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The Risks of Race in Addressing Health Disparities

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There are undeniable differences among population groups in the incidence, prevalence, mortality, and social burden of serious diseases. However, some ways of representing the problem of health disparities may have unintended and unfortunate consequences. In particular, how we think about “race” and “ethnicity” carries grave risks.

Science and medical researchers often accept racial and ethnic categories as demographic truth, and they rarely parse the various ways these concepts are understood either in everyday speech or in scientific contexts. The medical scientific literature posits “race” and “ethnicity” as causal factors in a range of population differences: in access to health services, in the different effects of a given drug, in the presence of risk factors like hypertension, in behavior (think of “race and diet”), and in genetic susceptibility to disease. And now a pharmaceutical product’s viability can be assessed on the basis of demographic considerations that really only reflect marketing strategies (as happened with BiDil), not scientific knowledge of “racial” differences in drug metabolism.

“Race” is mostly misused and misunderstood.

Obviously, if some people have a higher risk of coronary heart disease, then they need special medical attention, and we should support the production of pharmaceuticals or other interventions to treat them. But the groups apparently most at risk are also least studied. For this reason, it is not clear that differences in rates and outcomes are truly due to “race” rather than to environmental conditions and social context that have physiologic ramifications.

Undoubtedly, there will be reasonable opportunities to use racial and ethnic categories, but the categories should be analyzed in a more integrated way than they have been. For example, variations in some portions of DNA called “microsatellites” are conserved down through generations and so may be useful intermediate biomarkers of geographic ancestry. Because these segments are “junk DNA” that don’t code for proteins, however, they have no influence on physiological traits, and therefore have no bearing on differential rates of disease and say nothing about differences between “races.” Yet people continue to misinterpret them as evidence of “racial differences.”

The picture is bad as well when we turn from the medical scientific domain to social and behavioral research, where terms like “race” and “ethnicity” and labels like “cultural” often still reflect unexamined assumptions about blame and responsibility, the locus of agency, and social causality. Some initiatives in “cultural competency” or “cultural literacy,” for example, seem to suggest that only some groups have “culture,” and having culture becomes an obstacle to the receipt of good care.

In fact, what we know is that different groups are treated differently when they seek health care, and that this results in poorer health outcomes. We also know we usually aren’t good at helping patients navigate the health care system, although some recent efforts, like “patient navigator initiatives,” offer hope that we can get better.

There are other signs of change. Population scientists increasingly recognize how assumptions about “race” and “ethnicity” are promoted by social phenomena like the categories used in

population survey instruments, journal publication guidelines, and the editorial review of research. Further, since neither researchers nor respondents are always certain how ethnicity may be distinguished from race in a survey instrument, researchers have begun to change how surveys are designed and analyzed and how the data is weighted. Scientists doing research on “biobehavior” processes—such as the psychoneurology of immune system response—are increasingly likely to consider the context of family or community across the life cycle. And recent support from funding agencies for “community-based participatory research” is a significant step toward getting community stakeholders involved in research design and implementation.

These developments will help refine our concepts of human variation in the science of medicine and public health. Amidst all the discussion of ever-shrinking resources, a narrow identity politics that encourages internecine struggles among populations only obstructs efforts to truly reduce health disparities.