

Socioculture and the Delivery of Health Care

Who Gets What and Why

by Lena G. Caesar and David R. Williams

One of the major challenges facing health care professionals today is how to provide effective and culturally sensitive intervention to a burgeoning multicultural population. The most recent United States census reveals that there has been a significant increase over the past 10 years in the number of ethnic/racially diverse individuals. Experts predict that by the year 2050 this group will comprise close to 50% of the population. This demographic reality is of major interest to speech-language pathologists and audiologists, since individuals from minority groups are at greater risk for diseases that can result in communication disorders.

Race and Health

Race/ethnicity is a strong predictor of an individual's health status. These differences have persisted despite evidence that the overall health status of the American population has

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 box below). Infant death rates have declined over time for both racial groups but, whereas African American infants were 1.6 times more likely than White infants to die before their first birthday in 1950, African American infants were 2.4 times more likely to die than their White counterparts in 1998. Data on minority groups other than African Americans have only more recently become available, but Hispanics and American Indians also have higher disease and death rates than Whites for several of the leading causes of death. Moreover, for American Indians who live on or near reservations, their gap in health relative to Whites is wider today than in 1955 for death rates for diabetes, liver cirrhosis, and suicide.

How can these racial/ethnic differences in health be explained? Traditionally, biology was seen as the cause. The biological view was based on the assumption that genes, which determine race, also determine the number and types of an individual's health problems. Although there are genetic variations among human population groups, recent scientific evidence clearly indicates that racial categories are genetically more alike than different, so that racial categories do not capture well the existing patterns of genetic variation. All human beings share 75% of known genetic factors, and 95% of genetic differences exist among persons

within each racial group. Race is thus more of a social than a biological category, and the fact that we know what race we belong to actually tells us more about our society than about our genetic makeup.

Infant Mortality Rates 1950-1998

Year	White (W)	African American (AA)	AA/W Ratio
1950	26.8	43.9	1.6
1960	22.9	44.3	1.9
1970	17.8	32.6	1.8
1980	10.9	22.2	2.0
1990	7.6	18.0	2.4
1998	6.0	14.3	2.4

Source: National Center for Health Statistics, 2000; Deaths per 1,000 live births

significantly improved over the past 50 years. For example, although death rates for both Whites and African Americans were at least 40% lower in 1998 than in 1950, the present overall death rate for African Americans is still about 1.5 times higher than that of Whites—identical to what it was in 1950.



Illustration by Mike S. Shoff

Race and Socioeconomic Status

Since racial categories do not do a good job of capturing variations in genetics, many health researchers are now suggesting that racial/ethnic differences in economic circumstances, or socioeconomic status (SES), may be the factor most responsible for the racial/ethnic differences in health status. It is common knowledge that most African Americans, Hispanics, and American Indians have lower levels of income, education, occupational status, and wealth than do most Whites. For example, data on poverty reveal that the rates of poverty for African Americans and Hispanics are three times higher than that of Whites.

Although race is related to SES, the two concepts are not equal, so that although African Americans are generally poorer than Whites, two-thirds of African Americans are not poor, and two-thirds of all poor Americans are White. It is also not generally recognized that there is dramatic variation in economic status within the Asian American population, with some Asian groups such as the Hmong, Cambodian, and Laotian generally having higher levels of poverty and lower family 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 race/ethnicity, and racial variations in economic circumstances account for most of the racial/ethnic differences in health. The box at right illustrates the large differences in health by income for African Americans, Whites, and Hispanics. Consistently, poor people report worse health than their more affluent counterparts.

Strikingly, the differences in health within each racial/ethnic group are substantially larger than the overall racial/ethnic differences. However, when African Americans and Whites at similar levels of economic status are compared, African Americans still exhibit poorer health patterns than do Whites. Thus, although SES accounts for much of the racial differences in health, SES alone does not provide a full explanation of the African American-White disparities in health. When compared at similar levels of economic status, the levels of health are almost identical for Hispanics and Whites. The Hispanic population has a relatively large number of immigrants who are low in SES but in relatively good health. At the same time, as their length of stay in the United States increases, health tends to decline.

Additional Reading

Mayberry, R. M., Mill, F., & Ofili, E. (2000). Racial and ethnic differences in access to medical care. *Medical Care Research and Review*, 57, Supplement 1, 108-145.

Van Ryn, M. (2002). Research on provider contribution to race/ethnicity disparities in medical care. *Medicare Care*, 40, Supplement, 1-140-1-151.

Williams, D. R. (1999). Race, SES, and health: The added effects of racism and discrimination. *Annals of the New York Academy of Sciences*, 896, 173-188.

Williams, D. R., & Collins, C. (1995). U.S. Socioeconomic and racial differences in health: Patterns and explanations. *Annual Review of Sociology*, 21, 349-386.

Williams, D. R., & Rucker, T. D. (2000). Understanding and addressing racial disparities in health care. *Health Care Financing Review*, 21, 75-90.

These findings point to several important issues:

- The health of many racially/ethnically diverse adults may be affected not only by their current economic status, but also by exposure to economic adversity in early life. Compared to their White counterparts, individuals from minority cultures are more likely to have experienced economic hardship and deficient medical care in childhood and adolescence.
- Among minority populations, income may not be an adequate indicator of economic status. Whereas African American households earn about 60 cents for every dollar earned by White ones, African American families have only 10 cents in wealth for every dollar owned by their White counterparts. Moreover, racial/ethnic differences in wealth are evident at all levels of income and are largest at the lowest income level. Among the poorest 20% of Americans, the wealth of Whites is 10,000 times larger than that of African Americans (\$10,257 vs. \$1).
- Research also shows 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. Besides, national data indicate that, 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 \$7,000 more than African American and Hispanic males. The purchasing-power of a given level of income is also greater for Whites compared to African Americans. In many of the central-city neighborhoods where African Americans live, the goods and services available are poorer in quality but higher in price than in more affluent suburban areas.

In summary, an 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 social and economic inequalities also are confronted.

Race/Ethnicity and Access to Health Care

Compared with White populations, African Americans and other minorities have lower levels of access to medical care. Although health care accessibility is not the only factor that determines an individual's overall health, medical institutions

Percent of Persons Reporting Fair or Poor Health by Race/Ethnicity and Income, 1997

	White	African American	Hispanic
All	8.0	15.8	13.0
Poor	20.6	25.6	19.8
Near Poor	14.1	19.5	14.0
Non-Poor	5.7	9.6	8.8

Source: National Center for Health Statistics, 2000

can play important roles in health maintenance. This is especially true for disadvantaged groups who are already struggling with multiple social issues. For example, although prenatal care has relatively little impact on the infant mortality of middle-class women, it can be an effective, positive 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 their White counterparts; many of the jobs available to minorities do not include health insurance benefits; closures of hospitals and health care facilities occur more frequently in low-income and minority communities; and the movement from a fee-for-service to a managed care health system may be having a negative impact on minority access to health care.

Another important but painful social reality is discrimination. Although very few White Americans express racially prejudiced attitudes today, national data on stereotypes reveal that White people continue to view racial/ethnic minorities more negatively than themselves. For example, 56% of Whites believe that African Americans prefer to live off welfare, 29% view African Americans as unintelligent, 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 off welfare, 6% that Whites are unintelligent, 5% that Whites are lazy, and only 16% that Whites are violence-prone.

Overall, White persons viewed African Americans more negatively than any other group, and Hispanics were viewed twice as negatively as Asians. A large body of psychological research indicates that an individual who holds a negative stereotype will discriminate against someone who fits the stereotype. Strikingly, this research reveals

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that stereotype-linked bias is both automatic and unconscious, even among persons who are not prejudiced.

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. Across virtually every therapeutic intervention, ranging from high-technology procedures to the most elementary forms of diagnostic and treatment interventions, minorities receive fewer procedures and poorer quality medical care than

Whites. These differences persist even after differences in health insurance, SES, stage and severity of disease, comorbidity, and type of

Implications for SLPs and Audiologists

The elimination of societal discrimination in education, employment, housing, criminal justice, and other sectors of society may be a precondition to eliminating racial/ethnic differences in SES, which, in turn, would improve the access of disadvantaged populations to desirable services such as health care. Low SES has been identified as one of the crucial factors responsible for the large health differences evident in minority groups. It is important to note, however, that since two-thirds of all poor persons in the United States are White, the problems of economic disadvantage transcend race and affect the health of the entire nation.

Taking the social circumstances of clients into account enhances the effectiveness of the provision of services. In a classic study, over 200 low-income patients matched on age, race, gender, and blood pressure history were randomly assigned to one of three groups. The first group received routine hypertensive care from a physician, while the second group attended weekly clinic meetings for 12 weeks run by a health educator in addition to their routine care. These sessions provided information regarding hypertension. In addition to routine care, the third group was visited by health workers recruited from the local community who had been provided with one month of training to address the diverse social and medical needs of persons with hypertension.

These outreach lay workers provided information on hypertension, but also discussed family difficulties, financial strain, employment opportunities and, as appropriate, provided support, advice, referral, and direct assistance.

After seven months of follow-up, an evaluation revealed that patients in the third group were more likely to have their blood pressure controlled than patients in the other two groups. In addition, those in the third group knew twice as much about blood pressure and were more compliant with taking their hypertensive medication than patients in the other two groups. Importantly, the good compliers in the third group were twice as successful at controlling their blood pressure as good compliers in the health education intervention group. Thus, even the effectiveness of the pharmacological treatment was enhanced in the group that also addressed the underlying stressful conditions of these hypertensive persons. This study dramatically illustrates that reducing stress and helping patients deal with the challenges of their socioeconomic context can importantly affect the success of interventions.

Along with poverty, subtle discriminatory practices and attitudes on the part of health care providers also have been found to negatively affect service to clients from minority cultures. There is clearly a need for concerted efforts by

organizations responsible for the education, training, and licensure of health professionals to raise awareness levels about unconscious discrimination and to develop effective strategies to combat it. It is likely that cultural sensitivity training programs that emphasize the distinctive behaviors of some subgroups could enhance negative stereotypes.

How should communication disorders specialists respond to this somewhat dismal picture of minority health in the United States? Here are some suggestions:

- **Become an agent of change** by being conscious of, and speaking out against, both the subtle and blatant forms of bias still evident in health care delivery and policies. Remember that minority populations are negatively affected both by the behavior of large-scale institutional processes and by the behavior of individuals.
- **Consciously monitor deep-seated personal stereotyping**, which though unconscious and unthinking, can negatively affect the quality of service that minority populations receive.
- **Avoid judging "the book by its cover"**—that is, be cautious about employing "skin color" or other physical features as the yardstick for measuring sociocultural variables such as health status, SES, or education. Remember that minority status should not be equated with being poor, lazy, violent, or noncompliant.
- **Seek out opportunities for becoming better informed** about the specific attributes of other cultures. Remember that, although minority populations as a group do have similar experiences, there is great diversity among different cultural groups.



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medical facility are taken into account. Moreover, they persist in contexts such as Medicare and the Veterans Administration Health System, where differences in economic status and insurance coverage are minimized.

Discrimination can also be evident at the institutional level. Research has long indicated that poor people and racial minorities receive inferior care from health care providers who often view them as undesirable patients. Economically disadvantaged groups are frequently forced to negotiate a broad range of system barriers such as long waiting times, complex bureaucratic procedures, and slow and inadequate communication. Problems of patient-provider communication are exacerbated among persons of low SES, with higher SES patients receiving not only better technical and interpersonal 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 causes of racial differences are complex and include such factors as the unequal distribution of medical resources and patient preferences, as well as trust, knowledge of pathologies, and patient familiarity with medical procedures. However, recent research suggests that discriminatory behavior that is unconscious, unthinking, and unintentional may be a routine part of service delivery by persons who do not endorse racism.