Racial Disparities in Health Care

Racial differences in health care has become more and more prevalent over the years. “Socioeconomic status whether measured by income, education, occupational status, or wealth is a strong predictor of variations in health and has often been viewed as the driver of racial inequities in health.” (Williams, Lawrence, Davis, Vu, 2019) Racial disparities have always been problematic in healthcare, I believe now more individuals are speaking out and brining awareness to this situation. I am opposed to the idea of racial disparities in the healthcare system. I will use scholarly articles and my own personal experience to support my stance.

“Racial and ethnic differences in health, in which socially disadvantaged racial populations have worse health than whites, are large, pervasive across a broad range of outcomes, and persistent over time.” (Williams, Lawrence, Davis, Vu, 2019) A large percentage of individuals belonging to minority communities tend to be disadvantaged. This includes lower levels of education; individuals reside in areas with greater environmental hazards and most jobs held by minorities can be extremely taxing on the body.

Another huge social economic disadvantage is the lack of health insurance. Twenty-five percent of Americans classified as minority does not have health insurance. The lack of health insurance gives individuals in these communities less access or none at all to the resources and healthcare they need. I have heard countless stories of individuals not wanting to see a doctor to get a check up on something minor in hopes to avoid the major bill they will receive. That issue that was once minor can sometimes turn into a life-threatening emergency. If there were better resources for these individuals this cycle would be nonexistent.

While the issue on minorities without health insurance is essentially important, we will be focusing on racial disparities in the quality of care for minorities that have access to insurance

and the healthcare system. “Racial and ethnic disparities has shown itself in the utilization of cardiac diagnostic and therapeutic procedures, prescription of analgesia for pain control, surgical treatment of lung cancer, referral to renal transplantation, treatment of pneumonia and congestive heart failure, and the utilization of specific services covered by Medicare (e.g., immunizations and mammograms).” (Betancourt, Green, Carrillo, Ananeh-Firempong, 2003) Additional factors that can aid in racial disparities are patients’ health beliefs, values and preferences.

I believe the cause of racial dipartites stems from a lack of communication between healthcare providers and their patients. “These include variations in patient recognition of symptoms; thresholds for seeking care; the ability to communicate symptoms to a provider who understands their meaning; the ability to understand the prescribed management strategy.” (Betancourt, Green, Carrillo, Ananeh-Firempong, 2003) These factors have been proven to influence patient and the physician’s decision-making process. Somewhere the communication has been lost which contributes to the disparities in our healthcare system.

Since this the topic of cultural competence has been introduced into the conversation. “A culturally competent health care system has been defined as one that acknowledges and incorporates at all levels, the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.” (Betancourt, Green, Carrillo, Ananeh-Firempong, 2003) Cultural competence is a way to break barriers between patient and provided regardless of any social economical factor the patient might face.

A study was conducted on racial disparities and cultural competence and what can be done to improve the outcome. Identified were three sociocultural barriers that can contribute to the racial differences within our system. The first was organizational barriers, described here was

the improvements that need to be made in the availability and acceptability of health care for members or minorities. The healthcare workforce should reflect the composition of the general population. “Despite representing almost 28% of this nation’s population, African Americans, Latinos, and Native Americans make up only 3% of medical school faculty.” (Betancourt, Green, Carrillo, Ananeh-Firempong, 2003) The second was structural barriers, here economic forces drive both structure and function. Structural barriers show its true colors when patients are faced with the challenge of choosing health care from organizations that are complex and bureaucratic. Our last point consists of the clinical barrier, here we see the interaction between patient and provider. This occurs when sociocultural differences are not entirely accepted and or understood. “Research has shown that provider-patient communication is directly linked to patient satisfaction, adherence, and subsequently, health outcomes.” (Betancourt, Green, Carrillo, Ananeh-Firempong, 2003)

There is another topic I would like to touch on that stems from disparities in health care. The topic of the racial and ethnic minority infants and mothers have worse birth outcomes than Caucasian individuals. A study was performed to compare infant mortality rates with women who participated in a WIC program in Kansas. “According to the World Health Organization, approximately 13 million babies are born preterm each year. The proportion of premature births in Kansas were 8.3% for Caucasians, 12.9% for Blacks, and 9.1% for other racial subgroups in 2014. Various factors have been attributed to preterm births such as infection during pregnancy, or other conditions such as diabetes or hypertension.” (Keene Woods, Reyes, Chesser, 2016)

Low birth weight (LBW) is another factor of concern for improving pregnancy outcomes. LBW can be caused by preterm birth, or various other factors such as maternal heart disease, diabetes, hypertension, addiction such as smoking or alcohol, poor nutrition, and being a teenage

mother. In 2014 in Kansas, the proportion of LBW were 6.5% for Caucasians, 13.4% for Blacks, and 7.6% for other racial subgroups. The overall results of this study were IMR was 6.4 per 1000 births. Infant mortality for Caucasians was lower than for non-Caucasians (5.8/1000 vs 9.2/1000, $P < .001$). Infant mortality for Blacks was greater than for non-blacks (13.3/1000 vs 5.9/1000, $P < .001$) (Keene Woods, Reyes, Chesser, 2016)

Myself alongside many individuals close to me have experienced racial disparities in health care in some shape or form. Being an African- American female from the inner city in itself already attaches a stigma to my name. I always knew racial disparities occurred, but it is not until it happened to me, I opened my eyes and realize there needed to be change. In 2016 I was pregnant with my first child and in the delivery room. My husband and I both work in the medical field but at the time we felt there was no reason to mention that.

At one point, my IV became swollen and painful, I expressed this to my nurse twice and she disregarded my requests. The third time I said to the nurse, “My IV is infiltrated and my bolus is finished.” Immediately she turned around and was frazzled and finally attended to my needs. A few moments after she wanted to know what my husband and I did and where we worked. During this time my primary focus was my health and the health of my child, so I did not shed much light on that situation.

Another incident occurred recently where I had an appointment to visit a specialty physician in a predominately Caucasian area where most of their patients were also Caucasian. The sectary took my insurance card and said, “Wow you have great insurance, you’re one of the lucky ones.” She then made attempts to find out where I worked and my title. It was almost as she was shocked, I had insurance one and two I had such a great insurance plan.

It was not until these incidents occurred that I realized some sort of change has to happen. The incident while pregnant with the IV, I thought to myself why did I have to prove I was educated for my nurse to take my pain serious. No matter what level of education an individual has their needs should be met at all times, in a health care setting. As the previous articles revealed minority women are losing their lives during child birth at an alarming rate compared to any other race. Our voices, health and lives are just as important as anyone else, after all we are all human created by God. I believe practicing cultural competence is a great start. The better the communication is between the patient and the provider will increase in patient satisfaction, which will lead to adherence and result in better health outcomes.

In addition to cultural competence, I have decided to take action and be the change that is needed in my community. I currently have my bachelor's in health science and decided to go back to school to obtain a degree in nursing. I am in the process of launching a social media page to bring awareness to this topic and provide solutions to minority women who might experience this one day. I believe the first step is acknowledging the problem and the second step is figuring out what you can do to help. The hope is that minority Americans will get access to the heath care needed and be treated as equals. The quality improvement of our health care system will not only benefit minorities but raise the standard in health care for all Americans.

Reference Page

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