Is health care racist?

Many health care inequalities seem to be racially based. Racism and racial conflict in America can be explained in the context of three historical time periods and the prevailing economic systems of those times. The problem of access to basic health care for the black underclass is enormous. Traditional solutions of health education, health promotion, and low-cost health care have done very little to change the outcomes of increased morbidity and mortality. Health care professionals need to confront the real problem of inadequate life chances and limited economic resources for the underclass through research and the restructuring of our health care delivery system.

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IN AMERICAN society, many health care inequalities exist along racial lines. Blacks are 1.3 times as likely to die of heart disease, 2 times as likely to die of stroke, 2.2 times as likely to die of diabetes, 3.2 times as likely to die of kidney disease, and 6 times as likely to be murdered as are their white counterparts. Hypertension, a probable contributor to several of these diseases, strikes one quarter of the black population while affecting only one tenth of the white population. Cancer is detected later and has a higher mortality rate in blacks than in whites. Black women are three times as likely to die in childbirth as are white women, and indicative of the alarming black infant mortality rates is the finding that a black infant is two times as likely to die before age 1 as is a white infant. Black teenagers are twice as likely to become pregnant and six times as likely to be killed as are white teenagers. Of the 15 leading causes of death in the United States, blacks have the highest death rates for all but 2 of them[1–3]; blacks are more often uninsured

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than are whites.[4] Although heredity may be a factor in many of these conditions, the significance of these statistics in conjunction with socioeconomic considerations suggests a multifactorial answer with poverty exerting a major influence in producing disparities in health care.

The purpose of this article is to heighten the reader's awareness of the inequalities involved in health care access. Included in this discussion are examinations of the significance of black–white racial conflict in a historical perspective, health care access for the medically indigent, and the failure of traditional solutions.

HISTORICAL OVERVIEW OF RACIAL CONFLICT IN AMERICA

Black Americans occupy a unique place in American history. To understand and appreciate the present situation of the black poor and health care, a brief historic overview of race relations between blacks and whites will be helpful. Prior to this discussion, several terms need to be defined. The box[5,6] summarizes the authors' definitions of racism, prejudice, discrimination, and class divisions as they apply to this article.

Wilson[6] argues that there are three major periods in American race relations, each of which has been shaped by economic systems of production as well as by laws. The first period is the preindustrial era. This period was characterized by the slave-based plantation economy of the South from the early to mid-1800s. In this system, a relatively small, elite group of white planters developed enormous regional power. Because free white workers were not central to the labor supply, slavery became a mode of increasing production and the economic power of the white plantation owners. Race relations assumed a paternalistic quality, specifying duties, norms, rights, and obligations of slaves and masters. Racial antagonism can be explained by the deliberate exploitation of the slave-labor blacks by the capitalist whites.

After the Civil War, despite the abolition of slavery, racial antagonism continued. This may also be explained by an economic

Definitions of Terms Used in the Discussion of Race and Class Conflict

Racism: the subordination of people of color by white people; at the very least, this subordination involves power plus prejudice.[5]

Prejudice: preconceived ideas or opinions about an individual or group based solely on race, sex, or national origin.

Discrimination: when opportunities or choices are limited to people because of race, sex, or national origin.[5]

Class: any group of people who have similar goods, services, or skills to offer for income in a given economic order and who therefore receive similar financial remuneration in the marketplace.[6]

Lower class: a population that represents the very bottom of the economic hierarchy and includes not only those workers whose incomes fall below the poverty level, but also the more or less permanent welfare recipients, the long-term unemployed, and those who have dropped out of the labor market.[6]

Underclass: the more impoverished segment of the lower class.[6]

theory, but one different from that of the preindustrial era. In the late 19th and early 20th centuries, industrialism flourished. The white working class and the urban blacks were competing for similar jobs. White workers increased their power through unions (which blacks could not join) and demanded higher wages and more fringe benefits. As a result, managers used blacks as strikebreakers or permanent replacements for white workers. The more management used blacks to undercut white laborers, the more racial conflict arose between the two groups. Added pressures came from racial competition for housing, neighborhoods, and recreational areas. Thus capitalists exploited the black workers with low wages and created an atmosphere of competition between the two groups (black and white workers), which fueled racial antagonism.

The postindustrial–modern period extends from the 1940s to the present. The patterns of race relations of this time do not fit either of the above eras. Once racial barriers were broken down in unions, blacks and whites presented a more united front to management, thus decreasing competition and racial tension. In the 1960s, unprecedented civil rights legislation was passed, giving blacks greater political and social equality in the areas of education and job opportunities. According to Wilson,[6] the ultimate basis for the current racial tension is the deleterious effect of basic structural changes in the modern economy on black and white lower-income groups. These changes include uneven economic growth, increasing technology and automation, and industry relocation out of urban areas. Blacks are disproportionately represented in the underclass population, in that about one third of the entire black populace resides in the underclass.[6] Also, since 1970, poor blacks and poor whites have evidenced little progress out of the underclass. Hence, Wilson posits that economic class is now a more important factor than race in determining job placement and life chances for blacks. What does this mean for the underclass in terms of health care?

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HEALTH CARE ACCESS

Scope of the problem

Access to basic health care or, more accurately, lack of access is an urgent issue currently troubling society. Organizations such as the International Council of Nurses and the World Health Organization (WHO) devote much attention to this issue.[7] Because of this concern for the delivery of adequate levels of health care, WHO set forth the goal of "the attainment by all peoples . . . of a level of health that will permit them to lead a socially and economically productive life."[8(p8)] Attainment of this goal will require two kinds of action. The first type of action, the delivery of primary health care, involves such strategies as improved management of health care resources, health education, and health development. But, as Hindson[8] points out, this type of action can be expected to have little effect on improving health unless a second type of action, the "defeat . . . of the anti-health forces"[8(p9)] such as poverty, sup-

pression, and dehumanization, is undertaken.

Basic to this idea are the concepts that certain societal aspects such as poverty, lack of access to resources, and unequal life chances are foundational causes of poor health and the inability to obtain adequate health care and that these issues must be addressed if the goal of adequate health care for all is to be achieved. Ironically, the United States is one of the richest countries in the world, yet it is experiencing what some call a crisis in health care delivery. Areas of critical concern are access to health care for the indigent and access to health care for the uninsured or underinsured. Just what is the extent of this crisis?

Although medical indigence and lack of access to health care are areas often neglected in reports, the problem is still known to be enormous. Conservative estimates of the number of people who face problems in obtaining access to health care due to a lack of any health insurance coverage begin at 35 million to 45 million.[4,9] This number doubles when those who are underinsured are taken into account and reaches 100 million when the elderly who frequently do not have coverage for extended service needs are included. These estimates place two out of every five members of the population at some risk for not being able to obtain health care in a time of need. The uninsured are not necessarily the unemployed. Half of the medically uninsured are full-time employees and their dependents.[10]

Merely having insurance, however, does not assure access to needed health care. Hayward and associates[11] studied 7,633 adults to determine patterns of health care access. Predictably, the uninsured had lower access to health care. More surprising, though, was the finding that problems with access to health care exist among insured (Medicaid included) working-age adults. Even greater problems in access to health care exist among the insured poor, black, or Hispanic persons. Indeed, being black, poor, or Hispanic were independent predictors of inadequate access. Possible reasons for these findings posited by Hayward et al[11] include

- copayments, high deductibles, and other restrictions that may deter the poor from pursuing health care;
- physicians who may fail to provide care to Medicaid recipients due to poor reimbursement;
- lack of transportation, medical facilities, and caregivers in poor, ethnic communities that may make access problematic; and
- cultural and bureaucratic hostilities or outright discrimination that may set up institutional barriers to obtaining health care.

Federal programs designed to provide access to health care for the poor or "health care poor" have never completely met the needs of the medically indigent. In this era of increased budget deficits and an administration that advocates a minimal role for the federal government in providing this care,[10] the crisis in health care access can only be expected to deepen. Poverty and the numbers of poor and near poor are increasing and are projected to continue to increase while health care funding for the poor has declined.[12,13] The results, under the present administration's "new federalism," include reduced funding for Medicare, Medicaid, and other programs such as nutrition funding for women and children, and a shifting of responsibility for these programs to the state governments.

These changes have had great impact: The number of people eligible for Medicaid significantly decreased as eligibility was linked to qualifications for such programs as Aid to Families with Dependent Children (AFDC). At the same time, more stringent criteria for AFDC eligibility were created. The net result was to disqualify large numbers of indigent people (generally single-parent women and children) from both AFDC and Medicaid. In any case, Medicaid always excluded certain groups of the poor such as single adults, childless couples, intact families, and the near poor. The last, despite their slightly better-sounding designation, often have less access to health care because they are ineligible for assistance despite demonstrated need and the inability to afford other health insurance. In 1988, more than 50% of US citizens with incomes at or below poverty level were not eligible for Medicaid.[9]

In addition to reducing funds, new federal policies that give more responsibility to the states have changed patterns of fund administration and thus adversely affected health care access. The diversity of the states' responses to these policies prompted one author to comment, "eligibility and administration vary so much from one state to another that inclusion, scope of coverage, and access to care may be an accident of residence."[14(p288)] Additionally, the majority of states have reduced Medicaid funding and made requirements for eligibility more stringent.[4]

Where does the medically indigent person who requires hospitalization go? The role of providing uncompensated care has largely fallen on public hospitals. Previous methods of providing uncompensated care (cost shifting and dependence on the federal government) have fallen to the demands of economic pressures.[15] Profit and nonprofit hospitals utilize only approximately 3% to 5% of their revenue for uncompensated health care[16]; and as the for-profit sector increases, there are burgeoning concerns over the provision of uncompensated care. Large numbers of public hospital closures and the closure of hospitals serving urban minority communities have potentially serious implications for access to health care for the medically indigent as these hospitals are large providers of indigent health care.[4] Thorpe and Brecher, in studying access to health care and the public hospital, conclude that an operating public hospital "does not simply reduce the burden on private hospitals in a city; it is also likely to be a net addition to the volume of care available to the medically indigent."[15(p322)] Closure of public hospitals or lack of public hospitals in an area thus adversely affects health care delivery to the poor because private hospitals do not compensate for the loss or lack of health care.[15]

In addition to concerns over lack of access to health care for the medically indigent, there are concerns over the quality of health care provided to the poor. Lack of access to preventive or primary health care, lack of adequate referrals or follow-up, lack of access to many services and usual diagnostic procedures, and inappropriate emergency department transfers from private to public hospitals contribute to a reduced quality of health care for the poor.[13,16]

Relationship between medical indigence and race

As may seem obvious, the medically indigent confronted with problems obtaining access to health care are most often those

people living in poverty or near poverty. Simply stated, poverty seriously limits access to adequate health care. Additionally, those families in which the main wage earner is unemployed or sporadically employed are uninsured or underinsured and thus face the hazard of medical indigence. People under age 24 are often uninsured. Finally, members of racial minority groups, particularly blacks and Hispanics, are more at risk than whites for medical indigence.[4]

Descriptions of those living in poverty and facing the potentially serious consequences of medical indigence reveal that blacks are disproportionately faced by this threat.

Approximately 27% of all Americans live in poverty or near poverty, whereas 36% of all blacks live in poverty.[17] Although figures vary depending on the source, census figures from 1962 to 1982 estimate that the percentage of blacks living below the poverty level for all of this 20-year period was at least twice the percentage of whites living below the poverty level.[18] Black children and female-headed black households have been hit particularly hard by poverty. Almost 50% of black children are poor, and the poverty rate for female-headed families nears 57%.[17,19]

Unemployment, sporadic employment, and employment in low-paying jobs all put people at risk for medical indigence because they do not provide a high enough income with which to purchase health care and health insurance. Again, blacks are particularly affected in this area. Black unemployment rates are significantly higher (often double) than those for whites; median black family income is significantly lower; and blacks (especially black women) are frequently employed at lower-paying jobs without benefits or insurance.[2,18,19]

In summary, those at special risk for medical indigence include those people living in poverty and those people with limited or no employment opportunities. Because blacks are overrepresented in the ranks of the poor, unemployed, and low-wage employed, they are particularly in jeopardy of medical indigence, lack of access to health care, and the consequences.

Consequences

The relationships among poverty, access to health care, health status, and race are complex, but that there are relationships seems clear. Gordon-Bradshaw[2] notes that advances in health care have failed to correct the "serious inequities in the health care system and health status for the most vulnerable . . . poverty wreaks havoc on people of color because of their limited resources and lack of access to health care, and lends credence to the adage 'those who suffer most get the least.' "[2(p254)]

Blacks in this country have increased mortality and morbidity for a number of diseases and illnesses.[1] Genetic predisposition has been implicated as the source of much of the problem in increased black mortality and morbidity, especially in the case of hypertension and its sequelae. Increasingly, however, the evidence points to the contributions of life-style risk factors such as poor nutrition, inadequate and delayed health care, exposure to excessive health risks, inadequate living conditions, and stress.[1,2,14] These high-risk life-style factors are, in many cases, attributable to "a legacy of economic deprivation and social oppression."[1(p126)] As Mechanic[14] points out,

"throughout the life span poverty and poor health reinforce one another."[14(p283)]

Good nutrition, early and continued prenatal care, and adequate postnatal care can reduce the alarming maternal and infant mortality rates among blacks. Early detection and adequate treatment of cancer, hypertension, and their sequelae can contribute to reductions in black morbidity and mortality in these areas. Proper nutrition can contribute to reduced morbidity and possibly reduced mortality and can reduce the risk factors for the development of hypertension and heart disease. Improved living conditions and less exposure to environmental hazards can reduce morbidity and mortality from many causes. But these measures can be expensive and are prohibitive for many poor or near-poor blacks. Access to health care and access to the means of acquiring and maintaining health are simply out of the reach of those not able to pay for such access.

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WHY TRADITIONAL SOLUTIONS HAVE FAILED

Traditional solutions to the health care problems of the poor have their roots in the phenomenon known as "blaming the victim."[20] In this phenomenon, the victims of societal inequities such as inadequate health care, rather than the societal structures themselves responsible for the problems, are targeted for change or action. Although the destructive effects of poverty are recognized, the problem (and thus the solution) is said to reside within the victim. On the surface this ideology appears well-meaning, even humanitarian.[20] Problems are recognized and studied, and solutions are recommended and acted on. However, the result of this sort of action is that the root causes are never addressed and, thus, long-lasting solutions are not forthcoming. As Ryan writes,

> They turn their attention to the victim in his post-victimized state. They want to bind up wounds, inject penicillin, administer morphine, and evacuate the wounded for rehabilitation. They explain what's wrong with the victim in terms of social experience *in the past*, experiences that have left wounds, defects, paralysis, and disability. And they take the cure of these wounds and the reduction of these disabilities as the first order of business. They want to make the victims less vulnerable, send them back into battle with better weapons, thicker armor, a higher level of morale."[20(p332)]

Better weapons, thicker armor, and a higher level of morale in the war against poor health and inadequate health care in the underclass translate into health education and assisting individuals and families to cope with poverty and its consequences. It cannot be denied that health education is important, but health education alone fails to address the fundamental issue, which is lack of resources. Education concerning proper and healthful nutrition, the importance of early health care, and risk factor reduction is of relatively little use to the individual or family too poor to purchase healthy food, obtain preventive health care, or take advantage of risk factor reduction strategies. Teaching people to cope with poverty and inadequate health care blames the victims for their problems and fails, again, to address

the rudimentary issues of the failure of society to provide certain individuals with the opportunities and life chances to avoid poverty. Attempting to teach people to cope with poverty "unwittingly or not . . . reinforces the thinking that poverty is unavoidable. Historically, the poor have been held responsible for their own plight. Because the poor are disproportionately people of color and women, such an explanation easily assumes racist and sexist overtones."[17(p20)]

It can be argued that one of the driving forces for allocation of resources for research, education, practice, and theory development for professions such as nursing and medicine is the philosophy of science that those professions choose to embrace. What the appropriate and significant research questions are for a discipline, what constitutes theory,[21] and what direction education and practice should take are all determined largely by the scientific philosophy adopted by the discipline. The current predominant philosophy in the health care field (although not exclusively) is that of the so-called "received view" or logical positivism.[22,23] Research, education, and practice driven by this philosophy have failed to identify the fundamental issues in the provision of health care for the poor and have failed to derive meaningful solutions to the problem. Usually, either health education, health promotion, or low-cost health care is seen as the solution. In reality, health education and health promotion will most likely do very little to change the outcomes because the economic crisis of the lower class is the root of the problem. Even when low-cost health care is provided to poverty areas, many cannot afford to take leave of a menial-paying job, cannot afford transportation to the health care clinic, or have no resources to pay the low-cost fee. In this day of cost containment and competition in health care, the amount and type of charity care offered by health care providers are shrinking, concomitant with a swelling underclass population.[4,12]

The logical positivist would argue that the problems of poverty, social structure, and access to health care are sociopolitical problems, not scientific problems, and as such do not present questions appropriate for scientific inquiry. Poverty and its health care implications are wide-ranging, resource-consuming, seemingly perpetual problems confounding not only society in general but also nursing and other health care disciplines. That it is a problem suitable for concerted scientific inquiry seems clear. Perhaps a scientific philosophy that embraces problem solving as its core[24] is immanently more suited to addressing the unsolved issues of inadequate and inaccessible health care for the indigent.

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Is health care racist? There are no doubt individual instances of racism in the delivery of health care. There are recent disturbing reports of disproportionate medical treatment along racial lines,[25] and underrepresentation of blacks in clinical trials of new drugs.[26] However, the authors would argue that the problem of inadequate health care for blacks is largely due to socioeconomic constraints rather than race.

Lasting solutions to the problems of poor health in the indigent and the provision of access to quality health care will involve a restructuring of the health care delivery system that will ensure access to adequate and timely health care for all. Most importantly, fundamental changes must be made in the

societal structures and policies that contribute to poverty. One reason for failure to solve the problems of poor health status and inadequate health care access in the indigent may be due to the predominating philosophy of science that does not regard these issues as legitimate pursuits of science. Most current theories concerning improvement in these areas are based on describing the relationships between health education, coping with poverty, and improved outcomes in health status. The failure of these theories to propose lasting solutions to the problems may be due to failure to adequately and accurately conceptualize the problem as one of poverty and unequal life chances.

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