Health disparities

Health & Medicine

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The National Center for Health Statistics has identified that racial and ethnic minorities experience higher rates of mortality and morbidity than non-minorities in the United States. In this context, the minority population includes African American, Asian subgroups, Native Americans and more recently, Hispanics. In spite of the general improvement of health condition of all American racial and ethnic groups, it is worth noting that the paired burden of decreased life expectancy and excess morbidity rate, within minority groups, has been noted over the last centuries, and has currently been identified as one of the major constrains to transformations in public health nursing. For example, health statistics indicate that African Americans experience the highest mortality rates from cerebrovascular disease, HIV/AIDS, cancer and heart disease more than any other racial or ethnic group in the United States (Stanhope & Lancaster, 2012). Most of the American Indians die from unintentional injuries, cirrhosis, liver disease and diabetes. The reasons for these health disparities among racial and ethnic groups is complex and clearly not understood, but they largely relate to socioeconomic differences, environmental degradation, differences in health-related risk factors, and direct and indirect impacts of racial and ethnic discrimination (Stanhope & Lancaster, 2012). This paper, therefore, reflects on two articles and establishes whether the information and data presented hold true in addressing health disparities among racial and ethnic groups in the U. S., and further recommends solutions to practices or beliefs that seem to support these biased patterns.

Jack Geiger, in his article “ Racial and ethnic disparities in diagnosis and treatment: a review of the evidence and a consideration of causes,”

reviewed a number of researched works addressing health disparities issues in the United States. He established that the fundamental explanations of disparities and the key determinants of population health status among American racial and ethnic groups lie in physical, social, and economic environment, which are, in turn, influenced by the larger society's values, norms, political economy, and social stratification systems (Geiger, 2003). He further identifies that the two variables that most studies frequently cited as the leading cause of disparities reflected beliefs and values which are common in the larger society. The first is biological differences (racial) as a significant contributor to health disparities. I agree with the author that, in spite of the current understanding of race as a social concept, the notion of the significance of racial grouping, in terms of medical grounds, continues to appear even in the current societies. The second cause is racial and ethnic discrimination itself. As a practicing nurse, I agree with the author that cases of biases among health providers exist in many health institutions. Smedley, Stith and Nelson in " Unequal treatment: confronting racial and ethnic disparities in health care" identify that racial and ethnic minorities usually receive lower intensity and quality of healthcare and other diagnostic services across a number of disease areas and medical procedures (Smedley, Stith, & Nelson, 2003). They associate these disparities with an individual's insurance status, quality of care received and the characteristics of healthcare providers. I agree with the authors that people who are privately insured usually receive a higher quality of care than those who are publicly funded. Additionally, the minority groups usually have lower access to specialty care than whites who are mostly treated in health settings that provide high-technology procedures.

In combating health disparities identified and described in the two articles, I recommend that both federal and state governments should try to increase the number of minority physicians, both in public and private hospitals, to reflect the diversity of the U. S. population. Physicians should also be educated on how to manage health literacy among patients. Finally, state governments should enhance the use of physician’s non-English language skills in clinical settings (Barr, 2008). These will endure that quality healthcare is provided to all Americans irrespective of their racial or ethnic backgrounds.

References

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