

Health Disparities In African American Population

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Health Disparities Among African Americans

Health disparity refers to any form of inequality that may be experienced in access to healthcare or provision of healthcare across different ethnic, racial and socioeconomic groups. Among ethnic and racial minorities in the US, health disparities are a known problem, especially for African Americans, Native Americans, Asian Americans, and Latinos. There are several reasons behind the formation of these disparities, including poverty, poor healthcare access, inadequate level of education, exposure to environmental problems, and behavioural and individual factors. The paper seeks to critically study the available research that discusses health disparity experienced by the African American population in particular and analyses the causes and factors presented by different studies to ascertain the accuracy of the findings. The overall findings of the research, as well as personal experiences, agree with the assertion that the US suffers from racialized access to healthcare, supported by other socio-economic factors, which becomes a source of the disparity witnessed in the statistics.

Socioeconomic Status Race and Disease Patterns

According to a study done by Chiquita Collins and David R. Williams (1995), to explain, pattern research has been done that states that the differences in health arise due to socioeconomics and racial status (Collins, 1995). To map patterns of the social distribution of disease over time, several reviews have been done to calculate statistics and compare results from various studies. Imbalance in health occurs due to social structures and procedures such as work, racism, childhood SES, migration, and acculturation. Different economic signs show the decreased economic rank of African Americans. The rise in black-and-white discrimination and reduction in black economic welfare is linked with unsatisfactory black health over some health rank indicators. In addition, black migration was unequally distributed, whereas poor white urban areas were scattered all over the city. This alienation leads them to consumption of more alcohol and tobacco. There are three ways by which racism can affect, firstly it can bind the approach to the quality and quantity of health-related irresistible services. Secondly, it can change social rank, such as SES indicators are unequal across the human race. Thirdly, this type of discrimination can produce psychological stress, which can affect mental and physical health. The study also discusses that Biological reasons can easily distract attention from ongoing policies and societal arrangements that shape the health ranks of population groups (Collins, 1995). One of the restrictions this study imposes is that, however, SES tend to be associated with health results. Whichever indicators are used, all SES measure has their group of limitations and

advantages. Moreover, the study depends on other data sources, which should be recovered with primary studies to reinforce results. This study uses the sociological approach, which is a plus point that provides a useful understanding of the map it develops.

Social Environment and Chronic Health Conditions

In another study, the author (Collins O. Airhihenbuwa, 2006) asserts that eliminating disparities in health between white populations and African Americans in the US requires focused improvement in the social environment of Black populations. The chronic conditions that exist in the social environment are causes of the health disparities that have been the subject of the analysis. To start with, residential neighbourhoods in suburban and urban communities across the US continually showcase patterns of historical race segregation (Collins O. Airhihenbuwa, 2006). Relevant literature that spanned multiple areas, such as gender, power, and culture, as well as racism and identity, was reviewed in the study and applied to the translation and dissemination of context-based interventions, promising practices, and vital research on health disparities. In the study, cultural observations also raised critical points in the discourse that surrounded health disparity elimination and suggested that how the solutions are framed for a problem is not necessarily according to how a problem is defined. Adding to that the research also examines the influence of the intersection of gender and race on health conditions in the US, for instance, it compares heart disease rates in African American men is 1.5 times greater than African American women and twice as greater than White men (Collins O. Airhihenbuwa, 2006). The study also reviews how institutionalized racism acts structurally on internalized identities, actions, and possibilities for African Americans, marking the relevance of race in determining health disparities. The study is compelling in the sense that it critically approaches the solutions to the problem by suggesting how an issue within a racial frame does not necessarily require a solution within that same frame, the solution may lie elsewhere such as in ethnic and cultural frames within which the community lives in. Some limitations of the study were over how gender constructs align with those structural forces that affect health disparities within communities.

Residential Segregation and Healthcare Access

Another useful study in this regard researches the effects of residential segregation in leading to racial disparities in access to healthcare (David R. Williams, 2001). The author considers segregation in residential areas to be one of the fundamental causes and reviews evidence that demonstrates how the [socioeconomic status](#) of SES is affected by segregation, which leads to a disparity in employment and education opportunities. The study argues that highly segregated high schools or elementary schools affect SES, which in turn leads to health disparity. A skills mismatch has also been created in urban area jobs where the training and skills needed are not found as much in African Americans. Additionally, segregation left blacks isolated from social networks and role models of stable employment, which provided useful leads to finding potential employment opportunities. Those cultural responses that deteriorate commitment to values and norms are also an essential factor. The

study also accounts for a range of pathogenic residential conditions that can adversely affect health due to the segregation of communities. Poor housing conditions, as well as the quality of housing, also adversely affect health, and raised costs of groceries and commonly consumed items lead to poor nutrition, which the author argues leads to health disparities (David R. Williams, 2001). The study's conclusion points toward effective efforts that need to confront segregation to eliminate racial health disparities and its pervasive consequences. Some multivariate analytic models that are theoretically driven could further identify how social and physical environment characteristics relate to one another in combination with individual characteristics and predispositions to influence health in interactive and additive ways.

Poverty and Mental Health Service Utilization

Racial and ethnic disparities in mental health service access have been studied at different poverty levels in research (Julian Chun-Chung Chow, 2003), that compares clinical and demographic characteristics as well as service use patterns of Blacks, Asians, Whites, and Hispanics in high poverty and low poverty areas. The study incorporated the use of logistic regression models to assess patterns of service use of different races in various poverty areas. It showed that in a poor neighbourhood, the residence moderates the relationship between mental health service use and access and ethnicity/race. The study samples were obtained from New York City to assess whether racial disparities vary with different poverty levels according to residence (Julian Chun-Chung Chow, 2003). The 'New York State Office of Mental Health Patient Characteristic Survey data was collected by state and local programs funded by the 'New York State Office of Mental Health.' It found that compared to Whites, Black people were more likely to be referred by the criminal justice system or social service agencies to mental health services than Whites, as compared to being referred by family, themselves, or friends. Some limitations in the research occur as it did not incorporate research on minority children's patterns of entry, as well as some cultural factors such as stereotyping and stigmatization that could provide a broader indication.

Perceptions of Racial Disparity in Healthcare

Another study used in this regard uses a different angle to examine racial health disparity. It critically investigates and differentiates between the personal understanding of racial disparity and racial differences in healthcare (Paul L. Hebert, 2008). It is argued that since a disparity is not measured directly but as a difference or residual between two groups, there is a problem in ascertaining when a difference becomes a disparity and requires consideration of other factors that may contribute to the differences observed. Some facts regarding a person may be inalterable, such as age, which affects age without having any causal relationship to race. He further argues that choices that are unconstrained and informed should also not be considered a contributive factor in racial disparity. There are faint lines that often separate a choice strongly affected by the environment from one that is unconstrained. An example presented is that doctors may hold some forms of stereotypes or bias

that relate to a racial minority patient's inability to convey symptoms accurately for the doctor to interpret or with regards to their health-related behaviour that may not be malicious. The subject, however, may find this to be related causally to race and imposed without his or her consent or knowledge and, therefore, racially unjust. There is a further possibility that in literature, many actual disparities do not get adequately reported because of the assumption of researchers that a particular racial disparity may not exist until it is significantly witnessed as a factor in statistical models (Paul L. Hebert, 2008). Overall, this research pointed out many factors that are necessary to make inferences regarding health disparity, which may have been ignored in some studies.

Collaborative Strategies for Health Equity

Today, researchers, clinicians, public health practitioners, community stakeholders, and social services should work together to develop approaches that are effective in improving healthcare conditions for all Americans. It requires concerted efforts to address the plethora of environmental and social contextual barriers faced by the African American population, as well as the high burden of traditional health risks among this population. Further nuanced studies in this regard should be conducted to critically approach the issue from a holistic perspective to understand the sociological, socioeconomic, or biological factors that may be contributing to racial health disparities.

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