

The relationship between ethnic disparities and health

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Access to quality healthcare is an important necessity for all mankind. Every health system aims at ensuring improved efficiency and quality of health care to the entire population and also achieving equality in the provision of health services. Improved health includes the provision of quality inpatient and outpatient care, provision of essential education aimed at improving quality of life, and engaging in evidence-based intervention measures to improve public health. However, studies indicate the existence of significant disparities in healthcare services based on racial and ethnic differences. In particular, the ethnic disparity is a widely researched topic as it touches on the existence of social and economic disparities among different groups of people. The existence of social and economic imbalances has a direct impact on how different people access quality health care how healthcare policy reforms are implemented to address the issue of quality healthcare services for all. While health inequality issues have been reported mostly in developing countries on basis of social and economic factors, little is known on the challenges that face minority groups in accessing quality healthcare in developed countries. As a result, most healthcare institutions have been faced with the issue of racial and ethnic and racial inequalities in the provision of quality, unbiased healthcare services to the population. As healthcare and ethnicity become a major concern, it is essential to implement a policy program that advocates for standardized protocols to ensure equity in the provision of healthcare and health-related services.

Background

Health disparities can be described as the differences that exist between different groups of people in the attainment of quality health potential. Health potential can be measured in terms

of the differences in prevalence mortality, incidences, burden of care, and vulnerability (Bacui et al., 2017). Health disparities can be influenced by racial and ethnic differences, gender, sex, and socioeconomic differences that inhibit the group from achieving optimal health, resulting in poor health outcomes. On the other hand, racial and ethnic differences are socially constructed traits that influence self-identification and categorization of a person or a group of people based on place of origin and cultural boundaries such as religion, language, color, and country of origin (Harris et al., 2013). The existence of systemic differences in health inequalities have been associated with different social and economic issues experienced by people in the society. As Mathews et al. (2015) notes, the systemic drivers, such as racial and ethnic bias, create salient identities that result in unequal distribution of health opportunities across different racial and ethnic groups. Furthermore, the existence of differences in the determinants of health such as quality education, access to water, food, health facilities, and conditions in which different people live influences health outcomes.

Internationally, there is substantial evidence that indicates the existence of unequal health outcomes between different ethnic groups in the same territory. For instance, in the United Kingdom, people from black and minority ethnic groups such as the Caribbean, Indians, and Pakistanis among other minority groups were reported to have generally poor health outcomes as compared to the general White majority group (Fiscella and Sanders, 2016). Similarly, countries such as Canada, New Zealand, and Australia reported unfair inequalities in healthcare access and outcomes between the indigenous and non-indigenous populations within the same territory, where the indigenous minority groups were disadvantaged in accessing quality health outcomes (Harris, Cormack, and Stanley, 2013). In the United States, a similar situation is witnessed by the

existence of unequal health outcomes and determinants of health between different ethnic communities.

Racial disparities and health inequalities

Ethnic and racial bias is a detrimental factor that contributes to health inequality and poor health outcomes. Ethnicity and minority race are historically associated with social disadvantage, especially in the allocation of resources and fair treatment. Historically, factors such as slavery and forced relocation had created racial marginalization among the African Americans and the Native Americans. Such marginalization issues had shaped the quality of education, employment, and residential segregation, health literacy, and poverty levels. As Harris et al. (2013) highlight, such cumulative social disadvantages contribute to poor health. Various factors contribute to health disparities including lower socio-economic status, poor health literacy, limited social support, language barriers, and ineffective health policies (Chauhan et al., 2020). Historical cases of racial discrimination have been reported, especially by minority groups, especially in the provision of safe care. Minority groups have reported feeling unsafe and being treated indifferently when receiving care. According to Chauhan et al. (2020), unsafe and discriminatory experiences are caused by biased clinical judgment, failure to interpret services and provide the patient with adequate information to enhance health literacy, and reliance on informal translation mediums when interacting with patients with lingual differences.

Statistics also indicate that minority groups are more prone to long illnesses and chronic diseases. According to research by Carratala and Maxwell (2020), 13.8 percent of African Americans reported poor health on average compared to Whites American. Chronic illnesses such as hypertension and asthma were also more prevalent among the African American

minority groups compared to the similar cases reported among the Non-Hispanic Whites in 2017. Other long-term illnesses such as cancer, diabetes, and heart diseases were reported to be higher among the Hispanic Whites and African Americans compared to the prevalence of similar illnesses among the white population. However, the reported cases of mental health were prevalent among the Non-Hispanic whites compared to the Hispanic and African American populations. Among the reported cases of mental health issues, Non-Hispanic Whites are more likely to receive medical prescriptions compared to other minority groups. One of the identified hindrances to low reported cases of mental illnesses includes the discriminatory process and discretion in handling mental health issues.

Differences in mortality rates and causes of deaths are also significantly different among different racial groups. Statistical evidence shows that the rate of infant mortality is higher among the minority African Americans, Alaskan Natives, and Hispanic groups, where there are 11, 9.2, and 5.4 infant deaths per 1000 live births respectively (Carratala and Maxwell 2020). According to the US Department of Health and Human Services Office of Minority Health (2020), the major causes of infant mortality across minority ethnic groups include low birth weight, congenital malformations, maternal complications, unintentional accidents, and sudden infant deaths syndrome (SIDS). The major causes of death across all minority groups in the United States, where the major causes of death include accidents, cancer, heart disease, and diabetes. However, while the minority groups display poor health outcomes, evidence shows that people from some ethnic groups have better health outcomes. For instance, a review by Mathews (2015) indicates that people of Asian origin have reported low levels of anxiety and depression. Similarly, Carratala and Maxwell (2020) reported that Hispanic Whites have a longer life expectancy of 81.9 years.

While institutional and community factors contribute to inequalities in health care provision, patients' ethnic beliefs and practices, language, and culture also play a major role in determining the quality of care. For instance, while cigarette smoking is associated with health risks such as lung cancer, Alaskan Americans recognize tobacco as a symbol of their culture whereby tobacco smoking is widely used in cultural ceremonies and as a healing substance. Similarly, some cultural and religious beliefs that prohibit women from talking to male strangers can lead to poor health outcomes. Further, factors such as the language barrier can result in poor patient-clinician communication, thus impacting the desired health outcomes (Chauhan et al., 2020). Failure to recognize the individual perceptions resulting from ethnic and racial differences and embracing healthcare setting that embraces inclusivity and diversity have also contributed to the poor health outcomes (Nair and Adetayo, 2019). An inclusive healthcare setting promotes a setting where there is someone to tend to the varied needs of patients from diverse cultural and ethnic backgrounds.

Access to healthcare insurance is also detrimental in determining health outcomes. However, a report by Artiga and Orgera (2019) highlights major differences in access to health insurance covers among different ethnic groups. The report indicates that although the number of people with health insurance covers has increased significantly in the last decade, the number of people likely to remain uninsured is relatively high among African Americans, Hispanics, and other minority groups compared to White Americans. The rate of uninsured people in 2017 was highest among the Hispanics and African Americans at 19% and 11% respectively, compared to 7% of the uninsured White Americans (Artiga and Orgera 2019). However, 44 percent of the African Americans were using government health insurance covers compared to the majority of Non-Hispanic whites who had access to private insurance covers. Access to insurance coverage

influences the ability to access to quality and experience of care. For instance, uninsured patients and those with public insurance report poor experience of care while patients with private insurance coverage have reported quality and best health care experience (Fiscella and Sanders, 2016). The uninsured population also experiences lower rates of preventive care such as cancer and diabetic screening.

Furthermore, racial and ethnic stereotypes play an important factor in determining health outcomes. Issues related to racial profiling and stereotypes and implicit biases influence a person's unconscious cognitive biases that shape behavior and attitudes (Fiscella and Sanders, 2016). For instance, racial profiling of African American and Hispanic youths could influence the target population into engaging in risky health behaviors such as drug abuse and violent behaviors. Profiling also contributes to the existence of poor mental health among the minority groups and decreases the chances of seeking medical attention among the marginalized groups. Systemic disparities based on racial and ethnic differences have also played a detrimental role in influencing health change at the institutional and community level. For instance, racial discrimination in access to employment affects the ability to access quality housing, health insurance, and basic amenities. Differential resource allocation at the community level, such as increased waste disposal in communities occupied by minority groups increased health risks to such communities.

Finally, determinants of health such as poor living conditions, access to education, and socioeconomic disparities have played a detrimental role in influencing health outcomes across ethnic groups. According to Mathews (2015), there is a strong correlation between socioeconomic status and health outcomes. Socioeconomic status affects health, where minority

groups are at a disadvantage due to the prevalent high unemployment rate, high poverty level, poor housing, and low access to basic needs such as clean drinking water, balanced diet, and sanitation. Further, some minority ethnic groups live in geographical areas with limited access to healthcare facilities, while the poor socioeconomic factors limit most of the minority groups from getting health insurance coverage for better health care.

Policy suggestion

Addressing the issue of racial and ethnic disparities to achieve improved health outcomes is a sensitive and complex issue that involves individual, community, and institutional engagement. For instance, individual perceptions rooted in ethnic bias can be difficult to address. However, health systems can work to improve health outcomes across all groups of people by making the inclusion and diversity policies that govern health care a mandatory practice across the health care system. Jankelová et al. (2020) highlight that one way of improving health care outcomes is through the creation of a culture that embraces the diversity of the workforce and the patients and promotes an environment that accommodates people of diverse affiliation, may it be ethnic, cultural, socioeconomic status, and gender affiliations. Diversity and inclusion is a multifaceted concept that involves utilizing a collaborative approach to improve health outcomes. As noted earlier, some patients may file to access health services due to fear of racial discrimination, language barrier, religious and cultural beliefs, and out of the perception that only a healthcare provider from the same ethnic group can understand their health issues. Thus, implementing mandatory policies that promote diversity can help in bridging the gap created by racial and ethnic inequality.

According to Grant et al. (2013), a diverse workforce promotes a holistic approach to decision-making and the provision of health care services. A holistic approach includes the adoption of a coherent and collaborative approach in the research and decision-making process. The approach also encourages collaboration with communities to identify problems that different communities are facing and highlights ways to resolve such issues to improve health quality. Furthermore, a diverse healthcare facility is able to effectively provide services to people from different ethnic and racial groups, especially resulting in reduced language barriers which are among the major hindrances to quality care. Research also shows that some patients are more comfortable when they are attended by the healthcare providers from similar racial/ethnic groups. Finally, creating a diverse workforce makes it possible for the health care providers to understand major health problems affecting different ethnic groups and come up with strategic approaches to address the highlighted issues. For instance, a workforce with African American practitioners can get more insights into the hindsight biases that might contribute to mental problems and lifestyle health issues among the African American population (Chauhan et al., 2020). Further, diversity promotes a community-based participatory approach in conducting research that demolished racism and promote targeted intervention programs. According to Woolf and Purnell (2016), the community-based participatory approach makes it easy for public health professionals to infiltrate marginalized communities to provide health care services such as community education, immunization, and screening without getting much resistance.

One of the processes of implementing inclusion and diversity policy is ensuring the existence of a standardized management protocol. According to Leotsakos et al. (2014), standardized protocols include evidence-based guidelines that provide a practical framework for handling patients, decision-making, and provision of algorithms for treatment in critical care.

Unfortunately, one of the challenges of improving health outcomes is the failure to provide standardized evidence-based interventions in hospitals, across different healthcare facilities, and different ethnic and cultural groups. Variations in health provisions have a significant impact on the anticipated outcomes. Such variations can be affected by ethnic and cultural biases, sociocultural differences, language barriers, and historical discrimination that create biases and resistance among the patients (Harris et al. 2013). Thus, having a standardized protocol that includes having a diverse interdisciplinary team for handling diverse patients can help in promoting health care equity, thus reducing ethnic-based healthcare disparity. Healthcare protocols enhance communication between health providers, facilitate the use of evidence-based practices in addressing community intervention programs, and reduce treatment uncertainty that may be caused by issues such as ethnic and racial biases. For instance, having a standardized protocol that controls the health care system ensures an equal distribution of resources and services across different groups of people. Further, the policy should include training programs on inclusion and diversity. Training the healthcare workforce on the diverse culture helps in mitigating ethnic bias and myths that could affect quality of care (Woolf and Punnell, 2016).

Perceived benefits

Inclusion and diversity approach in healthcare has several benefits other than reducing disparities in health care provision across diverse ethnic groups. According to Grant et al. (2013), inclusion and diversity programs promote a holistic evidence-based approach that results in increased health outcomes. Success is achieved through a multifactorial approach that promotes combined efforts between health practitioners from diverse ethnic groups in making targeted decisions. Such a collaborative approach enables organizations to develop stretch plans to monitor health outcomes for different population groups and come up with objective goals that

can be used to bridge the historical gaps in racial and ethnic health disparities. Also, implementing a policy that fosters a diverse workforce reduces instances of resistance and complaints by the patients.

Furthermore, inclusive-based evidence-based plans result in reduced healthcare costs. A report by Healthy People 2020 indicates that the increased cost of health care is one of the major determinants of health that has affected people from marginalized groups. Health care costs can increase as a result of factors such as getting informal translation devices, prolonged consultation hours as a result of language barrier or resistance from the patient, among other factors, however, with a diverse workforce; there is a streamlined service, as the patients get services from a provider of their choice.

Conclusion

This analysis indicates a strong relationship between health outcomes and ethnicity. The analysis indicates substantial disparities in healthcare outcomes between minority and majority ethnic communities. Factors such as differences in socioeconomic aspects, historical ethnic disparities, and cultural factors have contributed to the disparities. However, in addressing the existing inequalities based on racial and ethnic differences, the paper recommends a mandatory health policy that will promote inclusion and diversity across the health system. Inclusion and diversity policy will aid in creating an interdisciplinary workforce that will provide diverse health care services to cater to the needs of patients from diverse cultural and ethnic backgrounds. A diverse culture will also promote an evidence-based approach in community research and implementation of community-based intervention programs to address various determinants of health that limit health outcomes across populations.

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