CHAPTER ONE

Introduction

Why We Should Study Race, Ethnicity, and Health

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During the twentieth century there was a literal and figurative change in the "face of America." At the beginning of the century racial issues were essentially concerns with relations between black and white Americans. However, by the end of the century the relative sizes of American racial and ethnic groups had changed, and Latinos and Asian Americans made up a sizable proportion of the U.S. population. According to projections from the U.S. Census Bureau (summarized in Figure 1.1), this pattern is part of a long-term trend. During the twenty-first century U.S. racial and ethnic minorities are expected to constitute a steadily larger minority and eventually a majority of the U.S. population.

Another important trend that has unfolded during the twentieth century is the steadily improving health profile of Americans. As Figure 1.2 shows, early in the century the average white American lived fewer than fifty years. Life expectancy for African Americans was around thirty-five years. By the end of the century, life expectancy for all Americans exceeded sixty-five years, yet the disparities among racial and ethnic groups remained generally constant. As racial and ethnic minorities come to make up a larger percentage of the total population, the overall health statistics in the United States will increasingly reflect the health status of those minorities. Consequently, it is becoming increasingly important to monitor the health status of racial and ethnic minorities, and finding ways to improve minority health has taken on heightened urgency.

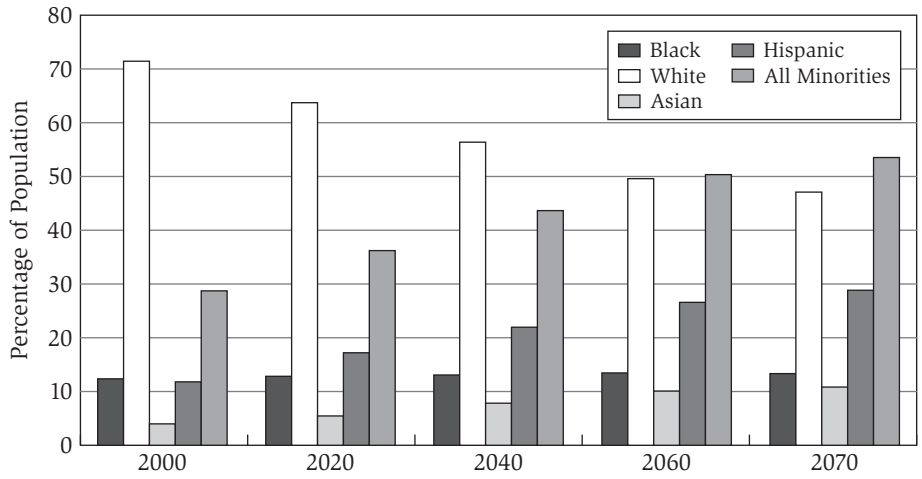

Figure 1.1 Projected Racial Diversity in the United States in the Twenty-First Century.

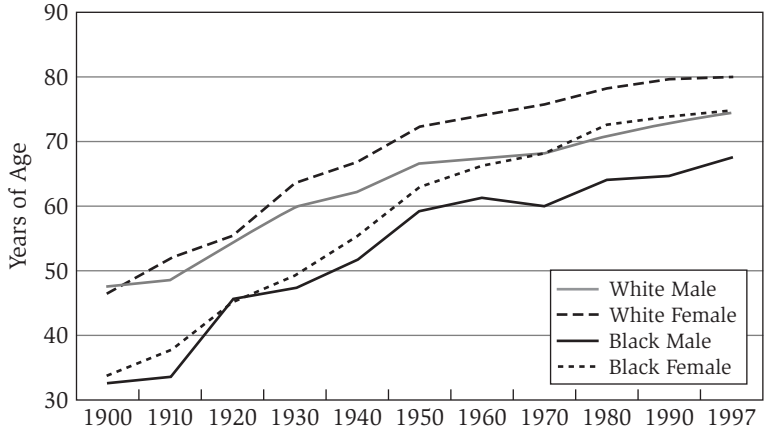

Figure 1.2 U.S. Life Expectancy by Race, 1900–1997.

There are substantial differences among the health profiles of U.S. racial and ethnic groups.[1] Researchers have demonstrated this fact for centuries.[2–4] Figure 1.3 shows mortality rates for U.S. racial and ethnic groups for the year 2000. African Americans have the worst health profile, and Asian Americans have the fewest health problems. Such disparities in health status are well documented

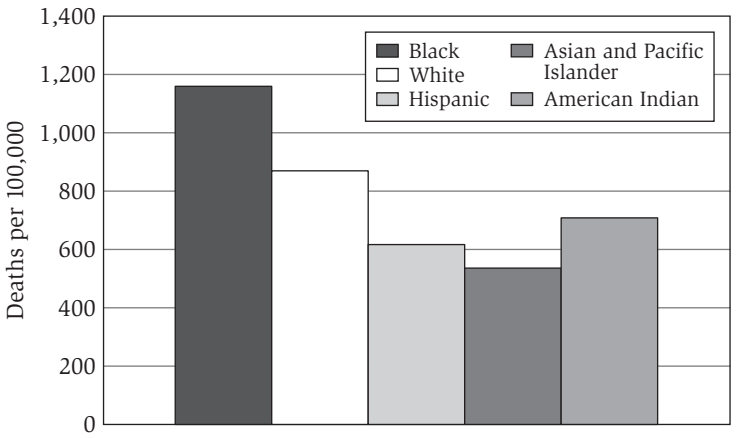

Figure 1.3 U.S. Age-Adjusted Death Rates by Race and Hispanic Origin, 1996–1998.

Source: Eberhardt, M. S., Ingram, D. D., Makuc, D. M., et al. (2001). Urban and rural health chartbook. In *Health, United States, 2001.* Hyattsville, MD: National Center for Health Statistics, p. 164, table 29.

and widely known. However, research on race, ethnicity, and health is controversial, probably owing in part to the thorny role that race has played in U.S. history and contemporary culture.[5] Because of this history, race engenders emotion, and emotion is often the antidote to rational thought. Some have called for an end to research on race and health.[6–9] Medical journal editors now discourage the use of the term *race* in submitted manuscripts. In fact, physical anthropologists no longer recognize race as a valid concept.[10,11] Other disciplines have also begun to debate the viability of the concept of race.[12,13]

The argument against continuing to conduct research on race and health goes like this:

Proposition 1. Race is not a valid biological concept, therefore

Proposition 2. Race is not a valid scientific concept, therefore

Proposition 3. Continuing to document racial differences in health bolsters pseudoscientific and even racist arguments about the existence of biological differences between what we call races and thus about the genetic inferiority of certain groups.

Although it is easy to be sympathetic to propositions one and three, it is at the second proposition that the reasoning goes astray. The problem is in using biology as the arbiter of what is scientific. As knowledge of human genomic makeup has unfolded, it has become increasingly clear that the widely held

belief that there are biological differences between racial groups is incorrect. However, even though race may be a biological fiction, it is nevertheless—as the articles in this reader demonstrate—a profoundly important determinant of health status and health care quality.

THE PURPOSE OF THIS BOOK

So what is race, and why do racial disparities exist? These are the central questions this book is designed to address by bringing together a set of articles and chapters previously published in scientific journals and books. Together, these materials provide an overview of our current state of knowledge as we attempt to answer these questions.

The chapters in this book address race, ethnicity, and health only in the United States. I set this limitation because different cultures and countries respond differently to race and ethnicity. This being the case, I felt it best to address the broader international context in a separate volume. Moreover, this compilation is not intended to be merely a listing of the "best" articles in minority health. My goal has been to compile a set of articles with range and depth that will provide an overview and a strong foundation for those interested in learning about health disparities that reflect race and ethnicity.

An advisory committee and an editorial board, made up of experts in minority health, were kind enough to provide me with valuable feedback during the selection process. However, the final selections were my own, and any omissions should be attributed to my judgment (or misjudgment) alone.

ORGANIZATION OF THIS BOOK

Race, Ethnicity, and Health is divided into seven parts. The chapters in Part One provide a historical and political context for the study of research on race, ethnicity, and health. Nancy Krieger addresses the history of the ways in which race has been used as a political tool in health and public policy. Vanessa Gamble's classic article on the Tuskegee Syphilis Study details the long-term consequences of mistrust resulting from that experience. William Vega and Hortensia Amaro offer a profile of the health of the Latino population, noting once-ignored differences from other minority populations. Thomas LaVeist addresses political aspects of minority status and health, demonstrating the interrelationships among political power, racial segregation, poverty, and health.

In Part Two we move to discussions of the theoretical and conceptual underpinnings of race and ethnicity. These chapters address the questions, what is

race, and how should it be used in health research? Richard Cooper looks at the social forces that give rise to racial differences; Thomas LaVeist describes the caution and skepticism required of researchers who employ race as a variable; Carles Mutaner, F. Javier Nieto, and Patricia O'Campo address the methodological, empirical, and ethical weaknesses of arguments for a biological basis for certain racial differences; and David Hayes-Bautista and Jorge Chapa offer a conceptual analysis of the terminology used in the United States for persons of Latin American origin.

The two chapters in Part Three, by Robert Mayberry, Fatima Mili, and Elizabeth Ofili and by Kevin Fiscella and colleagues, summarize findings on disparities in health care access, utilization, and quality. The chapters in Part Four then seek to explain why racial and ethnic variations in health status exist. These chapters address a variety of hypotheses, including Arline Geronimus's weathering hypothesis and Sherman James's John Henryism theory. Chapters by W. Parker Frisbie, Youngtae Cho, and Robert Hummer; Richard David and James Collins; Gopal Singh and Stella Yu; and Luisa Franzini, John Ribble, and Arlene Keddie examine the interrelationships among immigration, assimilation, and acculturation. A well-known paradox in the health literature is that although Latinos (especially Mexican Americans) have a generally worse health profile than white Americans, Mexican immigrants have better health than white and Mexican Americans. However, as their time in the United States extends, their health status begins to approximate that of Mexican Americans. As Singh and Yu demonstrate, similar findings exist for African and Asian immigrants.

Another possible explanation for health disparities is exposure to racism. The chapters by Camara Jones and by Rodney Clark et al. describe the theoretical basis for this hypothesis, and David Williams and Chiquita Collins and also Elizabeth Klonoff and Hope Landrine discuss empirical tests. The final chapters in Part Four explore the idea that disparities among the racial and ethnic groups are caused by differential exposure to health risks. Michelle Pearl, Paula Braveman, and Barbara Abrams and also Williams and Collins examine socioeconomic status. Kimberly Morland et al. demonstrate that food stores are less available in minority communities, and R. Sean Morrison et al. demonstrate that pharmacies in those communities are less likely to carry pain medication. Limited availability of products that sustain good health is typically accompanied by overavailability of products injurious to health, as discussed by Robert Bullard (solid waste sites), Thomas LaVeist and John Wallace (liquor stores), and Marsha Lillie-Blanton, James Anthony, and Charles Schuster (crack cocaine).

In Part Five we turn to the health care system and examine the role of health care providers in producing health disparities. Knox Todd and colleagues demonstrate that African American patients were less likely than white patients to receive pain medication when they came to a hospital emergency room.

Schulman and colleagues show that African American women were less likely than white men to be referred for heart surgery. Betsy Sleath, Bonnie Svarstad, and Debra Roter discuss the racial differences they found in the prescribing of psychotropic medications. And Michelle van Ryn and Jane Burke explore physicians' attitudes toward African American and white patients.

Part Six of this reader presents two views of patient factors in health care disparities. Numerous studies have found (as, for example, Schulman et al. did) that there are racial differences in the receipt of heart surgery. Most of these studies have speculated that the difference is caused by patient preferences, that is, African American patients prefer not to have the procedure. Jeff Whittle et al. provide a good test of the patient preference hypothesis. Then Chamberlain Diala and colleagues study racial differences in patients' attitudes toward use of mental health services.

Finally, Part Seven presents three important discussions about provider-patient interaction. Lisa Cooper-Patrick et al. and Somnath Saha et al. test whether matching patients and doctors by race has a benefit in terms of patients' perception of their health care experience. And Jersey Chen and colleagues test whether matching patients and doctors by race has an effect on the racial disparity in the receipt of heart surgery.

Notes

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