Racial and Ethnic Health Disparities among Women In the United States.

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Over the last decade, the issue of racial health disparities has become one of the most pressing problems pressing this nation's health care system. It has been proven through several studies that racial and ethnic minorities, compared to whites, often have less access to health care, receive lower-quality health care, and have higher rates of illness, injury, and premature death.

The problem of health disparities has led the U.S. Department of Health and Human Services to establish the elimination of health disparities by 2010 as a national goal and has inspired members of Congress to introduce legislation to help achieve that goal.

However, the recent threats to public health programs such as Medicaid and SCHIP (the State Children's Health Insurance Program), the increasing numbers of people without health insurance coverage, the persistently disproportionate prevalence and incidence of chronic diseases and

conditions among racial and ethnic minorities make reducing and ultimately eliminating these health disparities very challenging.

The term “health disparities” is an umbrella term that includes disparities in health and disparities in health care. Although these terms are often used interchangeably, they are two different concepts:

Disparities in health:

Refer to differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death.

Disparities in health care:

Refer to the differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services.

It is most important to understand each of these concepts because different factors contribute to each. These factors, however, are interrelated. For example, personal behavior and decisions about health, environmental

factors, and genetics are factors that are known to contribute to disparities in health.

Studies have also found that factors such as discrimination bias, language barriers, and preferences about health care practices contribute to disparities in health care. When individuals have reliable, consistent access to health care, they have greater access to health monitoring and are more likely to receive screenings, timely diagnoses, and appropriate treatment of chronic diseases and conditions. However, racial and ethnic minorities are disproportionately more likely than whites to be underinsured or to lack health insurance coverage altogether. For example, although racial and ethnic minorities constitute one third of the total U.S. population, they comprise more than one half (52 percent) of the insured population.

Dr. Martin Luther King Jr. famously wrote in his “Letter from Birmingham Jail” that “Justice too long delayed is justice denied.”

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

Life expectancy for women has nearly doubled over the past 100 years, from 487 in 1900 to 79.5 in 2000. Yet, minority women continue to lag about 5

years behind white women in life expectancy. For example, in the year 2000 white women could expect to live to the age of 80 compared with 74.9 for black women. Minority women continue to fair worse than white women in terms of:

- Health status
- Rates of disability and
- Mortality

For some conditions, the disparities are growing despite new technologies and other advancements that have been made in recent years. For example, about one black women in four over 55 years of age has diabetes.

The prevalence of diabetes is at least two to four times as high among Blacks, Hispanics, American Indians, and Asian Pacific Islander women as it is among white women.

Breast Cancer mortality has been declining among U.S. women since 1990, but the decline has been much greater among white women than black women. Although breast cancer death rates are falling, the incidence of new breast cancer continues to rise. Blacks and poor people are much more likely than whites and more affluent people to die from cancer. Breast

screening is less common in counties that have many uninsured women. Breast screening declined significantly for women earning $25,000 to $75,000 with high rates of uninsured. Black women and Hispanic women had higher screening rates with low rates of uninsured. Cost sharing and in mammography is a major concern among black women and women with lower incomes and education levels. Often they are not cover by health plans and are required to share the cost. (Co-pay)

The lack of health insurance is a barrier to receiving services. Compared with White women, black women are twice as likely, and Hispanic women are nearly three times as likely to be uninsured. Furthermore, Blacks and Hispanics are more likely than Whites to lack a usual source of care and to encounter other difficulties in obtaining needed care.

According to the center of Disease Control and Prevention, a patient's self assessment of health is a reliable indicator of health and well being. When asked about their health status, minorities are more likely than whites to characterize their health status as "fair".

Nearly 17% of Hispanic women and more than 15% of Black women say they are in fair or poor health, compared with 11% of white women.

Other findings are:

- Heart disease death rates are more than 40% higher for African Americans than Whites.
- The death rate for all cancer is 30% higher for African Americans than for Whites.
- African American Women have a higher death rate from breast cancer despite having a mammogram screening rate that is nearly the same rate for white women.
- The death rate from HIV/Aids for African Americans is more than seven times than of whites. In fact, HIV/ Aids is now the leading cause of death for African Women ages, 25-34.

Hispanics living in the US are almost twice as likely to die from diabetes as are non Hispanics whites. Although constituting only 11% of the total population in 1996, Hispanics accounted for 20% of the new cases of tuberculosis. Hispanics also have higher rates of high blood pressure and obesity than non – Hispanics whites.

There are differences among Hispanics population as well. For example, whereas the rate of low birth weight infants is lower for the total Hispanic

population compared with that of whites, Puerto Ricans have a low birth weight rate that is 50% higher than the rate for whites.

American Indians and Alaska Natives have an infant death rate almost double that for whites. The rate if diabetes for this population group is more than twice that for whites. The Pima of Arizona have one of the highest rates of diabetes in the world.

American Indians and Alaska Natives also have disproportionately high death rates from unintentional injuries and suicide.

Asian and Pacific Islanders, on average have indicators of being among the healthiest population groups in the U.S. However, there is great diversity within this population group and health disparities for some specific segments are quite marked, for example, women of Vietnamese origin are nearly 5 times the rate of white women.

Health care is a basic human right for all persons. Providing the care needed to maintain health, prevent disease, and restore health after injury or illness is a responsibility each person owes others. In Ezekiel 34:4a, God points out

the failures of the leadership of Israel to care for the weak: “You have not strengthened the weak; you have not healed the sick. You have not bound up the injured.” As a result, all suffered.

It is unjust to construct or perpetuate barriers to the physical or mental wholeness for any of God’s children whether they are red, yellow, brown, black or white. We must eliminate health disparities among the different segments of our population.