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

Decrease in Blood Pressure

Number of Individuals

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

Inferred Ancestry

Adapted by CTLT from Bamshad, M. JAMA 2005;294:937-946.
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 (i.e., 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 than 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)

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<thead>
<tr>
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<th>MD and parent ethnicity are different (reference value)</th>
<th>MD and parent ethnicity match (change with matching)</th>
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<tbody>
<tr>
<td>MD patient-centeredness</td>
<td>249 utterances per visit</td>
<td>71 (6 - 136)</td>
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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