Socioculture and the Delivery of Health Care

Who Gets What and Why

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One of the major challenges facing health care professionals today is how to provide effective and culturally sensitive care for the growing multicultural population. This is not a new phenomenon. In the United States, racial and ethnic differences in health status have been documented since the early 1900s. These differences are often attributed to social, economic, and cultural factors, which can result in unequal access to health care.

Race and Health

Race is a complex issue and can be defined in many ways. It includes biological, cultural, and social dimensions. People of different races may experience different health outcomes due to these factors. For example, African Americans and Native Americans have higher rates of diabetes, hypertension, and obesity compared to other racial groups.

Infant Mortality Rates 1990-1995

<table>
<thead>
<tr>
<th>Year</th>
<th>White (M)</th>
<th>African American (M)</th>
<th>White (A)</th>
<th>African American (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>26.8</td>
<td>42.3</td>
<td>7.6</td>
<td>12.2</td>
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<tr>
<td>1991</td>
<td>22.2</td>
<td>40.2</td>
<td>7.2</td>
<td>11.2</td>
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<tr>
<td>1992</td>
<td>17.6</td>
<td>36.2</td>
<td>6.5</td>
<td>11.2</td>
</tr>
<tr>
<td>1993</td>
<td>15.2</td>
<td>34.2</td>
<td>6.2</td>
<td>10.4</td>
</tr>
<tr>
<td>1994</td>
<td>13.2</td>
<td>30.3</td>
<td>6.0</td>
<td>10.0</td>
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<tr>
<td>1995</td>
<td>11.9</td>
<td>29.2</td>
<td>5.6</td>
<td>9.6</td>
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</table>

Infant mortality rates significantly decreased over the past 50 years. However, rates remain higher for African American infants compared to White infants. This disparity highlights the ongoing need for addressing health disparities.

Race and Socioeconomic Status

Socioeconomic status (SES) is a key factor in health outcomes. For example, African Americans are more likely than Whites to live in poverty, have less education, and have lower income. These factors can contribute to higher rates of chronic diseases, such as heart disease and diabetes.

A look at the data on infant mortality reveals a widening racial gap in the health status of infants and children, reflecting more rapid health improvements over time for Whites than for African Americans (see table above). Infant death rates have declined over time for both racial groups, but infant mortality rates for African Americans are still higher than for Whites. African American infants are more likely to be born preterm, have lower birth weights, and have more complications during birth.

Preventative care and addressing social determinants of health are crucial in reducing health disparities. Governments and healthcare providers must work together to ensure that all individuals have access to affordable and quality healthcare services.

Within this racial group, race is defined in terms of a biological category, and the fact that African Americans have lower race-based birth weights, etc., might be more about our society than about our generic makeup.
Although race is related in SES, the two concepts are not equal, so that although African Americans are generally poorer than Whites, members of African American are not poor, and hundreds of all poor Americans are White. It is not generally recognized that there is dynamic variation in economic status within the Asian American populations, with some Asian groups—the Hmong, Cambodian, and Laotian—generally having higher levels of poverty and lower levels income than African Americans and American Indians.

Data on the association between SES and health reveal that SES is a stronger predictor of health than age, ethnicity, and racial variables in economic circumstances account for most of the racial/ethnic differences in health. The box on left illustrates these more differences in health for income for African Americans, Whites, and Hispanics. Consequently, people report worse health than their more affluent counterparts.

Seeking the differences in health within each racial/ethnic group are substantially larger than the overall racial/ethnic differences. Moreover, Asians, African Americans and Whites at similar levels of economic status are comparable. African Americans will likely report worse health than Whites. Thus, although SES accounts for much of the social differences in health, SES alone does not provide a full explanation. The African-American-white disparities in health. When compared as similar levels of economic status, the levels of health are almost identical for Hispanic and White. The Hispanic population has a relatively large number of immigrants who are largely from lower-to-middle-income good health. As the same time, as their length of stay in the United States increases, health tends to decline.

Additional Reading


These findings point to several important issues:

- The health of many racial/ethnic minorities always be affected not only by their current economic status, but also by exposure to economic differences in each. Compared to their White counterparts, individuals from minority populations are more likely to have experienced hardships and deficits in medical care in child health and adolescence.
- Among majority populations, income may not be an adequate index of race in socioeconomic status. Whereas African American households earn about 60 cents for every dollar earned by White rates, African American families have only 10 cents in health for every dollar earned by their White counterparts. Moreover, racial/ethnic differences in wealth are constant at all levels of income and 10 times higher than the lowest income level. Among the poorest 20% of Americans, the wealth of Whiter is $15,400 times larger than that of African Americans ($7,267 vs. $5,151).
- Research also show that, given the same level of income, African Americans and Hispanics are more likely than Whites and Asians to live in poorer, more undesirable neighborhoods. Socioeconomic status and income, at similar levels of education, Whites earn more than African Americans and Hispanics. For example, in 1998, a White male high school graduate had a median income that was $7,039 more than African American and Hispanic male.
- The purchasing power of the average person, all income is also greater for Whites compared to African Americans. In many cases, the cost of education, neighborhoods where African American live, the goods and services available are poorer in quality, cost higher price than more affluent white suburbs.
- It is the analysis of race-related differences in health status over the last half of the 20th century strongly suggests that racial inequalities in health parallel racial inequalities in economic status, and efforts to address racial inequalities in health may not be successful unless racial and economic inequalities are also considered.

Race/Ethnicity and Access to Health Care

Compared with White populations, African Americans and other minorities have lower levels of access to health care. Although health care accessibility is not the only factor that determines an individual's overall health, medical conditions can play important roles in health maintenance. This is especially true for disadvantaged populations who are already struggling with multiple social issues. For example, although personal care has relatively little impact on the infant mortality of middle-class women, it can be as effective, expensive resource for poor women.

Several factors have been found to account for the lower levels of access to health care for minority populations. Minorities tend to have higher rates of unemployment than White counterparts, many of the poor available to minorities do not include health insurance benefits, closer to hospitals and health care facilities occur more frequently in businesses and minority communities, and the movement from a fee-for-service to managed care systems may be having a negative impact on minority access to health care.

Another important but rarely focal social reality is discrimination. Although very few White Americans report racially prejudiced attitudes, national data on stereotypes reveal that White simple continue to see racial-ethnic minorities more negatively than themselves. For example, 75% of Whites believe that African Americans are untrustworthy, 44% view them as lazy, and 51% believe that African Americans are prone to violence. In contrast, only 4% of White people believe that Whites prefer to live on welfare, 5% that Whites are unemployable, 5% that Whites are lazy, and only 15% that Whites are untrustworthy.

Overall, White persons view African Americans more negatively than any other group, and Hispanics were viewed twice as negatively as blacks. A large body of research suggests that indicates that an individual who holds a negative stereotype will discriminate against someone who fits the stereotype. Strongly, this research reveals...
Implications for SLIS and Audiologists

The elimination of material discrimination in the workplace, society, and other aspects of society must be a priority in addressing racial/ethnic differences in SIS, which, in turn, would improve the access of disadvantaged populations to effective services such as health care. The data presented here is one of the most detailed analyses of the nature of racial/ethnic differences in SIS, which has implications for health care reform. The problems of communicative disorganization and language bias in the health care system are significant. In the worst-case scenario, these problems can lead to discrimination and misdiagnosis.

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Could it be that many well-intentioned professionals who are personally opposed to racism are nonetheless biased in the delivery of care to minority group members? Several hundred research studies suggest that this is the case.

Medical facility are taken into account. Moreover, they present common features that are often overlooked. These are the Veterans Administration Health System, where differences in economic status and insurance coverage are measured.

Discrimination can be as evident as the structural view. A recent National Health Survey has been conducted, which shows that poor people and racial minorities receive inferior care from health care providers who view them as inferior patients.

Essentially, these disadvantaged groups are frequently treated as if they were on the far side of every treatment, with longer waiting times, poorer access to specialists, and more of the same discrimination.

Problems of physician-patient communication in these groups are exacerbated among patients of low SES, with higher SES patients receiving not only better medical care but also more positive communication.

Discrimination on the part of health care workers and institutions is not the sole cause of disparities in health care. The cause of these differences is complex and includes such factors as the unequal distribution of medical resources and physician preferences, as well as racial and ethnic differences in medical procedures. However, recent research suggests that the discriminatory behavior that is widespread, inadequate, and unnecessary may be a cause part of every delivery by persons who do not recognize racism.

These research has provided information on the role of such factors as class, race, and ethnicity, and may influence future strategies to improve the delivery of health care to minority groups.