the white Europeans who devised it were at the top (Milner, 1990, 201).

These biased and inequitable tendencies were exacerbated by traditions of fee-for-service medical practice and the incorporation of the Hippocratic Oath, along with what many medical ethicists consider its self-serving medical ethical tradition and weak social covenant. As Veatch points out regarding the Hippocratic tradition, "It is consequentialistic; it is paternalistic; it is individualistic . . . [and] It permits physicians with bizarre and confused notions of benefit and harm to wreak havoc on unsuspecting patients" (1981, 147, 150). Further, "The Hippocratic tradition . . . does not have in its history even a token of a principle of justice or equality that could prick the conscience of the physician" (Veatch, 1981, 65). Its leanings toward individualistic contracts between independent agents; its vows to hide "trade secrets," even incompetence; and its pledges to channel the educational process to advantage each others' children have been downplayed as factors normalizing the "walling off" of the poor and dis-

advantaged from medical care and “normalizing” the medical profession as a socially distant upper-class activity (Byrd and Clayton, 2000; Goldberg, 1990; Veatch, 1981).

By the third century BC in Alexandria, the overutilization of the poor, defenseless, and disenfranchised for medical experimentation and demonstration purposes was established as “Herophilos and Erasistratos...laid open men whilst alive—criminals received out of prison from the kings—and whilst these were still breathing, observed parts which beforehand nature had concealed” (Majno, 1975, 354). Moreover, Galen—an academic physician-scientist and medical demigod who dominated Western medicine from AD 200 to AD 1700 (or 45 generations)—inserted his overtly racist and biased views into the formal medical corpus “documenting” black inferiority at physiologic, clinical, and intellectual levels (Davis, 1984; Devisse, 1979; Drake, 1987, 1990; Lewis, 1990). Bias, inequities, and inequalities were, thus, operationalized in the Greco-Roman world not only at the social but at ideological, so-called scientific, and health delivery levels as slaves, non-whites, the disadvantaged, and non-citizens received lesser, often very different, health services (Byrd and Clayton, 2000; Drake, 1987, 1990; Finley, 1983; Porter, 1999).

Prior to the Greek experience, the precursor civilizations of Western science and medicine were clustered around Mesopotamia and Egypt, starting around 4000 BC. Though these *archaic medical systems* were plagued with serious social, process, and structural biases and inequities based on slavery and class, there seemed to be little concern with race. Moreover, the Egyptian health system embraced some communitarian, public health, and egalitarian principals that were much ahead of their time (Byrd and Clayton, 2000; Lyons and Petrucelli, 1978; Porter, 1999; Thorwald, 1962).

The Middle Ages

After the sixth-century collapse of the Roman Empire, Christian monks and Arab scholars recorded and perpetuated Western medical and health-care traditions throughout the Middle Ages. As clerical suzerainty over medicine and health from AD 500 to AD 1130 waned, Arab Moslem culture became dominant between the eighth and twelfth centuries. Fueled by the wars of the reconquest on the Iberian peninsula between the white Christians and African Moors, increases in anti-black prejudices and biases and the exclusive relegation to slave status for people of color in Moslem and Christian societies resulted. Racial, class, and ethnic bias contained in the preserved Platonic-Aristotelian, Hippocratic, Galenic medical corpus combined with the inequities contained in patriarchal slave-based Moslem societies to promote a growing deprecatory view and treatment of blacks in both Moslem and European cultures and to undergird the receipt of less

and lower quality healthcare for slaves and nonwhite people (Byrd and Clayton, 2000; Finley, 1983; Lewis, 1990; Sanders, 1978).

The Renaissance

The Galenic-Greek-Arabic medical corpus and traditions remained dominant in the West during the Renaissance. Some influential physician-scientists such as Paracelsus hypothesized that blacks were inferior to whites (Stannard, 1992, 209). Royal, clerical, and aristocratic patronage for health-related enterprises such as medical schools and hospitals influenced the medical profession's acceptance as a prestigious pedagogy and profession in European Medieval universities, but the mantle of elitism distanced the profession socially from the populations they served. Moreover, the health system itself remained inequitable and strongly structured along class lines (Bullough, 1966; Sirasi, 1990; Wear, 1992). As the Mediterranean and Atlantic slave trades during the fourteenth and sixteenth centuries ended a drought of European and African contact, iconographic and documentary evidence suggests rising levels of bias, prejudice, and discrimination against blacks in Europe (Devisse, 1979; Devisse and Mollat, 1979; Pieterse, 1992). More destructive were the residual biases, practices, and hatreds generated by the Moslem-African versus Christian-European wars in Spain, a nascent Atlantic slave trade, and the travelers' tales (which at the time had a veneer of science) depicting African and other nonwhite people as inferior to Europeans. These developments set the standards for the inequitable and unequal hierarchical health arrangements, political ideology, and later scientific justifications for the slave trade and overseas conquests and domination during the Age of Discovery (Byrd and Clayton, 2000; Davidson, 1961, 1984; Jordan, 1968; Klein, 1978; Lewin, 1988; Sanders, 1978; Stannard, 1992).

The Age of Science and Enlightenment

Inequities already established in health and healthcare in Western Europe and America continued and increased during the Age of Science and Enlightenment—the period between 1600 and 1800. Huge gaps existed in access to and the quality of healthcare delivered to the peasant masses and European aristocracy, and many aspects of these systems were exported worldwide to the colonies (Ackerknecht, 1982; Lyons and Petrucelli, 1978; Numbers, 1987; Rosen, 1993; Wear, 1992). French physician Francois Bernier wrote the first scientific article on racial classification in the Paris *Journal des Scavans* in 1684, and Carl Linnaeus, a Swedish physician-scientist and the "Father of Biological Classification," published *Systema Naturae*, a seminal work establishing binomial nomenclature as the standard in biological clas-

sification, which appeared in several editions after 1735. Both used skin color as major classification criteria and both marginalized blacks, the former as a different species (Davis, 1966, 454; Marshall and Williams, 1982, 242-243) and the latter adding degrading psychological and behavioral characteristics (Byrd and Clayton, 2000, 94-95, 214; Jordan, 1968, 218-222; Marshall and Williams, 1982, 245). Other dominant physicians and natural scientists of the era such as George-Louis Leclerc Buffon, Johann Fredreich Blumenbach, Petrus Camper, and Georges Cuvier all added to the bias-producing myth of white male superiority and non-white inferiority in their teachings, scientific discourse, and published works. The growing influence of science manifested in that much of this hierarchical material was utilized to justify social inequities and inequalities such as slavery, colonization and exploitation, and social segregation and stratification (Boorstin, 1989; Byrd and Clayton, 2000; Gossett, 1965; Gould, 1981; Haller, 1971; Haller and Haller, 1977; Jordon, 1968).

Enterprises contributing substantially to biases, inequities, and inequalities in health and healthcare during the period from 1600 to 1800 were the Atlantic slave trade and the worldwide establishment of European colonies (Byrd and Clayton, 2000; Kiple and King, 1981; Savitt, 1978; Sheridan, 1985). The Atlantic slave trade and New World slavery were not only dominant world events, they were also deficit-producing situations healthwise for the expropriated Africans and the Native Americans forced into slavery. Both situations produced new epidemiologic exposures, crowd diseases, marginal nutrition, poor sanitation, disciplinary brutality, and high mortality rates. More important may have been the deleterious effects these events had on the health system *subculture* (Byrd and Clayton, 2000; Kiple and King, 1981; Savitt, 1978; Sheridan, 1985; Stannard, 1992; Watts, 1997). In the North American English colonies, the aforementioned slave health deficit was perpetuated, a slave health subsystem was institutionalized, and black slaves joined the poor and disenfranchised by being overutilized for surgical, medical demonstration, and dissection purposes. Meanwhile, the health system and the delivery of health services were founded and structured on the basis of race, class, and puritan-oriented moral judgments—inherently biased and inequitable ideological, structural, and process arrangements. In English North America, oversight of the health and healthcare enterprise was under the stewardship of a tiny cadre of elite, often European-trained, physicians and boards of elite and wealthy Christian philanthropists (Blakely and Harrington, 1997; Byrd and Clayton, 1991, 1992, 2000; Dowling, 1982; Kiple and King, 1981; Rosenberg, 1987; Savitt, 1978; Schultz, 1992; Sheridan, 1985).

The Colonial, Republican, Jacksonian, and Antebellum Periods

In the rapidly evolving medical and scientific communities during the American Colonial, Republican, Jacksonian, and Antebellum periods between 1619 and 1861, *scientific racism* burgeoned. As Reed pointed out, before the twentieth century “Scientific racism was not ‘pseudoscience’ but an integral part of the intellectual world-view that nurtured the rise of modern biology and anthropology” (1989, 1358). During the early nineteenth century the scientific study of race not only became more hierarchical with blacks, other non-whites, and women being relegated to the lower echelons of humanity, it continued to be dominated by European males. Influential studies by prominent academic European physicians such as Charles White (*Account of the Regular Gradation in Man*, 1799), James Cowles Prichard (*Researches into the Physical History of Man*, 1813-1847), Charles Hamilton Smith (*The Natural History of the Human Species*, 1848), and Robert Knox (*The Races of Men*, 1850 and 1862) (Banton, 1986; Byrd and Clayton, 2000) supplemented those by the three most dominant natural scientists of the nineteenth century, Georges Cuvier, Charles Darwin, and Sir Charles Lyell, all of whom held blacks in low esteem (Gould, 1981, 35-36). However, between the 1830s and the Civil War, the “American school” of anthropology emerged, which was the first seriously considered American scientific movement. Building upon the work of Louis Agassiz, a physician and chief biologist at Harvard, and Samuel George Morton (*Crania Americana*, 1839, *Crania Aegyptiaca*, 1844), a prominent University of Pennsylvania academic physician, the first extensive body of quantitative data in support of “polygenism”—the theory that human races were separate biological species and descendants of different Adams—took the scientific lead in the reification of race and its relationship to racial hierarchies and biological determinism. Americans dominated the field until they were supplanted by Darwin’s theory of evolution after 1859 (Byrd and Clayton, 2000, 2001b; Gould, 1981; Haller, 1971; Reed, 1989; Stanton, 1960).

The Civil War

With the exception of the material circumstances of Southerners and their slaves, whose health status and outcomes were adversely affected by major shortages in providers and medical resources, there were no discernable changes in the hierarchical and layered delivery of healthcare for non-military populations on the basis of race, gender, moral judgments, and class during the Civil War. Black Union Army soldiers received inferior healthcare at all levels, from the Medical Bureau in Washington, to the field hospitals and combat units, individual professional

providers, to the field soldiers on the battlefields. In lieu of the generalized improvements in medicine, public health, and health services as a result of the Civil War, higher African-American mortality rates and poorer health outcomes reflected another set of realities—black social and economic collapse; health segregation, discrimination, and exploitation at all levels throughout the Civil War, Reconstruction, Gilded Age, and Progressive eras; collapse of the slave health subsystem; and refusal by the mainstream health system to incorporate Freedmen (Barbeau and Henri, 1974; Byrd and Clayton, 2000; Cobb, 1952; Cornish, 1966; Duffy, 1990; Rabinowitz, 1978). Meanwhile all African Americans, whether slave, free, or contraband, suffered health crises related to the war and abetted by collapse of the slave health subsystem. Disappearance of the bedrock of traditional slave providers and slavery's institutional justifications for the delivery of some healthcare, along with continued anomic and discriminatory wartime acts and policies toward the few trained black physicians, exacerbated an already critical situation (Byrd and Clayton, 2000; Cobb, 1952a, 1952b, 1981; Duffy, 1990; Mohr, 1986; Morais, 1967; Shryock, 1966). Black Civil War soldiers were utilized as subjects of the United States Sanitary Commission Anthropometric Study—the largest “scientific” comparison of the races ever undertaken—an enterprise undertaken to “document” black inferiority and white superiority for the next half-century (Byrd and Clayton, 2000; Haller, 1971).

The Reconstruction, Gilded Age, and “Progressive” Eras

The Reconstruction period threatened the disappearance of the entire black population due to social conditions exacerbated by health or health-related causes. Epidemics, homelessness, breakdowns in housing and sanitation, and abandonment of the Freedmen by the mainstream health system were all factors. Emergency measures and Freedmen's Bureau legislation led to a “First Reconstruction in black health,” which led to the opening of African-American-accessible hospitals, clinics, and medical schools. This reversed some of the results of bias and inequities in the health system and may have saved the black population from extinction (Byrd and Clayton, 2000; Morais, 1967). Throughout the nineteenth century, physicians, politicians, and other opinion leaders utilized biased analyses of the Ninth, Tenth, and Eleventh censuses of 1870, 1880, and 1890, corroborated by insurance company data produced by companies such as Prudential—to confidently predict such an outcome (Byrd and Clayton, 2000, 411; Numbers, 1978, 16-19; Tucker, 1994, 33). Perhaps the most important countervailing force was the establishment of entrepreneurial precedents that established separate, albeit limited in some respects, black health, health delivery, and health professions training

traditions and institutions (Byrd and Clayton, 1992, 2000; Cobb, 1981; Morais, 1967). The nadir of black health during and immediately after the end of Reconstruction in 1877 was related to social chaos and dislocation affecting the Freedmen, barriers to black entry into the mainstream health system, the termination of most of the Freedmen's Bureau health activities by 1872, the lack of health facilities and personnel willing to serve African Americans, all of which were exacerbated by rampant scientific racism sweeping over the society and the health system. The growth of a "Negro medical ghetto"—a group of black health professionals and institutions serving the black community—and the acceptance of separate but unequal health, healthcare, and tiers of the health system based on race and class as the norm characterized the Gilded Age and Progressive eras of the U.S. health system. Persistent bias and inequities in the health system were also caused by the split of the medical profession into white (the American Medical Association) and black (the National Medical Association) factions, the former becoming a monolithic supporter of social conservatism and the status quo while the latter crusaded for health justice and equity and established the tradition of promoting egalitarian approaches to health and healthcare (Byrd and Clayton, 1992, 2000, 2002; Cobb, 1981; Duffy, 1990; Morais, 1967; Tucker, 1994).

The Early 20th Century

Early nineteenth-century scientific racist movements such as anthropometry, phrenology, and craniometry were displaced by movements such as social Darwinism, eugenics, and psychometric testing later in the century. Both the medical and scientific establishments provided elaborate classifications for and predicted the imminent extinction of inferior "races" such as blacks, criminals, Jews, the Irish, the poor, and the insane. Much of the research and deprecation, especially with the rise of IQ testing, was directed at newly arrived white (e.g., Irish, Eastern European Jews) and non-white (e.g., Chinese, Mexicans, and Japanese) immigrant groups. Good breeding and sterilization of the "unfit" were posited as solutions to all social and many medical problems. Thus, medical and scientific developments continued to provide an underpinning for ongoing biases, inequities, and inequalities in health and healthcare as they related to race, ethnicity, gender, class, social status, and moral criteria (Byrd and Clayton, 2000, 2002; Chase, 1980; Haller, 1963; Kevles, 1985; McClintock, 1995; Reilly, 1991; Tucker, 1994; Weisbord, 1975).

As the United States emerged as a world power in the early twentieth century, the U.S. health system remained locked in patterns of bias, inequity, and inequality. Seemingly unable to shed its racial, class, gender, and moralistic shibboleths, the Progressive era worsened many racial,

class, and ethnic biases, prejudices, and inequities in the health system, often shifting issues such as poverty, insanity, imbecility, and congenital malformations, in attempts to divorce them from areas of social concern, into the domain of healthcare under the aegis of so-called scientific dispensation. So-called scientific data such as family trees and IQ tests were used to justify sterilization, incarceration, and immigration restriction. Biometric testing, which had classified most of the U.S. World War I soldiers as mentally limited or deficient, reached its zenith during the 1920s and was later adapted for educational selection and tracking. Between the late-nineteenth and the first quarter of the twentieth century, educational reform swept through the health professions training and research infrastructure. Medical schools and medical research laboratories became the darlings of the elite foundation and corporate benefactors, with black institutions relegated to a caste status remaining on the margins (Allen, 1995; Brown, 1979; Byrd and Clayton, 2000, 2002; Chase, 1980; Epps, 1989; Guthrie, 1998; Hunt, 1993; Jonas, 1989; Lemann, 1999; Summerville, 1983).

The health system at all levels remained racially segregated and highly discriminatory along race, class, ethnic, and gender lines. This reflected a continuum of nationally adopted health traditions and policies extant since the Colonial era, and a burgeoning, deficient, public, largely tax-supported subsystem for the poor, immigrants, or incapacitated was erected. Reform of the growing medical education and research system conformed to previous race-, gender-, and class-biases and inequities (Byrd and Clayton, 2000, 2002; Dowling, 1982; Flexner, 1910; Hunt, 1993), and the medical profession became more elite, homogenous, and distant from the general public they served. The cultural fabric of the society changed with an unquestioning acceptance of biologically, statistically, and psychologically determined principles of scientific racism, while growing eugenics and social Darwinism movements shaped and influenced the health system with regard to immigrants, blacks, the impoverished, and the mentally challenged. At the same time, an increasingly dominant private health system for the well-to-do and middle class blossomed with new medical advance and technology (Byrd and Clayton, 2000, 2002; Chase, 1980; Haller, 1963; Kevles, 1985; Reilly, 1991; Tucker, 1994).

As a result of these occurrences, white health improved dramatically. In contrast, the health of African Americans improved very little, remaining the worst of any racial or ethnic group as they continued to receive little or deficient healthcare, especially in rural areas. As well, immigrant health was poor as they were either excluded or marginalized by the mainstream health system, being confined in many instances to the system's deficient public or charity-supported lower tiers. At the same time, Eugenics and social Darwinism movements flourished, shaping and influencing the health system with regard to the care and disposition of immi-

grants, blacks, the impoverished or the mentally challenged while the Negro medical ghetto continued to grow in size and complexity (Cobb, 1947, 1948, 1981; Gamble, 1995). Scientific exploitation of blacks and the poor continued (Byrd and Clayton, 2000, 2001; Chase, 1980; Kenney, 1941; Townsend, 1911) and underrepresented African-American physicians came of age with their own agenda (Byrd and Clayton, 1992, 2000, 2002; Bullough and Bullough, 1972; Chase, 1980; Cobb, 1947, 1948, 1981; Dowling, 1982; Farley, 1970; Farley and Allen, 1989; Leavitt and Numbers, 1985; Rosenberg, 1987; Starr, 1982).

The Great Depression and World War II

The Great Depression disrupted and almost destroyed a health system with contours one could recognize today. By World War II, this forced more government involvement in healthcare and some restructuring of the system, especially as related to healthcare financing. Nevertheless, patterns of bias and inequities in health and healthcare continued as black and white health inequities and gaps continued at the policy, systems, professional, health status, outcomes, and services levels. White health progress slowed, the medical profession remained segregated by race with the white profession becoming a power center and a leader in the fight against progressive health reform (other opponents included insurance companies, a conservative series of Congresses, some members of the pharmaceutical industry, and white health professions organizations). The black profession continued to be victims of discrimination while the Negro medical ghetto continued, and repeated efforts to reform the health system along unitary, egalitarian and more communitarian lines failed (Beardsley, 1987; Byrd and Clayton, 1992, 2002; Campion, 1984; Cray, 1970; Hirshfield, 1970; Morais, 1967; Starr, 1982; Stevens, 1971, 1999).

Groundwork for Civil Rights in Healthcare

From a bias and equity perspective the two decades after World War II (1945-1965) laid the groundwork for Civil Rights Movements in both the healthcare system and society at large. Nevertheless, the same health and healthcare patterns of bias and inequities detailed above continued until 1964, when the courts outlawed government-sponsored hospital segregation and in 1965, when Congress passed the Medicare and Medicaid legislation (Title 18/19). This took place despite vigorous opposition from the AMA and the healthcare and medical establishments. A successful civil rights struggle often led by black physicians, especially W. Montague Cobb, and organizations such as the NAACP culminated in a national civil rights campaign for justice and equity in health and healthcare, a

series of desegregation lawsuits won against segregated medical schools and hospitals, and a series of Imhotep Hospital Integration conferences that took place between 1957 and 1964, which ultimately led to desegregated hospitals (Beardsley, 1987; Byrd and Clayton, 1992, 2000, 2002; Cobb, 1981; Cray, 1970; Morais, 1967; Smith, 1999).

Simultaneously, due to pressures to further scientific advance and climates of national urgency generated by World War II and the Cold War, unethical experimentation on blacks, incarcerated populations, military populations, infirm elderly, and other disadvantaged groups increased in volume and intensity. The silences surrounding the atomic bomb experiments on U.S. soldiers, widespread institutional research abuse, government radiation and nuclear experiments on individuals, and the Tuskegee experiment would not break until later (Beecher, 1966; Byrd and Clayton, 2002; Hornblum, 1998; Jones, 1993; Washington, 1994a, 1994b; Welsome, 1999).

A Civil Rights Era in Healthcare

Between 1965 and 1980 some of the most momentous progress in healthcare history for African Americans and other disadvantaged groups occurred. For blacks, the period between 1965-1975 represented a "Second Reconstruction in health and healthcare" as: there were dramatic improvements in black health status and outcomes; access, and quality of care improved dramatically as hospitals desegregated, affirmative action began increasing minority representation and access to health professions, and a community health center (CHC)/neighborhood health center (NHC) movement burgeoned (Byrd and Clayton, 1992, 2000, 2002; Davis and Schoen, 1978; Sardell, 1988). These events occurred despite lax enforcement of the Civil Rights laws applicable to health and healthcare (Smith, 1999; U.S. Commission on Civil Rights, 1999a, 1999b; Wing and Rose, 1980). Nevertheless, mainstream resistance to reform of the system occurred, as many white doctors refused to participate in Medicaid/Medicare programs; dual track health and public policy, public health, and health system strategic planning relative to blacks and the disadvantaged poor remained in place; covert racial segregation was often maintained and institutional racism went unaddressed; blacks, ethnic minorities, and the poor were still largely confined to the public healthcare sector (e.g., public hospitals, NHCs, CHCs, teaching hospital clinics, and health departments); mainstream medicine and its establishment continued to fight against progressive health reform and policies; and increasing inequities for black doctors continued to be incorporated into professional training—principally as underrepresentation—and intensified in the peer review processes (Byrd and Clayton, 1992, 2000, 2002; Campion, 1984; Cobb, 1981; Ehrenreich and Ehrenreich, 1970; Morais, 1967; Sidel and Sidel, 1984; Smith, 1999).

A Retrenchment Era in Healthcare

After the legislative defeat of the AMA and the mainstream system in 1965 with the passage of Medicare and Medicaid and a short period of being held at bay, mainstream resistance to reform of the system continued unabated. Retrenchment after 1975 consisted of unaddressed health system structural segregation, discrimination, and institutional racism; continued ethnic, class, gender, cultural segregation and discrimination in health and the health system; stagnation or deterioration of health status and outcomes for blacks and the poor; steep cuts in public funding for healthcare; and complicity in non-enforcement of civil rights laws and regulations (Byrd and Clayton, 1992, 2000, 2001b, 2002; Campion, 1984; Cobb, 1981; Morais, 1967; Smith, 1999).

There was continuing evidence of bias and inequities in American medicine, health, and healthcare during the Reagan-Bush era from 1980-1992. In fact, new areas cropped up and several established areas intensified and included increasing race- and class-based inequities and gaps in health status and outcomes; drastic cuts in public healthcare sector funding such as Medicare, Medicaid, and tax-supported institutional funding cuts; retrenchment on Civil Rights laws; maintenance of structural inequities and segregation of the health system; and continued under-representation of blacks and other disadvantaged minorities in the health system and health professions (Andrulis and Carrier, 1999; Byrd and Clayton, 2001, 2001b, 2002; Clayton and Byrd, 2001; Smith, 1999). Black doctors suffered increasing professional inequities centered around the managed care peer review process as: black doctors continued to be reviewed without benefit of representation in the peer review process; and as providers for poorer and sicker patients, which is the typical black/minority provider profile, black doctors received systematically harsher treatment. There was also an increased prevalence of patient and practice profiling, economic credentialing became widespread, and practice norms and profiles continued to be determined by the white, less ill, majority (Andrulis and Carrier, 1999; Byrd and Clayton, 2002; O'Bannion, 1995). Other systemic bias and inequity problems surfaced as 1) the Malone-Heckler report (U.S. Department of Health and Human Services, 1985b) reminded the nation of continuing racial and ethnic health disparities despite the Second Reconstruction in healthcare; 2) increasing uninsured rates disproportionately affected minorities, children, and the working poor; 3) a "Mainstream health crisis" (runaway cost inflation, 14% of GDP consumed by health, huge health budget, growing numbers of uninsured) emerged; and 4) the little acknowledged and constitutionally different "African-American and disadvantaged patient health crisis" (segregated health/health policy/health system, structure-based race/class inequities

and inequalities, origins almost four centuries old, health insurance crisis) formed what was in reality a “dual health crisis in black and white” (Byrd and Clayton, 2000, 2002; Clayton and Byrd, 1993b, 2001; U.S. Department of Health and Human Services, 1985a; Woolhandler and Himmelstein, 1992, 1998). Nevertheless, after revelations surrounding the Tuskegee experiment, documentation of scores of thousands of unethical sterilizations and surgical abuse, widespread experimental abuse of prison and military populations, and instances of experimental exploitation and abuse of frail elderly populations and disabled children, some improvements occurred in these areas regarding blacks, the disadvantaged, and other vulnerable groups (Byrd and Clayton, 2002; Chase, 1980; Hornblum, 1998; Jones, 1993; National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979; Reilly, 1991; Washington, 1994a, 1994b; Welsome, 1999).

Failed Reform and Corporate Takeover

The 1993-1994 period was dominated by the failed Clinton health reform (Johnson and Broder, 1996; Skocpol, 1997). Between 1995 and 2001, what some view as a corporate takeover of medicine, health, and health care by an insurance company-dominated managed care infrastructure has occurred. However, bias, inequity, and inequality in health and health care are still problems as “patchy destabilization” of the health system is occurring with increasing regularity; de-funding, contraction, and neglect of the public healthcare sector continues; managed care organizations selectively lock out black and poor patients and the providers that care for them; inequitable managed care peer review continues for black and disadvantaged minority doctors; biased clinical decision-making, a tradition more than 380 years old in America, continues; and increasing race-, ethnic-, and class-based inequities, inequalities, and disparities continue (Andrulis and Carrier, 1999; Byrd and Clayton, 2002; Clayton and Byrd, 2001; Collins, Hall, and Neuhaus, 1999; Garrett, 2000; Gray, 1991; Knox, 1999; Mayberry, Mili, and Ofili, 2000; Navarro, 1993; Schulman et al., 1999; Starr, 1982).

A Health System Shedding Some Negative Aspects of Its Past?

The Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Health Disparities represents an important early step at solving a major set of problems in the United States’ health system. The roots of American racial and ethnic health and healthcare disparities are more than 2,000 years old. The adverse health experience of Native Americans and African Americans are the oldest, with the former being

five centuries old and the latter nearly four centuries old. Both groups' health experiences parallel their citizenship and social status in many respects. For African Americans there have been two periods of health reform to address black health inequities and disparities. The First Reconstruction in Black Health occurred between 1865 and 1872 and the Second Reconstruction in Black Health occurred between 1965 and 1975. Both were underfunded and stopped too soon to have permanent positive effects on Black health. For other ethnic minorities, especially non-Europeans, disparate health is a persistent norm. As we enter the new millennium these racial and ethnic disparities in health care remain to plague the system (Byrd and Clayton, 2000, 2002; Collins, Hall, and Neuhaus, 1999; Mayberry, 2000; U.S. Department of Health and Human Services, 1985a; Williams, 1999).

Many actions must be taken if amelioration of the nation's history-, health system-, and medical-social culture-based racial and ethnic health and health care disparities is to occur. Specific recommendations are in other realms of this report, but changes will have to occur in these general areas:

- (1) Ideological and philosophical levels;
- (2) Educational levels—diversity, cultural competence, anti-bias;
- (3) Health policy level;
- (4) Structure and processes levels of health system;
- (5) Functional component levels of the health system;
- (6) Race, class, and ethnically relevant research levels;
- (7) Specific interventions levels required; and
- (8) Community advocacy, adoption, and involvement levels (Byrd and Clayton, 2001a, 2002).

This study represents the nation's potential to ameliorate a set of problems that are over 394 years old for the Native American community,* over 382 years old for the African-American community, is a growing problem in various Hispanic communities, and is becoming more of a problem in various Asian/Pacific Islander communities (Byrd and Clayton, 2000, 2002; Garrett, 2000; Malone and Johnson, 1986; Mayberry, Mili, and Ofili, 2000; Sullivan, 2000; U.S. Commission on Civil Rights, 1999a, 1999b; Williams, 1999). As Laurie Garrett observed:

American . . . health leaders . . . struggle with questions of race, genetics, ethnicity, and economic class, unable to define the relative impacts those

* This applies to the Native American health experience in the North American English colonies. If Christopher Columbus's landfall is taken as the starting point, 105 years are added making a grand total of 499 years.

had on individual and population health. And that debate, coupled with social exclusions from the health system . . . form a critical, lasting, and shameful theme of U.S . . . health (Garrett, 2000, 306).

The issues have again been placed on the agenda, and the health system, public health, the political process, and American public are at another crossroads. The future health of America's health system, and indeed its population, may hinge on attaining a satisfactory resolution of its racial, class, and ethnic disparities—one of the major sets of twenty-first-century health system problems that lingers from the nation's health past, in an antigovernment age with an impending majority minority population. This background information has been provided to lend some of the historical, sociocultural, and medical-social facts and contexts necessary to understand and eliminate the health system flaws and biases related to our complex racial and ethnic health experience (Bonnyman, 2000; Byrd and Clayton, 2000, 2002; Garrett, 2000; Johnson and Broder, 1996; Skocpol, 1997).

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GLOSSARY

ACCULTURATION The modification of the culture of a group or an individual, a process encompassing infancy onward, as a result of contact with a different culture. This cultural assimilation, which can take two

to three generations, moves toward the dominant Anglo-Protestant culture.

AMERICAN INDIAN OR ALASKAN [sic] NATIVE* A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliations or community recognition.

ANGLO-PROTESTANT A more accurate term for those often referred to as White Anglo-Saxon Protestant Americans.

ANGLO-SAXON a term that originally referred to Germanic tribes, the Angles and the Saxons, that came to the area now called England in the fifth and sixth centuries A.D.; it was later applied to the inhabitants of England and to those English who came to North America.

ARCHAIC MEDICAL SYSTEM Though possessing religion and magic as distinct features, archaic medical systems were distinguished by empiricism, systemization, practical organization, recording its experiences and cases for future utilization, and incorporating some public health measures into its corpus of knowledge and practice.

ASIAN OR PACIFIC ISLANDER A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

ASSIMILATION An incoming group's adoption of the cultural traits and identity of the host group or integration into the primary networks and secondary organizations of the host group.

BIAS 1. A preference or an inclination, especially one that inhibits impartial judgement; 2. An unfair act or policy stemming from prejudice.

BLACK A person having origins in any of the black racial groups of Africa.

CLASS A social stratum whose members share certain economic, social, or cultural characteristics.

CONSTRUCTIONIST Refers to the social formed dimensions of an inquiry. Such an inquiry includes elements such as the history, social dimensions, and culture shaping a subject.

CULTURE The accumulated store of shared values, ideas (attitudes, beliefs, values, and norms), understandings, symbols, material products, and practices of a group of people. Culture has both *material* and *non-material* aspects.

DEMOGRAPHY The study of the characteristics of human populations, such as size, growth, density, distribution, and vital statistics.

* This population is currently referred to as "Alaska Native."

DISCRIMINATION Actions carried out by members of dominant groups, or their representatives, that have a differential and harmful impact on members of subordinate racial or ethnic groups.

DOMINANT GROUP A racial or ethnic group with the greatest power and resources in a society (also called a majority group).

ETHNIC AMERICAN Historically, groups that have been designated with a hyphenated name: "African Americans," "Asian-Americans," "Native-Americans," "Hispanic-Americans." The hyphenation implies that a second person would not recognize these individuals as Americans unless designated as such.

ETHNIC GROUP A group socially distinguished or set apart, by others or by itself, primarily on the basis of cultural or national-origin characteristics.

ETHNICITY Ethnicity is a concept referring to a shared culture and way of life, especially as reflected in language, folkways, religious and other institutional forms, material culture such as clothing and food, and cultural products such as music, literature, and art. The collection of people who share an ethnicity is often called an ethnic group.

EUROPEAN AMERICAN Denotes individuals usually called "white" which need no designation (such as ethnic or hyphenated Americans) because they are recognized and presumed to be Americans.

HEALTH A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. [WHO definition]

HEALTHCARE Those services provided to individuals or communities by agents of the health services or professions, for the purpose of promoting, maintaining, monitoring, or restoring health. Health care is broader than, and not limited to medical care, which implies therapeutic action by or under the supervision of a physician.

HISPANIC A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

IDENTIFICATIONAL ASSIMILATION A term involving giving up one's ethnic identity for that of the dominant Anglo-Protestant culture, or an incoming group's development of a sense of identity linked to that of a host group.

IDEOLOGICAL RACISM An ideology that considers a group's unchangeable physical characteristics to be linked in a direct, causal way to psychological or intellectual characteristics and that, on this basis, distinguishes between superior and inferior racial groups.

INSTITUTIONALIZED RACISM Differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of

custom, practice, and law, so there need not be an identifiable perpetrator. It is often evident as inaction in the face of need.

INTERNALIZED RACISM Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth. It is characterized by their not believing in others who look like them, and not believing in themselves. It involves accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-determination, and one's range of allowable self-expression. It manifests as an embracing of "whiteness" (use of hair straighteners and bleaching creams, stratification by skin tone within communities of color, and "the white man's ice is colder" syndrome); self devaluation (racial slurs as nicknames, rejection of ancestral culture, and fratricide); and resignation, helplessness, and hopelessness (dropping out of school, failing to vote, and engaging in risky health practices).

LIFE SCIENCES An inclusive term designating all branches of science (i.e., biology, medicine, anthropology, epidemiology, or sociology) that deal with living organisms and life processes.

MAINSTREAM A term that is often used to describe the "general market," usually refers to a broad population that is primarily White and middle class.

MEDICINE The science and art dealing with the prevention, cure, or alleviation of disease...the Western Greek model sites of activity are: the bedside, library, hospital, community, and the laboratory.

MINORITY A group that is singled out because of physical or cultural characteristics whose members become objects of discrimination; it typically has less power and resources than the dominant group (also called a subordinate group).

MODEL MINORITY STEREOTYPE The non-Asian stereotype that views certain Asian American groups as uniquely exemplary in socioeconomic and moral characteristics compared to other people of color.

PERSONALLY MEDIATED RACISM Prejudice and discrimination, where prejudice means differential assumptions about abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race.

PREJUDICE An antipathy, felt or expressed, based upon a faulty generalization and directed toward a group as a whole or toward individual members of a group.

RACE 1. As many physical anthropologists abandon racial taxonomies altogether, race can be more objectively considered a sociocultural concept wherein groups of people sharing certain physical characteristics are treated differently based on stereotypical thinking, discriminatory

institutions and social structures, a shared worldview, and social myths; 2. A term developed in the 1700s by European analysts to refer to what is also called a racial group (see racial group).

RACIAL GROUP A social group that persons inside or outside the group have decided is important to single out as inferior or superior, typically on the basis of real or alleged physical characteristics subjectively selected.

REDUCTIONISM The belief, very prevalently used in science, that the whole of reality consists of a minimal number of entities or substances. The major methodological reductive triumph of recent years is the demonstration that the classical unit of heredity, the gene, is a macromolecule—deoxyribonucleic acid, or DNA.

SCIENTIFIC RACISM The creation and employment of a body of legitimately scientific, or patently pseudoscientific, data as rationales for the preservation of poverty, inequality of opportunity for upward mobility, and related regressive social arrangement. Usually creating a myth of two distinct races of mankind—one consisting of a small, healthy, wealthy, educable elite, while the second race is a far larger population of poor or nonwealthy, vulnerable, and allegedly uneducable by virtue of hereditarily inferior brains—scientific racism has often also institutionalized and lent scientific respectability to racist dogma and practices that were all far, far older than science itself.

SLAVE HEALTH DEFICIT The dramatic and deliterious Black/White differentials in health status and outcome presumed to be the consequence of slavery and subordinate racial status.

SLAVE HEALTH SUBSYSTEM The inconstant, inferior, alternate health system made up of traditional healers, root doctors, granny midwives and nurses, overseers, and planters' wives, sometimes backed up by formally trained physicians, provided African Americans during slavery. Some plantation infirmaries and hospitals and slave dispensaries and hospitals served as institutional sites.

STEREOTYPE A rigid, oversimplified, often exaggerated belief or image that is applied to both an entire category of people of a racial or ethnic outgroup and to each individual within it, usually negative, that is false or that greatly distorts the real characteristics of the outgroup.

SUBCULTURE A subculture pertains only to those standards that are operative when a person is acting in a particular social capacity or group. For example, occupations and ethnic groups develop their own subcultures—standards for what exists, what goals are to be valued, how one should behave—which are relevant when one is acting either on the job or as a member of the ethnic group but which are largely

irrelevant outside those contexts. The medical profession and health system are excellent examples of subcultures (see culture).

SUBORDINATE GROUP A group that is singled out because of physical or cultural characteristics for differential and unequal treatment and whose members become objects of discrimination; it typically has less power and fewer resources than the dominant group.

WHITE A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

WORLDVIEW A culturally structured, systematic way of looking at, perceiving, and interpreting various world realities. The Western racial worldview holds that racial groups are by nature unequal and can be ranked along a gradient of superiority—inferiority.

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