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Racial Disparities in the U.S. Healthcare System

J. Paul Nielsen

There is well-documented literature on the general pattern of poorer health among members of racial or ethnic minority groups (Nerenz et al., 2004). Determining the causes of these racial disparities in quality of healthcare is the subject of extensive study, investigation, and deliberation. Many of the racial disparities in health and health care reflect the combined effects of poverty and lack of health insurance (Isaacs et al., 2004). Most alarmingly, however, is the difference in quality of care between Caucasians and other minorities seen when controlling for income, insurance status, and severity of symptoms (Snyder, 2002). Even when they had overcome barriers to getting healthcare, African-American and other minority populations were still less likely to receive certain high-tech, expensive, yet common procedures such as coronary bypass operations, kidney dialysis, and kidney transplants (Saltus, 2007). Other documented disparities include low-income minorities having fewer and less adequate prenatal care visits, higher risk of cancer mortality, and less frequent follow-up visits (Nerenz et al., 2004). These statistics represent the disturbing truth that the U.S. healthcare system is riddled with flaws that allow Caucasian Americans to receive top-quality care while minorities slip through the cracks. The difficulty lies in identifying and correcting these flaws. Potentials for discrepancies in quality of care are present at both the healthcare systems-level and at the provider level, and solutions should be tailored to address the problem at both levels simultaneously.

Certain systems-level factors play a critical role in deterring minorities from receiving optimal healthcare. There are over 14 million Americans who are not proficient in English (Henry J. Kaiser Family Foundation, 2007). Many health care facilities lack the resources, knowledge, or institutional priority to provide interpretation and translation services for patients that do not speak English (National Academy of Sciences, 2003). Clearly miscommunication between the physician and patient because of language barriers will negatively affect quality of care. Additionally, one in five Spanish-speaking Latinos reports not seeking healthcare due to language barriers (Henry J. Kaiser Family Foundation, 2007). Healthcare facilities must put a higher priority on bridging the language barriers that exist for non-English speaking patients. Additionally, time pressures on physicians may hamper their ability to assess minority patients, especially when cultural or language barriers are present. This challenge in capitation situations where there is a financial advantage to physicians for seeing as many patients as possible. It remains critical that physicians pay sufficient time to every patient to properly consider and evaluate the patients' conditions. A final issue at the systems-level that may be contributing to disparities in healthcare among races is the shift to managed-care systems. The increasing efforts by states to enroll Medicaid patients in impersonal managed care systems may disrupt traditional community-based care and displace providers that are familiar with the language, culture, and values of ethnic minority communities (National Academy of Sciences, 2003).

In addition to systems-level causes of racial disparities in healthcare, provider mentality regarding minorities, both overt and subconscious, likely affect the quality of healthcare delivered. A report by the National Academy of Sciences underscores the modern reality of stereotypical views of minorities held by society at large (National Academy of Sciences, 2003). Survey research suggests that most (between 50-75%) Caucasian people believe minorities are less intelligent, more prone to violence, and less likely to be employed (National Academy of Sciences, 2003). Although healthcare providers are hopefully more tolerant than the general society, subtle manifestations of deeply ingrained biases could taint their clinical decisions when

treating minority patients. If physicians, like society at large, believe that minorities are less intelligent, providers may be less likely to attempt patient education. Additionally, given such stereotypical views held by society, it is likely that minority patients mistrust Caucasians and therefore are more likely to refuse treatment, fail to comply with medical advice, and become disengaged in the treatment process. Patients' and providers' behaviors likely influence each other reciprocally and reflect the attitudes, expectations, and perceptions that each has developed over years of experience and exposure to societal and cultural opinions regarding other races. Therefore, ensuring providers are aware of the prevalence of racism should become an important target for interventional efforts.

Obviously the difference in quality of healthcare between minorities and Caucasians remains alarmingly prevalent (Henry J. Kaiser Family Foundation, 2007). Inexpensive interventions involving systems modification and provider education may vastly improve the relatively poor quality of healthcare received by racial minorities in the U.S.

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