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Racial Disparities in Accessing Health Care and Health Status

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Abstract

Point (Overview): Interpersonal and institutional racial biases are the principal reasons for racial disparities in accessing health care and disparities in African Americans' health status, which can only be addressed by acknowledging and putting an end to interpersonal and institutional racial bias in the health care system that adversely affects the health status African-Americans.

Counterpoint (Overview): The irrational structure of health care, which is based on ability to pay, rather than need is the main cause of racial disparities in health, which will not be equalized until the structure of the health care system is fixed or when African Americans' economic inequalities are addressed.

Defining the Problem: The U.S. Department of Health and Human Services ("HHS") defines health disparities as differences in health between groups of people who have systematically experienced greater obstacles to health based on their racial group; socioeconomic status; or other characteristics historically linked to discrimination or exclusion. Decades of government reports and research studies have shown that racial disparities in accessing quality health care and health status continue to exist, particularly between African-Americans and Caucasians. The largest disparity in health status was and remains to be between African-Americans and Caucasians.

In 1985, the Secretary of HHS issued a landmark report, the Heckler Report, which exposed the existence of racial disparities in the U.S. health care system (Office of the Director, 1985). In 2003, the groundbreaking Institute of Medicine Study ("IOM study") Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare acknowledged the continuation of racial disparities in health status and accessing health care and provided suggestions for the elimination of these disparities (IOM, 2003). Finally, in 2007 the National Healthcare Disparities Report ("NHDR") noted that racial disparities in health status and accessing quality health care were not getting smaller; instead the gaps had not only persisted, but also gotten worse (HHS 2008).

In addition to these reports, empirical research studies have shown that racial disparities in health care have worsened. In 1985, 60,000 excess deaths occurred each year in minority populations. By 2005, an estimated 83,570 African-Americans died each year that would not die if African-American death rates were equivalent to Caucasian rates (Satcher, 2005). In fact, research studies have shown that in 1950 before the end of legalized racial segregation, the life expectancy rates of 65 year old African-Americans and Whites was the same. Since 1950, African-Americans' life expectancy has continued to decline even after the advent of Title VI of the Civil Rights Act of 1964 ("Title VI"), which granted them "equal" access to health care services. In response to this data, the government has issued several initiatives to put an end to racial disparities in access to health care and health status.

In 1990, HHS issued the first national health initiative, which provides science-based ten-year national objectives for improving the health of all Americans. In the first national health initiative, called Healthy People 2000, one of the main objectives was to reduce health disparities among all Americans. In 1998, President Bill Clinton announced the Initiative to Eliminate Racial and Ethnic Disparities in Health Care that was supposed to eliminate racial and ethnic health disparities in six key areas of health status, including infant mortality, by the year 2010. In 2000, the Healthy People 2010 initiative was issued with an objective of eliminating racial disparities in health care. In 2010, the Healthy People 2020 initiative expanded the goal of eliminating racial disparities in health care to include achieving health equity and improving the health of all groups. In spite of all the research, government reports and initiatives, health care disparities persist and in some cases have worsened. A recent report estimated that 30.6%, or $230 billion, of direct medical expenditures between 2003 and 2006 were excess costs due to racial disparities in health status and access to health (LaViest, 2009).

Scholars and researchers have asserted a panoply of causes for the continuation of racial disparities in access to quality health care and health care status, including, cultural differences, insurance status, socioeconomic status, and education levels. Yet, innumerable research studies show that even when all these factors are controlled racial disparities in health care persist, leaving race as the only plausible explanation for the continuation of disparities. But what does race have to do with it?

Some argue that race means that there are biological differences that explain these disparities in health outcomes; however, biologically race differences accounts for at most .03% of genetic variation (Mak, 2006). Thus, if race plays a role in racial disparities, genetic research suggests that it is due to the social construction of race not biological differences. As Professors David Williams and Pamela Jackson noted, "race is a marker for differential exposure to multiple disease-producing social factors. Thus, racial [disparities] in health should be understood not only in terms of individual characteristics but also in light of patterned racial inequalities in exposure to societal risks and resources." (Williams and Jackson, 2005). Unfortunately, the significance of societal risks, such as racial bias in causing racial disparities in health care is often ignored. However, some credible and robust research studies have suggested that racial bias is the chief factor in the continuation of racial disparities in health care.

There are three levels of racial bias: interpersonal, institutional, and structural. Interpersonal bias is the conscious (explicit) and/or unconscious (implicit) use of prejudice in interactions between individuals. Interpersonal bias is best illustrated by physician's treatment decisions based on racial prejudice and its effect on African-Americans' health status. Institutional bias operates through organizational structures within an institution that "establishes separate and independent barriers" to health care services, which is best demonstrated by hospital closures in African-American communities. Finally, operating at a societal level, structural bias is the organizational structure of society, which privileges some groups, while denying others access to health care. An example of structural bias is the rationing of health care based on ability to pay rather than need. Seemingly similar, there is a significant difference between institutional and interpersonal bias versus structural bias. Both interpersonal and institutional biases focus on the direct racial effects of individual or institutional actions, whereas structural bias measures how non-race based factors, such as economic inequalities, indirectly affect racial minorities (Grant-Thomas and Powell, 2006).

Keywords: implicit bias, racial bias, institutional racial bias, structural racial bias, interpersonal racial bias, racial disparities, Title VI, hospitals, nursing homes

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