

# Race, Ethnicity, and the Health of Americans

ASA SERIES ON HOW RACE AND ETHNICITY MATTER

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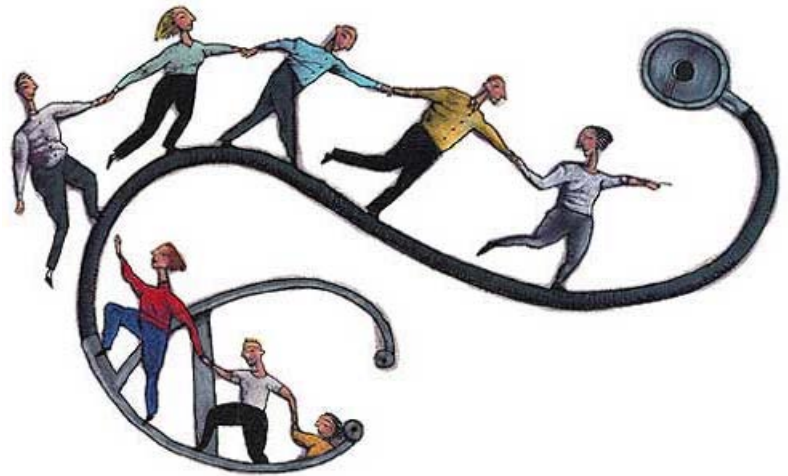
## SERIES BACKGROUND

This on-line publication by the American Sociological Association (ASA) is one in a five-part series on the institutional aspects of race, racism, and race relations, a project intended to help commemorate the ASA centennial (1905-2005) and designed for a general readership. As a professional membership association, the ASA seeks to promote the contributions and uses of sociology to the public. These synthetic summaries provide an overview of the research evidence on how race remains an important social factor in understanding disparities in the well being of Americans in many important areas of life (including employment, health, income and wealth, housing and neighborhoods, and criminal justice) although demonstrable changes have occurred in American society over the last century.

Published under the auspices of ASA's Sydney S. Spivack Program in Applied Social Research and Social Policy, these syntheses are based upon a vast literature of published research by sociologists and other scholars. This body of research was reviewed and assessed at a working conference of 45 social scientists that attempted to create an integrated map of social science knowledge in these areas. The effort was organized by Felice J. Levine, former ASA Executive Officer, Roberta Spalter-Roth, Director of the ASA Research and Development Department, and Patricia E. White, Sociology Program Officer at the National Science Foundation (when on detail to ASA), and supported by generous grants from the Ford Foundation and the W.G. Kellogg Foundation.

In conjunction with the Clinton administration's Presidential *Initiative on Race: One America*, the ASA was encouraged by the White House Office of Science Technology Policy to undertake this ambitious examination of relevant arenas of research, explicate what the social sciences know, dispel myths and misconceptions about race, and identify gaps in our knowledge. The purpose of the President's overall initiative, begun in late 1997, was to "help educate the nation about the facts surrounding the issue of race" and included many activities such as university, community, and national dialogues; government initiatives and conferences; and topical reports.

The ASA's original materials have been updated, synthesized, and developed for this Centennial Series under the direction of Roberta Spalter-Roth. The authors of this summary are **Roberta Spalter-Roth, Terri Ann Lowenthal, and Mercedes Rubio.**



**At the dawn** of the twenty-first century, Americans are in general healthier than ever before as a result of technological advances, preventive medicine, and broader access to health care; yet some racial and ethnic groups are less healthy, receive poorer care, and cannot expect to live as long as others (40). Statistics show marked differences in life expectancy, mortality, incidence of disease, and causes of death across racial and ethnic groups. Why is this?

According to popular opinion, racial groups are viewed as physically distinguishable populations that have a common ancestry (1). Although genetics and biology account for some aspects of the variation in health status among racial and ethnic groups, social science research demonstrates the powerful influence on health of risk-taking and preventive behavior, social and economic inequalities, communities and environments, health policy, and racist practices. These overlapping dynamics play a significant role in explaining racial and ethnic disparities in health outcomes (21; 27; 33; 47; 58; 80).

Even with the growing sophistication of biological and genetic research, sociology reminds us that race is not an immutable category; rather it is a “social category,” subject to change, with real consequences for health and well-being (16).

The United States health care system has been described as “provider-friendly” (31). Racial prej-

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udices and practices are institutionalized in this system and frequently result in unequal access to medical care, unequal treatment for similar severity of illnesses and conditions, and differences in health insurance protection (24). Public policies are also part of the equation for they can

either reinforce or mitigate these racially disparate practices (47, 48, 49).

This summary report on race, ethnicity, and the health of Americans begins by describing key differences in indicators of life and death health status among racial and ethnic groups. Further, it uses sociological and other social science concepts and research to explain how these differences occur by examining the role of income, neighborhood segregation, and racial discriminatory practices. These data show how at individual, community, and institutional levels, differential access and treatment constructs, creates, and maintains racial differences in health status.

**LIFE AND DEATH CHANCES: WHAT THE DATA SHOW**

Life and death measures of health status, including life expectancy, infant mortality, mortality and causes of death, mental health and

psychological well-being are ways to measure the health of a nation. In the United States, these health indicators reveal marked disparities among racial and ethnic groups.

Although Americans on average live longer than in the past<sup>1</sup>, African Americans can expect to live an average of five fewer years than whites. When sex is included in the analysis, white women have the longest life span of 80.3 years, while African American men have the shortest of 68.8 years (see Table 1). Unfortunately, comparable data are not available for other racial and ethnic groups.

There are also striking racial and ethnic differences in infant mortality rates. African American infants have the highest mortality rates and are more than twice as likely as white infants to die in their first year of life. Asian-Pacific American infants have the lowest mortality rates, but there are notable differences within this population group: Infant mortality ranges from a low of 4.3 for Japanese Americans to a high of 8.2 deaths per 1000 live births for Native Hawaiians. Similarly, while Latino infants overall are less likely than non-Hispanic white infants to die in their first year of life, differences among Latinos range from 4.7 deaths per 1000 live births for Cubans to 8.1 for Puerto Ricans living on the mainland (see Table 2).

As with life expectancy, death rates vary among racial and ethnic groups.<sup>2</sup> Asian-Pacific Americans have the lowest death rates, and African Americans the highest—a pattern that holds true for men and women of both races. Whites have the second highest overall death rates of all major race and ethnic groups. African Americans have higher death rates than non-Hispanic whites for eight of the ten leading

<sup>1</sup> In 1950, life expectancy (at birth) for all Americans was 68.2 years; by 2000, life expectancy was 77.0 years.

<sup>2</sup> Age-adjusted death rates, which reflect the likelihood of death at a given age, fell 39 percent from 1950 to 1998, for the population as a whole.

**TABLE 1. Life Expectancy at Birth, by Race and Gender (Selected Years 1970–2002)**

YEAR	LIFE EXPECTANCY AT BIRTH								
	ALL RACES			WHITE			BLACK OR AFRICAN AMERICAN		
	Both Sexes	Male	Female	Both Sexes	Male	Female	Both Sexes	Male	Female
<b>1970</b>	70.8	67.1	74.7	71.7	68.0	75.6	64.1	60.0	68.3
<b>1980</b>	73.7	70.0	77.4	74.4	70.7	78.1	68.1	63.8	72.5
<b>1990</b>	75.4	71.8	78.8	76.1	72.7	79.4	69.1	64.5	73.6
<b>1995</b>	75.8	72.5	78.9	76.5	73.4	79.6	69.6	65.2	73.9
<b>1999</b>	76.7	73.9	79.4	77.3	74.6	79.9	71.4	67.8	74.7
<b>2000</b>	77.0	74.3	79.7	77.6	74.9	80.1	71.9	68.3	75.2
<b>2001</b>	77.2	74.4	79.8	77.7	75.0	80.2	72.2	68.6	75.5
<b>2002</b>	77.3	74.5	79.9	77.7	75.1	80.3	72.3	68.8	75.6

Source: National Center for Health Statistics. 2004. *Health, United States, 2004*, with Chartbook on Trends in the Health of Americans, Hyattsville, MD.

**TABLE 2. Infant Mortality Rates According to Race: United States 1996–1998**

Race of Mother and Hispanic Origin of Mother	Rates*	White/Nonwhite Ratio
<b>White, non-Hispanic</b>	6.0	
<b>Black, non-Hispanic</b>	13.9	2.32
<b>American Indian or Alaskan Native</b>	9.3	1.55
<b>Asian or Pacific Islander</b>	5.2	0.87
Chinese	3.4	0.57
Japanese	4.3	0.72
Filipino	5.9	0.98
Hawaiian and part Hawaiian	8.2	1.37
Other Asian or Pacific Islander	5.5	0.92
<b>Hispanic origin</b>	5.9	0.98
Mexican	5.8	0.97
Puerto Rican	8.1	1.35
Cuban	4.7	0.78
Central and South American	5.2	0.87
Other and unknown Hispanic	6.8	1.13

\*Infant deaths per 1000 live births.

Source: National Center for Health Statistics, 2001, p. 153 as cited in Rubio and Williams, 2004.

causes of death. Cause-specific mortality gaps among these groups are, in some cases, substantial; for example, the death rate from HIV-related disease is ten times greater for African Americans than for non-Hispanic whites. This result is obtained by dividing 8.32 by .79 (see Table 3). Primary causes of death also differ between Mexican Americans (the largest Hispanic sub-

group in the United States) and whites, even though the two groups have comparable life expectancies and mortality rates.

Along with key indicators of mortality and life expectancy, researchers also study indicators of mental health. Until recently, research on the mental health of race and ethnic groups has

**TABLE 3. Age-Adjusted Death Rates for Whites for Selected Causes of Death and for Ratios of other Race and Ethnic Groups Compared to Whites, 2000**

	WHITE	AFRICAN AMERICAN	AMERICAN INDIAN	ASIAN	HISPANIC	WHITE, NOT HISPANIC OR LATINO
<b>ALL CAUSES</b>	<b>849.8</b>	<b>1.32</b>	<b>0.84</b>	<b>0.60</b>	<b>0.78</b>	<b>1.01</b>
<b>Diseases of heart</b>	<b>253.4</b>	<b>1.28</b>	<b>0.70</b>	<b>0.58</b>	<b>0.77</b>	<b>1.01</b>
Ischemic heart disease	185.6	1.17	0.70	0.59	0.83	1.01
<b>Cerebrovascular diseases</b>	<b>58.8</b>	<b>1.39</b>	<b>0.77</b>	<b>0.90</b>	<b>0.79</b>	<b>1.00</b>
<b>Malignant neoplasms</b>	<b>197.2</b>	<b>1.26</b>	<b>0.65</b>	<b>0.62</b>	<b>0.68</b>	<b>1.02</b>
Trachea, bronchus, and lung	56.2	1.13	0.58	0.50	0.44	1.04
Colon, rectum, and anus	20.3	1.38	0.66	0.63	0.70	1.01
Prostate	27.8	2.45	0.71	0.45	0.78	1.01
Breast	26.3	1.31	0.52	0.47	0.64	1.02
<b>Chronic lower respiratory diseases</b>	<b>46.0</b>	<b>0.68</b>	<b>0.71</b>	<b>0.40</b>	<b>0.46</b>	<b>1.03</b>
<b>Influenza and pneumonia</b>	<b>23.5</b>	<b>1.08</b>	<b>0.95</b>	<b>0.84</b>	<b>0.88</b>	<b>1.00</b>
<b>Chronic liver disease and cirrhosis</b>	<b>9.6</b>	<b>0.98</b>	<b>2.53</b>	<b>0.37</b>	<b>1.72</b>	<b>0.94</b>
<b>Diabetes mellitus</b>	<b>22.8</b>	<b>2.17</b>	<b>1.82</b>	<b>0.72</b>	<b>1.62</b>	<b>0.96</b>
<b>Human immunodeficiency virus (HIV) disease</b>	<b>2.8</b>	<b>8.32</b>	<b>0.79</b>	<b>0.21</b>	<b>2.39</b>	<b>0.79</b>
<b>Unintentional injuries</b>	<b>35.1</b>	<b>1.07</b>	<b>1.46</b>	<b>0.51</b>	<b>0.86</b>	<b>1.01</b>
Motor vehicle-related injuries	15.6	1.00	1.75	0.55	0.94	1.00
Suicide	11.3	0.49	0.87	0.49	0.52	1.06
Homicide	3.6	5.69	1.89	0.83	2.08	0.78

Source: U.S. Department of Health and Human Services. 2003. *Health, United States, 2003*. Washington, DC: U.S. Government Printing Office, Table 29.

Note: Ratios are obtained by dividing the age-adjusted death rate of African Americans, American Indians, Asians, Hispanics, and non-Hispanic or Latino whites by the rate for whites.

focused primarily on whites and African Americans.<sup>3</sup> Behavioral and social science research has not identified significant differences between African Americans and whites in the incidence of major clinically diagnosed disorders; indeed African Americans and Chinese Americans have somewhat *lower* rates of psychiatric disorders and Mexican Americans and whites have comparable rates (53; 64; 83). Other research has found a lower-than-average incidence of psychiatric disorders among Chinese Americans (64), but significant incidence among American Indians and Alaska Natives.

### EXPLAINING HEALTH OPPORTUNITIES

What explains these differences in health and psychological well being? The fact that there are strong biological and genetic similarities among racial and ethnic groups provide a framework for social science research to explore the wide range of interrelated factors. These include individual behaviors, socioeconomic status, residential segregation, community environments, and institutional practices that affect personal health status, collective well-being, and racialized perceptions of others.

#### Race, Behavioral, and Cultural Factors

Individual-level behavioral factors affecting health differences are generally divided into risk-taking and health-promoting behaviors. These behaviors include the frequency of preventive exams (prostate cancer screening, self-breast exams, pelvic exams, etc.), health-promoting behaviors (proper nutrition, physical activity, adequate sleep, etc.), and health-compromising behaviors (smoking, use and abuse of alcohol and addictive drugs, etc.). Research by epidemiologists shows that African Americans are less likely

than white Americans, and Asian Americans more likely to engage in preventive health practices related to diet, smoking, exercise, and use of screening tests (6; 11; 12; 66).

Cultural practices of racial and ethnic groups—labeled as “cultures of machismo,” “cultures of shame,” or “cultures of repression,” for example—are sometimes used to explain some of these group differences (18). Attitudes and emotions such as stigma and shame can reduce the likelihood of successful treatment. For example, research suggests that some cohorts of Asian-Pacific Americans are less willing to seek medical care for socially stigmatized problems (64; 69), while gay African American men are more likely to hide an HIV-positive diagnosis and less likely to seek early treatment than whites (62). American Indian, Mexican American, and African American males more often than white American males take part in risk-taking behaviors that result in death by accident and homicide (72). Other studies highlight the apparent mental health benefits for African Americans of collective activities such as church going, family gatherings, and church-based social services (7; 32; 41). For the foreign-born population (particularly Hispanics and Asian Americans), language barriers and unfamiliarity with the U.S. health care system can impede communication between practitioners and patients, who therefore may also stay away from a variety of medical services (45, as cited in 37).

Other studies show that linking health behaviors to cultural norms can perpetuate stereotypes and mask root causes of unhealthy practices. Culture is not static; it changes over time and under different conditions. For example, smoking rates,

<sup>3</sup> Researchers have had difficulty constructing adequate samples to explore mental health issues affecting the numerically small and diverse Asian-Pacific American population (64). There is also little nationally representative data on the mental health status of Hispanics in the United States. The phenomenal growth in both populations over the past two decades, however, should provide new opportunities for expanding research into understanding their psychological well-being.



which vary widely among Asian subgroups, can be driven by factors such as English-language ability and length of U.S. residency (42, cited in 19; 74). Poverty, lack of medical insurance, and rural isolation, rather than cultural norms, contributes to reduced preventive health care among poor Hispanic women (87).

### Race and Socioeconomic Factors

Socioeconomic factors are robust predictors of both life span and freedom from disease and disability (21; 55). Unequal life expectancy and

**“There is strong evidence that health insurance increases access to quality medical care and that people with medical insurance are more likely to be healthier, but access to health care is not the whole answer.”**

mortality reflect racial and ethnic disparities in poverty, education, and wealth as well as income (86). Numerous studies have found that when socioeconomic and related environmental factors (i.e., over-crowded housing, convenience of medical care, sanitation, and environmental pollution) are controlled, there is a decline in the differences in mortality, a decrease in cause-specific mortality, and mental illness decline for groups with disproportionately high rates (6; 19; 20; 54; 55; 59; 78; 80; 88). For example, a 1996 study of racial and ethnic mortality gaps found that if African Americans, Native Americans, and Mexican Americans have the same education, income, and marital profile as white Americans, their likelihood of dying from homicide, drinking, and illegal substance abuse decreases significantly (55). A subsequent study of disparities in the incidence of various diseases examined the correlation between wealth and health differences; the study also considered education levels, household income, employment characteristics, and availability of health insur-

ance (21). Equalizing these factors significantly reduced the likelihood that middle-aged African Americans would suffer from fatal diseases, major impairments, and disabilities, but it did not erase the racial and ethnic differences completely. This is because income inequality does not explain all the marked health differences among racial and ethnic groups (39; 78, 79, 80).

### Race, Neighborhood, and Community Environments

A growing body of research links the extreme levels of residential segregation of African Americans in central city and suburban neighborhoods to adverse health conditions, such as heart disease, hypertension, diabetes, tuberculosis, and low birth weight infants, all which have a cumulative affect on health across the life course (52; 82). A lack of health-promoting care and services in many racially and economically segregated communities provides a partial explanation for the link between residential segregation and the lack of physical well being (58; 82).

Race as well as the economic characteristics of neighborhoods is linked to the distribution of resources that support health (35; 61). Living in communities that lack transportation, fire and police presence, job opportunities, medical services, and quality education widens the health disparity gap (17; 27). For example, those living in neighborhoods viewed as unsafe are less likely to engage in preventive physical activity (17). Other researchers suggest that the mental health of those living in poor and hyper segregated neighborhoods (including feelings of powerlessness, anxiety, and depression) lead to unhealthy risk-taking behaviors and poor coping mechanisms that may contribute to illness (58). Recent studies also show that people exposed to multiple adverse neighborhood conditions, including poverty, geographic isolation, pollution and trash, vandalism, drug use, and lack of amenities, tend to suffer from depression and hopelessness (56).

Some research findings suggest that racial segregation and discrimination can adversely affect the health of those experiencing it; one study found that one-quarter to one-third of African American adults who experienced recent overt discrimination were more likely to report symptoms of depression and were at significant risk for major depression (6). These studies show that African Americans are exposed to more stressful life events and chronic stressors; experience more traumatic events, especially those related to violence; and feel less sense of control and well-being than whites; they also have a greater sense of alienation and mistrust (5; 83; 85). Chronic stressors associated with poor physical environments result in sub-clinical, stress-related mental illnesses, such as depression and post-traumatic stress disorder. Although minorities have relatively low rates of mental illness, those that have these conditions are more likely to be untreated and they suffer a greater loss to their overall health and productivity (24).

#### **Race, Access to Health Care, and Health Policy**

Racial and ethnic disparities in access to health care is a major contributing factor to disparities in health, with the lack of health insurance coverage having a strong negative cumulative impact on health (51). Unlike other industrialized nations, the United States does not have a national health policy (50). Stakeholders such as the American Medical Association, employers' groups (such as the U.S. Chamber of Commerce), and organizations of private insurance companies have successfully mobilized to

defeat national health insurance and have supported provider—rather than patient—friendly policies (31; 50). In the absence of a national health insurance program, health care for physical and mental conditions remains unevenly distributed among the population.

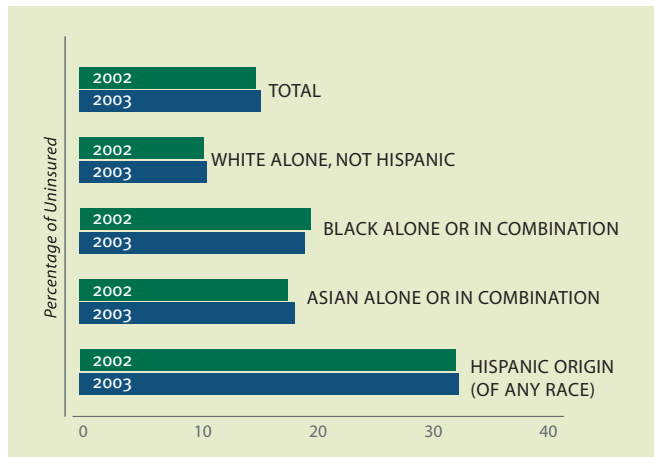
Racial and ethnic variations in the source and stability of health care coverage are related to differences in socioeconomic characteristics. Income, employment status, industry, size of employer, and union membership affect access to insurance, as do marital status, family type, and citizenship (15).<sup>4</sup> Table 4 shows the percentage of uninsured adults under age 65 by race and ethnic group. Table 5 shows the percentage of each group covered by private health care coverage (either directly through their own employer or through their spouse's coverage) and by public coverage (primarily Medicaid).

The variation in insurance coverage shown in these tables reflect the over-representation of young, single Hispanic and African American males in temporary and low-skilled jobs, who are generally ineligible for government programs such as Medicaid because they are neither disabled nor custodial parents. Therefore, they are the least likely to have health care coverage (13). Whites, with higher incomes, employment in professional jobs, and in mainstream companies are most likely to be insured through employer-provided plans, either as an employee or a family member. The patterns for Asian Americans are relatively similar to those of whites. African Americans are

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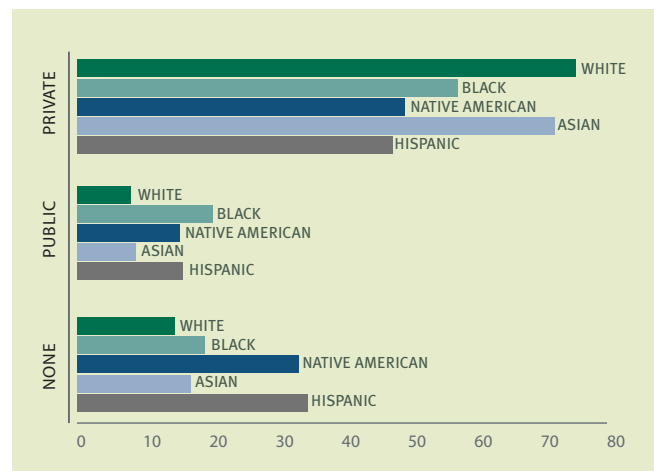
<sup>4</sup> There are three primary sources of health insurance: (1) employer-provided plans; (2) benefits offered through a relative's insurance plan; and (3) publicly funded insurance for the elderly (Medicare) and low-income families (Medicaid). Medicare, available to people age 65 and over, includes hospital insurance (Part A) and supplemental medical insurance (Part B) for a fee. Medicaid, authorized under Title XIX of the 1965 Social Security Act amendments, is a federal-state matching entitlement program providing medical assistance for low-income persons who are aged, blind, disabled, members of poor families with dependent children, and poor dependent children whose parents do not qualify for Medicaid. States are required to offer an array of basic medical services (increasingly by insuring patients through managed care delivery services such as health maintenance organizations in order to contain costs) (13).

**TABLE 4. People under Age 65 Without Health Insurance Coverage, by Race and Hispanic Origin, 2002 and 2003**



Source: U.S. Census Bureau. 2004. *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, P60-226, Table 5.

**TABLE 5. Percentage of Racial and Ethnic Groups under Age 65 with Private, Public, and No Health Insurance in 2001**



Source: U.S. Department of Health and Human Services. 2003. *Health, United States, 2003*, Washington, DC: U.S. Government Printing Office, Tables 127, 128, 129.

less likely than whites to be covered under private health care coverage because a larger percentage are unemployed, employed in low-wage jobs, or work in industries that typically do not offer health benefits, such as retail and

personal service (15). African American women also are less likely than white women to receive health coverage through a spouse, but are more likely to use public insurance coverage if they are poor and have children. Employer-provided coverage is even less available to Hispanics (especially Mexican Americans) because of their high concentration in service sector industries, second only to that of African Americans (70). In 2003, Hispanics under age 65 were nearly three times as likely as non-Hispanic Whites (32.7 versus 11.1 percent) to be uninsured (see Table 4).

Health insurance provided by the federal government through the states provides increased access to health care for many Americans, especially through programs that target children, the disabled, the elderly, and the low income (22; 47, 49). Medicaid is a source of insurance for about one-in-five African Americans between the ages of 18 and 65 and about one-in-six Hispanics and Native Americans (Table 5).

Despite the positive effects of Medicaid on minority access to health coverage, the long-standing history of segregation continues to influence the quality of treatment for patients of different racial and ethnic groups. The federal government played a significant role in providing health care in the wake of the Great Depression, but these programs did not benefit everyone equally. For decades, the “separate but equal” policy ensured racially stratified medical training, racially segregated hospital wards, and racially segregated hospital systems in at least 14 states (48). “Separate but equal” racial discrimination permeated nearly every facet of the health system, producing unequal health outcomes that promoted, produced, and reproduced inequalities in health.

In 1964, the Supreme Court prohibited “separate but equal” hospitals and training, and Title VI of the 1964 Civil Rights Act banned racial discrimi-



nation in all federally supported programs. When Medicare and Medicaid emerged as major sources of revenue for health care providers in 1965, southern hospitals agreed to desegregate their facilities, hire African American doctors, and integrate nurse-training programs (47; 49; 60). Agreements to desegregate hospitals increased access to health care, but the hospital system itself remained unequally distributed through segregated neighborhoods with whites having greater access than minority groups. This pattern

remains today (24). For low-income, Medicaid-ineligible patients, impersonal, inconsistent, and ultimately expensive medical care through hospital emergency rooms is often the only available option for treating routine as well as serious health problems (24). The structure of delivering medical care in the United States, with its legacy of institutionalized racist practices and continuing racism, would need to change or universal health care would not eliminate health disparities by itself.

**TABLE 6. White Americans' Stereotypes**

Percentage Agreeing that Most Group Members...				
	BLACKS	WHITES	HISPANICS	ASIANS
<b>ARE UNINTELLIGENT</b>				
Unintelligent	28.8	6.1	29.1	13.2
Neither	45.0	33.3	42.6	38.0
Intelligent	20.0	55.4	18.4	37.3
DK/NA	6.2	5.2	9.8	11.5
<b>ARE LAZY</b>				
Lazy	44.3	4.9	33.5	15.0
Neither	34.0	36.4	33.7	27.7
Hardworking	16.8	54.5	23.9	47.2
DK/NA	4.9	4.2	9.0	10.1
<b>PREFER WELFARE</b>				
Prefer Welfare	56.1	3.7	41.6	16.3
Neither	26.5	21.5	30.5	31.6
Prefer self-support	12.7	70.5	18.3	40.6
DK/NA	4.7	4.3	9.7	11.5
<b>ARE PRONE TO VIOLENCE</b>				
Violence prone	50.5	15.7	38.3	17.2
Neither	28.3	42.3	34.0	41.1
Not violence prone	15.2	36.6	17.8	29.6
DK/NA	5.9	5.5	9.8	12.1

Source: Davis and Smith 1990 as cited in Rubio, Mercedes, and David R. Williams.

### Institutional Racism

Racism remains an issue in the United States. As recently as 1990, a substantial percentage of whites saw African Americans and Hispanics as unintelligent, lazy, and prone to violence (see Table 6). As a result, even when people have equal access to health care, daily practices in

**“Reducing poverty, integrating neighborhoods, raising education levels, and reducing prejudice against racial/ethnic minorities would improve the likelihood of healthier and longer lives for minority groups.”**

institutions and by individuals within these institutions differentially affect racial/ethnic groups. For example, research shows that whites often receive higher quality, more aggressive health treatment than racial/ethnic minorities (57; 80). Institutional and systemic barriers

continue to prevent health improvements for some groups as reported by the Institute of Medicine (23; 24). These studies point to factors beyond socioeconomic status to explain disparities, including time pressures on physicians resulting from the organization and financing of health care (particularly managed care), provider bias against minorities, language barriers, as well as the location of health care facilities.

Research has documented continued systemic and individual patterns of discrimination that result in uneven application of many diagnostic procedures and treatments, and differential death rates for curable conditions, even among patients with health insurance (14; 6; 23; 37; 60; 78; 80). For example, a 1992 study of hospital patients showed that African Americans were less likely than whites to receive the 16 procedures most commonly performed on Medicare beneficiaries, especially newer treatments that are elective or require a referral (38; 60; 78). In another study of delays in transferring hospital patients to

nursing homes in North Carolina, researchers found that race was the strongest predictor of delayed placements, after controlling for payment status and medical condition (75, as cited in 60). Racial stereotyping and provider bias has also been found to reinforce inequalities in health care. In one study of clinical encounters, doctors described African American patients—regardless of their education and income levels—as less intelligent, less educated, more likely to abuse alcohol and drugs, less likely to follow medical advice, and less likely to participate in rehabilitation than white patients (73). Another study found that doctors often stereotype Asian American patients as compliant and often as “problem-free” (25). Research suggests that these views provide a rationale for frequent use of triage approaches in treating minorities in the context of perceived time and resource limitations (73).

Stereotyping patients can also result in misdiagnoses (76). For example, one study found inconsistent treatment for elderly minority cancer patients in pain: African Americans were 1.6 times less likely than whites, and Asians and Latinos 1.4 times less likely to receive medication, despite symptomatic complaints or other evidence of chronic pain (3). The infamous Tuskegee Syphilis Experiment conducted between 1932 and 1972, in which poor African American men were not told of their condition by the Public Health Service and were left to degenerate from the disease is perhaps the most dramatic example of racist practices (26). Its legacy lingers along with the legacy of segregation and discrimination in health care. Many African Americans continue to distrust the health system and the largely white medical establishment (6). Hispanics and Asian immigrants also face language barriers and this affects their satisfaction with the quality of their care (68). Medical evaluation and diagnostic tools that fail to account adequately for economic, neighborhood,

cultural, and language differences between racial and ethnic groups, as well as between patients and the health care personnel administering these tools, increase the likelihood of racial disparities in treatment.

### CONCLUSION

The American medical community increasingly recognizes that continued inequalities in health care adversely affect the overall well-being of the increasingly diverse population in the United States. In 1990, the Council on Ethical and Judicial Affairs of the American Medical Association reviewed social science research into disparate care and treatment and concluded that health care providers offered different levels or courses of treatment to patients of different races and ethnicities, regardless of insurance coverage, treatment preferences, socioeconomic status, and educational levels. Recent reports from the U.S. Department of Health and Human Services (72) and the Institute of Medicine (23, 24) concluded that, in addition to socioeconomic disparities and unequal access to health insurance, systemic bias and racial stereotyping in the provision of health care and health treatments contribute to unequal health outcomes among race and ethnic groups. Along with the National Institutes of Health, both call for development and implementation of clinical strategies to reduce inequalities in the health care system.

Research also shows that racial and ethnic differences in health outcomes stem from socioeconomic inequalities, adverse conditions in segre-

gated neighborhoods, as well as institutional practices that favor whites over minorities. Reducing poverty, integrating neighborhoods, raising education levels, and reducing prejudice against racial/ethnic minorities would improve the likelihood of healthier and longer lives for minority groups. There is strong evidence that health insurance increases access to quality medical care and that people with medical insurance are likely to be healthier, but access to health care is not the whole answer. Policymakers, civic leaders, and health care providers must address the lack of health care as well as the factors associated with extreme residential segregation (especially among African Americans) that contribute to poor health. Access to affordable health care, neighborhood cleanliness and safety, proximity of amenities that promote healthy lifestyles, and desegregation are among the issues that bear substantially on life or death, illness or health.

With more detailed and consistent data, social science research can continue to document the changes in the relative availability, quality, and effectiveness of health care for racial and ethnic groups. Sociological research would benefit from larger national surveys that can closely monitor the health gap for Asian-Pacific Americans, Hispanics, and native Americans and Alaska Natives; produce useful data on health outcomes and the quality of medical care for subgroups within these larger populations; and distinguish characteristics, such as native or foreign born, that bear on the delivery of health services. •

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