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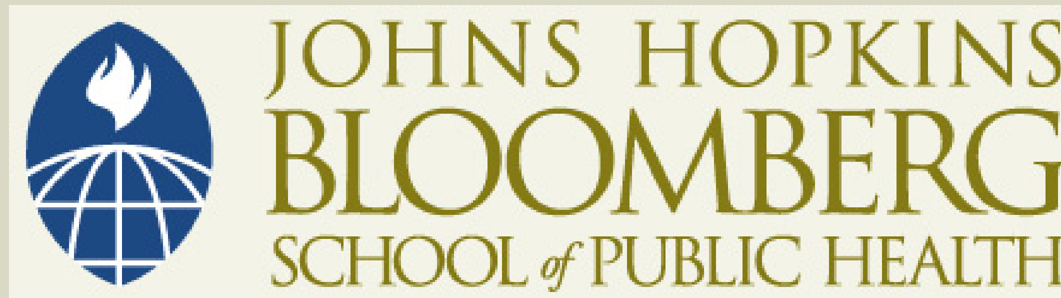

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Race and Racial Disparities in Health and Health Care

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Main “take-home” points

- “Race” has become a meaningful but meaningless term
- Might we consider it a self-perpetuating social construction?
- It is meaningful as a social construction because of its relationship to health status and health services

Definitions

- Race: original definition – “shared biologic origin”
  - Considered “self-evident” in European scientific tradition, a “natural fact” that there was a hierarchy of types of humans endowed with different strengths and weaknesses
  - Highly resistant idea, despite increasing proof that it has little basis in human genetics

Definitions

Ethnicity: label given to a group of people with a shared language, history, and national origin

Ethnicity: label given to a group of people with a shared “culture” (set of shared beliefs, attitudes, values, behaviors)

History of racial classification in the US (Nobles)

- 1790-1840
  - Constitution mandated a census to assure equal representation in new government
  - Enumeration based on status as free or slave and whether paid taxes
  - Categories
    - Free white males and females
    - Anyone else who was free regardless of color
    - Slaves
    - Indians

Who counted in 1790

- All free persons = 1
- Slaves = 3/5 person
- Indians = 0 (not taxed)

- Why the distinction between white and not-white free (though counted the same)
  - Nobles: “natural fact” ?; otherwise not clear

Scientific era – 1850-1920

- Theory of "polygenism"
  - Races distinct and unequal, separate origins
  - Mixtures would be unfertile, unfit
  - "Lesser" races dominant and mixtures would eventually "revert" to them over generations

[see movie: "Rabbit-proof Fence"]

Scientific era – 1850-1920

- Pressure to use Census to investigate polygenetic hypotheses
  - First developed “mulatto” (any *perceptible* trace of African blood)
  - Later expanded to “quadroon,” “octroon” to further estimate amount and type of mixture
  - US Indians now counted to measure disappearance (thought to be proof of their inferiority)

1930-1960

- Social changes
  - Beginnings of Civil Rights movement
  - Nazi atrocities committed in name of race
- Scientific advances
  - Data from cultural anthropology
  - Findings of some important but relatively minor biologic differences

1930-1960

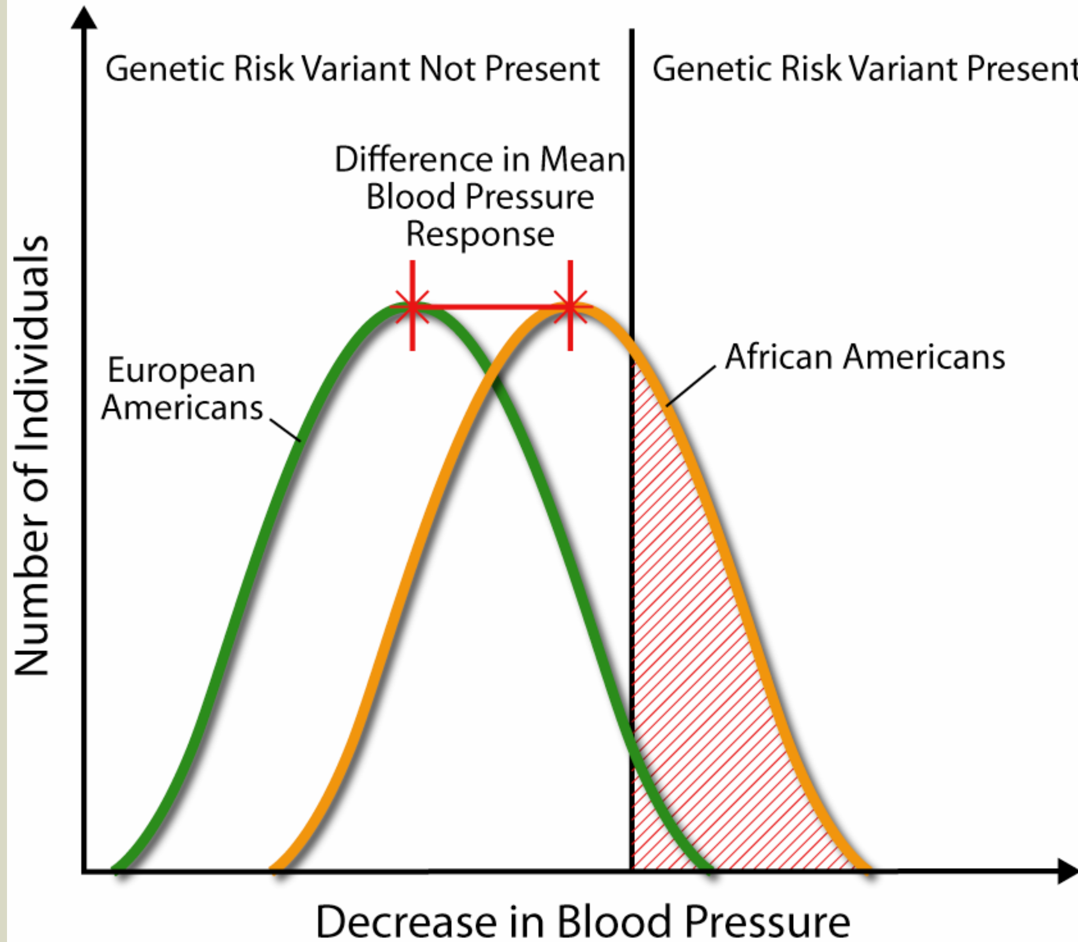
- Classifications “simplified”
  - White [not defined, anything not something else]
  - Non-white [includes obvious “other” and any mixture of “other” and white
  - So distinction still hangs on

Civil Rights Era 1970 +

- Civil Rights Act of 1964, Voting Rights Act of 1965 make segregation and discrimination illegal
  - But now need to measure “race” to ensure enforcement
  - ‘Hispanic’ added as an “ethnicity” (not “race”)
  - ‘White’ still seen as homogeneous entity
  - “Asian” categories expanded

Degree of variation among populations

- Variants present in one population are generally present but not necessarily common in other populations
- *Geographic* ancestry and knowledge of genetic diversity in that specific region of the world related to genetic risks
- Relationship of “race” to geographic ancestry varies
- So maybe “biogeographic ancestry” is a more useful way of gauging possible clinical/public health significance in risks and protective factors



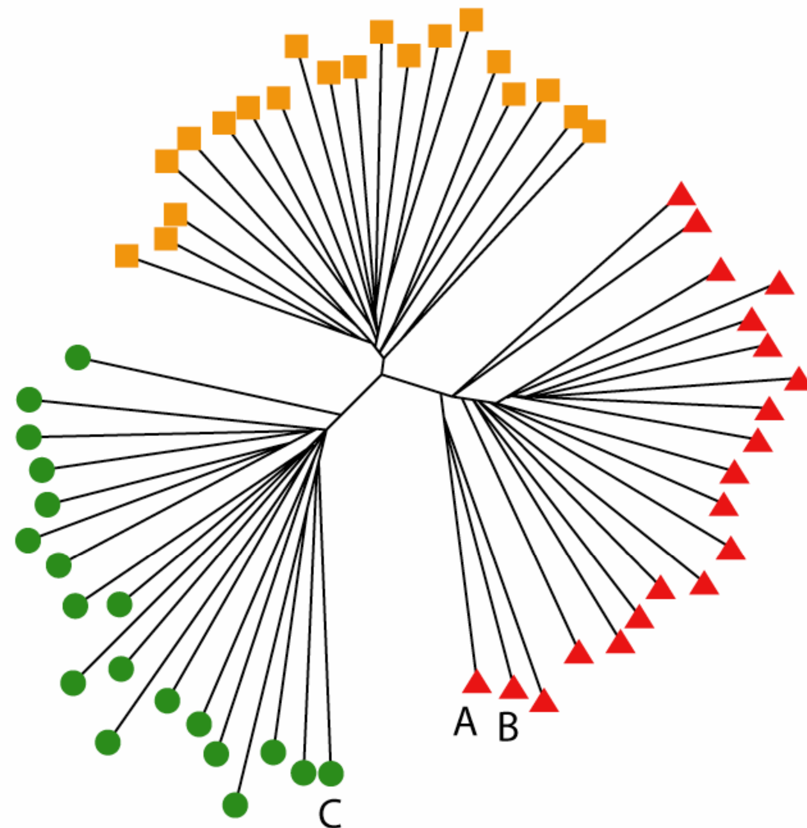
Hypothetical Relationship Between Genetic Risk, Ancestry, and Race
Genetic Risk Variant Not Present
Genetic Risk Variant Present
Difference in Mean Blood Pressure Response
European Americans
African Americans
Number of Individuals
Decrease in Blood Pressure
Adapted by CTLT from Bamshad, M. JAMA 2005;294:937-946.
CTLT

Network of Genetic Relatedness and Examples of Genetic Distance

European Americans (N=20)

African Americans (N=20)

Asian Americans (N=19)

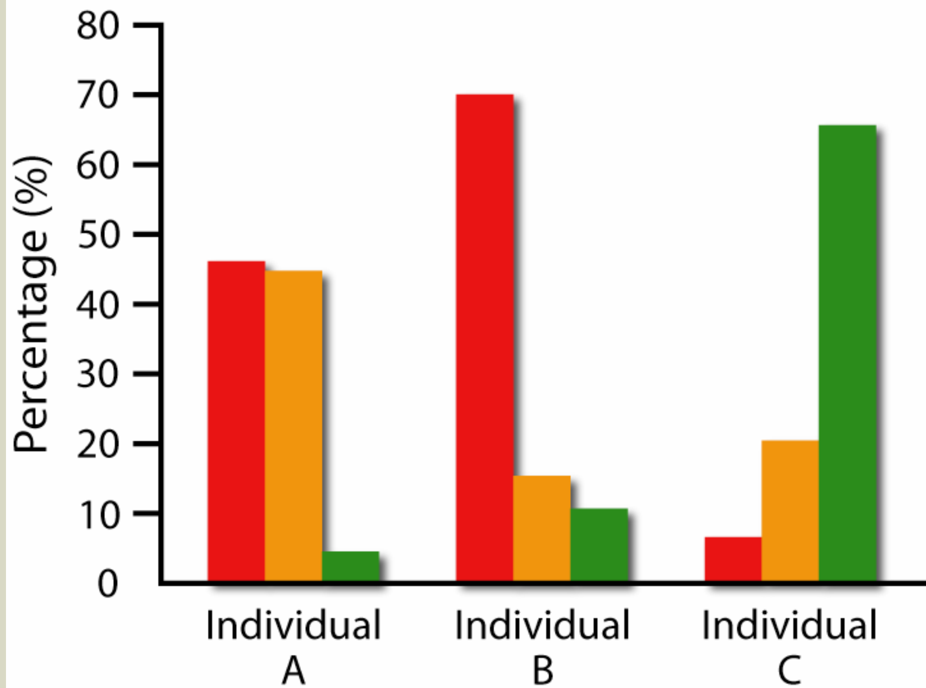


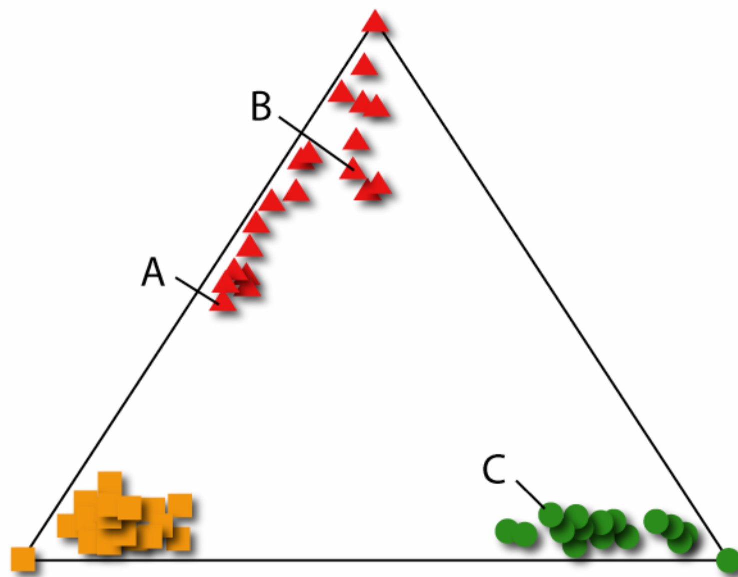
Genetic Distance Between Individuals Within the Same Population

Genetic Distance Between Individuals From Different Populations

Adapted by CTLT from Bamshad, M. JAMA 2005;294:937-936.

CTLT





European Americans
African Americans
Asian Americans

Adapted by CTLT from Bamshad, M. JAMA 2005;294:937-946.

CTLT

What forces perpetuate “race”?

- Attempt to identify populations at risk of being harmed by social norms (among the powerful) that we wish to change
  - Desire to count those eligible for special benefits or compensation
  - Desire to measure compliance with laws aimed at changing social norms

American Indian tribes

- In US law varies by program/issue
  - Eligibility for social programs
  - Jurisdiction in criminal matters
  - Preferences in government hiring
  - Administration of tribal property
- Can be divisive among Indians
  - Not all tribes "recognized" by government (ie, seen as having political/economic relationship with federal government

American Indian tribes

- Definitions have at least two perspectives
  - Cohen (in Rhoades p63): person who:
    - 1. Has some ancestors who lived in "America" prior to its "discovery" by Europeans, *and*
    - 2. Recognized as an Indian by his or her tribe or community
- Tribes have economic and cultural motivations to define membership

Motivations to develop a racial identity (racial socialization)

- Point around which to build a community
  - Pride, sense of collective duty, mechanism for preserving cultural attributes
- Alternative to political definitions if needed
- Means of excluding those seen as who seek to “crash” and obtain scarce resources
- Means of advocating for access to services
- Preparation for bias

Adverse sides of racial socialization?

- Vicarious traumatization from collective experiences of discrimination
- Negative expectations about opportunities
- Self-fulfilling influence on cross-cultural interactions
- Others?

So why do we use “race” as a variable in public health?

- Possibly appropriate
  - Experience or practice of discrimination is a relevant variable
  - Studies of populations that self-identify in this way
  - Studies linked to policies/laws that use this label
  - Studies of the legitimacy of using the label

Why use “race” as a variable?

- Probably not appropriate
  - Conscious or unconscious proxy for income, SES, place of residency
  - Studies that assume race has inherent biologic associations to broad characteristics like behavior or intelligence

Why use “race” as a variable?

- ??
  - Studies targeting populations with apparent differences in gene prevalence
    - Tay-Sachs (Eastern European Jews)
    - Sickle cell disease (African-Americans)
    - Cystic Fibrosis (Caucasians)
    - Liver enzyme polymorphisms (various)
  - Associations likely to change with geographic mobility

Racial disparities in health in the US

- US African-Americans have higher rates than Whites for 13 of 15 leading causes of death
- Life expectancy at birth
  - Female AA: 74.7; White 79.9
  - Male AA 67.2; White 74.3
- Accounting for poverty reduces some but not all differences

Questions about disparities

- Cultural differences in interaction, definitions of health and illness?
- Prejudicial attitudes on the part of care-givers?
- Consumers' avoidant behavior based on fear of discriminatory treatment

Questions about disparities

- Lack of access to services and health-related resources (including education)?
- Increased exposure to health risk factors in immediate environment?

Concern about provider behavior

- Kidney transplant
  - Blacks less likely to be offered option
- Pain management
  - Whites more likely than Black, Hispanic to be assessed and offered medication
- Mental health
  - “Non-whites” more likely to be considered psychotic, hospitalized involuntarily, placed in seclusion

Concern about providers

- Child welfare
  - Black youth more likely to be sent to juvenile justice system versus mental health
  - Black children more likely to be reported as suspected victims of abuse
- Asthma
  - Blacks less likely to be prescribed preventive medication

Explanations?

- Overt prejudice and racism?
- Unconscious bias and stereotypes?
- Cross-cultural misunderstanding and miscommunication?
- All of the above?

Bias/stereotypes

- Disparities mirrored in analysis of hypothetical cases
  - Identical except for patient race
  - African-Americans more likely to be considered non-adherent to treatment
  - African-Americans seen as lacking social support for arduous treatments

Poor cross-cultural communication skills

- Failure to explain medical terms
- Failure to probe ambiguous words
- Failure to follow-up on patient cues
- Inability/unwillingness to probe for alternative explanatory models or other attitudinal or emotional issues

Should patient and provider be matched on race?

- Physician ethnicity is associated with patients' comfort discussing sensitive psychosocial and emotional problems.
- Patients from ethnic minority groups, in general, report difficulty communicating with doctors of a different ethnicity.

Are all matches “good?”

- Ethnic mismatch alone may not predict communication difficulty
    - African-American patients rate African-American doctors as more participatory that White (Cooper-Patrick 1999)
    - Asian GP’s *under-detect* distress in Asian patients, compared to White GP’s (Odell 1997)

Differences in doctor behavior at first visits

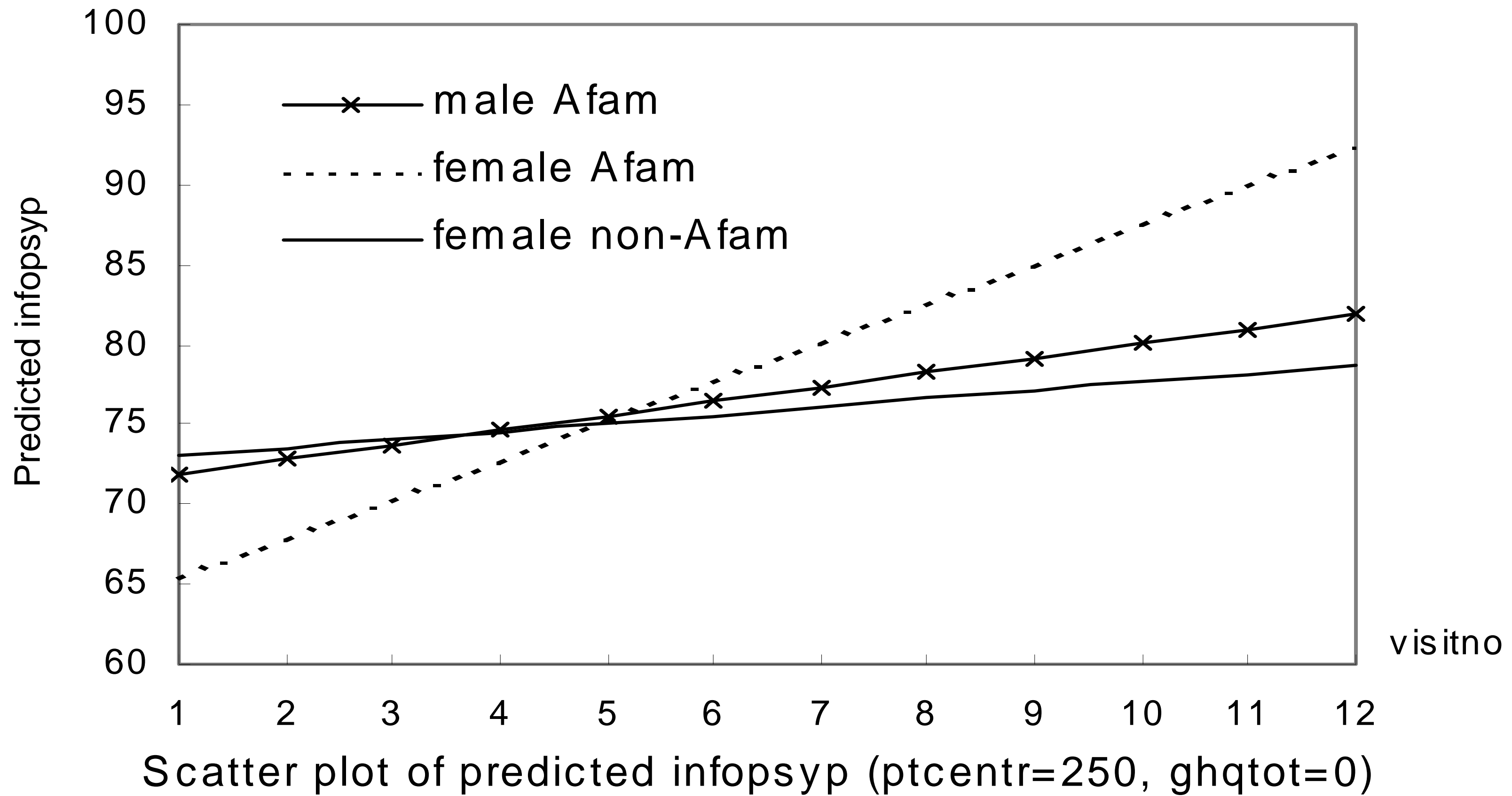
- Doctors were more patient-centered when their ethnicity matched that of the mother (pediatric residents)

	MD and parent ethnicity are different (reference value)	MD and parent ethnicity match (change with matching)
MD patient-centeredness	249 utterances per visit	71 (6 - 136)

Ethnic differences in first visits

- African-American mothers made fewer psychosocial utterances
- average of 80/visit compared to 101/visit by white mothers (average difference 21.2 utterances, 95% confidence limits 1.6 to 40.8).

Parent information-giving as a function of visit number, adjusted for patient-centeredness, by doctor gender and parent ethnicity



¿Conclusions?

- “Race Matters” (Cornell West)
- A pseudo-scientific term has taken on political, social, cultural meaning
- We probably use racial labels too casually
- Racial attitudes, like cultural beliefs, are probably “overlearned” and therefore likely to be unconsciously used as a basis of action