

## Race, Ethnicity, Class and Culture

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Closing the Gap, The U.S. and U.K. Collaborate on Minority Health • March 1998

Several studies have shown that the highest rates of poverty are concentrated among the same U.S. subgroups of non-White people who are also those with disproportionately worse health status. This health status of racial and ethnic minorities in the U.S. is a function of the very structure of the U.S. society. In this structure, racism and economic inequality are institutionalized.

The result of this stratification is that greater deprivations accrue to those who are poor and non-White. This is true in every arena—material, emotional, psychological, and of every commodity: health, education, and political and economic power.

The health care delivery system is no different than all other components of the U.S. social structure in terms of its reaction to race and class. In fact, health care in the U.S. is a multi-billion dollar industry that, in and of itself, is reflective of race and class divisions within society.

In each component of the industry, there are very powerful interest groups, each with their own paid lobbyists, who are constantly at work to protect the industry's dominance in the health care marketplace.

Within this context, access to regular, ongoing primary health care in the U.S. is contingent upon the possession of health insurance, whether public or private, which is directly connected to one's employment or lack thereof. This is a problem for significant numbers of minorities who tend to have higher rates of unemployment. Eligibility for Medicaid, the public insurance available to the poor, is based on stringent guidelines for means testing, which have now become even more rigorous as a result of welfare reform.

The situation leaves large numbers without health insurance. Estimated to be anywhere from 40 to 75 million, the uninsured are actually two groups: the never insured and the sometimes insured. The latter group are the working poor whose low-income jobs customarily do not provide health benefits nor pay enough to purchase private insurance.

U.S. health care delivery and policy targeting minorities has historically employed two opposing but similar approaches in terms of outcome. In one approach, the importance of race is downplayed or negated in health analysis. In the other approach, the claim is made that minorities experience poor health and premature death because of pathological behavior that includes a choice to smoke, drink heavily, consume the wrong foods, engage in unprotected sex and violent behavior, and lead sedentary lifestyles.

This latter approach, known as “blaming the victim,” is reminiscent of earlier justifications used to defend health care policies that denied health care to Blacks during a time when racism was sanctioned by law throughout a majority of states in the Union. People thought that minorities were dying, so a commitment to care for them would be wasted. Unfortunately, variations of this argument continue to undergird minority health policy today. There are assumptions that individuals alone can control their health destiny without consideration of their economic capacity to do so, or the availability, cultural compatibility, or accessibility of health care services.

It is important to note that this connection between health status, race and ethnicity, and socioeconomic status is not unique to the United States. This is a global condition that is well documented in the international health literature. The National Health Service (NHS) in the U.K. was designed largely to serve a homogeneous White population. So though the U.K. has a system of universal health access, minorities there—as is the case for minorities in the U.S.—do not always receive culturally and linguistically appropriate care.

Both the U.S. and the U.K. are aware that any improvement in the health status of racial and ethnic minorities must flow from a strong research agenda. To deliver effective primary care services to the entire population of both countries, we must first acknowledge some critical factors. One is that given what we now know about the progressive nature of health deterioration over time and how this is influenced by behavior change, we must recognize that medicine has failed us in terms of its ability to help us change behavior. This is not to detract from the amazing life-saving technological advancements over the last 50 years. But the challenge of both countries is how to best bring about behavioral change, considering the extent to which health behavior and practices are influenced by culture.

In many ways, the development of primary care as a national health services delivery strategy that meets the needs of everyone demands a new kind of research—one that is population driven. Research and needs assessments of minority communities must be conducted using totally new paradigms. The community must be involved in planning the research. Community members must be trained to serve as point persons in data collection, as they are much more likely to obtain data that is accurate than the outside researcher. And as data is analyzed, minority groups being studied must help interpret data. This type of research is beneficial because health education flows in two directions rather than one. ❖

