

**MINORITY ACCESS TO HEALTH CARE  
THE SOCIAL CONSTRUCTION OF HEALTH CARE DISPARITIES:  
GIVING VOICE TO THE EXPERIENCES OF WOMEN OF COLOR**

By

Cynthia L. Manns

A DISSERTATION

Submitted to  
Michigan State University  
in partial fulfillment of the requirements  
for the degree of

Sociology—Doctor of Philosophy

2016

## **ABSTRACT**

### **MINORITY ACCESS TO HEALTH CARE THE SOCIAL CONSTRUCTION OF HEALTH CARE DISPARITIES: GIVING VOICE TO THE EXPERIENCES OF WOMEN OF COLOR**

By

Cynthia L. Manns

In recent years, there have been numerous studies looking at the health care disparities of racial and ethnic populations in the United States. When attempting to research health care disparities in the United States, questions arise with regards to the conceptualization of race and ethnicity. One of the greatest challenges confronting those who seek to improve the physical and mental health of underserved groups is the fact that many of the people most in need of care often have different understandings of health, the body, diet, and how to interact with institutions who deliver health care services. In many cases there are cultural and language differences, as well as geographic, limited resources of clients that act as further barriers to quality health care for African American women. When evaluating solutions to these problems, it is important to explore the intersections of race, gender and class, as well as the differences that may exist in terms of mental and physical health of women of color.

This study will test the following hypotheses: 1) Black women have more environmental and personal stressors which may lead to poor health outcomes; 2) What are the patterns of health care utilization for black women and 3) How does discrimination/stress influence health care utilization for black women?

This quantitative study examines a subsample of African American women from the National Survey of American Life (NSAL) 2001-2004, a study on racial and ethnic

differences in mental and psychological conditions as well as a comparison of health service utilization. The data examines variables of race, age, education levels, discrimination, employment status, stress, and psychological/chronic conditions which may impede minority women's ability to access health care. *The National Survey of American Life (NSAL)* is a comprehensive study of the mental health of black Americans. The study, conducted between February 2001 and June 2003, is part of a *National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys (CPES)* initiative. The NSAL adult sample is an integrated national household probability sample of 3,570 African Americans, 1,621 blacks of Caribbean descent (Caribbean blacks), and 891 non-Hispanic whites living in areas where at least 10% of the population is black, all aged 18 and over.

The results of this analysis indicates that there is a strong correlation between chronic health conditions, age and utilization of health care services. Multiple regression analysis shows that black women are less like to use health services than white women, and older black women in particular are less likely to utilize health care services. Discrimination was shown to be significant in determining depression among black women, and stress is positively associated with higher levels of stress. However, discrimination and stress are not significant predictors of health services usage among black women. This dissertation evaluates the current literature on minority health care, focusing on the health care disparities that exist among African American women in the United States.

Copyright by  
CYNTHIA L. MANNS  
2016

For Barbara Jean Williams Smith—my best friend and greatest fan. I could never have asked for a more loving and supportive mother. You believed in me, and you gave me the strength and courage to believe in myself. Everything I am, or ever will be is because you loved me.

## ACKNOWLEDGEMENTS

I would like to start by thanking Dr. Clifford Broman. Your encouragement and support of me has been an inspiration for me to continue with my research and my passions—even when I didn't know where I would find the strength. I would also like to extend a very special thanks to Dr. Steven Gold-You taught me how to critical think and be a visual sociologist—it is who I am now. To Dr. Tom Conner—You are amazingly brilliant! From you I learned to take numbers and create research. To Tammy Spangler—your support and guidance is truly a gift and I could never have made it through the program without you.

I started this journey when my son was three-years-old. Often, I would stay up at night to study, and he would always be there, right by my side. His laughter, joy and very presence has helped to motivate me, and seeing him begin his on adult educational journey now makes me realize that all the hard work was well worth it. I love you Justin with all of my heart. You have taught me to have patience, hope and above all to multi-task. You are my greatest achievement, and I live to see you live your dreams. Make each day count!

I would like to say thank you to my sister and my friend, Laura. You have been a wonderful friend to me. I am very grateful for your kindness and friendship.

Finally, I have a very special thanks to extend to my beloved sister, Donna. You have always been there for me, and your unfaltering support has given me strength to fulfill my dreams. Thank you for being my “big” sister. Life is an amazing journey.

## TABLE OF CONTENTS

LIST OF TABLES.....	ix
LIST OF FIGURES.....	xi
INTRODUCTION.....	1
A Black Woman’s Story .....	1
CHAPTER 1: RATIONALE AND CONCEPTUAL MODEL .....	9
Conceptual Model.....	12
Figure 3: Proposed model of race, SES and discrimination .....	13
CHAPTER 2: LITERATURE REVIEW.....	15
Perceptions of Racial Discrimination .....	16
Health Behaviors of Minorities .....	18
Defining Race in Health Care: Cultural or Biological? .....	20
The Triple-bind: Racism, Discrimination and Socioeconomic Status .....	23
Controlling for Race/Ethnicity in Research .....	25
A Brief History of Health Care for Blacks .....	28
The Use of Race in Health Care.....	29
Inequalities in Health Care.....	30
Women and the Health Care System .....	32
Important Mediating Factors in Women’s Health .....	34
Socioeconomic Differences .....	34
Socioeconomic Status and Health.....	35
CHAPTER 3: METHODOLOGY.....	38
Conceptual Framework.....	38
Research Questions/Hypotheses: .....	39
Data Analysis Plan .....	40
Sample .....	40
Measures: Sociodemographic Correlates.....	41
Mean Across Race for the Other Independent Variables .....	47
The Impact of Stress .....	48
CHAPTER 4: MULTIPLE REGRESSION.....	53
Discrimination and Stress Impacts .....	59
CHAPTER 5: DISCUSSION.....	65
Overview of my Findings .....	65
Regular Source of Health Care.....	66
Age .....	67
Feminization of Poverty .....	69
Racial Barriers .....	70
Discrimination .....	72

Depression/Stress .....	73
Education/employment .....	77
Insurance .....	78
Limitations to study .....	78
Personal Control .....	78
Future Recommendations .....	80
CONCLUSIONS .....	85
APPENDIX .....	90
BIBLIOGRAPHY .....	93
BIBLIOGRAPHY .....	94



## LIST OF TABLES

Table 1: Distribtuion of the National Survey of American Life (NSAL) sample Compared by race and ethnicity.....	42
Table 2: Descriptive variables for women only .....	44
Table 3: Race differences in having a usual source of medical help .....	45
Table 4: Depression (CES-D scale) .....	45
Table 5: Chronnic conditions .....	46
Table 6: Mean of every day racial discrimination -lifetime .....	47
Table 7: Mean for stress differences between black and white women.....	48
Table 8: Mean for variable: currently working .....	52
Table 9: Mean of respondents' years of school .....	52
Table 10: Mean age of respondent .....	52
Table 11: Correlation matrix .....	53
Table 12: Multiple regression of predicting depression by race and age .....	54
Table 13: Multiple regression of predicting chronic illness by age and race.....	55
Table 14: Multiple regression im having a usual source of medical help by age and race .....	55
Table 15: Multiple regression for depression by age, race, working status and education .....	56
Table 16: Multiple regression for chronic illnies by age, race, working status and education.....	57
Table 17: Multiple regression in having a usual source of medical help by age, race, working status and education .....	58
Table 18: Multiple regression of having a usual source of medicalhealp by age, race, and discrimination .....	59

Table 19: Multiple regression of having a usual source of medical help by age, race, and discrimination.....	60
Table 20: Multiple regression for chronic conditions, by age, race and discrimination stressor.....	61
Table 21: Regression model of depression, age, race, working, education discrimination stressor .....	62
Table 22: Regression model of having a usual source of medical help by age, race, working, education, discrimination and stressor. ....	63
Table 23: Regression model of chronic illness, age, race, age, working, education, discrimination, and stressor.....	64

## LIST OF FIGURES

Figure 1: Death rate of women in the United States by race and age 15-54.....	6
Figure 2: Loss or gain in life expectancy in years .....	10
Figure 3: Proposed model of race, SES and discrimination.....	13
Figure 4: Conceptual model revised.....	66
Figure 5: Rate of potentially preventable hospitalizations among adults aged $\geq 18$ years, by race/ethnicity.....	82

## INTRODUCTION

### *A Black Woman's Story*

*In May of 1996, a young black female enters the emergency room of a local Michigan hospital at 3 a.m. She is complaining of severe abdominal cramping. She states that she has had the problem for several months, and often it gets worse right before her menstrual cycle. She admits to having several alcoholic beverages earlier in the evening, but re-states that the pain has been bothering her for some time. She is a full-time student, and she has no health insurance when school is not in session. The emergency room staff treats her with an IV and sends her home with a \$550 bill and a prescription for Tylenol-3.*

*The woman returns to the health system six months later with the same complaint. She must go through the university clinic in order to use the extremely limited insurance offered by the university that she attends. She is referred to a gastroenterologist, who performs a sigmoidoscopic procedure on her. Nothing shows up, and she is sent home with literature on Irritable Bowel Syndrome, and told to eat more fiber and take Citracel*

*Several months pass, and the woman is still having the same problem with severe abdominal cramps. In July of 1997, the woman discovers that she is pregnant and decides to keep the baby. In August, the woman makes her first prenatal visit by going through the health clinic at the University. She is then referred to the University women's health clinic for her first visit. The visit is uneventful, but she aware of the fact that the staff has made several references to her student health insurance. The nurse*

*informs her that her insurance only allows for one ultrasound. She returns to the clinic three weeks later with complaints of severe abdominal cramps and spotting.*

*The clinic performs an ultrasound (the only one her insurance states she is entitled to), and she is told that she has a small fibroid, and that a small tear in the placental sac was causing the spotting. If the bleeding doesn't stop, the pregnancy will not continue. The woman returns home, scared and worried, but two weeks later the pain and bleeding have subsided. Throughout her pregnancy she felt like she received adequate care, but she often felt uncomfortable because of her unmarried status and the fact that she had student insurance.*

*She gave birth three weeks before her scheduled due date to a six-pound healthy baby boy. She decides to nurse the infant and does so for two years. She is aware of the fact that the mysterious pain in her side has subsided. Two months after she stops breastfeeding her son, she discovers that she is pregnant. She is now married and is under her husband's health insurance. She decides not to return to the university physicians. The pregnancy ends in a miscarriage, and after a routine checkup, her gynecologist informs her that she has three small fibroids, which may have contributed to the demise of the pregnancy.*

*A month later, the woman returns to her physician with complaints of severe abdominal pain, which her doctor assumes is being caused by the fibroids. She performed a hysteroscopic procedure to determine the exact size and location of the fibroids. There is nothing notable in the size and location of the fibroids to account for the pain that the woman is experiencing, nevertheless, the physician prescribes a 3-month regime of Lupron. Lupron is the name brand for a GnRH inhibitor that stops the*

*production of estrogen in the body, and puts the patient into a temporary menopausal state.*

*The woman takes the medicine for two of the three prescribed months, but stops because the symptoms associated with menopause are too great for her to bear. Six months later her pain returns, and it is the worse that it has ever been. Her physician refers her to a specialist, who happens to be a physician at the university clinic that she was seen at during her pregnancy. The woman feels that the doctor is kind, and the staff treated her quite differently now that she was married and had better insurance.*

*Surgery to remove the fibroids is scheduled for six months later, and she endures a tremendous amount of pain up until her surgery date. When she awakens from the anesthesia, the surgeon explains to her that she had what is called “severe endometriosis.” Endometriosis is a condition in which the uterine tissue grows outside of the uterus and causes severe pain. The surgeon removed endometrial tissue from the woman’s colon and ovaries. He also removed the three small fibroids. When she asked him why no one had ever suspected endometriosis before, he defensively told her that it was not always easy to diagnose. The woman was stunned and angry. She had been suffering for almost five years and no one had ever suggested that she might have endometriosis.*

The above story illustrates just a small fraction of the problems that currently plague The United States health care system. The patient's story suggests that there are cultural, class and race discrimination that may have impacted the quality of care that she received. Because she had no health insurance, she was "turfed" out of the emergency room. Because she had limited insurance, she was informed that she would not be eligible for more than one ultrasound. Because she was African-American, she may have been misdiagnosed with fibroids, even though the medical literature on fibroids clearly states that small fibroids are usually asymptomatic. This patient did not fit the "stereotypical" profile that at that time was used to diagnose the disease of endometriosis. Studies dating back to the 1970s indicate do not include African American women, and new research indicates that many African American women still continue to be misdiagnosed (Gaines, 2011). The question that remains is why?

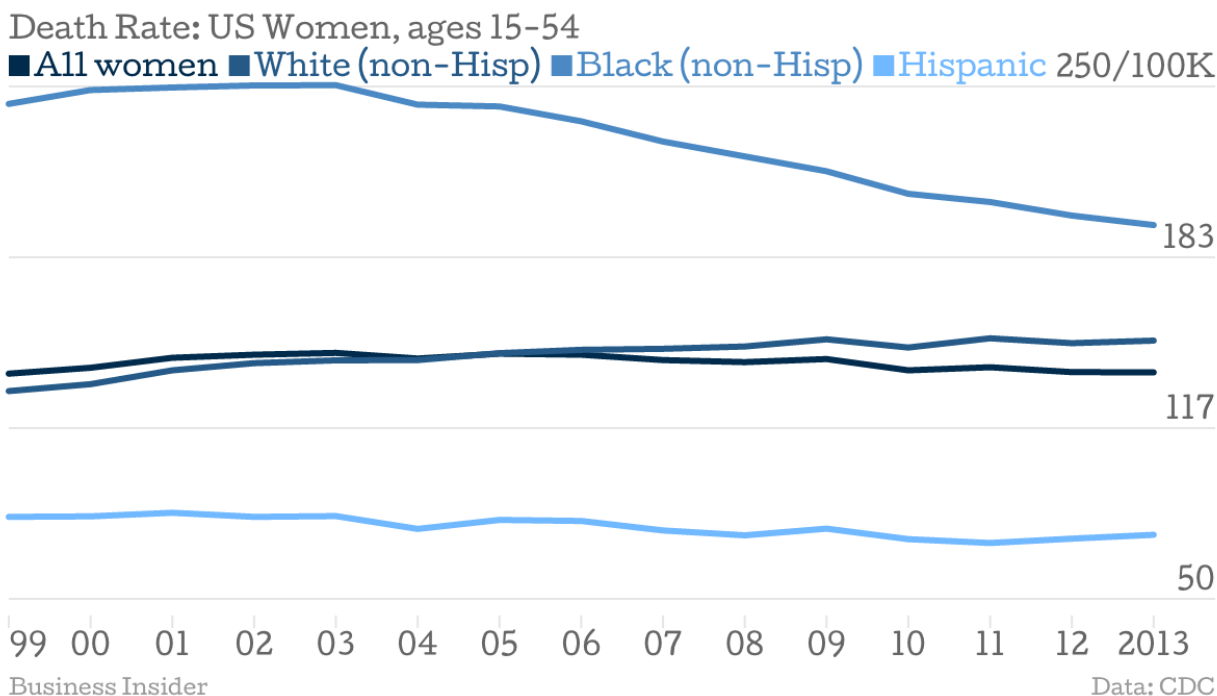
The health status of African Americans in the United States continues to be the subject of numerous studies in recent years, and yet while researching for this dissertation, the information that I obtained was often inconsistent, convoluted and not focused on the issues that minorities face while negotiating health services. Clearly we understand that health care disparities exist, but researchers are still struggling with understanding why they are persistent within minority populations (Meredith and Griffith-Forge, 2002). African Americans make up approximately 13.2 percent of the United States population or approximately 42 million (U.S Census Bureau, 2014), but they are grossly overrepresented in nearly every major disease category, and this trend seems to be on the rise (Office of Minority Health, 2012). The life expectancy for whites is

currently 78.9 years compared with 75.1 years for blacks (Arias, 2014). Heart disease is 25 percent more prevalent in blacks than in whites. On average blacks are 2 times as likely to have diabetes as whites of similar age (Office of Minority Health, 2012). The cancer rate for blacks is 20 percent higher than that for whites (Wacholder, 2007). HIV cases with black men who have sex with men are increasing, while the rate for white men who have sex with men continue to decline. Over 70 percent of the new HIV/AIDS cases are among African Americans (CDC NCHS, Nation Health Statistics, 2008). Overall, the death rate among African Americans is 30 percent higher than whites (Williams, 2007).

For African American women, the statistics are even more discouraging: one out of every four over the age of 55 has diabetes (Robbins, et al, 2001; Minority Women's Health, 2010). There are more white women diagnosed with breast cancer annually, yet the mortality rate for black women is far greater. The disparity in mortality rates between white and African American women increased progressively between 1980 and 2000, so that by 2000 the age-standardized death rate was 32 percent higher in African Americans (American Cancer Society, 2009). Figure 1 illustrates the death rate disparity between black and white women.



**Figure 1: Death rate women in the United States by race and age 15-54**



Source: Center for Disease Control (CDC), 2014.

The health of a society is often measured by its' infant mortality rates, and at present, infant mortality rates for whites are among the lowest in the world, unfortunately, this is not true for African Americans. Two of the most disturbing problems in the current rhetoric on minority health care are the infant mortality (IMR) and low-birth weight (LBW) among African Americans. In all fifty states, both the infant mortality, and low-birth weights for African American women are in the double-digits. Nationwide, the infant mortality rate for blacks is 13.9 per 1,000--about two times the rate of whites. In the state of Michigan, the mortality rate for black babies is three times that of whites (National Center for Health Statistics, 2012.) Although infant mortality has decreased among all races within the past 20 years, the gap between white and black infant mortality has increased (National Center for Health Statistics, *Health, United*

*States 2005*). African American babies born in the U.S. today are two-and-a-half times more likely to die before their first birthday than white babies (Satcher & Higginbotham, 2008). In 1999, the infant mortality rate for African American women was 12.6 (per 1,000 live births), compared to 5.7 for White women; more than twice the rate for whites (CDC NCHS, Nation Health Interview Survey 2004). Black women are three times more likely than white women to die during pregnancy, yet researchers have yet to unravel this daunting problem.

These statistics paint a very disturbing health profile for most African Americans—in particular African American women, the focus of this study. Despite vast improvements and advancements in disease management and health, disparities continue to exist for black women.

As researcher, I have spent my career studying racial inequalities and the intersections of race, gender and class. I have narrowed my focus of research on the health care disparities that exist for African American women. When attempting to research health care disparities in the United States, there are no general guidelines among researchers on how to adequately address the issues of race, poverty, class and discrimination. Research is often inconclusive because although you can argue that race and gender discrimination exist, it is extremely difficult to measure it quantitatively, as there can be other variables that may account for health disparities (diet, personal behaviors, heredity). Some researchers attempt to “control” for race and ethnicity, others use race and ethnicity interchangeably, and still others evaluate focus on the cultural and psycho-social needs and environments of their patients—which may be a

leading cause to late and/or misdiagnosed diseases. Clearly this is a complicated and multi-varied problem that is challenging for researchers to examine.

Moreover, there are gaps in the research that need to be addressed, as it is often very challenging for researchers to show direct correlations between race and poor health outcomes. This research seeks to provide a better understanding of the relationship between race, gender and health by examining key variables such as education, stress, age, and health care utilization. These variables have been shown to be significant in this analysis, and may explain the daunting health care statistics for African American women in the United States.

## CHAPTER 1: RATIONALE AND CONCEPTUAL MODEL

This dissertation is very personal for me. The story described earlier is based on my own person experiences as an African American woman navigating through the US health care system. As patient, I observed how the medical institution functioned, and in many ways the treatment that I received seemed to vary—depending on my age, my marital status and my class. As a sociologist, I have always been extremely fascinated with the sociology of health and the intersections of race, gender and class. Additionally, I have noted how people are transformed and objectified within the health care system as Goffman’s theory of Dramaturgy illustrates (1959). Medical sociology evaluates the societal factors related to health, as well as the social construction of health (Weiss & Lonquist, 2015). What is often missing from the quantitative medical research is the actual nuances that women of color experience as patients in a system that often seems to overlook their needs.

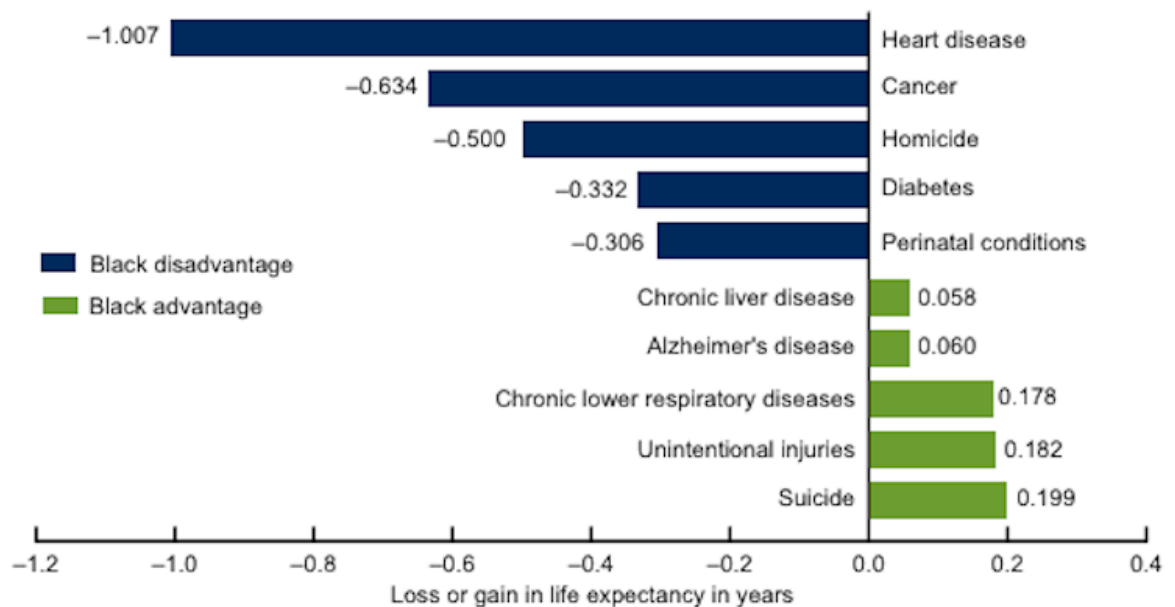
When contextualizing the relationship between race and health, how should researchers incorporate the constructs of socioeconomic status, racism and discrimination in their findings? Troy Duster argue against using biological constructs, as they are often subjective and based on “socially defined principles and prejudices (Duster, 1991). Some research has focused only on socio-economic status; others have looked only at race/ethnicity, some used race, some education level, and yet the answer as to why African American women are still at such a high risk for hypertension, diabetes, infant mortality, cancer and other significant illnesses remains elusive.

This dissertation will examine several variables that may contribute to poor health outcomes for African American women. I will be exploring the mediating factors of

depression/mental health issues, discrimination, education and demography to determine what factors are most relevant when evaluating health care utilization for African American women. Additionally, it is very important to address the intersections of race, class and gender when evaluating any institutional disparity.

African American women’s health issues are part of the larger concern of minority’s health care issues. When evaluating the health care status of people of color, it has been repeatedly shown that blacks are disproportionately represented in 8 of the 10 major disease categories (Williams, 2012) despite vast improvements in health care overall. Figure 2 illustrates the huge loss in years of life associated with the major diseases that kill African Americans.

**Figure 2: Loss or gain in life expectancy in years**



Source: CDC, 2014

Minorities—black women in particular--still suffer from poor health outcomes when compared to whites of the same age. Reasons vary from poor urban areas that have created social and economic deficits for blacks (Wilson, 1991), to lower socioeconomic status of minorities which indicates lower education and income (Braithwaite and Taylor, 1992; National Center for health Statistics 1993; Polednack, 1989). The question remains—are poor health outcomes due to institutional racism or are there other issues that have been left unaddressed?

Race continues to be utilized in health care research, but is it evaluated in the appropriate fashion? Race is a social construct that can change due to time and demography. Fujimura, et al, (2008) question where we should continue to look at environmental and genetic reasons for health disparities, but acknowledge the need to not move away from racial categories, but instead understand the social construction of race in health deals with far more than biological or genetic differences in health disparities.

Overt racism is *not* the issue; it is the power that has been disproportionately built within our American institutions. We have clear evidence that the educational and criminal justice institutions marginalize minority populations (Boob, 1993), and the institution of health is no exempt from closer examination. Poor health outcomes are most likely due to institutional racism, as much of the research on this subject suggests. Modern racism is often reflected within our institutions, and this may be linked to the lack of quality health care, and the mental/physical well-being for minority patients. Stress is often used as a catch all cause for many ailments, yet there is little doubt that stress is a factor in many cases of chronic illnesses. The objective of this dissertation is

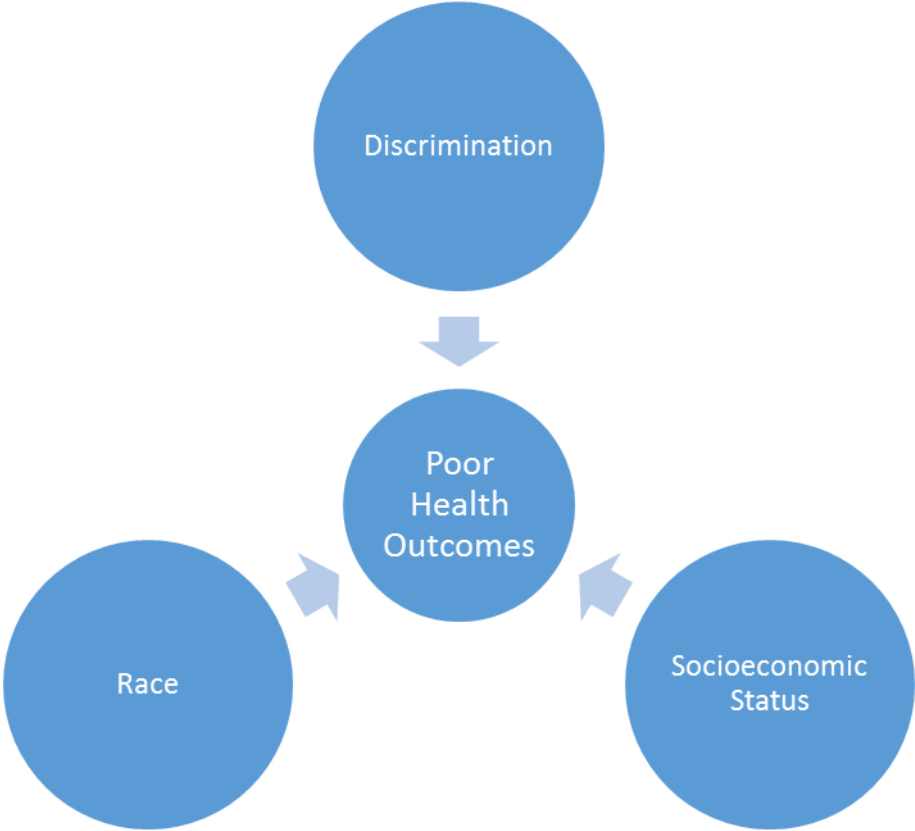
to evaluate environmental and personal stressors which may lead to poor health outcomes; health care utilization among black women, and finally the impact of discrimination and stress in health care utilization. My goal is to show that African American women inherently deal with far more stress than what may have been previously indicated, and this combined with discrimination could account for the large health care disparities seen among black women.

### *Conceptual Model*

The conceptual model for my analysis is illustrated in Figure 3. The model consists of 1) Race—comparing the health care experiences of black versus white women, 2) Socioeconomic status of women (education and employment status), and 3) the effects of discrimination. The framework of this model also evaluates the dependent variables of chronic illness—defined as a health condition that requires long-term management (WHO), depression and having a source of regular health care services.

The conceptual model is intentionally focused on these variables in order to evaluate the validity of the research questions behind this analysis. Much of the literature on health care either focuses too specifically on one health topic (infant mortality) or is too broad in its scope (race) to really focus on the issues that black women experience. By narrowing the focus to race, socioeconomic status and discrimination, a more cohesive argument can be made about the significance of these measures.

**Figure 3: Proposed model of race, SES and discrimination**





There is research that suggests that socioeconomics may play a role in poor health outcomes (Kirby & Kaneda, 2005). However, this research focuses more the effects of poor neighborhoods, and not on employment status. Additionally, there is research that confirms that discrimination leads to depression and poor health outcomes for African American women (Shultz et al, 2005), and its and there is a plethora of research confirming that discrimination is a reality for minorities. However, there are few studies that combine the variables of race, socioeconomic status and depression –in order to evaluate whether or these variables also affect how African American women are treated *within* the health care system. Furthermore, the ongoing debate over the significance of race versus class remains (Pappas, 1994), and it the relationship between race and health services needs a modern contextualization to reify the distinctions of classism versus racism.

## CHAPTER 2: LITERATURE REVIEW

There is growing evidence that the American health care system is systematically neglecting to address the medical needs of black women and these women face an even greater risk of health inequities due to what many call “the triple bind”—gender, race and social status. For example, studies on infant mortality and hypertension indicate that socioeconomic status is a significant factor, but alone cannot explain away all the variance (Lillie-Blanton et al, 1996). More researchers are realizing the importance of including “nonwhite” populations in their studies; however, the use of race as a biological category is unsubstantiated.

There are various institutional and sociological problems which may impede the quality of care that black women receive. In order to fully comprehend the health care plight of minorities, it is important to look at the racial, gender and class inequalities that exist within our social institutions, as well as to contextualize the geographical and psycho-social barriers that may impact black women’s ability to receive adequate health care. As mentioned previously, there have been numerous studies looking at health care disparities of racial and ethnic populations in the United States. Although there have been huge health care advances over the last century, overall, African Americans and other minorities are still over-represented in nearly every disease category, and this trend seems to be on the rise. Research indicates that the probable causal factors for health care disparities are the racial and ethnic differences in the quality and quantity of care (Williams and Tucker, 2000), as well as social and environmental factors.

When attempting to research women’s health in the African American community, a host of questions arise with regards to the conceptualization of race and

ethnicity. Researchers often disagree on the significance of culture, socioeconomic status (SES), and biological determinants when addressing minority health disparities. Race and ethnicity are often used interchangeably, or “controlled” for in research models.

One possible explanation for these inconsistencies in research may be that there is an inadequate understanding of the structural and cultural barriers that exist for minorities when attempting to access health care (Williams, 1992). When race is viewed as a socially constructed category, it is also necessary to address the historical constructs of race. The categories of race are direct reflections of the social climate of a particular time, and they carry very different meanings in different societies. In the United States, race has rigidly been used to define what is white, and what is “not white.” Audrey Smedley (1996) states “race was a folk concept that was elevated to the ranks of scholarly discourse when scientists began developing rationalizations and justifications for existing social realities” (P. 321). In other words, race has been used to substantiate and propagate the oppression and exploitation of individuals for political and economic gains.

#### *Perceptions of Racial Discrimination*

It has been shown that African Americans underutilize health care services, and the possible causes are education and economic levels as well as inequality in the health care system. In order to fully understand women’s health disparities in African American populations, it is necessary to look at institutional racism and the perception of racism as crucial components in understanding why blacks underutilize health services. Research addressing health disparities are often reluctant to directly confront

the issue of racial discrimination. Williams and Rucker believe that the evidence is clear that racial discrimination is a major problem for our society as a whole. In their article “Understanding and Addressing Racial Disparities in Health Care,” Williams and Rucker outline the racial disparities in health care and discuss the issue of racism within social institutions. They do not believe that personal discrimination from health care providers is a major contributor to the health care crisis among African Americans, however they do insist that institutional racism may be the major problem in health care. The article describes racism as “an organized system, rooted in an ideology of inferiority that categorizes ranks and differentially allocates societal resources to human population groups” (Williams and Rucker, 2000). The study concludes that in order to improve the health status of minority populations a “societal-wide” movement is necessary in order to eradicate discrimination in education, employment, housing, and criminal justice (Williams and Rucker, 2000).

Perceptions of discrimination can have a profound and lasting impact on the recipient. In terms of health care, it can often be detrimental. An individual, who enters into the health system and feels that she/he is being treated unfairly, may opt not to return or delay further treatment. Furthermore, it can affect the doctor-patient interaction and the trust needed in order to adequately diagnose and treat illness. A study on perceived discrimination among women and minorities found that they were more likely to minimize personal discrimination and blame themselves instead for the negative feedback that they received (Ruggiero and Taylor, 1997). While the study suggests that minimizing discrimination has positive effects on self-esteem, it also

points to the fact that by not acknowledging societal discrimination, minority groups will have little success in overcoming discriminatory practices (Ruggiero and Taylor, 1997).

There is an abundance of literature detailing race and ethnicity in health care disparities, however, the amount of literature that directly details racial discrimination is extremely limited.

### *Health Behaviors of Minorities*

This dissertation focuses specifically African American women and their experiences with health care issues in the United States. While other minorities also have similar health care disparities, inclusion of every minority group is beyond the scope of this dissertation. However, the dramatic surge in the diversity of our nation has led to a greater recognition of the importance of providing culturally competent and linguistically appropriate health care. A growing literature reveals that culture and language significantly impact clinical care, including health care processes, morbidity, mortality, quality of care, and patient satisfaction, issues of intense interest in this age of managed care. A recent review, for example, demonstrated that failure to consider a patient's cultural and linguistic issues can result in a variety of adverse consequences, including miscommunication, poor continuity of care, less preventive screening, difficulties with informed consent, inadequate analgesia, decreased access to care, use of harmful remedies, delayed immunizations, and fewer prescriptions (Flores, 2000).

Currently, over 78 million Americans, or about 30% of the nation's population, are of nonwhite race or ethnicity (U.S. Census, 2013). One out of every three US children (18 years old) is nonwhite (U.S. Census, 2000). Of the approximately 74

million children living in the U.S. in 1999, 47.9 million (65%) were non-Latino white, 11.6 million (16%) were Latino, 10.8 million (15%) were non-Latino African-American, 3 million (4%) were Asian or Pacific Islander, and 714,000 (1%) were Native American (U.S. Census, 2010). It is estimated that by 2025, almost 40% of Americans and about half of all U.S. children will be nonwhite (Branch & Fraser, 2000).

In order to determine what other dynamics may contribute to the health (or lack of) in minority populations, it is important to evaluate their help-seeking/health behaviors. Health care seeking behavior is described as the actions that an individual takes when they feel that they are sick. This includes the steps taken by the person when they perceive that he/she has a health problem (Bailey 1991). This model is comparable to the Gurin et al. (1960), *Help-Seeking Model*. This model conceptualizes prospective patients seeking help as a series of decisions which include: (1) the decision that a problem exists, (2) the decision that help is needed to solve the problem, (3) the decision to actually seek professional help, and, (4) the decision about the choice of professional helpers. In terms of defining when a health problem exists, research has shown that African-Americans often ignore symptoms until it impedes everyday living (Bailey 1991). It has been shown that blacks, particularly the elderly, have a lower perception of health status compared to whites (Bailey, 1991).

There are other issues that impede many minorities' ability to seek help. Often, because of socioeconomic and cultural constraints, many blacks are unable adopt the sick role (Parsons, 1951). This is true in particular for African-American women, who often are the sole providers for their families (Bailey, 1991). Additionally, although

chronic illnesses are common, it may be that many physicians are still utilizing Talcott Parson's outdated model of health to treat people who are in need of continual care.

*Defining Race in Health Care: Cultural or Biological?*

Historically, race was considered a biological category, and it is only recently that this belief has been challenged. The biological construct has been under extreme scrutiny, and researchers have found the biological categorization of race to be flawed and inconsistent (Brown et al., 1999). Attempts at classification have led to a tremendous amount of confusion and debate among biologists, geneticists and anthropologists (Marger, 2000). The *Encyclopedia of Sociology* lists race as a combination of "geographic, ecological and morphological factors" (1996). One definition states that race is "a category of people who, through centuries of interbreeding, have developed some roughly similar physical features like skin color (Kerbo, 1989). Still another definition states that race consists of certain hereditary characteristics found only in a particular group (Marger, 2000).

While the United States is still struggling with the concept of a "post-racial" society, it is clear that there problems with racial still exist within our institutions. As a black woman who has had varied experiences within the health care system, the concern with these definitions of race lie in the fact that provide very little insight into the social construction of race. What does it mean when a African-American woman seeks out health care and she feels that she is treated differently because of her skin color? Why do people of color continue to be marginalized in the health care system?

There are still researchers who are proposing that biological differences do in fact exist. For example, blacks are disproportionately more likely to have hypertension

than whites. Some health researchers have proposed various hypotheses to explain this phenomenon (Cockerham, 1998):

1. The genetic hypothesis, which has its historical roots in the acceptance of the Darwinian “nature versus nurture” argument.

2. The physical exertion theory that blacks are more likely to engage in manual labor than whites, thus putting them at a greater risk for hypertension.

3. The associated disorder hypothesis that states that blacks are more prone to certain diseases.

4. The psychological stress hypothesis that states that blacks are victims of every day discrimination, and that this leads to poor health outcomes.

5. The diet hypothesis emphasizes that blacks may have eating habits that put them at risk for hypertension.

6. The medical care hypothesis which posits that blacks receive inadequate health care and thus explains the higher morbidity and mortality from hypertension.

Despite all the above rationales, the exact *cause* of hypertension among African Americans still remains elusive, and science cannot offer a viable conclusion for this health disparity. This is one of many examples that exemplify the problem with defining race in health research. Researchers are in agreement that besides classifying people based on phenotypical traits, there is no clear way to identify racial categories from a biological standpoint (Marger, 2000). In fact, evidence clearly indicates that the biological concept of race is invalid and that there is only one species of the human race; which means there are no true biological categories of race.



This is not to say that there are not inherent biological differences, and that some of these differences may actually be confined to a biological race category. There is clear evidence that certain inherited disease traits are more common in particular groups of individuals. For example, Tay Sachs is an inheritable disease found among people of Eastern European Jewish descent, and Sickle Cell Anemia is more prominent in African Americans (Williams, et al. 1994). However, the overall problem with the definition of race does not lie in the few biological examples of differences; it lies in the social, economic and political struggles that exist because of the racial ideology behind the differences. Therefore, it seems that the most logical and consistent approach in evaluating race lies in looking at race as a *social* concept.

When race is viewed as a socially constructed category, it is also necessary to address the historical constructs of race. The categories of race are direct reflections of the social climate of a particular time, and they carry very different meanings in different societies. In the United States, race has rigidly been used to define what is white, and what is “not white.” Audrey Smedley (1996) states “race was a folk concept that was elevated to the ranks of scholarly discourse when scientists began developing rationalizations and justifications for existing social realities.” Industrialization helped to define and classify people’s ethnic and racial status; in other words, race has often been used to substantiate and propagate the oppression and exploitation of individuals for political and economic gains.

There are current scholars who believe, as did Marx and Weber, that race has become insignificant, and that class structures and political views are what currently divide the strata (Wilson, 1978). According to William Julius Wilson, there have been

three defining stages of race in America: 1) the exploitation of African Americans through slavery, 2) the emancipation of slaves and the industrial revolution that followed, and finally, 3) the current stage where racial inequities have become class inequalities (Wilson, 1978).

Wilson's ideology has been largely criticized, mainly because he ascribes class as more significant than race, which totally dismisses the issues of discrimination that minority groups (especially African Americans) face in America (Doob, 1999). Additionally, our political ideologies—i.e., our public policies (*Healthy People 2010*)—are constantly dealing directly with racial issues. This is clear when addressing health care disparities in the United States. Race is often examined as a determinant of poor health outcomes, and many researchers while studying this phenomenon fail to look at the broader social issues surrounding race (Bonilla-Silva, 1997).

#### *The Triple-bind: Racism, Discrimination and Socioeconomic Status*

In the previous section, race was described both biologically and socially. Ethnicity was discussed in terms of cultural identity. In attempting to understand the true meaning of racism, it is important to reflect upon those inconsistent viewpoints of race within our social institutions. It is also paramount that we discuss the current racial ideology of the United States. Racism can be defined as “prejudice plus power.” Racism involves the systematic oppression of groups of individuals based on their color or ethnic identification (Rothenberg, 1998). According to Joe Feagin (2001), institutional or structural racism refers to “a system of oppression of African Americans and other people of color by white Europeans and white Americans.” Gary King defines institutional racism as a covert and systematic racism found within social systems and

institutions (1996). Lawrence Bobo (1997) addresses the concept of “laissez-faire racism” and distinguishes it from “symbolic racism.” Bobo’s “Laissez-faire racism” encompasses stereotyping, victim blaming, differentials in socioeconomic stature, and policies that allow racism to influence social conditions and institutions. His theory contends that even if overt racism is eliminated, the historical oppression still puts most African Americans at a disadvantage. Of all the definitions presented here, Bobo’s offers the most realistic assessment of the problem. Racism is everywhere, and yet because of its overt and insidious nature, it is very difficult for most researchers to study directly, and it is easy to overlook.

In contrast, discrimination refers to the practices and behaviors that systematically disadvantage one group over another. Essed describes discrimination in terms of its relationship to racial ideologies and practices (1991). The effects of institutional racism and discrimination have a cumulative effect, which often has a direct impact on the socioeconomic (SES) status of minority groups. SES refers to education, income and employment level, and it is in these areas where discrimination can have lasting results. There are researchers who believe that race should be used as a “proxy” for SES (Krieger, 1993); still others feel that race is what determines SES (Williams and Yu, 1999). Ulbrich et al. (1989) found that SES and race interact to increase symptoms of psychological distress, and Broman’s (1995) research found an interaction between education and unemployment in terms of stress.

The relationship between SES, discrimination and racism are complex, but they are invariably related. Racism affects SES, discrimination is a result of racism. Researchers cannot expect to shed light on any health issue that they study without

addressing all three. Research that attempts to “control” for any of these variables will undoubtedly fail to understand the complete relationship between social stratification and health.

### *Controlling for Race/Ethnicity in Research*

The current literature on race and ethnicity is extremely complicated and confusing. Many researchers, in their attempt to isolate other variables have tried everything from attempting to “control for race” (Brown et al. 1999) or not including it at all. This makes it extremely difficult to understand the social complexities of the meaning behind race, and often leads to incomplete or inaccurate analysis of the problem being studied. Studies on infant mortality provide a perfect example of the problems that researchers face with using race in their studies. In 1989, the National Center for Health Statistics (NCHS) began using the “race of the mother” to code for the “race of the child” (Petrini, Damus and Roy, 1998) in lieu of using the race of both parents. The study done by Petrini, Damus and Roy compare birth defects/infant mortality (BD/IMR) based on “race of the child” and rates based on “race of the mother.” What they found was that assigning infants to the “race of the mother” category only increased the gap in BD/IMRs between black and white infants. The study concluded that it was necessary to find better ways to measure race and the correlating factors of socioeconomic class and health.

Another disadvantage to using race in health research is that it often places too much emphasis on the category of race, which often leads to blaming the victim, instead of addressing the underlying causal factors. For example, legal authorities in South Carolina began prosecuting women who were using drugs during their

pregnancy. The program was initiated at a public hospital, which provided services mainly to poor black women. These women were tested for drugs, and if they tested positive, they only had one opportunity to submit to drug treatment. Many of these women were eventually incarcerated; some were even handcuffed and shackled during their deliveries (Thomas, 2001). Clearly this is a case of a well-intentioned policy gone wrong. In an attempt to reduce infant mortality and increase prenatal care, poor black women were criminalized and victimized by a system that was already failing them.

A similar study on the effect of racial and ethnic differences attempted to control for other risk factors, such as lack of health insurance and participation in the WIC program (a supplemental food program for Women, Infants and Children; Frisbie, et al., 1983). Again, the conclusions showed that large health disparities still persisted, and with African Americans experiencing a much higher rate of problematic birth outcomes (Frisbie, et al., 1983). One final study on mortality found a correlation between neighborhoods with low income and high concentrations of African Americans (LeClare, Rogers and Peters, 1997). The study concluded that geographic isolation increased social inequality for African Americans; however the study did not discuss racism, political or economic ideologies that promote segregated communities within the United States.

All of these studies have one significant flaw in common: the researchers are placing too much emphasis on the category of “race,” without defining what variables they are using to construct race, and whether or not they are using a biological or sociological framework. Moreover, not enough emphasis is being placed on other

possible causal factors such as institutional discrimination and inadequate health care. It is a head-in-the sand approach to attempt to analyze race in health care without *directly* addressing the intersections of discrimination, racism and socioeconomic status.

The abovementioned studies illustrate one of the disadvantages of using race in research, however, if used correctly, race can be a powerful tool in understanding health care disparities. Using race in literature helps to clearly define what the health disparities are (infant mortality, diabetes, heart disease), and who is at greater risk for developing them. In “An Essay on Race, Racism and Health,” Thomas LeVeist states that race should be used in research to explore the “theoretical and empirical links between racism, race and health” (LeVeist, 1996). LeVeist believes that race should no longer be considered a confounding variable, but instead view race in terms of the “individualized” and “structural” racism that heightens an individual’s exposure to health risks.

In research it is common practice to control for variables. To control for a variable is to try to separate its effect from the treatment effect, so it will not confound with the treatment (Babbie, 2004). There are many methods researchers use to control for variables. Some are based on matching individuals between treatment and control; others use assumptions about the nature of the effects of the variables to try to model the effect mathematically, for example, using regression. The problem with controlling for race is that in the process of trying to isolate the confounding variable for the health disparity in question (i.e., hypertension); we end up ignoring the issues of power relations, social inequalities and racism. At the same time, if we attempt to use ethnicity instead of race as a variable, we find ourselves in the same position of not

understanding the ways in which institutional racism impacts the policies and behavior of health care providers (Thomas, 2001). The reality is that we cannot really control for either race or ethnicity without losing insight into the issue being studied. When we use oversimplified labels for race (black versus white) and ethnicity (Hispanic versus African American) for the extremely complex factors related to health, we are not capturing the dual hierarchies that class and race have on health (Moss, 1995).

Current research on mental health highlights the importance of evaluating the poorly understood risks for health and mental health problems with minorities (Aheshensal, 1992, Williams, and Fenton, 1994). Research is emerging that indicates that race is related to stress in the mental health of ethnic minority populations. Current interest in racial and ethnic health disparities underlines the critical importance of addressing the extent to which minority status increases risk for health and mental health problems (Aneshensel, 1992; Williams and Fenton, 1994). An emerging area of research is the contribution of race-related stressors to the mental health of ethnic minority populations.

#### *A Brief History of Health Care for Blacks*

The United States has a very clear, documented history of discrimination in health care, which dates back to the antebellum period. Prior to the Civil War, medical care was mainly an independent, fee-for-service endeavor. There were very few medical institutions, and because the country was mainly an agrarian economy, there were very few organized medical services, the exception being the health care services provided to slaves on the plantations (Smith, 1998). Plantation owners were the largest employers at the time, and they had a vested interest in the health of their workers. As

a result of their financial value, slaves often received better health services than poor southern whites and northern laborers (Smith, 1998). Large plantations had hospital facilities for their slaves, and many of the larger cities of the south had organized hospitals specifically for slaves (Smith, 1998).

After the Civil War ended, the plantation medical services ended as well. The federal government created the Freedman's Bureau to provide health services to freed slaves. Gradually, a segregated system of health care emerged, with most blacks being forced to use public hospitals, while the private facilities were reserved for whites (Smith, 1998). The *Flexnor Report* helped to solidify the division of care provided to blacks. The report helped to bring sweeping reforms that benefited the health profession, but it also limited the ability of blacks to enter into the medical field. As a result, medicine became a profession for elite, upper class white men (Smith, 1998), and though tremendous changes have occurred, African Americans account for only 4.4% of all physicians in the United States (Rao & Flores, 2007).

### *The Use of Race in Health Care*

Historically, race has been considered a biological category, and it is only recently that this belief has been challenged. The biological construct has been under extreme scrutiny, and researchers have found the biological categorization of race to be flawed and inconsistent (Brown et al., 1999). The *Encyclopedia of Sociology* lists race as a combination of "geographic, ecological and morphological factors" (2008). One definition states that race is "a category of people who, through centuries of interbreeding, have developed some roughly similar physical features like skin color



(Kerbo, 1989). Another definition describes race of consisting of certain hereditary characteristics found only in a particular group (Marger, 2000).

These vague and loosely defined definitions provide little insight into the social meanings of race. As mentioned previously, Tay Sachs and Sickle Cell Anemia are clearly linked to population genetic, but the health plight of African Americans does cannot be traced directly to genetic markers.

### *Inequalities in Health Care*

Inequality in health care consists of several factors, which include: unequal distribution of resources, lower quality of care, and geographic disparities. Quality health care services are paramount in the prevention and detection of disease.

Therefore, when looking at the higher rates of health disparities among black women, one has to question whether or not there is a difference in the quality of health care received by black women. Furthermore, we need to explore other racial inequalities within the health care system in order to identify what types of structural barriers may exist for African Americans in general when seeking health care services.

In the *Journal of Health Politics, Policy and Law*, David Barton Smith provides an excellent overview of many of the health care disparities that still exist for minority populations. Large differences of use are found in particular, for specialized procedures, such as hip replacement, arthroscopy and coronary artery bypass grafts (Smith, 1998). African Americans on dialysis are less likely to receive kidney transplants, and less likely to survive transplants. Overall, African Americans lag behind whites in prenatal care, childhood immunizations, and flu shots for the elderly and cancer screenings (Smith, 1998). Some of the explanations for these inequities

are (1) lack of insurance and inability to pay out-of-pocket expenses, (2) the bureaucracy of Medicaid reimbursements discourage provider participation, (3) geographic maldistribution of resources and, (4) lack of trust for health care services, which prevents early health interventions (Smith, 1998).

Racial discrimination by providers is also another possible factor. The study suggests that inadequate health education, health systems that are not user-friendly to members of certain cultures, and overt racism may all play significant roles in the health disparities that currently exist (Smith, 1998). Smith concludes that health service research and provider communities need to work together to make sure that they are making every effort to provide equitable services to all. Similar findings were reported in a study on race and class in the *Journal of the American Medical Association (JAMA)*. Two studies showed large racial and socioeconomic disparities in the delivery of health care (Ayanian, 1994). The study found that inequalities based on race and class were not limited to a particular type of hospital (urban teaching, urban non-teaching and rural), but were in fact widespread structural problems that existed across all three types of hospitals (Ayanian, 1994).

When evaluating health care disparities among African American women, it is important to look at the populations from a holistic perspective in order to understand the root causes of race-related health disparities. History often provides insight to complex issues—“if we do not study history, we are bound to repeat it,” is beyond an understatement when it comes to explaining racial disparities in health for blacks. For this reason, I briefly discuss health care history and race.

Racism within the health system may be one factor to consider. According to Gary King, “A strong symbiotic relationship has existed and continues between the medical/health complex and the larger society with respect to majority/minority group relations and racial inequality.” In other words, the problems within our society are reflected in our institutions. Wealthy white males control the American health care system, and it is *their* ideologies that set the current health standards. Minorities and women simply do not have enough power within the system.

### *Women and the Health Care System*

Historically, women have also been the victims of discrimination and unfair policies designed to limit their participation in the health care system. Although a few token women were accepted into medical programs in the early 20<sup>th</sup> century, it was clearly considered a profession for men. The requirement of a bachelor degree, the growing costs of a medical degree, and the social norms of the time all helped to drastically reduce the number of women entering into medical school. It did, however, pave the way for women entering into the nursing profession; a profession that is still in many ways controlled by men (Duffy, 1979).

Currently, even though women make up the majority of the patients, and over 85 percent of all the health care workers, the American health system is still dominated by white men, although there has been a tremendous increase in women entering into the field of obstetrics and gynecology (Our Bodies, Ourselves, 2005). Many women use their gynecologist as their primary care physician. Over the last two decades, there has been a huge influx of women entering into the field of gynecology. For

example, in 1980, only 30 percent of gynecologists were women, now they account for 76 percent of OBGYNs and this trend is expected to rise (Reyes, 2007).

There are many concerns that arise when we evaluating the US health care system in terms of how adequately it addresses the needs of women. Historically, women simply did not have the power or authority in the United States health care institution. As a result, many of the patriarchal attitudes from 100 years ago still pervade the ideology of the American health system. The levels of interpersonal and structural biases in health care often exclude women from decision-making; especially in reproductive care. Women physicians earn significantly less than their male counterparts (Reyes, 2007). Many normal processes such as pregnancy, menopause, and aging have all been over-medicalized. In 1991, one million hysterectomies were performed in the United States (Smith, 1998). Hysterectomy is very common surgery for women in the United States; the majority of these surgeries are for benign gynecological problems often associated with aging. While hysterectomies have declined, at the current rate it is estimated that one in nine women in the United States will have their uterus removed (Wu et al 2007). Even though hysterectomies have declines over the past decade, (600,000 annually), it still remains one of the most commonly performed surgical procedures in women (Wright, et al, 2013).

Gender bias in research is also a major concern. There has been a limited amount of research data on women, and much of the current research is based on research performed on men. Recent studies have provided sufficient evidence that women often present with different symptoms than men, and thus may react differently to medical treatments (Smith J., 1998). Heart disease is now the number one killer of

women, and this fact is due to a medical system that has completely disregarded women and their particular symptoms (Coulter, 2011). It is in this sense that American medicine has been used as an institution of social control that has limited the political power of women.

### *Important Mediating Factors in Women's Health*

In order to understand the plight of African American women's health, it is important to analyze the mediators that relate to overall health, as well as the health of African American women.

### *Socioeconomic Differences*

Socioeconomic status continues to be a strong indicator of health in the United States. Higher levels of education and income are inversely correlated with lower rates of mortality, and the gap between the SES groups appears to be growing (Williams and Collins, 1995). Clearly, people within higher SES groups have access to quality care, and are more apt to utilize health care services. Since the 1970s, there has been a significant increase in income inequities--the wealthiest populations are obtaining even more wealth, while the lower income populations are facing more economic hardships (Williams and Collins 1995). Not surprising, the majority of individuals represented in the lower SES group are women, children and minorities.

Additionally, there has been a severe decline in the economic status of blacks. Since 1973, low-income blacks and Hispanics family income has been declining, and black children living below the poverty line has increased (Williams and Collins, 1995). Whites have almost 12 times the amount of wealth that blacks have. Blacks are more

likely to be unemployed, to earn less than equally qualified whites, and to be severely affected by government policy changes (Bobo et al, 1997).

Race and SES status have a strong association, and often race is used as an indicator of SES. Often, researchers will attempt to “adjust” for SES when examining racial health disparities (Williams and Collins, 1995). While adjusting for SES often reduces racial differences in health, blacks still have overall poorer health outcomes than whites within each SES level (Williams and Collins, 1995).

### *Socioeconomic Status and Health*

Socioeconomic status (SES) has long been associated with better health outcomes. Every Western industrialized country displays strong gradient between SES and mortality (Moss, 1995), but recent research into the effects of SES and race offer a curious mix of results. Williams and Collins (1995) point out the advantages/disadvantages of using SES variables in health research. Most researchers use education as a stable indicator of SES, but it has been consistently shown that more health inequalities are associated with income than with education (Williams and Collins, 1995). A cross-sectional study on the relationship between wealth and income and selected racial differences in health examined relationship of SES and race with hypertension, diabetes, heart disease and arthritis (Kingston and Smith, 1997). The results were that African Americans reported higher rates in all categories, even when differences in education, income and wealth were “controlled” for. The conclusion was that SES was not a significant factor in the prevalence of chronic disease, and this suggests that other causal agents need to be evaluated. This again relates back to the inherent flaw that many studies on race exhibit. By not

acknowledging the social category of race, and the implications of the social construction of race, studies attempting to understand the correlation between SES and race will only provide half of the picture. Other studies suggest that there is not a strong correlation between income inequality and health. Research on factors such as behavioral, physical stressors, social relationships and support, environmental hazards, and health-damaging psychological states may be just as relevant as an individual's income, education and occupation decrease (House, 2001).

In contrast, in an article in *JAMA*, Kevin Fiscella et al. (2000) discuss the limitations in current quality assessment for identifying and addressing health disparities and propose five principles to address health disparities. (1) Disparities must be recognized as a significant quality problem. (2) Relevant and reliable data is needed to adequately discuss health disparities. (3) Performance measures should be stratified by SES and race/ethnicity. (4) Because SES and race/ethnicity of enrollees affect existing performance measures, population-wide performance measures should be adjusted for SES and race/ethnicity in order to have meaningful comparisons among health care organizations. (5) Correlation of the relationship between SES and race/ethnicity and morbidity must be addressed. The bottom line is that most managed care plans do not collect information on SES and race/ethnicity from its enrollees, and this missing information could redistribute funds in the areas where they are needed the most (Fiscella, et al. 2000).

In a critique of the book, *Why are Some People Healthy and Others Not? The Determinants of Health Populations*, (Edited by Evans et al., 1995) Nancy Moss analyzes the connection between social class and mortality. The book details many of

the health care concerns of minorities, including women's health. The book suggests that it is not possible to create an effective health care policy in the United States without an appropriate model of health and its predictors. Moss points out that the findings on African Americans--especially the data on women and children--leave little doubt that socioeconomic hierarchy discussions must include questions concerning race and ethnicity. Adler et al. (1993) argues for a more comprehensive approach to understanding the correlates of SES and health. Their critique of SES as an indicator of mortality points to a more multidisciplinary approach which addresses health care coverage, equal access, social, environmental and psychological constructs are evaluated as well (Adler et al, 1993).



## CHAPTER 3: METHODOLOGY

The purpose of this dissertation is to study women's health and women's health care disparities within the African American community in an attempt to identify possible causal factors for women's health disparities. This dissertation will be a quantitative study. I am analyzing data from the National Survey of American Life (NSAL). The NSAL is a comprehensive study of mental health of black Americans. The study was conducted between February 2001 and June 2003, and is part of an NIMH Collaborative Psychiatric Epidemiology Surveys (CPES) initiative. The NSAL adult sample is an integrated national household probability sample of 3,500 African Americans, 1,621 blacks of Caribbean descent and 891 non-Hispanic whites living in areas where at least 10 percent of the population is black and 18 years of age or older (NSAL). This was an ideal quantitative study because of the large sample size of African American women. I will only be evaluating a sample of approximately 3,800 African American women, women of Caribbean descent who identify as black, and white women. Of the 3,800 women, approximately 61 percent are African American, 26 percent are women of Caribbean descent who identify as black, and a little less than 14 percent are white women.

### *Conceptual Framework*

The key questions that this paper will address are:

1. How do environmental and personal stressors impact the health of black women?
2. What is the impact of discrimination on the health of black women?
3. How does stress and discrimination affect health service use for black women?

4. And what type of structural changes can be implemented to improve access to health care for black women and reduce overall health inequities within the African American community?

The hypotheses investigated in this study will focus on the health of black women, and health access issues for this population. An important concern in health disparities research is the lack of understanding of the perceptions and health behaviors of minority populations. These problems are related to the lack of adequate research in the areas of stress and minority women. It is clear that a cohesive framework must be investigated and developed in order to fully understand the totality of women's health in the African American community.

*Research Questions/Hypotheses:*

1. *Black women have more environmental and personal stressors which may lead to poor health outcomes.*
2. *What are the patterns of health care utilization for black women? And,*
3. *How does discrimination and stress influence health care utilization for black women?*

Conceptual Model:

1. Race and SES lead to poor health outcomes and affects service usage.
2. Other stressors: Discrimination

Variables

*The Independent Variables will be:*

1. *Race*—Race will be coded specifically as black or African American as I am only looking at African American women.

2. *SES*—Socioeconomic status will evaluate the level of education and whether or not the subjects are employed.

*The Dependent Variables* with be:

1. Chronic illness—chronic illness is defined as
2. Depression
3. Having a source of health care

#### *Data Analysis Plan*

Descriptive analysis will be performed first, with univariate and bivariate relationships examined. Then we will examine multivariate regression models, where the dependent variables are predicted.

#### *Sample*

The description below is drawn from Broman et al (2008). The National Survey of American Life (NSAL) is a comprehensive study of the mental health of black Americans. The study, conducted between February 2001 and June 2003, is part of an National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys (CPES) initiative. The NSAL adult sample is an integrated national household probability sample of 3,570 African Americans, 1,621 blacks of Caribbean descent (Caribbean blacks), and 891 non-Hispanic whites living in areas where at least 10% of the population is black, all aged 18 and over. In both the African American and Caribbean black samples, it was necessary for respondents to self-identify their race as black. Those self-identifying as black were included in the Caribbean black sample if they answered affirmatively when asked if they were of West Indian or Caribbean descent or if they said they were from a country included on a list of Caribbean area

countries provided by the interviewers. Most interviews were conducted face-to-face using a computer-assisted instrument and lasted an average of two hours and twenty minutes. The final overall response rate was 72.3%, but 70.7% for the African American sample, 77.7% for Caribbean blacks, and 67.7% for the non-Hispanic white sample. The focus of this paper is on the two black ethnic samples.

The NSAL sample is nationally representative of the African American and Caribbean black population, and is nationally representative of the white population that lives in predominantly black areas (Jackson et al., 2004). Of course this means that the sample is not representative of the entire white population in the United States, since most whites do not live in predominantly black areas. But my focus is on the black population primarily, and that sample is representative of the black population of the United States.

*Measures: Sociodemographic Correlates*

Sociodemographic correlates include race, (African American and Caribbean black vs. white), age, employment status (employed vs. unemployed and not in labor force), years of education completed, household income (divided approximately into quartiles of <\$18,000, \$18,000-\$31,999, \$32,000-\$54,999, \$55,000+), marital status (married or cohabiting, previously married, never married), place of birth (in US or not), region as defined by the Bureau of Census Department of Labor (Northeast, Midwest, South and West), and urbanicity as defined by the US Department of Agriculture's 2003 Rural-Urban Continuum Codes to include major metropolitan areas, other urban (suburbs with population 2,500 or greater), and rural (completely rural or less than 2,500 urban).

**Table 1: Distribution of the National Survey of American Life (NSAL) sample compared by race and ethnicity**

<b>DESCRIPTIVES</b>	<b>African American %</b>	<b>Caribbean Black %</b>	<b>White %</b>
Age			
18-29	24.4	31.1	16.8
30-44	35.4	34.5	29.7
45-59	23.8	19.4	27.9
≥60	16.4	15.1	25.5
Sex			
Male	44	50.9	41.8
Female	56	49.1	58.2
Working Status			
Employed	66.8	75.2	67.4
Unemployed	10.1	8.8	4.4
Not in Labor Force	23.1	16.0	28.2
Education			
0-11 years	24.3	20.9	16.7
12	37.7	29.7	32.9
13-15	23.9	26.1	24.2
≥16	14.1	23.3	26.2
Household Income			
0-17,999	31	21.3	24.1
18,000-31,999	25.1	25.1	22.4
32,000-54,999	23.5	22.0	26
≥55,000	20.4	31.7	27.5
Marital Status			
Married/cohabitating	41.7	50.1	48.1
Divorced/separated/widow	26.8	18.9	33.5
Never married	31.5	30.9	19.4
Foreign Born			
Born in US	97.7	34.9	96.7
Born outside US	2.3	65.1	3.3
<b>Overall N</b>	<b>3,570</b>	<b>1,621</b>	<b>891</b>

Sociodemographic information for this study is highlighted in Table 1. For African Americans, 24.4% of respondents were between the age of 18-29 (N = 806), 35.4% were between 30-44 (N = 1276), 23% were aged 45-59 (N = 855), and 16.4% were aged 60 and older (N = 633). For Caribbean blacks, 31% of respondents were between the age of 18-29 (N = 436), 34.5% were in the 30-44 age range (N = 605), 19.4% were aged 45-49 (N = 356) and 15.1% were over the age of 60 (N = 224). For African Americans, 56% of respondents were women, and 44% were male. African Americans 66.8% were employed, and for Caribbean blacks 75.2% were employed. The education levels were comparable for both groups—37.7% of African Americans had high school educations, and 29.7% of Caribbean blacks were high school educated.

The household income for African Americans and Caribbean blacks showed some slight differences. For African Americans, 31% of respondents reported an income between 0-17,999, compared with 21.3% of Caribbean blacks. The 18,000-31,999 and 32,000-54,999 income ranges were comparable for both groups. Again, there was a difference in the 55,000 and above category, with 20.4% of African Americans and 31.7% of Caribbean blacks, respectively.

The majority of respondents reported that they were married/cohabiting 41.7% of African Americans and 50.1% of Caribbean blacks, while 31.5% of African Americans reported never being married, compared to 30.9% of Caribbean blacks. This high percentage is most like a result of the large age range in the study. For African Americans, 26.8% reported being divorced/separated/widowed, compared to 18.9% of Caribbean blacks.

Not surprising, the overwhelming majority of African American respondents reported being born in in the United States (97.7%) compared with 34.9% of Caribbean Africans. The white cohort is included as a comparison to African Americans and Caribbean blacks. After this chapter, the white sample is not used in this dissertation. We include whites in this chapter as a way to more fully describe the data.

**Table 2: Descriptive variables for women only**

<b>Variable Name</b>	<b>N</b>	<b>Mean</b>	<b>Std. Dev.</b>	<b>Range</b>
Medical help	3682	1.43	1.25	1-5
Depression	3525	7.10	5.99	0-33
Working	3788	.65	.476	0-1
Education	3796	12.6	2.56	4-17
Chronic Conditions	3683	1.35	1.63	0-13
Discrimination	3750	3.01	3.96	0-10
Stressor	3683	1.41	1.28	0-5
Race (Black = 1)	3796	.86	.344	0-1
Age of Respondent	3796	43.16	16.44	18-94

Most of the women have a usual place where they go for medical help. There is a moderate amount of depression among the women. Looking at the demographic variables, 65 percent of the women are working, and education shows approximately one year of post-high school achievement. We also see the means for chronic conditions, discrimination and stressors, and those are relatively low in the sample as well. About 86 percent of the sample is African American and Caribbean black as compared to white. Lastly, the age of the sample is about 43 years old.

**Table 3: Race differences in having a usual source of medical help**

<b>Race</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Frequency</b>
Black	1.48	1.30	3174
White	1.43	1.24	508
Total	1.44	1.25	3682

Table 3 shows the mean results across race for the dependent variable: Is there a place or person that you go to for medical advice. For blacks the mean was 1.48 and the standard deviation was 1.30. White respondents mean was 1.45 and the standard deviation was 1.24. The results for this variable are not significant. There are no differences across the races for this variable. Women of both races are equally likely to have a place to go for medical advice.

One issue to consider is that fact that the age range of the women is from 18 to 91. The means that some of the women are on Medicare and, as a result, have a usual place where they would go for care. It is the case that the older age groups are more likely to have a usual source of care. For women under age 29, about 82 percent have a usual place for medical help. For women between 30 and 44 years of age, it is 87 percent and 93 and 97 percent, respectively for women ages 45 to 59, and over 60 years of age. Given these large overall percentages, it may not be surprising that there are no racial differences in table 3.

**Table 4: Depression (CES-D scale)**

<b>Race</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Frequency</b>
Black	9.03	6.15	3149
White	6.87	5.34	376
Total	7.10*	5.34	3525



As discussed earlier the CES-D scale is a measure of the level of psychological distress that an individual has. In Table 4, the CES-D scale results compares white women responses with black women’s responses on the depression scale. The mean score for this dependent variable, the CES-D score was 9.03 for black women, compared with 6.87 for white women. The results are significant for black women having higher levels of depression than white women.

Depression is a very common and treatable disease, affecting approximately 17-20 million Americans annually (National Alliance on Mental Illness, 2009). However, while African American women suffer from greater depression levels, often they do not seek out medical treatment. This may be due to issues of personal control, lack of trust of the health care system, or it is often views as a “personal issue or weakness.” These findings are consistent with most research on depression among African American women (Waite, 2008)

**Table 5: Chronic conditions**

<b>Race</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Frequency</b>
White	1.63	1.84	508
Black	1.30	1.60	3175
Total	1.34*	1.64	3683

Table 5 displays the mean and standard deviation for the variable asking respondent about their chronic medical conditions. For white women the mean was 1.63 and the standard deviation was 1.84 (N= 508). In contrast, the standard deviation for black women was 1.30 and the standard deviation was 1.30 (N = 3, 175). The results for this variable are significant. Black women reported having fewer chronic medical conditions than white women.

What is interesting about this data is that when evaluating the overall health of most African American women, they have much higher rates of hypertension, diabetes, cancer and other chronic illnesses than white women, yet they report having fewer chronic medical conditions. This may be indicative of the cultural ethos that many black people in general have—you do not go to the doctor unless you absolutely have to. Additionally, this may explain why the survival rates for blacks are significantly lower than whites for many treatable illnesses.

*Mean Across Race for the Other Independent Variables*

**Table 6: Mean of everyday racial discrimination - lifetime**

<b>Race</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Frequency</b>
White	.41	1.7	513
Black	3.4	4.1	3237
Total	3.0*	3.9	3750

Table 6 displays the results for the means for the independent variable of perceived racial discrimination experiences over the course of respondent’s lifetime. The results support the theory that black women experience more racial discrimination than whites. The mean for black women for this variable is 3.42, compared to .415 for white women.

Discrimination within institutions is not always easy to identify. As a minority seeking out health care, the questions must be asked: what types of services are being offered in their communities? Does insurance play a role? How positive is the doctor-patient interaction, especially in urban areas that are often understaffed and over-utilized?

**Table 7: Mean for stress differences between black and white women**

<b>Race</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Frequency</b>
White	1.0	1.1	508
Black	1.5	1.4	3175
Total	1.4*	1.4	3683

Table 7 displays the results for the mean difference in stress levels between black and white women in the study. The mean for black women for this variable is 1.5, and for white women it is 1.0. The results in this table show that black women have significantly higher levels of stress than white women do.

### *The Impact of Stress*

Stress can be defined as “a state of imbalance within a person, elicited by an actual or perceived disparity between environmental demands and the person’s capacity to cope with these demands.” Stress can be associated with *life events*—specific events that alter an individual’s life, such as the birth of a new baby, loss of a job or a loved one. In contrast, the second major stressor can be *chronic*—ongoing problems with health, home, job that individuals must contend with on a daily basis (Pearlin (1989). It can be characterized as emotional, chemical or physical factors that have an impact on an individual’s health (Gary, 1995).

Research done by Sauter, Murphy & Hurrell found that 11 million Americans have reported that stress levels have jeopardized their health (1990). Another study showed that multiple stress-related illnesses were reported by one out of every four respondents in their study (Spielberger & Reheiser, 1995). This indicated a strong correlation to the mental health of an individual affecting their overall physical well-being. Stress can lead to severe health problems, and 85% of all physical illnesses have a link to mental stress (Randolfi, 1996).

Stress affects everyone; however, African American women appear to be more vulnerable to the health problems associated with stress. Stress is further convoluted by racism, sexism and gender role expectations. This cluster of factors is unique to this segment of the population. Not only is stress exacerbated by these factors, but African American women also tend to be more susceptible to stress and have a stress response that differs from that of white women (Della et al., 1998).

Researchers have found that stress is related to chronic absenteeism due to work burnout and increased sick leave (Finn, 2000). Stress has become so common that many individuals regularly take time off referred to as "mental health days" or extended leaves of absence as a means by which to cope. When sick days run out, many end up receiving reduced paychecks if they have no vacation compensation to make up for days lost.

Some resort to filing for worker's compensation due to stress. However, if claims are settled in the favor of the employer, the stressed out employee may have no means of financial compensation for time lost. It has been estimated that illnesses that have their origin in stress cost the United States as much as \$66 billion a year due to time spent away from the job (Knotts, 1996).

Stress is normal and in certain situations, it can be beneficial. For instance, stress can produce the adrenalin necessary for meeting a deadline or running to catch the last train home (Harvard Medical School, 2002). Unfortunately, not all stress is good stress. The majority of adults who have suffered mental and physical ailments contend that these issues resulted from stress. It has been well documented that stress can lead

to the development of illnesses and injuries that may prevent individuals from living full productive lives (Spielberger & Reheiser, 1995).

The signs of stress can include sleeplessness, neck and backaches, inability to focus, pain and stiffness in joints, irritability, substance misuse and abuse, disordered eating, lethargy, diminished commitment to work, depression, anxiety, and marital problems (Harvard Medical School, 2002). When individuals are suffering from stress they may be unable to concentrate and may no longer be relied upon to successfully complete necessary tasks (Gilberg, 1993). When stressful situations are unrelieved, the body suffers. The release of stress-related hormones can lead to such physical illnesses as cardio-vascular disease and musculoskeletal disorders. These hormones have been linked to psychological disorders as well (McEwen, 2002).

Stress does not only affect mental and physical health; it may also affect an individual's *perception* of health. It has been found that the perceived health status of an individual has a major impact on his or her health outcomes. Pender (2002) has defined perceived health status as a psychological personal factor that can affect health behavior when health status is relevant to performing health related actions. For example, a woman who reports her health as "very good" may be less likely than a woman who reports her health as "poor" to make routine visits to a primary care physician. This perception can be skewed when an individual is under stress. They may think that they are healthier than they actually are. This may result in an individual's failure to take preventive measures or seek treatment for an ailment. When this occurs, health outcomes are likely to be negative. It must also be noted that the perceived

health status of African American women might also be skewed due to the aforementioned myth of the “Strong Black Woman.”

It has been discovered that stress affects women differently than it does men (Webb, Beckstead, Meininger, & Robinson, 2006). These differences may be best observed by examining the effects of stress on hormones. A hormone that has been associated with stress is estrogen. Studies have shown that estrogen levels are associated with heart disease. When estrogen levels are low, blood vessels do not dilate properly. The presence of estrogen is also necessary for the regulation of blood pressure. Researchers have discovered that when white women experience stress, their estrogen levels remain the same. However, when African American women experience stress, their estrogen levels drop (McEwen, 2002). This may explain the higher rates of heart disease and hypertension in African American women. When African American women experience stress, they lose the protective effects of estrogen.

Another hormone associated with stress is cortisol. One of the functions of cortisol is to aid in the release of the energy stores that are necessary for the body to cope with stress. When a high level of cortisol is secreted, the body goes into war mode and is prepared for stress conditions such as famine, trauma, hemorrhaging, fighting, or running. However, prolonged secretion of cortisol can be damaging (Chrousos & Gold, 1992).

In order for an individual to be well rested, his or her cortisol level must cycle properly every 24 hours. The cortisol cycle has a rhythm of 15 pulses per day. When an individual is not under stress, cortisol peaks in the early morning, declines as the day goes on, and drops significantly at night as an individual sleeps (Stone et al., 2001).

**Table 8. Means for variable: currently working**

Race	Mean	Standard Deviation	Frequency
White	.639	.481	516
Black	.654	.476	3272
Total	.652	.476	3788

Table 8 displays the results for the variable, “are you currently working?” For this variable there are no significant differences among women in this sample. Black and white women in this reported working in similar proportions for the population.

**Table 9: Mean of respondents’ years of school**

Race	Mean	Standard Deviation	Frequency
White	13.2	2.53	519
Black	12.6	2.55	3277
Total	12.7*	2.56	3796

Table 9 displays the mean years of school for respondents. Blacks mean years of school was 12.6, and whites mean years of school is 13.2 The results in this table are significant. White women have higher levels of education—which has direct impact on higher health status.

**Table 10: Mean age of respondent**

Race	Mean	Standard Deviation	Frequency
White	48.1	17.6	519
Black	42.4	16.1	3277
Total	43.2*	16.4	3796

Tab10 displays the mean age of the respondents for the survey. The mean for white women was 48.1, and for black women 42.4. The results found in this table are significant. White women are older than black women in this study.

## CHAPTER 4: MULTIPLE REGRESSION

The goal of this chapter is to examine how demographic variables impact depression, chronic conditions and the use of medical help for black and white women. We first present results looking at age and race, then we added employment status and education. After that, I look at how discrimination and stress may influence depression, chronic illness and having a usual source of health care. First I present a correlation matrix of the variables that are used in my multivariate analysis.

**Table 11: Correlation matrix**

---

	1	2	3	4	5	6	7	8	
(1) Medical Help	1								
(2) Depression	-07	1							
(3) Chronic conditions	10	16	1						
(4) Stress	-06	36	00	1					
(5) Age	17	-11	47	-29	1				
(6) Race	01	-11	-07	12	-12	1			
(7) Education	00	-22	-19	-07	-16	-09	1		
(8) Currently working	-03	-15	-31	02	-32	01	29	1	
(9) Discrimination	-03	28	-03	26	-11	12	04	09	1

---

Decimal points are omitted. Correlations above .03 are significant at  $p < .05$ .



Next I go through the multiple regression results. Unstandardized coefficients are used throughout. I chose not to use standardized coefficients because of the skew in the distribution of the dependent variables (Clifford Broman, personal communication).

**Table 12: Multiple regression of predicting depression by race and age**

---

Age	-.05*
Race	-2.48*
Constant	11.26
R <sup>2</sup>	.03
N	3525

---

Table 12 presents the multiple regression for predicting depression by race and age. This table indicates and race and age are significant predictors of depression. The results for age show that younger women suffer less from depression than older women. The results for race show that African Americans and Caribbean blacks suffer less from depression than whites.

**Table 13: Multiple regression of predicting chronic illness by age and race**

---

Age	.05*
Race	-.06*
Constant	-.62
R <sup>2</sup>	.22
N	3683

---

Table 13 shows the multiple regressions for predicting chronic illness by age and race. Age is a positive predictor of chronic illness. This indicates that older women have more chronic illnesses than younger women. In terms of race, black women have less chronic illnesses than white women.

**Table 14: Multiple regression in having a usual source of medical help by age and race**

---

Age	-.01*
Race	-.12*
Constant	2.11
R <sup>2</sup>	.03
N	3682

---

Table 14 shows that age and race are significant in predicting health service use. Both are negative. For age, this means that older women less likely utilize services. For race, this means that black women are less likely to have a usual source of health care than white women.

**Table 15: Multiple regression for depression by age, race, working status and education**

---

Age	-.08*
Race	-3.04*
Working Status	-1.74*
Education	-.54*
Constant	21.1
R <sup>2</sup>	.11
<b>N</b>	<b>3522</b>

---

Table 15 shows the regression of depression on the predictor variables. The results show that age, race, working status and education are significant in predicting depression. The inclusion of additional variables of employment status and education does not change this relationship. We still see that older women are less likely to use suffer from depression than younger women. For race, black women are less likely to have depression than white women. Employed women are less likely to suffer from depression than non-employed women. We can also see that higher levels of education are associated with lower levels of depression. Research done by Broman confirms this anomaly—because of stress, discrimination, poor living conditions, we expect depression to be higher, but it is lower for black women (Broman, 2012)

**Table 16: Multiple regression for chronic illness by age, race, working status and education**

---

Age	.04*
Race	-.12
Working Status	-.55*
Education	-.05*
Constant	.68
R <sup>2</sup>	.26
<b>N</b>	<b>3683</b>

---

Table 16 shows multiple regression for chronic illness by age and race, and the additional variables of working status, and education. The inclusion of additional variables does change the relationship. Age is still significant. Older women are more likely to have chronic illnesses than younger women. Race is not significant in this equation. This is different than the prior analysis; so the inclusion of employment status and education changes this relationship. For employment status and education, higher levels are related to lower levels of chronic illness. What this means is that women who are working and higher education have fewer chronic conditions and this explains the relationship between race and chronic illness.

**Table 17: Multiple regression in having a usual source of medical help by age, race, working status and education**

---

Age	-.01*
Race	-.13*
Working Status	-.05
Education	-.01
Constant	2.30
R <sup>2</sup>	.03
<b>N</b>	<b>3682</b>

---

Table 17 shows multiple regression for health service usage by age and race, working status and education. The inclusion of working status and education does not appear to change the relationship shown earlier. Older women are still less likely to have a usual source of health care than younger women. For race, black women are less likely to have a usual source of health care than white women. Employment status is *not* a significant predictor of having a usual source of health care, and neither is education.

**Table 18: Multiple regression for depression by age, race and discrimination**

Age	-0.01
Race	-3.08*
Discrimination	.07*
Stressor	1.69*
Constant	7.46
R <sup>2</sup>	.15
<b>N</b>	<b>3502</b>

Table 18 shows multiple regression for depression by age and race, discrimination and stress. The inclusion of additional variables does change the relationship. Age is no longer significant in predicting depression. Race remains significant; black women are less likely to suffer from depression than white women. Discrimination is significant in predicting depression; more discrimination experiences predict great levels of depression. Stress is also positively associated with depression in that higher levels of stress are predictive of higher levels of depression.

**Table 19: Multiple regression of having a usual source of medical help by age, race and discrimination**

---

Age	-.01*
Race	-.12*
Discrimination	.00
Stressor	.02
Constant	2.08
R <sup>2</sup>	.03
<b>N</b>	<b>3645</b>

---

Table 19 shows multiple regression for having a usual source of health care by age and race, discrimination. The inclusion of additional variables of discrimination and stress does not appear to change the relationship between health service usage, age and race. Older women are less likely to use health services than younger women. For race, black women are less likely to use health services than white women. Discrimination and stress are not significant predictors of health service usage.

**Table 20: multiple regression for chronic condition, by age, race and discrimination stressor**

---

Age	.05*
Race	-.13
Discrimination	.00
Stressor	.19*
Constant	-1.01
R <sup>2</sup>	.24
<b>N</b>	<b>3646</b>

---

Table 20 shows multiple regression of chronic condition by age, race, and discrimination stressor. The inclusion of additional variables of discrimination and stress does change this relationship. Age is still a predictor of chronic conditions. As women age, they have more chronic conditions. Race and discrimination are not significant predictors of chronic conditions in this equation. Stress is positively related to chronic conditions. Higher levels of stress are predictive of more chronic health conditions.

In the next section of this chapter, I examine multivariate models that examine simultaneously all of the variables in my model. We begin with table 21.



**Table 21: Regression model of depression, age, race, working, education, discrimination stressor**

---

Age	-.04*
Race	-3.69*
Working	-1.50*
Education	-.49*
Discrimination	.12*
Stressor	1.52*
Constant	16.61
R <sup>2</sup>	.22
<b>N</b>	<b>3502</b>

---

Table 21 shows the regression model of depression by age, race, working education, and discrimination stressor. Again, the inclusion of additional variables does not appear to change the basic relationship we saw earlier regarding age and race. Older women are less likely to be depressed than younger women. For race, black women are less likely to be depressed than white women. Education lowers depression, while experiences of discrimination raise depression. Stress also predicts higher levels of depression.

**Table 22: Regression model of in having a usual source of medical help by age, race, working, education, discrimination, and stressor**

---

Age	-.01*
Race	-.13*
Working	-.04
Education	-.01
Discrimination	.00
Stressor	.02
Constant	2.26
R <sup>2</sup>	.03
<b>N</b>	<b>3645</b>

---

Table 22 shows regression model of age, race, working, education and discrimination and stress in predicting having a usual source of care. Again, the inclusion of additional variables does not appear to change the basic relationship we saw earlier regarding age and race. Older women are less likely to have a usual source of care than younger women. For race, black women are less likely to have a usual source of care than white women. None of the other factors is significant in predicting having a usual source of care.

**Table 23: Regression model of chronic illness, age, race age working, education, discrimination, and stressor**

---

Age	.04*
Race	-.20*
Working	-.52*
Education	-.04*
Discrimination	.01
Stressor	.16*
Constant	.24
R <sup>2</sup>	0.27
N	3646

---

Table 23 shows regression model of chronic illness, age, race, working education, education and discrimination and stressor. Again, the inclusion of additional variables does not appear to change the basic relationship we saw earlier regarding age and race. Older women have more chronic illness than younger women. For race, black women are less likely to have chronic illness than white women. Education lowers chronic illness, while experiences of stress raise chronic illness. Discrimination is significant in predicting chronic illness.

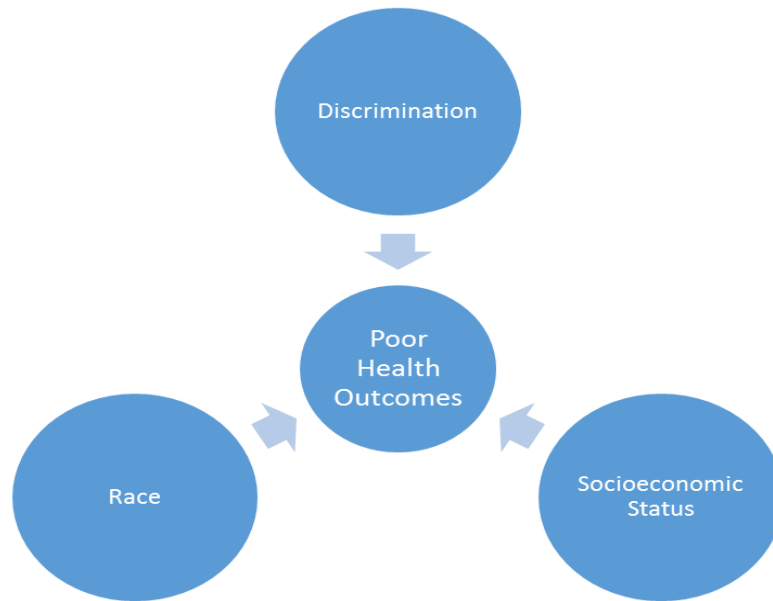
## CHAPTER 5: DISCUSSION

### *Overview of my Findings*

My basic findings are that age and race are the most consistent influences on the health of women in this sample. Older women are more likely to have a usual source of medical care than younger women. Older women have fewer symptoms of depression than younger women. And older women have more chronic conditions than younger women. Race also consistently differs. Black women are less likely to have a usual source of medical care than white women. Black women have fewer symptoms of depression than white women. And black women have fewer chronic conditions than white women.

Results for employment status, education, stress and discrimination were not as consistent in helping me to understand depression, chronic conditions and medical help. The most consistent results were for depression. Higher education and current employment are associated with fewer symptoms of depression. More discrimination and stress are associated with more symptoms of depression. Employment status, education and stress predicted chronic conditions. Higher education and current employment are associated with fewer chronic conditions. More stress is associated with more chronic conditions. Discrimination was not significant. None of these four factors were significantly associated with having a usual source of medical care. As I discussed earlier, this might be because many women had a source of medical care. The revised model of is illustrated in Figure 4.

**Figure 4: Conceptual model revised**



#### *Regular Source of Health Care*

My original hypothesis stated that Black women are less likely to have a usual source of health care than whites. This hypothesis is supported by the data. Age and race of respondent (independent variables) indicates that older black women are less likely to seek health care than whites. Possible reasons for not having a usual source of health care may be directly related geographical barriers to quality health services. The majority of minorities in the United States live in large urban areas. According to the US Census (2010), there are 10 states where 60 percent of African Americans reside. These are: New York, California, Texas, Florida, Georgia, Illinois, North Carolina, Maryland, Michigan and Louisiana. Five of these had more than 2 million Blacks each:

New York, California, Texas, Florida and Georgia (US Census, 2010).

There are inherent geographical problems for Black Americans seeking quality health care in larger cities. In Chicago, the majority of African Americans live on the South or West side of the city. Poverty in these areas is extremely high, and like the other social institutions that serve these populations, health care is not exempt from being below standards. African Americans do not have the same quality of health services that are provided in neighborhoods where whites reside. For example, the top Level 1 trauma centers in Chicago are located in neighborhoods where African Americans would have to travel more than 5 miles to reach (Illinois Department of Public health, 2004). This can be a challenge for poor women and elderly who may not have access to transportation. This is further complicated by financial and insurance issues. Even though poor individuals may have insurance, this does not mean that they are able to use this insurance everywhere. In fact, many top quality physicians will NOT accept Medicaid, or Medicare (Baffour, & Chonody, 2009). A lack of economic means often translates to a lack of access to quality health care. Unfortunately, we could not test these hypotheses about geographical locations given this data set because these tests would have required ecological data that wasn't present in this data set. However, given the segregation that exists in this country, this would likely be a variable that contributes to why elderly black women do not seek health care on a regular basis.

### *Age*

In the United States, the proportion of the population aged  $\geq 65$  years is projected to increase from 12.4% in 2000 to 19.6% in 2030 (U.S. Census, 2014). The sex distribution of older U.S. residents is expected to change only moderately. Women

represented 59% of persons aged  $\geq 65$  years in 2000 compared with an estimated 56% in 2030 (U.S. Census 2004). Elderly women are more likely to have long-term, chronic disabling diseases, and women account for 75% of all nursing home residents (Freund and McGuire, 1999). As the "baby boomer" generation approaches retirement and life expectancy continues to increase, the U.S. finds itself in the midst of a demographic revolution. The senior population is twice what it was in 1960 and is expected to double again over the next thirty years. By the middle of the 21st century, seniors will outnumber children and youth for the first time. Furthermore, the trend is true worldwide. Few other changes are likely to exert as great an influence on society in the coming decades. Aging populations will have a pivotal impact on the health care system. Today, the life expectancy of men is 76 years old and for women it is 85 years old. With women living an average of 9 years longer than men, the majority of health care problems for the elderly will be those of elderly white women (Woods, 1995). Although extended life expectancy may seem like advancement in our society, the reality is that our society is not prepared to care for the upcoming aging population (Woods, 1995). This means that most of these women's last years will be spent in poverty. Because our health system is based on "men as the norm," women outliving their husbands will more than likely exhaust their income and savings with expenditures associated with their spouses' illness and death (Woods, 1995). For example, older men are more likely to die when they are ill and spend more days in the hospital, while older women are more likely to spend time in a nursing home (Lewis, 1986). This is a *critical issue* example of the overmedicalization versus lack of health care debate: Medicare supports care for acute illnesses (hospitalizations), but only provides a limited amount of support for nursing

and home care (Lewis, 1986). This leaves elderly women extremely vulnerable to “feminized poverty,” based on policies that clearly put them at a disadvantage over men (Lewis, 1986).

### *Feminization of Poverty*

Persistent poverty disproportionately affects women. Nearly 13 million women live in households with incomes below the Federal poverty level (Bianchi, 1999). For example, low-income black and Hispanic families have experienced declines in family income since 1973 (Williams and Collins, 1995). Poor or near poor women are more likely than high income women to report fair or poor overall health and limitations of activity; they are also more likely to report having anxiety or depression, arthritis, asthma, diabetes, hypertension, obesity, and osteoporosis.

Other studies support the hypothesis that elderly black women are less likely to seek out health care. According to a study by Wiltshire, et al, middle-aged black women were less likely than middle-aged white women to provide information to their physicians (2006). This may be due to lack of transportation, difficulties taking time off from work, longer waiting times, or geographical limitations. These are the issues that are addressed when evaluating other institutions, and health care is not exempt.

The other two hypotheses—education status and working status (independent variables), were not found to be significant in terms of medical utilization based on race and age. In summary, the data indicates that *only* age and race of the respondents are significant in terms of medical health usage. I challenge these results, as research continues to indicate that socioeconomic status (SES) has an inverse relationship to mortality. Higher education and income are strong indicators for lower levels of



mortality. New studies show affluent white males also suffer from poor health outcomes (Case and Deaton, 2015). It is concerning that researchers are comparing white males to minorities for several reasons: (1) The increase white male deaths is a new phenomenon, and more research is needed to evaluate the social-causal factors, (2) preliminary results indicate that the dramatic increase may be due to an increase in drug use and alcohol –related liver disease (Case and Deaton, 2015). These conditions are more closely related to lifestyle choices (perhaps stress). This new “issue” is not comparable to the longstanding research that clearly shows that disparities exist for minorities at of everyday racism (Feagin, 1997), white privilege (McIntosh, 1988).

### *Racial Barriers*

Race was found to be significant in terms of utilization of health care. Black women do not utilize health care as frequently as whites, and this may be correlated with the high mortality rates of African American women. Health care services are paramount in the prevention and detection of disease. When evaluating this data set, one has to question whether or not there is a difference in the quality of health care received by the poor. According to the U.S. Agency for Healthcare Research and Quality (AHRQ), about 20 percent of black Americans lack a usual source of health care as compared with less than 16 percent of whites. African-Americans are far more likely to rely on hospitals or clinics for their usual source of care (AHRQ, 2000). Race and ethnicity may influence a patient’s chance of receiving specific types of procedures and/or treatments. For example, African-Americans are 13 percent less likely to undergo coronary angioplasty and one-third less likely to undergo bypass surgery than are whites. Among preschool children hospitalized for asthma, only seven percent of

black children were prescribed routine medicines to prevent future asthma-related outbreaks compared to 21 percent of the white children. African-Americans with HIV infection are less likely to be on antiretroviral therapy, less likely to receive prophylaxis for *Pneumocystis* pneumonia and less likely to receive protease inhibitors than others with HIV (AHRQ, 2000). One other possible reason for underutilization of medical services by black women may be due to demographical challenges.

This data is indicative of a health care system that has systematically disenfranchised people based on their race and economic status. A small study of physician's decisions about whether to refer a patient for cardiac catheterization, provides some proof that race may be a factor that determines the quality of care people receive. This study involved actors citing similar economic backgrounds and found that black women were significantly less likely than white men to be recommended for referral, despite reporting the same symptoms (MCW HealthLink, 2000). This data suggests that institutional racism is still a major problem in the United States health care system and requires urgent improvement.

Institutional racism and the perception of racism are crucial components in understanding why minorities underutilize health services. There is an unfavorable historical relationship between minority groups and the American health care system. The institutionalized racism that exists today is marked by the implementation processes that directly affect the poor and minorities. Minorities in urban areas are far more likely to "experience long waits, to be unable to shop for services, and inevitably to receive poor health care" (Jones & Rice, 1987). Faced with long lines, limited

physicians and a general distrust of a system that has failed to meet minimum health care needs, there is little wonder that minorities are in such poor health.

There is a lack of adequate representation of minorities in the health care field. To make matters worse, there has been a steady decline in the number of minorities enrolled in U.S. medical schools, due in part to the rollback of affirmative action at many universities (Townes, 1998). Studies have shown that minority physicians are more likely to treat patients of their own race or ethnic group in areas that are underserved; care for poor and Medicaid patients; treat patients with no insurance and care for patients in poor health (Moy & Bartman, 1996, Cantor et al, 1996)

### *Discrimination*

In this data set, African American women reported higher levels of perceptions of discrimination. Perceptions of discrimination can have a profound and lasting impact on the recipient, and in terms of health care, it can often be detrimental. An individual, who enters into the health system and feels that she/he is being treated unfairly, may opt not to return or delay further treatment. Furthermore, it can affect the doctor-patient interaction and the trust needed in order to adequately diagnose and treat illness. A study on perceived discrimination among women and minorities found that they were more likely to minimize personal discrimination and blame themselves instead for the negative feedback that they received (Ruggiero and Taylor, 1997). While the study suggests that minimizing discrimination has positive effects on self-esteem, it also points to the fact that by not acknowledging societal discrimination, minority groups will have little success in overcoming discriminatory practices (Ruggiero and Taylor, 1997). A previous mentioned study by Wiltshire, et al (2006), supports this earlier research.

This study compared middle-aged black women and white women, and found that black women were less inclined to provide health care information to their health care providers. The researchers suggested that discrimination may play a significant role in this lack of disclosure (Wiltshire, et al 2006). Black women, more than white women, may feel that their opinions do not matter, and as a result, they are less likely to discuss health care problems (Wiltshire, et al 2006). Again, we have to examine the long-term lack of trust, that many minorities feel when they are dealing with the health care system.

### *Depression/Stress*

This data set did not show a significance in depression/stress for black women. When I first started doing minority health research, I wanted to study suicide rates in African American Women. I was surprised to learn that African American women have the lowest rates of suicide compared to white women, white men, and black men. Yet, this finding contradicts research that indicates that black women (Ward & Heidrich, 2009). In today's fast paced environment, the term "stress" is overused and misunderstood. Everyone experiences stress on some level, and minority and poor populations are no exception. African Americans are more prone to anxiety and phobic disorders (NRC, 2001), and are more likely to be misdiagnosed when treated (NRC, 2001). Recent immigrants of all backgrounds, who are adapting to the United States, are likely to experience a different set of stressors than long-term Hispanic residents (Krieger, et al, 2011). Stress can be defined as debilitating, emotional and physical responses that occur when the demands of life overwhelm the resources, needs, or capabilities of an individual. It may be characterized as an emotional, chemical or

physical factor that induces tension in the body or mind that play a role in disease causation and coping (Geronimus, et al, 2010). In fact, a group of researchers found that 11 million individuals have reported stress at levels that put their health at risk (Sauter, Murphy, & Hurrell, 1990).

Another team of researchers revealed that multiple stress-related illnesses were reported by one out of every four respondents (Spielberger & Reheiser, 1995). One possible reason that depression was not shown to be significant in black women may be due to the stigma attached to mental illness in the African American community. Ward and Heidrichs' research revealed that women "believed that mental illness is caused by several factors, including family-related stress and social stress due to racism, is cyclical, and has serious consequences but can be controlled by treatment" (2009). The majority of the subjects in this particular study utilized coping mechanisms such a prayer, however they also reported that they sought out medical and mental health care. Stigma was cited as one of the main reasons that women did not seek out health care. It could be that the NSAL study did not reflect this cultural ethos, but as a black women and professor, I do know that there is a huge stigma associated with mental illness in the African Community. Other studies support this theory that black women have been stereotyped into the "strong black woman" myth, and they simply are suffering in silence (Beauboeuf-LaFontant, 2007).

There is an extremely powerful link between the mind and body. To this end, mistrust can affect mental and physical well-being. Because of this connection, stress can lead to severe health consequences. In fact, researchers have been able to link 85% of all physical illnesses to mental stress (Randolfi, 1996). While the numerous

sources of stress that exist in our society have the potential to negatively impact anyone, it appears that African American women may have to contend with additional sources of stress. It appears that stress is further exacerbated by racism, sexism, and gender role expectations for African American women. This cluster of factors is unique to this segment of the population. Not only is stress exacerbated by these factors, but African American women also tend to be more susceptible to stress and have a stress response that differs from that of Euro-Americans (Della et al., 1998).

Stress can make it nearly impossible to balance the demands of work, family, and self as individuals feel less capable and lose the ability to think clearly and objectively. In the United States, stress has reached pandemic proportions. In recent years, the effects of stress have been examined by a number of researchers. A good example of the far reaching mental and physical effects of stress may be found by examining absenteeism in the workplace.

Researchers have found that stress is related to chronic absenteeism due to work burnout and increased sick leave (Finn, 2000). Stress has become so common that many individuals regularly take time off referred to as "mental health days" or extended leaves of absence as a means by which to cope. When sick days run out, many end up receiving reduced paychecks if they have no vacation compensation to make up for days lost.

Some resort to filing for worker's compensation due to stress. However, if claims are settled in the favor of the employer, the stressed out employee may have no means of financial compensation for time lost. It has been estimated that illnesses that have

their origin in stress cost the United States as much as \$66 billion a year due to time spent away from the job (Knotts, 1996).

Much of our current understanding of the mental health status of black women, is derived from epidemiological studies of prevalence rates of mental disorders, diagnostic entities established by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 1994). The advantage of focusing on rates of disorders is that such findings can be compared with and contrasted to findings from studies in other domains (e.g., clinical studies) using the same diagnostic criteria. In addition, diagnostic entities are now often associated with specific pharmacological and psychosocial treatments.

Although there are several advantages to examining DSM-based clinical entities, there are at least three disadvantages. One limitation is that individuals may experience considerable distress—a level of distress that disrupts their daily functioning—but the symptoms associated with the distress fall short of a given diagnostic threshold. Thus, if only disorder criteria are used, some individuals' need for mental health care may not be recognized. A second disadvantage is that the current definitions of the diagnostic entities have little flexibility to take into account culturally patterned forms of distress and disorder. As a result, disorders in need of treatment may not be recognized or may be mislabeled—this is especially true for African Americans. They are twice as likely to be diagnosed with schizophrenia (Bruce, 1999) than whites. A third limitation is that most of the epidemiological studies using the disorder-based definitions are conducted in community household surveys. They fail to include non-household members, such as persons without homes or those who reside in institutions. Because of these limitations,

it is important to broaden the review of research on mental health needs to include not only studies that report on disorders, but also studies that report on symptoms, symptom clusters, culturally patterned expressions of distress and disorder, and high-need populations not usually included in household-based surveys (Bruce, 1999).

As Martha Bruce (1999) points out, the phenomenology in psychiatric diagnoses makes it difficult to rely on the object indicators of an illness. More often than not, psychiatric illness for the underserved are misdiagnosed, overmedicalized, or completely ignored. At the same time, research shows that there is an inverse relationship between social status and many mental disorders (Dohrenwend, 1990). As stated above, African American males are diagnosed more with schizophrenia, alcohol abuse and general mental impairment (Bruce 1999, Kessler et al., 1994) than white males who present with the same symptoms. This is a clear indication of medical discrimination practices which still pervade our health care system.

### *Education/employment*

Education levels among white and black respondents were similar, and generally employed black women reported lower levels of stress. In this difficult economy, it would seem prudent that most people who have jobs would have lower levels of stress. However, stress and work are often correlated, so this variable did not provide much information.



## *Insurance*

Health care reform promises that all Americans will have access to health care, However, African American women face other issues when dealing with health care. First, most black women already have limited insurance, which in turn limits their ability to receive quality care. According to Roberts and Rhoads, one of every five black, non-Hispanic woman under the age of 65 had no health insurance (2010).

*The Affordable Care Act*, also known as “ObamaCare,” was enacted to reduce the costs of health care and provide health insurance for those who are uninsured or underinsured (Leigh, 2012). It remains to be seen how effective this act will be, however it could potentially reduce poor health outcomes if the Act recognizes that poor health outcomes are multi-varied. We still must address issues of racism and discrimination, as well as socioeconomic variables that limit black women’s access to quality health care (Leigh, 2012). This study did not address the need for more insurance options for black women, and only time will tell if the Affordable Care Act will help assist those who do not have access to quality health care.

## *Limitations to study*

### **Personal Control**

One clear issue that needs to be addressed is the concept of personal control. It may be possible that African American women do not see out health care due to an overall mistrust of the American health care system. This mistrust or lack of “personal control,” may cause women to ignore symptoms of illness. More importantly, feelings of helplessness may prevent many women from seeking health care, even when it is

evident that it is needed. In other words, African American women do not seek out medical care until it is too late.

As a minority woman, I have often felt the stress of being ignored or not significant, especially when I did not have good health insurance. A minority woman enters into the health system, and she immediately is transformed, based on her gender, race and her socioeconomic status. Goffman's Dramaturgy theory (1959) suggests that our "front stage" persona is automatically presented when we are dealing with people in everyday life. When a minority woman enters into a health care arena, often you are no longer treated as a person—you become whatever illness that you have, and depending on the quality of the health care providers, many minority women may feel an immediate loss of personal control. This theory makes sense when you consider the issue of power. Who has the power—the doctor who is fully dressed and has a defined status that is higher than yours, or the patient, who is undressed, afraid, and may not be as well-educated? This situation alone may cause women to avoid going to see their physicians; especially if the outcome was negative.

Ross and Sastry (1999) discuss the terms of self-efficacy, helplessness and subjective alienation in terms of how these concepts apply to an individual's perceived locus of control. The current theories on causal factors of health disparities for minorities often focus primarily on the issues of poverty and lack of health insurance. Theories on help-seeking behaviors (Gurin et al, 1960) and the ability to access health care have also been used in an attempt to identify why the underserved populations lag so far behind in their health status.

The sense of personal control or lack thereof can have serious consequences on an individual's mental and physical well-being. It has been shown that there is a negative association between the sense of personal control and mental health factors. A belief in personal control is correlated with lower levels of psychological stress (Ross & Sastry, 1999). The concept of perceived external control is contrasted with perceived internal control. Both of these concepts are learned, the former is a belief that outcomes are out of one's control, the latter is that outcomes are in their control.

*Most of the research on this subject has suggested that blacks in general have a lower sense of personal control than whites (Ross & Sastry, 1999). The reasons behind this lack of personal control are correlated with discrimination and lower socioeconomic status. Many blacks may be unwilling to seek out medical attention for the simple fact that the patient is often the one who feels the least amount of control in a doctor-patient encounter. Moreover, because of class and language differences, they may be less likely to ask questions, disagree with the physician or initiate dialogue (Waitzkin, 1991).*

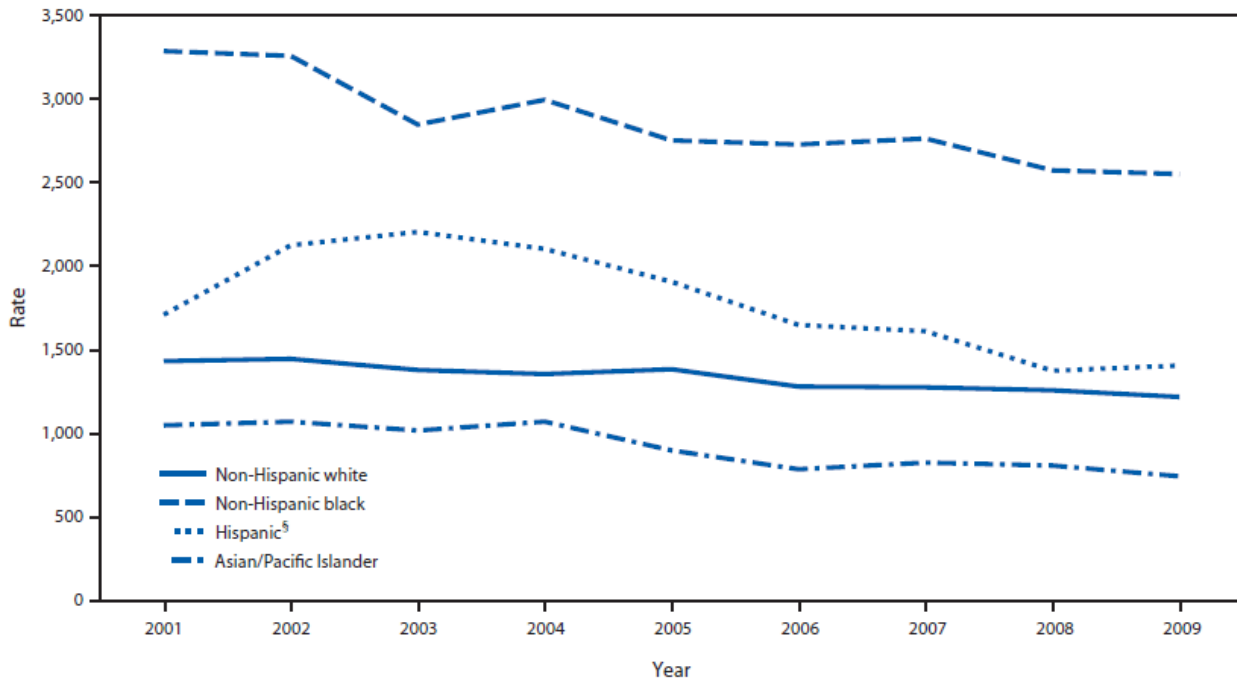
#### *Future Recommendations*

While this study did open shed some light on some of the variables associated with poor health outcomes, it did not completely address all of the research questions that were listed. My goal was to show that black women have poor health outcomes due to their race, level of education and discrimination. Numerous studies have shown that discrimination and racism exist, however my analysis did not show any direction causation that aligned consistently with the information provided in my literature review. We know infant mortality is higher among black women. We know that heart disease,

breast cancer and diabetes mortality rates are higher for black women than for whites. We know that the overall health of black women is significantly lower than that of white women. We know in general that African Americans are not as healthy as their whites. The research is solid in this area. Future research needs to continue to probe these “knowledge gaps” that we clearly know exist. This paradox must be unraveled so that we can begin to provide the recommendations to health care providers that will reduce health care disparities. We cannot continue to explore variables that we have already exhausted. We have looked at social determinants such as SES, environment, access to insurance, but these only provide a partial answer to a huge question (Michalopoulou, et al, 2009).

There is a plethora of research that conclusively provides evidence that minorities may not receive the same care as whites—but this is the conundrum: how can we measure it quantitatively? Figure 5 shows the rate of preventable hospitalizations by race. This illustrates a clear and fairly large disparity that exists between blacks and whites over an 8-year period. How can we pinpoint exactly what the causal factors are? What suggestions can be recommended to ensure that future researcher can actually identify and align the variables accurately?

**Figure 5: Rate\* of potentially preventable hospitalizations† among adults aged ≥18 years, by race/ethnicity — United States, 2001–2009**



**Source:** Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, State Inpatient Databases disparities analytic file, 2001–2009.

\* Per 100,000 population.

† For diabetes, hypertension, congestive heart failure, angina without procedure, asthma, dehydration, bacterial pneumonia, and urinary infections.

§ Persons of Hispanic ethnicity can be of any race or combination of races

It is never easy to address racism and discrimination because often it is so normalized, it becomes part of the institutions themselves. In other institutions such as education and the criminal justice system, racism and discrimination can easily be identified and tracked. This is not the case in health care, as we view this institution differently. From a sociological perspective, physicians are viewed quite differently than law enforcement, or educators. People who seek out health care do so because they need help. Perceptions and reality are not always aligned, and when evaluating the poor health outcomes for African American women, this study only opened a floodgate

of more questions about the relationship between race and health. For future studies, I recommend:

1. The relationship between stress and discrimination be measured. Surveys about perceptions of physicians and doctors may give us clues to the cultural competency, or areas where stress and discrimination can be reduced.
2. More minority women need to be included in research studies about women. Additionally, we must always address the intersections of race, class and gender. Patricia Hills-Collins (2009) refers to the “matrix of domination,” in which we need to study each type of inequality together, as each form of inequality reinforced the other. We cannot gain any clear information without addressing all three issues. For example, heart disease is the number one killer of *ALL* women in the United States, not because women have greater incidents of heart disease than men, but because their symptoms are often ignored or dismissed (CDC, 2009). When combined with race and class, it is easy to see why black women are disproportionately represented in this disease category, and this is just one example. More research funding should be allocated for studies on women’s health care issues, and this should include specific directives for evaluating at-risk populations (race and class).
3. Finally, cultural competency seems to be a key factor in understanding the disconnect between minority women and their care-providers. In a perfect world, we would have a sufficient number of minority physicians, but as this

is not a realistic goal, we need to prepare physicians early in their training on how to manage and understand minority populations.

I know from my own personal experiences, that if I don't feel that a health care provider "sees" me, and understands my perspective, I shut down. The person in the white coat with their clothes on has the power. It is that simple. We need to educate health care providers so that they can begin to learn and understand the populations that they serve. This alone may begin to open doors of communications, and break down barriers that exist for both the patients and the health care providers.

## CONCLUSIONS

This story that began this dissertation based on my **own experiences** navigating the health care system. I was misdiagnosed with a host of diseases because I was African American and did not “fit” into the current “symptom” ideology. They now know that endometriosis can affect women of any age and race, and that it has absolutely nothing to do with delaying childbirth (Gaines, 2011). The only reason white, middle-classed women were diagnosed in the first place was because they had good health insurance from their jobs. This type of sexism/racism in health care has to be addressed. Since the time of my first surgery, I have had 13 surgeries—one of which almost cost me my life due to a medical error. Throughout my interactions with the health care system, I have become extremely cautious and educated. I feel that my education empowers me in ways that other minority women may not have. As a sociologist, I am trained to watch the reactions of others, and when I interact with doctors, and I use their nomenclature, I see that their attitudes change. They see “*me*” as a human being. This should not only happen for those who are educated or who have suffered, this should be the standard care for everyone.

My perceptions of the health care system are that I was treated poorly because I was young had no insurance, and stereotyped into a disease category because of my race. As I became better educated, my health care services did improve, but this does not provide me a shield against racism. Often I felt that physicians were simply not understanding my lack of agency when navigating through the health care system. Because endometriosis is a poorly understood, illness, I still am faced with challenges as I try to seek out information about the disease.



Race is a social construct which has been used intentionally and unintentionally by those in power. When looking at the health statistics of African Americans presented in this paper, one has to wonder if my own health care problems were related to my race, gender and class status. Unfortunately, my story is not unique, and represents **only** a fraction of the problems that currently exist for minority women. As I poured through literature on the subject on minority health for this dissertation, I was concerned over the lack of a clear understanding of the multifaceted problem that black women face: discrimination, race, lack of education and poor neighborhoods are highly correlated with poor health outcomes (Gelhart, 2008). Each of these components must be addressed if we are to every truly understand the total detrimental effects they have on minority women's health. I can only imagine how difficult it must be for other women who are less fortunate and less educated than me.

The overall negative health consequences to women as a result of information deficits can only be resolved when health care providers' reinvision the way in which women are treated in terms of patterns of diagnosis and treatment for key conditions. Medicalization is not a one-way process (Conrad, 1992), and in order to "demedicalize the current unnecessary health treatments that women are receiving, health care providers and patients must work together challenge the current status quo. Moreover, providers' perceptions of their ability to provide optimal care to their women patients must be re-evaluated. The issues addressed in this paper—overmedicalization, lack of adequate health care, patriarchal health care, and social control--are only part of the larger issue. There are also issues of health insurance coverage, health behaviors among women, and the geographic maldistribution of medical resources. Cultural

competency training for health care providers may improve the level of communication between the patient and the provider. The recruitment and retention of minority and women health providers would help eliminate many of the cultural barriers that exist today. Finally, health care should be made accessible and user friendly.

Women are major consumers of health care services, negotiating not only their own complex health care but often managing care for their family members as well. Their reproductive health needs as well as their greater rates of health problems and longer life spans compared with men make women's relationships with the health care system complex. Women are also more likely to be low-income and often face the added challenge of balancing work with family health and care giving responsibilities. For the one in five women who are uninsured, access to high quality, comprehensive care is even more difficult (Bianchi, 1999).

Women have a vested interest in the scope and type of services offered by the health care system, as well as in the mechanisms that fund their health care services. Because their access to care is influenced by a broad range of factors, analysis of women's health policy cuts across many sectors of the health care financing and delivery system, including reproductive health policy, reforms to publicly-financed health programs, as well as private sector efforts to contain costs and improve health. Women comprise the majority of beneficiaries in publicly –funded programs such as Medicaid, Medicare, and welfare, making them *key* stakeholders in public policy debates about the impact of reforms to these programs. Because of their lower incomes, affordability and cost of care are critical issues for women. When looking at the health statistics for

women, it is clear that race and class are significant indicators of outcomes (Krieger & Fee, 1994).

A triple bind seems to exist for women, minorities and the poor: race, gender and socioeconomic status often impede our ability to receive adequate health care. Our needs are not being met; our voices are not being heard. The American health care system is in serious trouble. While *ObamaCare* may have helped to reduce the number of people without health insurance, it has not addressed the problems that minority women continue to face. Additionally, because of the convoluted interpretations of *Obamacare*, many people are still not covered, and the prices of the insurance continue to be a challenge for many. It is becoming more difficult to receive basic care, as many providers will not accept Medicaid or government sponsored insurance. Moreover, people who do have insurance continue to have higher premiums and higher co-pays. What this means is that **everyone** will be impacted in the future. Health care is becoming too expensive for everyone except the wealthy, who don't need health insurance in the first place. It is important that all of us continue to challenge and directly address the inequities that currently exist within our health care system.

In the United States health care has become a commodity. Budget cuts and the ever-changing world of managed care, has left many of us wondering about the quality of care that we receive. The American health care system continues to expand, and yet we have health statistics for minorities that are comparable to third world nations. It is clear that there is an urgent need to re-evaluate the American health care system in order to resolve many of the health care disparities that are (and should not be) prevalent in the underserved and most vulnerable community. We need to take urgent

steps to ensure that every available resource is used in order to ensure that everyone has access to quality health care. The long-term costs to our society if we do not address this issue will no doubt be substantial. If research in African American women's health care is to be successful, a multi-discipline approach must be undertaken to address and understand the underlying causes of health disparities for this fragile population.

## **APPENDIX**

**Table 2 describes the dependent variables used in the NSAL study. Medical help is the code for the following question:**

*Now I'm going to ask about who you go to for medical help. Is there one place or person you usually go to when you are sick or need medical advice?*

The Center for Epidemiological Studies – Depression Scale (CES-D) is a scale that measures depressive symptoms in an individual to determine their or her depression quotient (Radloff, 1977). The CES-D scale consists of the following questions:

*Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week. The respondents' choice categories for the measure were (1) Rarely or none of the time (less than 1 day), (2) Some or a little of the time (1-2 days), (3) Occasionally or a moderate amount of time (3-4 days), and (4) Most or all of the time (5-7 days).*

1. I was bothered by things that usually don't bother me.
3. I did not feel like eating; my appetite was poor.
4. I felt that I could not shake off the blues even with help from my family or friends.
5. I felt I was just as good as other people.
6. I had trouble keeping my mind on what I was doing.
7. I felt depressed.
8. I felt that everything I did was an effort.
9. I felt hopeful about the future.
10. I thought my life had been a failure.
11. I felt fearful.

**Table 2 describes the dependent variables used in the NSAL study. Medical help is the code for the following question:**

12. My sleep was restless.

13. I was happy.

14. I talked less than usual.

15. I felt lonely.

16. People were unfriendly.

17. I enjoyed life.

18. I had crying spells.

19. I felt sad.

20. I felt that people dislike me.

21. I could not get "going."

## **BIBLIOGRAPHY**



## BIBLIOGRAPHY

- Adler, Nancy E, Boyce W. Thomas, Chesney, Margaret A., Folkman, Susan, Syme S. Leonard, (1993). Socioeconomic inequalities in health: no easy solution. *Journal of American Medical Association*, 269, 2(4).
- Agency for Healthcare Research and Quality (AHRQ), March 29, 2000.
- Akinmoladun, Tunde M, PhD,D.A.A.S., F.R.S.P.H. (2009). Health/health care disparities: are predominantly African American institutions making a difference? *Journal of the National Medical Association*, 10( 9), 967-9.
- Aneshensel, Carol S., Phelan, Jo C., Bierman, Alex (Eds.) (1999). *The Handbook of the Sociology of Mental Health*. (New York: Kluwer Academic/Plenum Publishers)
- AHRQ Publication No. 12-0006-3-EF, October 2012. *Disparities in Health Care Quality Among Minority Women: Findings from the 2011 National Healthcare Quality and Disparities Reports*. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/nhqrdr11/nhqrminoritywomen11.htm>.
- Arias, E. (2008). United States Life Tables. National Vital Statistics Report 201; 61 (3).
- Ayanian, John Z. Race, class and the quality of medical care. (1994) *Journal of American Medical Association*, 271(15).
- Baffour, T. D., & Chonody, J. M. (2009). African-american women's conceptualizations of health disparities: a community-based participatory research approach. *American Journal of Community Psychology*, 44(3-4), 374-81.
- Babbie, E. R. (1998). *The practice of social research* (Vol. 112). Belmont, CA: Wadsworth publishing company.
- Bailey, J. Eric. (1991). *Urban African American Health Care*. University Press of American, Maryland, 1991.
- Baquet, C.R., Horm, J.W., Gibbs, T, Greenwald P. (1991) "Socioeconomic Factors and Cancer Incidence among Blacks and Whites." *Journal of National Cancer Institute*. Vol. 83, 551-557.
- Bartman, B.A. & Moy, E. (1995) "Physician Race and Care of Minority and Medically Indigent Patients." *Journal of American Medical Association (JAMA)*, 273.
- Bayne-Smith, Maricia, (1996). *Race, Gender and Health*. Sage, California.

- Beauboeuf-LaFontant, Tamara. (2007) "You Have to Show Strength: An Exploration of Gender, Race, and Depression." *Gender & Society* Vol 21: 28-51.
- Beach, M. C., Hill-Briggs, F., & Cooper, L. A. (2006). Racial and ethnic differences in receipt and use of health information in encounters between patients and physicians. *Medical Care*, 44(2), 97–99.
- Becker, G., Gates, R. J., & Newsom, E. (2004). Self-Care among chronically ill African Americans: culture, health disparities, and health insurance Status. *American Journal of Public Health*, 94(12), 2066-73.
- Benz, J. K., Espinosa, O., Welsh, V., & Fontes, A. (2011). Awareness of racial and ethnic health disparities has improved only modestly over a decade. *Health Affairs*, 30(10), 1860-7.
- Bob, Lawrence, Kluegal, JR, Smith, RA (1997). "Laissez-faire Racism: The Crystallization of a Kinder, Gentler, antiblack Ideology." *Racial Attitudes in the 1990s: Continuity and Change*, Vol. 15 (23-25).
- Braveman, Paula A, M.D., M.P.H., Cubbin, C., PhD., Egerter, S., PhD., Williams, D. R., PhD., & Pamuk, E., PhD. (2010). Socioeconomic disparities in health in the United States: what the patterns tell us. *American Journal of Public Health*, 100, 186-96.
- Broman, Clifford. (1996). "The Health Consequences of Racial Discrimination: A Study of African Americans. *Ethnicity and Disease*, Vol. 6, 148-153.
- Broman, Clifford., et al. 2010. "Racial and ethnic self identification influences on physical and mental health status among blacks." *Race and Social Problems*.
- Broman, Clifford. 2012. "Race differences in the use of mental health services among young adults". *Psychological Services*. Vol. 9, No. 138-48.
- Case, Anne & Angus, Deane, (2015). "Rising Morbidity and Mortality in Midlife among white non-Hispanic Americans in the 21<sup>st</sup> Century." Proceedings of National Academy of Sciences of the United States (PNAS).
- Center for Disease Control National Center for Health Statistics (NCHS), *Nation Health Interview Survey*, 1999.
- Chen, J., PhD. & Rizzo, J., PhD. (2010). Racial and ethnic disparities in use of psychotherapy: evidence from U.S. national survey data. *Psychiatric Services*, 61(4), 364-72.
- Chumney, E. C. G., Mauldin, P. D., & Simpson, K. N. (2006). Charges for hospital admissions attributable to health disparities for African-American patients, 1998-2002. *Journal of the National Medical Association (JAMA)*, 98(5), 690-4.

- Collins, Patricia Hills. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). NY: Routledge.
- Conrad Peter, (1992). "Medicalization and Social Control". *Annual Review of Sociology*, Vol. 18, 209-2342.
- Conrad, Peter. & Schneider JW, (1995). *Deviance and Medicalization: From Badness to Sickness*. Temple University Press, Philadelphia.
- Conrad, Peter & Barker, Kristin, (2010). "The Social Construction of Illness, Key Insights and Policy Implications." *Journal of Health and Social Behavior*, Vol. 51 no. 1, 67-79.
- Coulter, Stephanie. (2011). "Epidemiology of Cardiovascular Disease in Women: Risk, Advances, and Alarms." *Texas Heart Institute Journal*, 38(2), 145–147.
- Din-Dzietham, Rebecca, MD, MPH, Hertz-Picciotto, Irva, PhD, MPH, (1988) "Infant Mortality Differences between Whites and African Americans: The Effect of Maternal Education," *American Journal of Public Health*, 88, (651-656).
- Doob, Christopher, (1999). *Racism: An American Cauldron*. Addison Wesley Longman Inc. New York. (109).
- Dubay, Lisa, Joyce, Ted, Kaestner, Robert, Kenney, Genevieve, M., (2001) Changes in prenatal care timing and low birth weight by race and socioeconomic status: implications for the medicaid expansions for pregnant women. *Health Services Research*, Chicago, 36, (2), 373-398.
- Duster, Troy, (2003). *Backdoor to Eugenics*. New York: Routledge, 2003.
- Errickson, S. P., Alvarez, M., Forquera, R., Whitehead, T. L., Fleg, A., Hawkins, T., Schoenbach, V. J. (2011). What will health-care reform mean for minority health disparities? *Public Health Reports* (1974-), 126(2), 170–175.
- Erving, C. L. (2011). Gender and physical health: A study of African American and Caribbean black adults. *Journal of Health and Social Behavior*, 52(3), 383-99.
- Essed, Philomena, (1991). "*Understanding everyday racism: An interdisciplinary theory*" (Vol. 2). Sage.
- Feagin, Joe. R., & Hernan, Verna. (2000). *White racism: The basics*. Routledge.
- Fiscella, Kevin, Franks, Peter, Gold, Marthe R., Clancy, Carolyn M. (2000), Inequality in quality: addressing socioeconomic, racial and ethnic disparities in health care. *Journal of American Medical Association (JAMA)*, 283(19), 2579-2582.

- Flores, G., & Lin, H. (2013). Trends in racial/ethnic disparities in medical and oral health, access to care, and use of services in US children: Has anything changed over the years? *International Journal for Equity in Health*, 12(10).
- Frisbie, WP, Biegler, M, de Turk, P., Forbes, D. Pullum, S.G., (1977-1983) "Racial and Ethnic Differences in Determinants of Intrauterine Growth Retardation and Other Compromised Birth Outcomes," *American Journal of Public Health*, 87(12).
- Gaiter, J. L., Potter, R. H., & O'Leary, A. (2006). "Disproportionate Incarceration Contribute to Health Disparities. *American Journal of Public Health*, 96(7), 1148-9.
- Gaines, Tyrese, (2011). "Chronic pelvic pain often misdiagnosed in black women study finds," <http://thegrio.com/2011/05/04/chronic-pelvic-pain-often-misdiagnosed-in-black-women-study-finds/>
- Gehlert, S., Mininger, C., Sohmer, D., & Berg, K. (2008). (Not so) gently down the stream: Choosing targets to ameliorate health disparities. *Health & Social Work*, 33(3), 163-7.
- Goffman, E. (1959). *The presentation of self in everyday life*. New York: Anchor Books.
- Hannan EL, Ryn MV, Burke D, Stone D, Kumar D, Arani W, et al. (1999). Access to Coronary Artery Bypass Surgery by Race/Ethnicity and Gender among Patients who are Appropriate for Surgery. *Medical Care*. 37, 68-77.
- Hambleton, I. R., Jeyaseelan, S., Howitt, C., Sobers-Grannum, N., Hennis, A. J., Wilks, R. J., Sullivan, L. W. (2015). Cause-of-death disparities in the african diaspora: Exploring differences among shared-heritage populations. *American Journal of Public Health*, 105, 491-S498.
- Hammond, Wizdom Powell, PhD., M.P.H., Mohottige, D., M.P.H., Chantala, K., M.S., Hastings, Julia F, M.S.W., PhD., Neighbors, H. W., PhD., & Snowden, L., PhD. (2011). Determinants of usual source of care disparities among african american and caribbean black men: Findings from the national survey of american life. *Journal of Health Care for the Poor and Underserved*, 22(1), 157-75.
- Hinterlong, J. E. (2006). Race disparities in health among older adults: Examining the role of productive engagement. *Health & Social Work*, 31(4), 275-88.
- House, James, S. "Relating Social Inequalities in Health and Income," (2001) *Health Politics, Policy and Law*.
- Israel, B. A., DrP.H., Coombe, C. M., PhD., Cheezum, R. R., M.P.H., Schulz, A. J., PhD., McGranaghan, R. J., M.P.H., Lichtenstein, R., PhD., . . . Burris, A., B.A. (2010). Community-based participatory research: A capacity-building approach for

policy advocacy aimed at eliminating health disparities. *American Journal of Public Health*, 100(11), 2094-102.

Jackson JS, Torres M, Caldwell CH, Neighbors HW, Nesse RM, Taylor RJ, Trierweiler SJ, Williams DR. The National Survey of American Life: A study of racial, ethnic and cultural influences on mental disorders and mental health. *Int J Methods in Psychiatr Res*. 2004;13:196-207.

Jackson, J. S., Knight, K. M., & Rafferty, J. A. (2010). Race and unhealthy behaviors: chronic stress, the HPA axis, and physical and mental health disparities over the life course. *American Journal of Public Health*, 100(5), 933-9.

Kahn, R. S., Wilson, K., & Wise, P. H., (2005). Intergenerational health disparities: socioeconomic status, women's health conditions, and child behavior problems. *Public Health Reports (1974)*, 120(4), 399–408.

Kim, Annice, E, PhD., M.P.H., Kumanyika, Shiriki, PhD., M.P.H., Shive, D., M.S.P.H., Igweatu, U., B.A., & Kim, S., PhD. (2010). Coverage and framing of racial and ethnic health disparities in US newspapers, 1996-2005. *American Journal of Public Health*, 100, S224-31.

Kingston, R.S., Smith, J.P. (1997) Socioeconomic status and racial and ethnic differences in functional status associated with chronic diseases. *American Journal of Public Health*, 87(5), 805-810.

Krieger, N., PhD., Kosheleva, A., M.S., Waterman, P. D., M.P.H., Chen, J. T., ScD., & Koenen, K., PhD. (2011). Racial discrimination, psychological distress, and self-rated health among US-born and foreign-born black Americans. *American Journal of Public Health*, 101(9), 1704-13.

LeClere, Felicia B., Rogers, Richard, G., Peters, Kimberly, D. (1997) "Ethnicity and Mortality in the United States: Individual and Community Correlates," *Social Forces*, 76, 169-98.

Leigh, W. A. (2012). The affordable care act and its potential to improve the health of african-american women. *Review of Black Political Economy*, 39(4), 461-464

McFayden, E., Jr. (2009). "Key factors influencing health disparities among African Americans." *Race, Gender & Class*, 16(3), 120-132.

McIntosh, Peggy (1988). "White Privilege and Male Privilege: A Personal Account of Coming To See Correspondences through Work in Women's Studies."

Meredith, Lisa S and Griffith-Forge Nell, (2002). "The road to eliminating disparities in health care," *Medical Care*, 40(9), 729-731.

- Michalopoulou, Georgia, Falzarano, Pamela, Arfken, Cynthia, Rosenberg, David, (2009). "Physicians' Cultural Competency as Perceived by African American Patients." *Journal of the National Medical Association*. Vol 101, (9).
- Minority Health in Michigan*, (1988) Michigan Department of Public Health.
- Minority Women's Health-Diabetes, 2010. Office of Women's Health, US Department of Health and Human Services. <http://womenshealth.gov/minority-health/african-americans/diabetes.html>
- Moss, Nancy, E. (1995), "Social Inequalities and Health," *Health Affairs*, 12(2).
- Office of Minority Health. (2012) "Diabetes and African Americans."
- Our Bodies, Ourselves: A New Edition for New Era*, (2005). Boston Women's Health Collective, Judy Norsigian, editor.
- Orsi, J. M., M.P.H., Margellos-Anast, H., & Whitman, S., PhD. (2010). "Black-white health disparities in the United States and Chicago: A 15-year progress analysis." *American Journal of Public Health*, 100(2), 349-56.
- Pappas, George (1994). "Elucidating the Relationship between Race, Socioeconomic Status and Health.: American Journal of Public Health Vol. 8 (892-893).
- Paschal, A. M., Lewis-moss, R., Sly, J., & White, B. J. (2010). Addressing health disparities among African Americans: Using the stages of change model to document attitudes and decisions about nutrition and physical activity. *Journal of Community Health*, 35(1), 10-7.
- Pager, D., & Shepherd, H. (2008). The sociology of discrimination: racial discrimination in employment, housing, credit, and consumer markets. *Annual Review of Sociology*, 34, 181–209.
- Pereira, C. C. A., Palta, M., Mullahy, J., & Fryback, D. G. (2011). Race and preference-based health-related quality of life measures in the United States. *Quality of Life Research*, 20(6), 969–978.
- Petrinini, Joann, Damus, Karla, Roy, Sinaly, (1998)"The Effect of Using "Race of Child" instead of "Race of mother" on the black-white gap in infant mortality due to birth defects, *Public Health Reports*, 113(3).

- Randall, R. Vernellia. (1994). Impact of managed care organizations on ethnic americans and underserved populations. *Journal of Health Care for the Poor and Underserved*. Vol.224.
- Rathwell, Thomas and Phillips, David. (1986) *Health, Race and Ethnicity*. Croom Helm, New Hampshire.
- Rao, Vijaya, & Flores, Glenn. (2007). "Why aren't there more African-American physicians? A qualitative study and exploratory inquiry of African-American students' perspectives on careers in medicine." *Journal of the National Medical Association*, 99(9), 986–993.
- Reyes, Jessica Wolpaw, (2007). Gender gaps in income and productivity of obstetricians and gynecologists. *Obstetrics and Gynecology*, 109, 1031-1039.
- Robbins, J. M., Vaccarino, V., Zhang, H., & Kasl, S. V. (2001). Socioeconomic status and type 2 diabetes of African American and non-Hispanic white women and men: Evidence from the third national healthy and nutrition examination survey. *American Journal of Public Health*, 91(1), 76-83.
- Roberts M, Rhoades JA. (2010) The uninsured in America, first half of 2009: estimates for the U.S. civilian noninstitutionalized population under Age 65. Statistical Brief #291, Agency for Healthcare Research and Quality, Rockville, MD, at [http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/st291/stat291.pdf](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st291/stat291.pdf)
- Ross, Catherine E, Sastry, Jaya. (1999). The sense of personal control: social-structural causes and emotional consequences. *Handbook of the Sociology of Mental Health*, edited by Carol S. Aneshensel and J C. Phelan. Kluwer, New York.
- Ruffin, J., PhD. (2010). The science of eliminating health disparities: Embracing a new paradigm. *American Journal of Public Health*, 100, S8-9.
- Ruggiero, Karen M. and Taylor, Donald M. (1997). Why minority group members perceive or do not perceive the discrimination that confronts them: The role of self-esteem and perceived control. *Journal of Personality and Social Psychology*, Volume 72, 373-389.
- Samnaliev, M., McGovern, M. P., & Clark, R. E. (2009). Racial/Ethnic disparities in mental health treatment in six medicaid programs. *Journal of Health Care for the Poor and Underserved*, 20(1), 165-76.
- Satcher, David, M.D., PhD., & Higginbotham, E. J., M.D. (2008). The public health approach to eliminating disparities in health. *American Journal of Public Health*, 98, S8-S11.

- Schulz, Amy J., Graylee, Clarence C., Williams, David R., Israel, Barbara A., Mentz, Graciela, Rowe, Zachary. "Discrimination, Symptoms of Depression, and Self-Rated Health Among African American Women in Detroit: Results from a Longitudinal Analysis." *American Journal of Public Health*: July 2006, Vol. 96, No. 7, pp. 1265-1270.
- Smedley, Audrey. 199. *Racine in North America: Origin and Evolution of a Worldview*, 2<sup>nd</sup> Ed. Boulder, Colorado: Westview Press.
- Snowden, L. R. (2012). Health and mental health policies' role in better understanding and closing African American–White American disparities in treatment access and quality of care. *American Psychologist*, 67(7), 524-531.
- Smith, David Barton, (1998). "Addressing racial inequalities in health care: civil rights monitoring report Cards," *Journal of Health Politics, Policy and Law*; Durham, 23(1), 75-105.
- St. Jean, Yanik, & Feagin, Joe, (1997). "Double Burden: Black Woman and Everyday Racism." Armonk New York.
- Subban, J. E., Terwoord, N. A., & Schuster, R. J. (2008). With or without intent: how racial disparities prevent effective implementation of care. *The Journal of Nutrition, Health & Aging*, 12(10), 770S-775S.
- Carl Thomas (2012). "Theorizing disability and chronic illness: Where next for perspectives in medical sociology?" *Social Theory & Health* (2012) 10, 209–228.
- Thomas, John F, PhD, LCSW, Temple, J. R., PhD., Perez, N., M.S., & Rupp, R., M.D. (2011). Ethnic and gender disparities in needed adolescent mental health care. *Journal of Health Care for the Poor and Underserved*, 22(1), 101-10.
- Thompson, N. Shawn & Chambers, Jr. W. John (2000), "African Self-Consciousness and Health-Promoting Behaviors among African American College Student". *Journal of Black Psychology*; Washington.
- Townes, Emilie, M. (1998), *Breaking the Fine Rain of Death*. Continuum, New York.
- U.S. Census Bureau. Resident population estimates of the United States by sex, race, and Hispanic origin: April 1, 1990 to July 1, 1999, with short-term projections to June 1, 2000. Available at: <http://www.census.gov/population/estimates/nation/intfile3-1.txt>.
- U.S. Department of Health and Human Services, Office of the Surgeon General, 2004.
- Valire, C. C. (2005). African Americans: disparities in health care access and utilization. *Health & Social Work*, 30(3), 265-70.



- Wacholder, S. (2007). Untangling differences in cancer mortality rates: A closer look at race and education. *Journal of the National Cancer Institute*, 99(18), 1356-7.
- Waite R, & Killian P. (2008). "Heath Beliefs about Depression among African American Women," *Perspectives in Psychiatric Care*.
- Waitzkin, Howard. (1991). *The Politics of Medical Encounters*. Yale University Press, New Haven and London.
- Ward, E. C., & Heidrich, S. M. (2009). African American Women's Beliefs About Mental Illness, Stigma, and Preferred Coping Behaviors. *Research in Nursing & Health*, 32(5), 480–492.
- Weiss, Gregory, L., Lonquist, Lynne E. (2015). *The Sociology of Health, Healing and Illness*. Pearson Publishing, New Jersey.
- Williams, David R., Collins, Chiquita, (1995). "U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations," *Annual Review of Sociology*, 21, 349-386.
- Williams, David R., Rucker, Toni D. (2000). "Understanding and addressing racial disparities in health care," *Health Care Financing Review*, Washington, 21(4), 75-90.
- Williams, D. R. (2012). Miles to Go Before We Sleep: Racial Inequities in Health. *Journal of Health and Social Behavior*, 53(3), 279–295.
- Wiltshire, J., Cronin, K., Sarto, G. E., & Brown, R. (2006). Self-advocacy during the medical encounter: use of health information and racial/ethnic differences. *Medical Care*, 44(2), 100–109.
- Winn, Mylon. (1988). *Competitive Health Care: Assessing an Alternative Solution for Health Care*, Michigan Department of Public Health.
- Wright, J. D., Herzog, T. J., Tsui, J., Ananth, C. V., Lewin, S. N., Lu, Y.-S., ... Hershman, D. L. (2013). "Nationwide Trends in the Performance of Inpatient Hysterectomy in the United States." *Obstetrics and Gynecology*, 122(2 0 1), 233–241.
- Wu JM, Wechter ME, Geller EJ, Nguyen TV, Visco AG. (2007). Hysterectomy rates in (the United States, 2003. *Obstetric Gynecology*. 110, 1091–5.