

## Re-Examination of Health Disparities in the United States: A 3-Pronged Health Intervention Proposal

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### **Abstract**

Decades of research have revealed immense disparities in health in the United States, but scholars are still working to pinpoint the causes of these disparities and find solutions. In this review, new ideas and current findings on the SES-health gradient and the effects of racism on health are analyzed in order to understand the current state of health disparities in the U.S. In addition to this new information, lessons learned from an analysis of the Affordable Care Act, were taken into consideration to develop a 3-pronged health intervention plan to tackle health disparities. The plan prioritizes a “Health in All Policies” approach that emphasizes the importance of understanding the effects of any policy on health and health disparities, assuring that everyone is actively working towards undoing health disparities in the work they do. Additionally, the plan includes a shift in focus from healthcare expansion to the social determinants of health in order to ensure that the root causes of health care disparities are being addressed rather than a temporary fix, highlighting that health can be addressed through a variety of policies. The third part of the intervention plan focuses on dismantling racism, assuring that people be held accountable for their implicit bias in order to address systemic racism. This 3-pronged approach will not be enough to completely undo health disparities, but it is a step in the right direction.

**Keywords:** Health Outcomes, Health Disparities, Socioeconomic Status (SES), SES-Health Gradient, Psychosocial Factors, Life Course Framework, Race, Racism, Discrimination, Hispanic Health Paradox, Healthcare, Health Interventions, Policy

## Introduction

Research on the socioeconomic status (SES) health gradient has revealed inequalities in infant mortality, adult morality, acute and chronic infectious and non-infectious diseases, and psychiatric morbidity. Individuals from a low SES background live 10 years less, on average, than their counterparts from a high SES background (DeRouen et al., 2017; Garrison and Rodgers, 2019; Hoffman et al., 2019; Krieger et al., 1997; Mackenbach et al., 2008). These findings have remained consistent for decades; however, researchers continue to add to this work by exploring the role of psychosocial factors and adopting a life course framework to understand better the cause of these outcomes. Link and Phelan (1995) developed the fundamental cause theory revealing that one's social condition is a great predictor of health. This theory states that the resources that come with a higher SES: prestige, knowledge, power, and money, allow for one to obtain quality health care, afford the costs associated with a healthy lifestyle, and make connections with people who can get them the best medical help, resulting in positive health outcomes.

Two decades later, Williams and Mohammed (2013) added a new layer to the health disparities discussion by emphasizing the profound influence of racism on health. Through systemic racism and implicit bias, people of color (POC), especially Black people, are placed in a disadvantaged position, when compared to a White person, simply due to the color of their skin. The system and institutions in place today were

not built to serve people of color, and the implicit bias of people in power, social workers, and health care workers perpetuates racism in every part of one's life, from education to seeking medical care. According to a study that blindly administered the Implicit Association Test to voluntary participants, many professionals, including doctors, were found to "have an implicit preference for whites over blacks". Interestingly, the study found that even among those who reported having no bias, the test revealed the opposite (2013). This finding illustrates how racism is engrained in our society, to the extent that people are not even aware of their own biases. Systemic racism impacts health directly and indirectly, because people of color are subject to a poorer quality of care and have constricted access to resources that promote health (Colen et al., 2018; Williams & Collins, 2001; Williams & Mohammed, 2013).

In attempts to address health disparities across SES, Congress passed the Affordable Care Act (ACA) in 2010. The ACA attempted to decrease uninsured rates by expanding Medicaid and providing subsidies to families in need, in hopes of improving health for low-income individuals (Buchmueller et al., 2016; Stimpson & Wilson, 2018). This health care expansion policy has been among the biggest health care initiatives in U.S. history. However, the effects of the ACA on health outcomes have been questioned (Gruber & Sommers, 2019; Levy & Meltzer, 2008; Stimpson & Wilson, 2018). Through an analysis of the ACA, the benefits and consequences of such

interventions will be discussed in order to understand what is essential in developing health interventions in the future.

In this review, new ideas and current findings on the SES-health gradient and the effects of racism on health will be discussed in order to understand the current state of health disparities in the U.S. In addition to this new information, lessons learned from a thorough analysis of the ACA, will be used to develop a 3-pronged health intervention plan to tackle health disparities. The plan prioritizes a “Health in All Policies” approach that emphasizes the importance of understanding the effects of any policy on health and health disparities, assuring that everyone is actively working towards undoing health disparities in the work they do. Additionally, the plan includes a shift in focus from healthcare expansion to the social determinants of health in order to ensure that the root causes of health care disparities are being addressed rather than a temporary fix, highlighting that health can be addressed through a variety of policy. The third part of the intervention plan focuses on dismantling racism, assuring that people be held accountable for their implicit bias in order to address systemic racism. This 3-pronged approach may not be enough to completely eliminate health disparities, but it is a step in the right direction.

### **A New Look at the SES-Health Gradient**

Researchers have had difficulty pinpointing the exact cause of health disparities and identifying the SES indicator (education, income, occupational and/or social status) that is most associated to

health (Darin-Mattsson et al., 2019; Garrison & Rodgers, 2019; Krieger et al., 1997; Phelan et al., 2010). The inability to find the exact cause of the SES-health gradient has sparked controversy on how to address the issue of health disparity. However, outside of this debate, researchers have begun to explore the psychosocial effects of living in poverty on one’s health, concluding that low SES individuals are more frequently exposed to stressors that negatively impact health outcomes (Matthews et. al., 2010). Furthermore, current research has begun to explore the life course framework of health, which claims that childhood environment has a big impact on health and health behavior in adulthood (Galama & Van Kippersluis, 2019; Hoffmann et al., 2019; Mittal & Griskevicius, 2016; Pakpahan et al., 2017). This section will evaluate debates on the causes of health disparities, explore the effects of psychosocial factors, and incorporate a life course framework in order to show that as long as inequalities in SES exist, the health gap will persist.

### *Addressing Disagreements Across Health Disparity Research*

While most scholars agree that SES is the leading determinant of health (Cundiff & Matthews, 2017; Darin-Mattsson et al., 2017; Garrison & Rodgers, 2019; Krieger et al., 1997; Phelan et al., 2010), many disagree on what indicator of SES mediates the SES-health gradient. In addition, many researchers have disputed the social causation versus health selection theories and are unable to determine which is most

correct. This section will explore these debates and argue whether or not more efforts should be spent elsewhere.

Research has revealed that multiple measures of SES: education, social class, occupational complexity, and income, are associated with health in old age. However, the inability to pinpoint one cause has sparked a long debate, and most still are not confident in a single dominant causal factor. By measuring the effect each SES variable has on health in old age while controlling for the others, Darin-Mattsson et al. (2017) reported that income is the best predictor, such that those with a lower income die younger than those with a higher income. However, many other studies have found education to be the strongest determinant (Montez et al., 2011; Ross & Wu, 1995). Ross and Wu (1995) found that obtaining a college education is strongly associated with higher self-reported health and higher physical functioning at any given time. Further, education has been found to significantly slow the decline in health over time. While these findings are widely supported, others believe that education is not the strongest determinant. Cundiff and Matthews (2017) identified an association between health and subjective SES, which confirms current popular belief that hierarchical rank and objective SES resources have separate, independent effects on health. The study reported that positive subjective SES resources were associated with better self-reported health and better biological-based health measures (2017). While Cundiff and Matthews (2017) did not claim subjective SES to be the biggest

health determinant, they argued that it affects health throughout the entire life course. All of these studies have valid conclusions, but they never seem to agree on which SES-related resource is the strongest determinant.

Link and Phelan's fundamental cause theory offers the perfect resolution to this debate (1995). Their early work revealed that fixing proximal issues was not enough to solve health disparities because other proximal issues would simply fill their position to perpetuate disparities. For example, decades ago, public health experts thought that addressing poor sanitation and overcrowding would solve health disparities, but instead pollution and limited health insurance accessibility would soon arise to maintain them. The fundamental cause theory (1995) uses a more holistic approach to interpret the effects of SES on health, such that it considers factors related to, but outside of SES measures. Link and Phelan (1995) explain that a high SES gives access to flexible resources that can be used to improve health via many pathways. Some of these resources include money, knowledge, power, healthy environments, and network connections, and it is the unequal distribution of these resources that mediates health disparities. The fundamental cause theory illustrates that health disparities can never be fully understood if viewed through a narrow scope, thus emphasizing the importance of looking at the bigger picture in order to properly address disparities. Rather than trying to isolate the distinct effect of income over education or any other measure of SES, public health experts and

researchers should seek to account for how these factors combine to shape health outcomes.

Furthermore, another major debate in the area of health disparities is social causation versus health selection. Social causation is the idea that there are social factors, related to SES, that impact one's health (Link & Phelan, 1995), while health selection is the idea that one's health determines what SES they can attain. While there is substantial evidence against selection as a dominant explanation, many sociologists agree that the theory makes some salient points. In determining whether health selection or social causation had the biggest effect on one's health, Hoffmann et al. (2019) discovered that both selection and causation were equally impactful on health from childhood to adulthood, but that social causation was much more important from adulthood to old age. While Hoffmann et al. (2019) was able to distinguish at what point in life each theory had the biggest impact, many still argue that health selection impacts SES throughout the entire life course (Pakpahan et al., 2017). At times, this debate becomes the 'chicken and egg argument', in which, as of now, no one can determine what causes what: Does poor health result in low SES or does low SES result in poor health? This debate is likely to continue, but in order to combat disparities in health, action must be taken to reduce resource inequality and develop interventions that do not require the use of resources or minimizes their relevance.

### *Psychosocial Factors*

Researchers have found that psychosocial factors may play a large role in mediating the relationship between SES and health. Psychosocial factors can be defined as influences that effect a person psychologically or socially, such as: one's cognitive response, mood status, and social factors. Matthews et al. (2010) explains that individuals with a lower SES encounter more frequent negative life events and greater chronic stress, which negatively influence health via multiple pathways. Low SES individuals are more vulnerable to the psychosocial effects of life stressors because they lack the SES-related resources, prestige, knowledge, power, and money that could help them cope with stressors (Matthews et al. 2010; Ross & Wu, 1995). For example, sudden unemployment is a bigger physical stressor for low-SES individuals, relative to their counterparts from a high-SES background, because they are less likely to have access to a safety net in the form of savings and social support. Combined with the fact that as SES status decreases, exposure to stressors increases, this association is thought to contribute to the SES-health gradient. For example, a study looking at the effects of life stressors, such as finances, parenting, relationships, and lifetime events, revealed that those exposed to less stressors experience a 35 to 45% reduction in excess mortality risk (2010). Essentially, individuals exposed to higher levels of stress are at a higher risk of mortality. This shows that life stressors have a salient connection to health. Furthermore, the study found clear connections between

negative emotions and/or emotional disorders with health outcomes. This is an important finding because it helps us understand how life stressors can lead to varying health outcomes.

Furthermore, Ross and Wu (1995) established that social-psychological resources, allocated to higher SES individuals, also aid in maintaining the SES-health gradient. As previously discussed, there are numerous resources available to those from a high SES background, but Ross and Wu (1995) introduce two new resources: a sense of control and social support. A sense of control is the belief that one's actions and decisions determine their outcomes, while powerlessness is the idea that one's outcomes are largely determined by other forces. Education, employment, and income increase one's sense of personal control. Education equips people with ability to critically think and solve difficult problems, while employment and income provide economic stability, thus making people feel as if they are in control. A sense of personal control improves health by enhancing health related behavior, while powerlessness is associated with feelings of uncontrollability and demoralization, which culminate in a suppressed immune system (1995). One study found that people with a higher sense of control know more about health and are less likely to smoke and abuse alcohol, thus reporting better self-rated health than those with a low sense of control (1995). In addition, another study found that low SES individuals agree that their access to care is restricted based on their SES, resulting in a feeling of powerlessness. Low

SES individuals reported that it took longer to find providers that accepted low SES patients, the places that did accept them were typically further away, and some never even sought care due to costs (Arpey et al., 2017). These findings show how a sense of control contributes to one's health and contributes to the health gradient. This emphasizes the importance of assuring everyone has equitable access to resources.

Similarly, social support is the feeling of being cared for and loved, valued as a person, and part of a network in which all can be counted on. Social support has been found to increase with education attainment, improve health ratings, and decrease mortality through psychological and behavioral mechanisms (Ross & Wu, 1995). Studies have revealed that social support decreases the prevalence of depression, anxiety, and other problems, which have been found to negatively affect health and increase the risk of mortality. For example, a study found that the mortality risk for a man with fewer social connections is 2.3 times higher than for a man with more social connections, this value was 2.8 for women (1995). Although social support is typically thought of as the personal relationships one has with friends and family, another form of social support comes from people in positions of power that can serve as advocates, such as doctors, politicians, and law enforcement. Here too, SES proves to be an important factor. Another study has found that physicians are biased towards patients with a low SES, in that they perceive them as unintelligent, irresponsible, irrational, and unlikely to

comply with medical advice. The same study also found that these perceptions impact the physicians' clinical decisions, such that: diagnostic testing is delayed, more generic medicine prescriptions are written, and less referrals are made for specialty care (Arpey et al., 2017). Thus, individuals from a low SES background are less likely to receive adequate care, which has clear health implications. Arpey et al. (2017) explains that patient's awareness of this bias could worsen health disparities, such that patients are less likely to disclose information or even seek care in the first place due to the lack of social support. This shows that there is a need to further train physicians, in that they be made aware of their implicit biases, so that they can assure they are treating patients equitably. Additionally, Matthews et al. (2010) found that various psychosocial resources decreased the mortality risk for certain health outcomes. For example, successful social integration, which provides a sense of social support, was found to decrease the risk of stroke by 37% when using education as a measure of SES. This finding is essential because it shows that adequate social support is key to good public health. Social support has been found to impact health in many ways, thus it is essential that individuals are not marginalized or seen as less.

While the effects of psychosocial factors on health are still being studied, there is sufficient evidence to establish that sense of control and social support matter for health. Thus, it is essential that health care experts give attention to this issue and

enact change to begin closing the health gap. Matthews et al. (2010) explains how psychosocial factors accumulate throughout the life span, but it is not yet known to what extent early life experiences can influence health in adulthood. This leads to the discussion of the life course framework.

### *Life Course Framework*

Many researchers have explored the impacts of early childhood environment on health later in life. Factors, such as socioeconomic disadvantage and psychosocial factors accumulate throughout the life span (Darin-Mattsson et al. 2017; Matthews et al, 2010), resulting in the creation of the life course framework. Hoffman et al. (2017) explains that health inequalities are best explained through a life course approach, in that it takes a lifetime of health impacting SES and SES impacting health to determine one's health later in life. This point revisits the debate of social selection versus social causation, but also shows that the health impact of SES extends throughout the entire life course.

One claim of the life course approach suggests that experiences and choices throughout one's life determine health behavior later in life. Galama and Van Kippersluis (2019) assert that the SES-health gradient is the result of rational, albeit constrained, individual choices over the life cycle. Economists have coined the terms, "value of health" and "value of life", in that people see their health and life as separate entities and weigh the two against each other when making decisions. For example, when someone with few economic resources is

offered a job at a chemical plant they are likely to accept the position, despite the grave health risks, in order to earn a paycheck. Furthermore, the economists, Galama and Van Kippersluis (2019), discuss how wealth and health exist in a cycle, in which better health means living a longer life, so people with more wealth are more likely to invest in their health because it would give them more time to enjoy the luxuries their wealth has bought them. For example, those from a high-SES background are likely to purchase healthcare and complete their yearly physicals, so that they can live to enjoy the luxuries that their savings and retirement safety net can buy them. Thus, this shows how wealth determines the likelihood of health investment. On a similar note, Mittal and Griskevicius (2016) explore how childhood SES determine health behavior as an adult. Despite the expansion of affordable healthcare to all citizens, many Americans remain underinsured or even uninsured. The most common reason is inability to pay for premiums, however a significant portion simply choose not to purchase health insurance. This study revealed that childhood experience plays a big part in determining health behavior later in life: individuals coming from a low SES background, independent of current SES, were less likely to purchase insurance, especially under financial duress (2016). However, the study also found that individuals, from a low SES background are more likely to purchase insurance when they are made aware of the base rates of insurance plans and the risk of a certain

disease. This finding is essential because it shows that people understand the importance of health care coverage, but choose not to invest in it unless they need it. These findings show how life experiences influence health behavior later in life, but it also shows how SES in early life matters for health decisions later in life (Pakpahan et al., 2017).

While the connection between early life SES and health decisions was explained above, many researchers have widened their lens to examine how childhood environment, measured through SES, education, and health, affects health outcomes in adulthood. Pakpahan et al. (2017) revealed a strong association between both childhood health and SES, and old age health. However, once mediators were taken into consideration, the effects of childhood SES significantly outweigh the effects of childhood health (2017). Essentially, there are many other factors that contribute to old age health, but the impact of childhood SES was consistent among these findings. This is a crucial finding because it shows that a low SES during childhood is associated with poor health in old age, no matter what SES is attained or health behaviors are adapted. However, the study reported that education was the mediating factor that made the most significant impact (2017). Education showed the clearest relationship between childhood SES and adult health, in that even after experiencing poor childhood circumstances, adult health could be improved if the child received an education. Thus, despite the strong effects of low SES during childhood

on health in old age, education can reverse these effects. On another note, the study revealed that childhood health was shown to have a direct effect on adult health (2017), in that a child's health at one critical point affects adult health, outside of the effects of life course mediators. However, another study revealed that health and all three SES measures, education, occupation, and material wealth, at one point in life are influenced by the prior status of these measures (Hoffman, 2019). Thus, these measures follow a trend throughout one's life, in that health and SES status later in life is determined by earlier standings of these measures and that these measures all affect health through many pathways. In conclusion, childhood SES and health show the most salient connection to adult health, but many problems stemming from childhood conditions can be remedied by intervention in adulthood or later in life. Thus, investing in young children (age 0-5) represents a prime opportunity to promote health and favorable SES conditions. Moreover, this investment should not cease there, it should continue throughout one's life, especially throughout their education. Research on the impact of early childhood conditions on adult health is a new frontier, so there is still much to be discovered.

Throughout this section, the SES-health gradient was discussed through a wide variety of perspectives. Even though there are disagreements about what factors best mediate the SES-health gradient, there is a clear consensus that SES is a leading determinant of health outcomes. While

understanding the true cause of the SES-health gradient can better help public health officials develop adequate interventions, the fact that people from a lower SES live 10 years shorter than those from a higher SES (DeRouen et al., 2017; Garrison & Rodgers, 2019; Hoffman et al., 2019; Krieger et al., 1997; Mackenbach et al., 2008) shows a clear need for immediate action. Using previously known findings and takeaways from current studies on psychosocial factors and the life course framework, public health officials should begin to develop interventions that address health disparities, while continuing research to better inform them on the most salient intervening mechanisms.

### **Race, Discrimination, and Health**

Link and Phelan's (1995) fundamental cause theory emphasizes that one's social condition is a strong predictor of health. This theory states that the resources that come with a higher SES: prestige, knowledge, power, and money, allow for one to partake in health promoting behaviors, resulting in positive health outcomes. However, statistics showed that among those with high SES, Black individuals still have worse health outcomes when compared with their white counterparts (Colen et al., 2018; Williams & Collins, 2001; Williams & Mohammed, 2013). This finding is not analogous with the fundamental cause theory because it shows that race has a larger impact than previously thought, so in response, Phelan and Link (2015) completed another study, arguing that one's race determines the availability of

race-related resources, which are different from SES-related resources. Some of these race related resources include freedom, beneficial social connections, power, and prestige. These excess resources contribute to health in many ways, such as stress levels, medical care quality, and the effects of neighborhood environment (Colen et al., 2018; Williams & Collins, 2001). Because these resources are allocated based on race, non-White ethnic minorities, especially Black people, are left without them, resulting in poorer health outcomes when compared to their White peers. For example, a recent study revealed that Black people face rates of hypertension, diabetes, and obesity that are 25%, 49%, and 59% higher, respectively, than those found among non-Hispanic Whites (Williams & Mohammed, 2013). Throughout this section, the connection between race and health will be discussed through multiple lenses: racism, the Hispanic health paradox, and accessibility to quality healthcare, to show the ways that our healthcare system is built to work against minorities and POC.

### *Effects of Racism*

Racism is still highly prevalent in contemporary society. Despite many Americans claiming to support equality, studies reveal that implicit bias, that favors White people over Black people, is prevalent throughout society (Williams & Mohammed, 2013). This means that most racism occurs through common behaviors that the perpetrators do not see as wrong.

For instance, interpersonal racial discrimination is still highly prevalent,

making it more difficult for minority POC to get jobs, rent apartments, purchase homes and cars, obtain mortgages and medical care, apply for insurance, and even hail a taxi (Williams & Mohammed, 2013). In addition, institutional practices such as wage gaps between Whites and their minority peers, stricter sentencing for Black people and other minorities, and economic barriers limiting access to education, stand out as profound barriers to social mobility (Malat et al., 2018). Colen et al. (2018) found that discrimination results in psychosocial stressors that have effects on one's physical health. The more frequent these stressors are activated, the more at risk an individual is. These stressors can lead to high blood pressure, higher heart rate, and elevated cortisol levels, which are known to cause higher rates of the "Big 4": cardiovascular disease, diabetes, cancer, and chronic respiratory disease (WHO). Even though discrimination affects all POC, no matter their SES, Colen et al. (2018) revealed that upward mobility is associated with increased exposure to discrimination, meaning that upwardly mobile non-poor African Americans and Hispanics experience these effects at higher rates. While some may think that social mobility would shield minorities from discrimination from their non-minority peers due to increased prestige, it is, in fact, the reverse, such that an upward mobile, minority individual is removed from a culturally sensitive, diverse environment and placed in a predominantly White environment, made up of people who are insensitive to the unjust experience of minorities and are most likely unaware of

their own implicit bias against minorities (Williams & Mohammed, 2013).

Discrimination is a large predictor of health outcomes, meaning that minorities subject to discrimination experience health deficits, no matter their SES. This finding helps explain the poorer health outcomes of wealthy POC, discussed in the beginning, but interpersonal discrimination is only the beginning of the injustice.

Institutional racism (also known as systemic racism) is racism that is made possible by the laws and policies in place (Williams & Mohammed, 2013). Malat et al. (2018) describes this racialized system as “whiteness”, meaning that these policies have ranked racial groups, excluded, segregated, and incarcerated some racial populations, and limited the rights and privileges of those deemed dangerous or undesirable (2018). The system in place today is not built to support or protect people of color, thus making it difficult for POC communities to succeed. Institutional racism affects all aspects of life: the justice system, education, political representation, healthcare, housing, and many others. While all of these areas can be studied to reveal injustices at the detriment of POC, residential segregation is a concept commonly studied in relation to health. Despite the passing of the Fair Housing Act, under the Civil Rights Act of 1968, prohibiting the refusal to sell or rent a home based on race, color, disability, and sex illegal, research has revealed that subtle and explicit discrimination in housing is still at play today (Williams & Collins, 2001). For example, a recent study revealed that the

national index of dissimilarity, a measure of segregation, was 0.66, which means that in order to eliminate segregation, 66% of Black people would have to move. Additionally, a value above 0.60 denotes extremely high segregation, and this study reported that 74 major metropolitan areas fit this category (2001). Residential segregation allows for resources to be unequally distributed, such that areas with more Black residents have poor education systems and limited employment opportunities, further restricting upward mobility. This means that some Black Americans may never obtain the SES-related resources that allow for better health care quality and a healthier lifestyle (Link & Phelan, 1995). Furthermore, majority Black residential areas tend to be physically closer to toxic pollutants like landfills, chemical plants, and others, revealing that residing in a disadvantaged neighborhood increases mortality (2001). Lastly, residential segregation has made it so that quality health care is scarce in neighborhoods with majority minority populations. This lack of health care has been connected to poor health outcomes (2001). Through these injustices, segregation increases the occurrence and frequency of psychosocial stressors among minority populations, and these stressors have been linked to health deterioration (Matthews et al. 2010). With this, it has been concluded that segregation is responsible for approximately 176,000 premature deaths annually (Williams & Mohammed, 2013). As stated, residential segregation is the aspect of institutional racism most widely studied, so there may

still be other causes of health disparities yet to be discovered. While some laws have been changed, the problem is deeply rooted in institutions and is difficult to overcome. Some improvements have been seen, but only by the small occurrence of upward mobility by minorities, not by a movement towards equality.

The last form of racism that will be discussed is cultural racism. Cultural racism is the idea that minorities are inferior to the superior Whites, and the prevalence of this ideology throughout society is what allows for all other forms of racism to persist (Williams & Mohammed, 2013). Cultural racism has led to internalized racism or self-stereotyping throughout minority populations that has been found to lower self-esteem and psychological well-being, severely deteriorating one's health. Stereotype threat is the activation of negative stereotypes in individuals from marginalized populations, creating expectations and reactions that result in feelings of inferiority that have significant negative effects throughout one's lifetime. A study measuring the effects of stereotype threat on blood pressure was conducted by administering a test that was introduced by videos containing high or low levels of stereotype threat. The results revealed that the stigma of inferiority, activated by introductory videos including high levels of stereotype threat, led to an increase in blood pressure for African Americans, but not White students (2013). Further research has revealed that this type of threat makes it difficult for POC patients to serve as their own advocate and communicate their needs

to get the appropriate care (2013). Thus, the inability to advocate for their health needs results in deteriorating health. On the other hand, Malat et al., (2018) discusses how certain beliefs and narratives among Whites makes mental disorders and other illnesses a threat. For example, when Whites hold themselves to higher standards, rooted in their feelings of superiority, and are unable to meet their goals, they are more likely to experience a mental health crisis (2018). Similarly, it was revealed that Whites and other high socioeconomic status people experience more emotional distress when faced with a stressor when compared to their socially-disadvantaged counterparts. This feeling of failure has led to an increase in suicide, opioid overdose, and alcohol misuse among Whites (2018). Malat et al. (2018) also explores how the racial prejudice of Whites increases the risk of mortality for low-SES Whites as well. Even though Whites do have a health advantage due to the color of their skin, the racialized, stereotypical concept of "whiteness" has backfired. White Americans have been accustomed to see social programs as handouts for POC communities labeled as needy and lazy. Their racial prejudice results in opposition to social programs meant to aid economically-disadvantaged populations, however this mindset has taken opportunities away from economically-disadvantaged White Americans as well. When compared to other OECD nations, White Americans are trailing in regards to health and overall life expectancy (2018). However, the largest issue with cultural racism and its relation to health is the effect

of unconscious bias. According to a study that blindly administered the Implicit Association Test (IAT) to voluntary participants, many professionals, including doctors, “have an implicit preference for whites over blacks” (Williams & Mohammed, 2013). This means that doctors with this implicit bias are more likely to fall short in providing medical care to POC, resulting in poor health outcomes. For example, a study found that minority patients experience reduced screening rates and increased treatment dropout and reported a delay in seeking help and filling prescriptions or avoidance of health care altogether (van Ryn et al., 2011). Combined, these findings show that minority patients receive a lower quality of care, resulting in poor health outcomes due to the inability to complete regular health checks. In order to best address the effects of cultural racism on health, a strategy must be developed to raise awareness of subtle, unconscious racism, especially among healthcare workers.

As the Black Lives Matter movement has erupted over the last few years to bring attention to the issue of racism, a faction of society still fails to acknowledge and correct their racist beliefs. Throughout this section, the negative health effects of the three most common forms of racism were discussed. If the effects of racism on POC communities are not enough to convince Americans to take action, emphasizing how racism also affects the health of Whites may be more convincing. The studies discussed above show how racism affects everyone’s health, thus racism

should be acknowledged as a public health crisis that requires immediate attention.

### *The Hispanic Health Paradox*

While all of the negative health effects of racism discussed above apply to the Hispanic/Latino community, health statistics reveal that Hispanics have a health advantage over other races (Acevedo-Garcia & Bates, 2008; Malat et al., 2018; Palloni & Arias, 2004). This finding shocked many because it opposes every theory on health disparity and is referred to as a paradox because despite the lack of SES- and race-related resources, Hispanics still have lower adult mortality, better infant health, better health behaviors, and lower rates of mental disorders than their White and Black counterparts (Acevedo-Garcia & Bates, 2008). There are many aspects that contribute to the health of Hispanics, including their citizenship status, time spent in the United States (US), immigration policy, prejudice, and health care utilization.

In order to fully understand this paradox, it is important to acknowledge that a significant portion of our Latino population are foreign-born migrants from a plethora of countries, Mexico, Honduras, Cuba, and Puerto Rico, just to name a few (Palloni & Arias, 2004). Knowing this, many researchers began to look at immigration status and policy as causes of this health paradox (Acevedo-Garcia & Bates, 2008; Morey et al, 2018; Palloni & Arias, 2004; Philbin et al., 2018). Acevedo-Garcia and Bates (2008) found that first generation migrants have higher health ratings than second generation migrants and

their successive generations, whom were born and reside in the U.S. This means that the amount of time spent in the U.S. plays a role in Latino health. The longer a Hispanic immigrant and their subsequent generations stay in the U.S, the more their health deteriorates. Projections expect this trend to continue, meaning that Latino health will continue to decline over time (2008).

Given that a large portion of the Latino population are immigrants, Philbin et al. (2018) wanted to see what effect immigration policy had on this community. Laws on immigration are frequently passed on the state-level, which means that the life of an immigrant looks different depending on what state they are in. The constant change in policy forces a life of adaptation and repeated stressors for immigrants (Philbin et al., 2018). There are various forms of immigration policy: immigration and enforcement, employment and labor, education, driver's license requirements, healthcare access, and many others. For example, within the past decade, ten states have passed a set of laws known as the omnibus laws, which limited undocumented immigrants' access to social services, imposed fines for the employment or harboring of undocumented immigrants, and made it legal for police to stop people for the sole purpose of verifying documentation (2018). These policies make it harder to participate in everyday life, by impeding social mobility, reducing access to health care and other resources, and increasing discrimination and the feeling of exclusion. While some states have adopted policies beneficial to immigrant communities, many

states choose to adopt more restrictive policy. This variation creates confusion, resulting in few immigrants that actually know their rights and many who fear deportation or punishment. Ultimately, the multitude of different immigration policies results in repeated psychosocial stressors that negatively affect the health of Latinos throughout the life course (2018). In addition to the detrimental health effects of immigration policy, the constant debate of immigration has made it an extremely polarized issue. This polarization has resulted in two extremes: one that welcomes immigrants and one that disdains their presence. The latter culminates in anti-immigration discrimination, which has been connected to illness for immigrant groups (Morey et al., 2018) due to the psychological effects of discrimination. Anti-immigration discrimination has no effect on Black (and White) Americans and does not impact all Latinos, rather it only applies to U.S.-born "other races", such as Asians and Hispanics, in that these groups experience increased mortality risks when subjected to this form of discrimination (2018). Furthermore, the same study found that the greater time spent in the US, the more exaggerated these negative effects are (2018).

Another factor that influences the health of Latinos is access and utilization of healthcare. This topic will be discussed more thoroughly in the next section, but must be addressed here as well because the Latino population has the highest uninsured rate and are least likely to utilize health care (Acevedo-Garcia & Bates, 2008; Philbin et

al., 2018). Even after the implementation of the ACA, Latinos were still the highest uninsured group (Chen et al., 2016). Another study found that at all ages and health statuses, Latinos, especially immigrants, were least likely to utilize healthcare, with the largest gap being found between Whites and Latinos in excellent health (Biener & Zuveka, 2019). Latinos not having access or choosing to opt out of health care have an increased risk of mortality.

Despite all of these health risks, Latino adults have a lower mortality rate than non-Hispanic whites (Acevedo-Garcia & Bates, 2008; Malat et al., 2018; Palloni & Arias, 2004). However, through various comparisons, studies reveal that this paradox only applies to foreign-born Mexicans and foreign-born Other Hispanics, excluding Puerto Ricans and Cubans (Acevedo-Garcia & Bates, 2008; Palloni & Arias, 2004). Thus, when looking at the health statistics of U.S.-born Latinos, they more closely align with the fundamental cause theory. In other words, the Hispanic health paradox does not apply to US-born Latinos, in that they experience poorer health outcomes, similar to other minority communities born in the US. This finding can be partially explained through so-called “salmon bias” or return migration, in that a sub-group of foreign-born Latinos have the ability to return home (Acevedo-Garcia & Bates, 2008; Palloni & Arias, 2004). Returning home means re-entering a community with limited exposure to discrimination and higher levels of social support, providing these groups the ability to alleviate the additional health deteriorating

stressors that come with being a minority in the U.S. (Acevedo-Garcia & Bates, 2008; Fenelon, 2017; Palloni & Arias, 2004). The “salmon bias” is further supported by the findings that revealed Hispanics living in a culturally diverse community experience better health outcomes than those living in a community lacking diversity (Fenelon, 2017; Palloni & Arias, 2004). However, this only applies to foreign-born Mexicans, and thus current evidence cannot explain the mortality advantage for other foreign-born Hispanics. Proximity to Mexico plays a large role in these differential findings because it is significantly easier for Mexican immigrants to return home to more accommodating environments than it is for immigrants from other countries (Acevedo-Garcia & Bates, 2008). Thus, the Hispanic health paradox doesn't mean that Hispanics have access to better health care or are treated adequately, it reveals that American society and the US healthcare system have negative consequences on the health of Latinos that can only be stopped or reversed by the ability to receive care in or escape to other countries. This finding again shows that the system in place today is not built to support or protect people of color, and in order to stop the highly avoidable loss of lives, action must be taken.

#### *Variations in Healthcare Accessibility and Quality*

In a later section, various interventions will be explored in order to pinpoint the best plan to reduce, health disparities. However, it is important to address the issue of healthcare in the context

of race, because studies have revealed gaps in utilization and quality across races (Acevedo-Garcia & Bates, 2008; Biener & Zuveka, 2019; Fiscella & Sanders, 2016). First, there is the issue of affordability. In the U.S., Latinos are the highest uninsured group, followed by African Americans, then Whites (Fiscella & Sanders, 2016). These disparities in health care coverage have negative consequences for the health of Latino and Black individuals. Even after the implementation of the ACA, Latinos remained the most uninsured group by a large gap (Chen et al., 2016). Chen et al. (2016) speculated that this is from a lack of Medicaid expansion in all states, especially right-leaning states with larger Latino populations, like Texas and Florida (KFF, 2020), and unclear eligibility guidelines for immigrants. Despite these initial findings, trends are showing that the ACA could eventually reduce or even eliminate racial disparities in insurance coverage (Chen et al., 2016). Healthcare utilization is key to maintaining one's health, however this is hard to guarantee due to the unaffordable nature of our health care system. Without healthcare insurance, it is hard to even afford the basics. Thus, those without coverage have a higher risk of mortality (2016).

Another issue concerning health care is quality. Fiscella and Sanders (2016) explore disparities in the quality of health care and pinpoint implicit bias, residential segregation, and differences in the type of insurance coverage as causes of this disparity. Implicit bias clouds the judgement of clinicians, impacting patient trust and

care (2016). As previously mentioned, van Ryn et al (2011) found that minority patients experience reduced screening rates and increased treatment dropout and reported a delay in seeking help and filling prescriptions or avoidance of health care altogether (van Ryn et al., 2011). Because of this bias, many minorities may never receive the care they truly need, resulting in health deterioration or in some cases death. Furthermore, Williams and Collins (2001) explains that residential segregation allows for the poorest quality hospitals, characterized by supply shortages and a higher rate of poor performing surgeons, to be located in predominantly minority communities. Additionally, Black and Hispanic individuals are more likely to have public health insurance, through Medicaid and other programs (Bulatao & Anderson, 2004). Even though any type of insurance coverage provides a benefit, the type of coverage determines the quality of care and available options. This is an important distinction because large disparities in health care quality, resource availability, and health outcomes were revealed when county hospitals were compared with private hospitals (2016). Healthcare under Medicare, Medicaid, and the public insurance programs are limited to state-funded hospitals, while private insurance provides better benefits and more options. Thus, the type of insurance coverage directly affects the quality of care. In combination, these findings have resulted in Black and Latino individuals with Medicare reporting the worst experiences while receiving medical care, compared to private

insurance holders from a minority background (Fiscella & Sanders, 2016). The inability to access quality medical care puts one at a higher risk of mortality. The U.S. healthcare system's failure to ensure quality healthcare to all populations puts the lives of minorities at stake every day. Further research is needed to design a system that prioritizes the health of all by ensuring health care equity.

Link and Phelan (1995) established the fundamental cause theory, linking SES to health outcomes. However, it is important to note that there are factors and resources outside of the SES-related resources that contribute to health. Throughout this section, the effects of racism, the Hispanic health paradox, and variations in accessibility and quality were discussed to highlight various race-dependent factors. Because these resources are allocated based on race, non-White ethnic minorities, especially Black people, are left without them, resulting in poorer health outcomes when compared to their White peers. The healthcare system in place today is built against minorities and is responsible for disparities in health, which result in the premature death of minorities. In order to address this public health crisis, steps must be taken to work towards a more equitable system.

### **Analysis of the Affordable Care Act**

Thus far, disparities in health across SES and race have been discussed. Link and Phelan (1995) developed the fundamental cause theory, revealing that one's social

condition is a great predictor of health outcomes throughout the life course. Williams and Mohammed (2013) later added a second layer to the SES-health gradient, clearly explaining how racism impacts the health of people of color in the United States via many pathways beyond SES. In attempts to address the declining health in America (Kaplan, 2019), Congress passed the Affordable Care Act (ACA) in 2010, with many of the key provisions going into effect in 2014. The ACA hoped to improve health throughout the nation through the expansion of health insurance and is considered one of the largest health interventions in recent U.S. history (Buchmueller et al., 2016; Stimpson & Wilson, 2018). Now that the ACA has been around for 10 years, multiple studies have been conducted in order to understand the implications of the policy. Through an analysis of these studies, the characteristics of a successful intervention will be identified to help develop a blueprint for future intervention designs.

Prior to the introduction of the ACA, there was large inequalities in health insurance coverage among Whites and African Americans/Hispanics (Buchmueller et al., 2016; Gruber & Sommers, 2019; Stimpson & Wilson, 2018). Additionally, many young adults ages 19-25 were uninsured (Buchmueller et al., 2016). The ACA was a Medicaid and private insurance expansion plan that would make insurance coverage more accessible to low-income adults, young adults, and lawfully present immigrants. In order to do this, the ACA consisted of additional funding to Medicaid

to cover couples without children below the federal poverty line (FPL), extension of dependent coverage to age 26, prohibited plans from denying coverage or overcharging, provided premium tax credits for insured families 100% to 400% of the FPL, and made additional subsidies available to those eligible. However, in 2012, the Supreme Court ruled that some portions of the ACA were unconstitutional, in regards to state powers, and made the Medicaid expansion optional.

Research reveals that implementation of the ACA significantly decreased uninsured rates among all groups, but especially in minority communities (Buchmueller et al., 2016; Gruber & Sommers, 2019). In addition, access and utilization was also found to increase across all types of care (Gruber & Sommers, 2019). However, Stimpson and Wilson (2018) revealed that disparities between noncitizens and natives increased. While most of these inequalities in coverage were caused by differences in income, citizenship status played a role as well (Buchmueller et al., 2016; Gruber & Sommers, 2019). Even though noncitizens have the highest uninsured rates, this expansion was limited to citizens. Furthermore, many studies also point to the Supreme Court's decision to make the ACA optional for states as another cause of this finding. The Republican platform is built around strict immigration policies and tends to leave health care out of the discussion, thus healthcare expansion to immigrants, documented or not, is not a priority in Republican states, resulting in many Southern states refusing to adopt the

expansion (KFF, 2020). Additionally, many states refused to expand Medicaid because they feared that it would eventually begin to affect their budget (Leonard, 2015).

However, many Southern states have a large population of Hispanics, both documented and undocumented, meaning that the ACA was not accessible to communities who, statistically, needed it most.

In addition to the Supreme Court decision impacting uninsured rates across noncitizens, refusal to expand Medicaid in states with larger minority communities, has facilitated large disparities in coverage (Stimpson & Wilson, 2018). A study revealed that all declines in uninsured rates cannot be attributed to the ACA Medicaid expansion because improvements seen in non-expansion states were likely due to heightened awareness of eligibility to programs already in place (2018). Essentially, the media attention of the ACA allowed citizens to be more aware of resources previously available to them, meaning local governments had done a poor job at spreading information about resources available in their state. This is a disheartening finding because it suggests that local governments failed to properly disperse funds, provided to them for Medicaid and Medicare programs, in order to spend it elsewhere. Lastly, Buchmueller et al. (2016) revealed a problem with uptake, in that minority groups were not as likely to take advantage of the expansion as was expected. Because a large portion of Americans were eligible for benefits, there was no way to be sure that benefits were going to those who may have needed it the

most. Williams and Mohammed (2013) thoroughly explain that race impacts SES through systemic racism, which serves as a barrier to upward mobility for minorities, especially Black and Hispanic communities. Thus, because minorities have restricted access to these SES-related resources, they are at a disadvantage, resulting in a disproportionate increase in coverage, favoring Whites (Buchmueller et al., 2016). Essentially, people from a higher SES background were more likely to take advantage of the ACA benefits because they have more social support, formal education, and other resources needed to navigate the complicated health care system (Link & Phelan, 1995). However, Buchmueller and colleagues (2016) found that linguistically and culturally targeted outreach strategies were effective at increasing up-take among minorities, suggesting that inclusivity and better information dissemination measures must be taken in order to reach the right communities.

While the primary goal of the ACA was to expand coverage to uninsured individuals, many health officials were hoping that expanding coverage could address health disparities as well. However, the health impacts of the ACA are not yet known due to the inability to study its effects in the absence of confounding variables (Gruber & Sommers, 2019; Levy & Meltzer, 2008). Most past studies have claimed that health care does in fact improve health, but have failed to acknowledge the problems of endogeneity and confounding variables, making their findings less compelling (Levy & Meltzer, 2008). Levy

and Meltzer (2008) explain that it is difficult to study the impact of health insurance on health because there are factors, such as SES and race, that determine, both, the likelihood of one purchasing health insurance and one's health status, which makes proving causation nearly impossible.

More recent studies, which have acknowledged and designed their projects to address the issue of endogeneity, have found that health insurance does not impact mortality, but does improve self-reported health (2008). These contradictory findings show the complexity of research on health insurance and why policymakers struggle to make decisions regarding health care. Although an increase in coverage is movement in the right direction, policymakers are ultimately looking for improvements in health outcomes. Thus, it is essential that research methods be developed to conduct these experiments. For example, in the UK, researchers designed three social experiments that involved the random allocation of various social services. Because this research design was relatively new, these studies raised great debate; however, Oakley et al. (2003) explained that the findings of these studies were valid because their interdisciplinary approach assured that scientific, ethical, and feasibility standards were met. Thus, to best answer the question: "does healthcare impact health", there is a need for more quasi-experiments and social experiments, that guarantee endogeneity and confounding variables are no longer an issue.

While most public health officials can agree that the ACA was successful in

expanding coverage, this legislation also had a number of important limitations. Most importantly, the ACA showed the importance of making sure the appropriate communities are being targeted and actually have access to such resources. The polarized nature of healthcare, which contributes to the notoriety of the ACA, made it difficult for all Americans to support healthcare expansion (Beaussier, 2014). For example, the Trump administration used the failure of the ACA to improve health and address disparities as an opportunity to express disapproval of healthcare expansion efforts, influencing Republicans to see healthcare expansion as a waste of tax dollars (Blumenthal, 2019). The way the ACA was expanded throughout the U.S. shows that many Americans see health care as a privilege and not a right. The unwillingness of state governments to accept funds provided to them by the federal government to expand Medicaid, while large portions of their minority and low-SES constituents are uninsured, suggests a lack of sympathy and motivation to advocate for those with limited resources. Until this changes, access to healthcare may never be equitable. Additionally, the importance of inclusivity and other information dissemination tactics in reaching racial minority communities shows that race and discrimination play a huge role in health behavior and access to care (Buchmueller et al., 2016; Williams & Mohammed, 2013). These findings show that even if healthcare is widely accessible, there are other factors at play inhibiting the uptake of health insurance, suggesting that other forms of interventions may better

address disparities in uninsured rates, and to an extension, health. The ACA is the largest, most recent healthcare initiative, and understanding its flaws and effects can help public health officials and policymakers better understand how to address health disparities and develop more successful interventions in the future. Implementation of the ACA shows that Americans may be beginning to see the importance of social programs in promoting equity, paving the way for more effective interventions.

### **The 3-Pronged Intervention**

Many health care officials felt that the ACA was a move in the right direction, and hoped that health care expansion would help to reduce disparities in health. However, the previous discussion shows how the ACA had important flaws and has done little to minimize health disparities. Furthermore, in attempts to understand the effects of more equitable social policies, a study compared health outcomes of single mothers in Sweden and Britain, which have more generous social policies and more conservative policies, respectively. However, despite these differences, the health of single mothers in both countries is relatively comparable (Whitehead et al., 2000). Despite Swedish policy doing a good job in addressing the needs of lone mothers, poor health was still frequently reported. Thus, it is not the policies that are failing, but there are simply bigger forces working against them (2000). The authors point to social support, psychosocial stressors, and societal pressures as causes for the

continued reporting of poor health (Marmot, 2017; Whitehead et al., 2000).

As discussed throughout the SES and race sections, people with a lower SES and racial minorities experience a life expectancy 10 years shorter, on average, and discrimination in every encounter with the health care system, resulting in higher mortality rates (Colen et al., 2018; DeRouen et al., 2017; Garrison & Rodgers, 2019; Hoffman et al., 2019; Krieger et al., 1997; Mackenbach et al., 2008; Williams & Collins, 2001; Williams & Mohammed, 2013). Due to these inequities, many lives have been lost prematurely, and this number will continue to increase unless action is taken. While health care expansion was an important start, the underlying inequities built into the healthcare system and other social institutions are the true cause of health disparities, and it is not until these issues are addressed that improvements will be seen. Utilizing information discovered about the social determinants of health and the effects of racism on health and considering the effects of the ACA, a 3-pronged intervention, prioritizing health by addressing the social determinants of health (Marmot, 2017) and dismantling racism, is devised to tackle health disparities.

#### *Universal Commitment to Diminish Health Disparities*

To start off, more attention must be given to health disparities in America. Young et al. (2015) explain how racial/ethnic health disparities have long been reported, but little has been done, until recently, to address the issue. This inaction

is partially caused by a lack of evidence showing the positive impact of past interventions on health outcomes, which is essential in understanding their effectiveness. Without this information, policymakers are slow to action because it is hard to gain support on a policy that is not likely to have a positive result. Furthermore, Young et al. (2015) show that 45 states had passed at least 1 bill targeting health disparities. While this is a promising finding, other findings suggest a lack of authentic action. The study reported that most states have local commissions or task forces, whose sole job is to report and research racial/ethnic health disparities, but little is known about the impact or actions of these agencies. Furthermore, the authors point out that more funding should be directed towards this issue, but add that measures must be taken to be sure this money is not reallocated to other issues (2015), suggesting that money previously allocated to address health disparities was spent on other sectors. However, the bigger issue is that the most common bills were awareness bills, such that they brought awareness to the issue, but did not allocate resources or take concrete action (2015). For example, Purtle and Roman (2015) discuss that awareness bills, such as the ones that implemented Breast Cancer and Autism Awareness Months, did little to address health concerns related to these diseases and potentially misinformed people on the determinants of adverse health outcomes. Additionally, Frieden (2010) explains how even the most impactful interventions fail to develop or are never brought up because it

may not be the best political move due to disagreements on whether health care is a right or a privilege. Evidence shows that community efforts to tackle issues are most successful due to the social support and motivation, that are a given with community initiatives (Brown, 2019). Thus, authentic engagement from the community and all stakeholders, local governments, health professionals, and the non-profit sector, is necessary in order to develop interventions that will have positive impacts.

Olafsdottir et al. (2014) further develops the idea of engagement by exploring the relationship between the welfare state and civil society. They show that the civil society and the welfare state work together in many ways to assure the needs of the people are met. Furthermore, civil society was found to act as a replacement or “safety net” in addressing the health needs of the people when the government fails to do so (2014). Thus, when the welfare state and civil society work together to address health disparities, positive effects on health and health inequalities are observed. In order to make strides in public health, politicians and citizens must prioritize health over financial and power gains. One promising strategy is the Health in All Policies approach, which holds that the effects on health and health disparities should be considered for all types of policies and projects (Young et al., 2015). For example, when policymakers are considering a policy that will regulate chemical waste, they must also consider the health threats that chemicals pose to specific communities. In order to hold policymakers

and project leaders accountable, an in-depth report on the health impacts or a specific law or project must be publicized and approved by a separate entity. This approach will assure that measures taken to improve health disparities are not undone by other agendas and that all stakeholders are prioritizing health.

### *Focusing on the Social Determinants of Health*

Link and Phelan (1995) developed the fundamental cause theory revealing that one’s social condition is a great predictor of health. This theory states that the resources that come with a higher SES: prestige, knowledge, power, and money, allow for one to obtain quality health care, afford the costs associated with a healthy lifestyle, and make connections with people who can get them the best medical help, resulting in positive health outcomes. Additionally, as seen with the ACA, addressing proximate risk factors, like health insurance, is less likely to improve disparities in health. Furthermore, Hoffman et al. (2017) explains that health inequalities are best explained through a life course approach, in that it takes a lifetime of health impacting SES and SES impacting health to determine one’s health later in life. Thus, policymakers must start paying careful attention to upstream social determinants of health, starting during childhood (Hoffman et al., 2017; Marmot, 2017). Public health experts have proposed that policy is needed to target child poverty, make education more accessible to all, establish a minimum income for healthy living, and assure communities are safe and

healthy (Brown et al., 2019; Frieden, 2010; Pakpahan et al., 2017; Williams & Purdie-Vaughns, 2016; Williams & Mohammed, 2013; Young et al., 2015).

Williams and Mohammed (2013) explore various policy areas and their connection to health to highlight that policies targeting other aspects of life, outside of health, can have a positive impact on health: such as housing, income, and education. For example, studies have found that improving neighborhood and housing conditions has been associated with better self-reported measures of health and higher rates of employment and lower levels of welfare use (Williams & Mohammed, 2013). Thus, policies focused on improving communities and decreasing crime, such as the Community Development Block Grant Programs, which provide additional funding to states, cities, and counties to aid in development, can help improve health (HUD Exchange). Additionally, further research found that increasing household income, through large-scale social programs like Food Stamps (SNAP), the Women, Infants, and Children (WIC) program, and elderly subsidy programs, was associated with lower rates of low birth weight, a higher average birth weight, lower rates of maternal smoking, a decrease in metabolic syndromes in adulthood, and an increase in the reporting of “good health”, especially among women with low education and Black people (Hoynes et al., 2016; Williams & Mohammed, 2013). Because these programs are essentially a cash transfer, these results suggest that increasing the minimum income nationally can have large,

positive effects on health. For example, the Obama administration was advocating an increase in minimum wage from \$7.25 to \$9.00, which is considered the new livable wage (National Archives and Records Administration). Additionally, increasing the minimum income will make housing more accessible and help tackle childhood poverty, which have profound effects on health.

Lastly, studies found that policies meant to tackle gaps in education achievement and make higher education more attainable had positive effects on health. For example, ParentsCorp was designed to tackle gaps in education achievement in New York City, however, the results not only showed improvements in education, but also in childhood obesity, anxiety, and depression in minority and low-income communities (Brown et al., 2019). Similarly, studies found that eliminating standardized testing and reducing residential segregation in schools have been found to make higher education, which is associated with better self-reported health and better health behavior (Williams & Mohammed, 2013), more attainable for all communities. Interestingly, studies have also found that psychological interventions improve education. A self-affirmation intervention was designed for black students in elementary school, and the study revealed that students that had participated in the program reported higher test grades and improved behavior (2013). Thus, policies focused on making public education equitable, allocating more funds to schools in impoverished communities, and making

higher education more attainable will have positive impacts on health.

The fundamental cause theory and the effects of the ACA highlighted that interventions are most successful when they are disease agnostic, in that they target various risk factors associated with multiple diseases. Throughout this section many policies were suggested, but policymakers should focus on increasing the minimum income to a livable wage of \$9.00, allocating more funding to improve schools, state hospitals, and community centers in impoverished communities, and make higher education more attainable by eliminating standardized testing throughout all levels of education, such as the State of Texas Assessments of Academic Readiness (STAAR) test, SAT/ACT, and GRE. Unlike the ACA, these disease agnostic interventions have been shown to improve health. There are thousands of policies that can address the social determinants of health, but these three are a promising starting point and will pave the way for future interventions.

### *Dismantling Racism*

Williams and Mohammed (2013) clearly explain how racism perpetuates health disparities via the effects of institutional racism and psychosocial stressors. Racism facilitates health disparities because it is engrained in American society and is upheld by an individual's implicit bias, forcing racial minorities to endure repeated barriers and stressors, which have negative effects on health (Williams & Purdie-Vaughns, 2016).

Thus, reducing the effects of racism is necessary to improve health disparities since race has been found to impact health, independent of SES.

As previously discussed, implicit bias, when unchecked, can be lethal to minorities (Fiscella & Sanders, 2016; Williams & Mohammed, 2013). However, studies have found that if physicians are made aware of this bias, they are more likely to hold themselves accountable in assuring they are treating a patient's medical needs and not merely reacting to the color of their skin (Fiscella & Sanders, 2016). Thus, a policy implementing cultural competency training for all health care workers will decrease occurrences of discrimination when racial minorities are interacting with medical institutions (Williams & Mohammed, 2013; Young et al., 2015). For example, a study conducted on a cohort of nursing students found that a cultural competency education, that included self-assessment, cultural knowledge, and cultural sensitivity training, was effective in increasing self-perceived knowledge and use of culturally competent practice, suggesting that such programs are effective in decreasing discrimination and improving quality of care (Brennan et al., 2017). Additionally, researchers have begun to see the importance of assuring that the health care workforce is representative of the U.S. population. Low rates of minority health professionals are reflective of a system that was not built to accommodate minority communities, thus echoing the importance of making education more attainable (Young et al., 2015). Interestingly, Williams and Mohammed

(2013) claim that biased media portrayals also contribute to racism. They suggest that media should monitor their racial biases and should be held accountable for perpetuating racism. While this may be difficult to accomplish due to freedom of speech and press, there may be a few ways to address this issue. First, similar to health care workers, newscasters, journalists, and other media producers should be required to participate in cultural competency education. In addition, a council should be put together to monitor and record instances of racial bias in media, which should be publicized so consumers can be aware of the racial bias being presented to them. Lastly, Buchmeuller et al. (2016) revealed a problem with up-take, in that minority groups were not as likely to take advantage of resources available to them. However, they found that linguistically and culturally targeted outreach strategies were effective at increasing up-take among minorities, suggesting that inclusivity measures must be taken to reach communities most in need.

Since people have a right to their own beliefs, racism can't just be made illegal; however, implementing widespread cultural competency training and making higher education more attainable are an important start to dismantling systemic racism and implicit bias. While most policies mentioned do little to address systemic racism directly, widespread cultural competency training will translate to improvements in systemic racism since it is perpetuated by individuals' implicit biases. When people are trained to check their bias and understand the experiences of

marginalized communities, they will be able to see the need for larger structural interventions. Thus, advancements in racial disparities in health rely mostly on individual action, to move past racist ideals and hold others accountable for their racist opinions.

This 3-pronged intervention proposal prioritizes a "Health in All Policies" approach, addresses the social determinants of health, and makes strides to dismantle racism. While this proposal will not be enough to completely eliminate health disparities, it is a step in the right direction. Furthermore, the plan focuses on policies that receive widespread public support.

### **Unintended Consequences**

As seen with the ACA, there is always room for interventions to have adverse effects on health outcomes. Because health disparities are mediated by SES and race and knowing that policies can impact health via multiple pathways (Link & Phelan, 1995; Williams & Mohammed, 2013; Whitehead et al., 2000) it is hard to predict the entire effect of an intervention.

While the interventions described above have been found to promote health across underprivileged communities, some interventions have been found to increase health gaps, such as the ACA and smoking cessation programs (Stimpson & Wilson, 2018; Williams & Purdie-Vaughns, 2016). For example, smoking cessation programs have been successful in reducing smoking, but because they are more accessible by the wealthy, the positive effect across lower

SES communities is of a smaller magnitude (Stimpson & Wilson, 2018). Despite a decrease in smoking, disparities in smoking rates have increased. Essentially, because people from a higher SES have increased access to resources and better know how to navigate the system, they reap the benefits of these interventions as well, typically to a greater extent. While health improvements are always good, the ability for higher SES individuals to better access resources, mean that they are disproportionately benefitted by these interventions, widening health disparities. Studies have found that downstream interventions, such as mass media campaigns and workplace bans on smoking, increased disparities, while more upstream interventions, such as provision of material resources and an increase in tobacco prices, were successful at decreasing smoking rates and reducing disparities. Thus, upstream interventions, targeting social determinants of health, are more successful at yielding results. Along the same lines, Brown et al. (2019) discuss how the timing and location of intervention is key in avoiding consequences. For example, the HIV/AIDS pandemic struck minority communities disproportionately, however rather than interventions being geared to these communities, they were designed to reach all Americans. Early awareness campaigns shared that HIV/AIDS mostly affected members of the LGBTQ+ community and intravenous drug users, thus anybody that was diagnosed with this disease was labeled as a pariah (Parker & Aggleton, 2002). This stereotype resulted in a stigma around the disease, making

individuals less likely to seek care. However, when interventions were designed to target the minority communities, most affected by this disease, improvements in health outcomes were seen (Young et al., 2015). While this issue is not as salient today, the stigma surrounding HIV/AIDS has had a lasting impact, making it a difficult disease to eradicate. There is always a risk that interventions will have unintended consequences. However, if policymakers target upstream interventions or social determinants of health and prioritize the communities that need the most assistance, adverse effects can be avoided.

### **Conclusion**

Throughout this review, new ideas and current findings on the SES-health gradient and the effects of racism on health were discussed in order to understand the current state of health disparities in the U.S. In addition to this new information, lessons learned from an analysis of the ACA, were taken into consideration to develop a 3-pronged health intervention plan to tackle health disparities. The plan prioritizes a “Health in All Policies” approach that emphasizes the importance of understanding the effects of any policy on health and health disparities, assuring that everyone is actively working towards undoing health disparities in the work they do. Additionally, the plan includes a shift in focus from healthcare expansion to the social determinants of health in order to ensure that the root causes of health care disparities are being addressed rather than a temporary fix, highlighting that

health can be addressed through a variety of policy. The third part of the intervention plan focuses on dismantling racism, assuring that people be held accountable for their implicit bias in order to address systemic racism. This 3-pronged intervention will not be enough to completely eliminate health disparities, but it promises to be a step in the right direction.

While this intervention proposal paves the way for a more hopeful future, Marmot (2017) explains that until nations prioritize equity over personal gain and economic growth, large improvements in health disparities and equity will be out of reach. Rather than focusing on personal growth, nations must prioritize inclusive growth, in that all communities see improvements, and not just those deemed as worthy. He refers to this idea as the good society, in that in a good society, inequalities are kept at a minimum. Even though the proposal addresses health disparities in the U.S., inequity is a global issue that puts billions at risk every day. Many nations have been so laser focused on economic growth and advancement that they have neglected to see how their actions affect others. In order to see improvements in quality of life and inequality, all must prioritize equity in the work they do.

### Conflict of Interest

There are no conflicts of interest to report.

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