DOWNLOAD PDF RACIAL AND ETHNIC CHASMS

Chapter 1 : Saudi Arabiaâ€™s Race Problem | Afro

The traditional definition of race and ethnicity is related to biological and sociological factors respectively. Race refers to a person's physical characteristics, such as bone structure and skin, hair, or eye color. Ethnicity, however, refers to cultural factors, including nationality, regional.

Pinterest My first visit to the Middle East was a spiritual and social learning experience. It highlighted the differences in our cultures as well as the commonality of the human experience. I cried viewing the majesty of Masjid Al-Haram in Mecca, smiled while dancing with children with special needs in Jeddah, and laughed at myself when I finally figured out what the water hoses were for in the bathroom stalls. As a part of a group of American hip-hop artists sponsored by the Department of State, I got the opportunity to share ideas with young Saudis throughout the country. One thing that surprised me was many acknowledged a race problem in their country. Jason Nichols The Saudis are a kind and gracious people, but have many areas in which they need to evolve. The opportunities for women and gays are limited and its justice system can be extremely harsh. In addition, they are involved in a deadly proxy war with Iran in Yemen which has claimed countless lives and displaced over 3 million people. I arrived in the capital city of Riyadh with this understanding. However, what first surprised me when I entered the U. I was taken aback. However, when I visited KSA, the people told a different story. They were looked down upon because the ethnic Saudis would say they came for Hajj and did not have the money or resources to return home. We visited an economically depressed neighborhood in Jeddah and played soccer with the children there. As an African American, I did not look out of place among the people in that community, the majority of which were Somalis, Sudanese, Eritreans, Nigerians, and Senegalese. Needless to say, this places an inordinate amount of power in the hands of employers to potentially exploit workers by preventing them from changing jobs, forcing them to work, and taking their passports so they are unable to leave. Saudi King Salman appears to want to bridge the racial and ethnic chasm in his country and has pledged to bring unity to the country. We are home to ICE raids on immigrant families, a broken immigration system, rhetoric of building walls between our nation and our neighbors, and a disproportionate amount of people of color in our prison system. I saw very few interethnic marriages, and the communities had an element of segregation in KSA. Many of the working class laborers were non-Saudi. However, among the youth that I encountered few were so disillusioned to identify as anything other than Saudi. As the Middle East opens up to western traditions, I believe a major voice for socially conscientious hip-hop could very well come out of that region, Continental Africa, or the Indian Subcontinent. However, for many, their favorite rapper was still Tupac. They identified with the pain and passion in his voice, which requires no translator and can only come from the sting of social marginalization and struggle. The fact that you can encounter racism, poverty and segregation in what is the holiest region in the world to 1.

Chapter 2 : EXECUTIVE SUMMARY - Unequal Treatment - NCBI Bookshelf

BERKELEY - Angered by the negative portrayal of their school, student leaders of ethnic groups at Berkeley High have rallied in response to "School Colors," a PBS documentary that showed students.

German warning in occupied Poland â€" "No entrance for Poles! Slavic , origin were not allowed to join some guilds. At first the laws were aimed primarily at Jews but were later extended to "Gypsies, Negroes and their bastard offspring". Jewish doctors were not allowed to treat Aryan patients nor were Jewish professors permitted to teach Aryan pupils. In addition, Jews were not allowed to use any public transportation, besides the ferry, and were able to shop only from 3â€"5 pm in Jewish stores. Women behind the barbed wire fence of the Lvov Ghetto in occupied Poland. Spring Jews and Roma were subjected to genocide as "undesirable" racial groups in the Holocaust. The Nazis established ghettos to confine Jews and sometimes Romas into tightly packed areas of the cities of Eastern Europe, turning them into de facto concentration camps. The Warsaw Ghetto was the largest of these ghettos, with , people. While the treatment of factory workers or farm hands often varied depending on the individual employer, Polish laborers as a rule were compelled to work longer hours for lower wages than Western Europeans â€" in many cities, they were forced to live in segregated barracks behind barbed wire. Social relations with Germans outside work were forbidden, and sexual relations Rassenschande or "racial defilement" were punishable by death. In the Tang dynasty issued an edict which forced Uighurs to wear their ethnic dress, stopped them from marrying Chinese females, and banned them from pretending to be Chinese. Chinese disliked Uighurs because they practiced usury. The magistrate who issued the orders may have wanted to protect "purity" in Chinese custom. In , when Lu Chun was appointed as governor of Canton, he was disgusted to find Chinese living with foreigners and intermarriage between Chinese and foreigners. Lu enforced separation, banning interracial marriages, and made it illegal for foreigners to own property. Lu Chun believed his principles were just and upright. Eight Banners The Qing Dynasty was founded not by the Han Chinese who form the majority of the Chinese population, but the Manchus, who are today an ethnic minority of China. The Manchus were keenly aware of their minority status, however, it was only later in the dynasty that they banned intermarriage. Han defectors played a massive role in the Qing conquest of China. Han Chinese Generals who defected to the Manchu were often given women from the Imperial Aisin Gioro family in marriage while the ordinary soldiers who defected were given non-royal Manchu women as wives. Han Bannermen were made out of Han Chinese who defected to the Qing up to and joined the Eight Banners, giving them social and legal privileges in addition to being acculturated to Manchu culture. This ethnic segregation had cultural and economic reasons: Han Chinese civilians and Mongol civilians were banned from settling in Manchuria. Ordinary Mongol civilians in Inner Mongolia were banned from even crossing into other Mongol Banners. A banner in Inner Mongolia was an administrative division and not related to the Mongol Bannermen in the Eight Banners These restrictions did not apply Han Bannermen , who were settled in Manchuria by the Qing. Han bannermen were differentiated from Han civilians by the Qing and treated differently. The policy of segregation applied directly to the banner garrisons, most of which occupied a separate walled zone within the cities in which they were stationed. While the Manchus followed the governmental structure of the preceding Ming dynasty , their ethnic policy dictated that appointments were split between Manchu noblemen and Han Chinese civilian officials who had passed the highest levels of the state examinations , and because of the small number of Manchus, this insured that a large fraction of them would be government officials. Italy[edit] In , the fascist regime led by Benito Mussolini , under pressure from the Nazis, introduced a series of Italian Racial Laws instituting an official segregationist policy in the Italian Empire , especially aimed against Jews. This policy enforced various segregationist norms, like the prohibition for Jews to teach or study in ordinary schools and universities, to own industries reputed of major national interest, to work as journalists, to enter the military, and to wed non-Jews. Rita Levi-Montalcini , who would successively win the Nobel Prize for Medicine , was forbidden to work at the university. Albert Einstein , upon approval of the racial law, resigned from honorary membership of the Accademia dei Lincei. Jewish segregation[edit] Jews in Europe generally were forced, by decree or by

informal pressure, to live in highly segregated ghettos and shtetls. Jewish population were confined to mellahs in Morocco beginning from the 15th century. In cities, a mellah was surrounded by a wall with a fortified gateway. In contrast, rural mellahs were separate villages inhabited solely by the Jews. Benjamin wrote about the life of Persian Jews: The passers-by spit in his face, and sometimes beat himâ€¦ unmercifullyâ€¦ If a Jew enters a shop for anything, he is forbidden to inspect the goodsâ€¦ Should his hand incautiously touch the goods, he must take them at any price the seller chooses to ask for them Sometimes the Persians intrude into the dwellings of the Jews and take possession of whatever please them. Should the owner make the least opposition in defense of his property, he incurs the danger of atoning for it with his life An extensive nomenclature developed, including the familiar terms " mulatto ", " mestizo ", and " zambo " the latter the origin of " sambo ". The Spanish had practiced a form of caste system in Hispania before their expulsion of the Jews and Muslims. Furthermore, he claimed that this segregation "created a precedent. This new order also failed to win legitimacy in the eyes of the world, and British control returned to the country in December , following the Lancaster House Agreement. New elections were held in , and Zimbabwe gained recognized independence in April , with Robert Mugabe as prime minister. Laws enforcing segregation had been around before , although many institutions simply ignored them. One highly publicized legal battle occurred in involving the opening of a new theatre that was to be open to all races; the proposed unsegregated public toilets at the newly built Reps Theatre in caused an argument called "The Battle of the Toilets". Apartheid " Apartheid ": Apartheid laws can be generally divided into following acts. Firstly, the Population Registration Act in classified residents in South Africa into four racial groups: Secondly, the Group Areas Act in assigned different regions according to different races. People were forced to live in their corresponding regions and the action of passing the boundaries without a permit was made illegal, extending pass laws that had already curtailed black movement. Thirdly, under the Reservation of Separate Amenities Act in , amenities in public areas, like hospitals, universities and parks, were labeled separately according to particular races. Additionally, the government of the time enforced the pass laws , which deprived black South Africans of their right to travel freely within their own country. Under this system black people were severely restricted from urban areas, requiring authorisation from a white employer to enter. Uprisings and protests against apartheid appeared immediately when apartheid arose. As early as , the youth wing of the African National Congress ANC advocated the ending of apartheid and suggested fighting against racial segregation by various methods. His success fulfilled the ending of apartheid in South African history. After Jim Crow laws were passed that segregated African Americans and Whites, the lives of those who were negatively affected saw no progress in their quest for equality. Racial segregation was not a new phenomenon, as almost four million blacks had been slaves before the Civil War. Signs were used to show non whites where they could legally walk, talk, drink, rest, or eat. Though many such laws were instituted shortly after fighting ended, they only became formalized after the end of the Reconstruction period. The period that followed is known as the nadir of American race relations. The legislation or in some states, such as Florida, the state constitutions that mandated segregation lasted at least until Brown v. Board of Education An African-American man goes into the "colored" entrance of a movie theater in Belzoni, Mississippi , Supreme Court majority in the Plessy v. Ferguson case explicitly permitted " separate but equal " facilities specifically, transportation facilities , Justice John Marshall Harlan , in his dissent , protested that the decision was an expression of white supremacy ; he predicted that segregation would "stimulate aggressions â€¦ upon the admitted rights of colored citizens," "arouse race hate," and "perpetuate a feeling of distrust between [the] races. Feelings between whites and blacks were so tense, even the jails were segregated. Black soldiers were often poorly trained and equipped, and were often put on the frontlines in suicide missions. The air force and the marines had no blacks enlisted in their ranks. There were blacks in the Navy Seabees. The army had only five African-American officers. Black soldiers had to sometimes give up their seats in trains to the Nazi prisoners of war. In Martin Luther King Jr. Augustine, Florida American sports were racially segregated until the mid-twentieth century. In baseball, the "Negro leagues" were established by Rube Foster for non-white players, such as Negro league baseball , which ran through the early s. Racial segregation in basketball lasted until , when the NBA became racially integrated. Detroit , In the reception to honor his Olympic success Jesse Owens was not permitted to enter through the

main doors of the Waldorf Astoria New York and instead forced to travel up to the event in a freight elevator. Lackey after being arrested for not giving up her seat on the bus to a white person Many U. While opposed to slavery in the U. S, in a speech in Charleston, Illinois in , Abraham Lincoln stated, "I am not, nor ever have been in favor of bringing about in any way the social and political equality of the white and black races, that I am not, nor ever have been in favor of making voters or jurors of negroes, nor of qualifying them to hold office, nor to intermarry with white people. I as much as any man am in favor of the superior position assigned to the white race". Virginia case in , the Supreme Court invalidated laws prohibiting interracial marriage in the U. Many of their efforts were acts of non-violent civil disobedience aimed at disrupting the enforcement of racial segregation rules and laws, such as refusing to give up a seat in the black part of the bus to a white person Rosa Parks , or holding sit-ins at all-white diners. By all forms of segregation had been declared unconstitutional by the Supreme Court, and by support for formal legal segregation had dissolved. Board of Education of Topeka, Kansas in outlawed segregation in public schools. The Fair Housing Act of , administered and enforced by the Office of Fair Housing and Equal Opportunity , prohibited discrimination in the sale and rental of housing on the basis of race, color, national origin, religion, sex, familial status, and disability. Formal racial discrimination became illegal in school systems, businesses, the American military, other civil services and the government.

Chapter 3 : Across the Chasm Aim 6: Health Care Must Be Equitable

Racial and ethnic minorities have worse overall health than that of White Americans. Health disparities may stem from economic determinants, education, geography and neighborhood, environment, lower quality care, inadequate access to care, inability to navigate the system, provider ignorance or bias, and stress (Bahls,).

Page 28 Share Cite Suggested Citation: The National Academies Press. The sources of these disparities are com- plex, are rooted in historic and contemporary inequities, and involve many par- ticipants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and pa- tients. Consistent with the charge, the study committee focused part of its analy- sis on the clinical encounter itself, and found evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment. Minorities may experience a range of other barriers to accessing care, even when insured at the same level as whites, including barriers of language, geography, and cultural familiarity. A comprehensive, multi-level strategy is needed to eliminate these dispari- ties. Eco- nomic incentives should be considered for practices that improve provider-patient communication and trust, and reward appropriate screening, preventive, and evidence-based clinical care. In addition, payment systems should avoid frag- mentation of health plans along socioeconomic lines. The healthcare workforce and its ability to deliver quality care for racial and ethnic minorities can be improved substantially by increasing the proportion of underrepresented U. In addition, both patients and providers can benefit from education. Patients can benefit from culturally appropriate education programs to improve their knowledge of how to access care and their ability to participate in clinical-deci- sion making. The greater burden of education, however, lies with providers. Cross-cultural curricula should be integrated early into the training of future healthcare providers, and practical, case-based, rigorously evaluated training should persist through practitioner continuing education programs. Finally, collection, reporting, and monitoring of patient care data by health plans and federal and state payors should be encouraged as a means to assess progress in eliminating disparities, to evaluate intervention efforts, and to assess potential civil rights violations. At a news conference, Tools spoke with emotion about his second chance at life and the quality of his care. Tools has since lost his battle for life, but will be remembered as a hero for undergoing an experimental technology and paving the way for other patients to undergo the proce- dure. Moreover, the fact that Tools was African American and his doctors were white seemed, for most Americans, to symbolize the irrelevance of race in According to two recent polls, a significant majority of Americans believe that blacks like Tools receive the same quality of healthcare as whites Lillie-Blanton et al. Behind these perceptions, however, lies a sharply contrasting reality. A large body of published research reveals that racial and ethnic minori- ties experience a lower quality of health services, and are less likely to receive even routine medical procedures than are white Americans. Significantly, these differences are associated with greater mortality among African-Ameri- can patients Peterson et al. Specifically, Congress requested that the IOM: For the full findings and recommendations, and a more extensive justification of each, the reader is referred to the committee report. Below, findings and recom- mendations are preceded by text summarizing the evidence base from which they are drawn. For purposes of clarity, some findings and recom- mendations are presented in a different sequence than they appear in the full report; however, their numeric designation remains the same. Populations with equal access to healthcare. Gomes and McGuire, Discrimination, as the committee uses the term, refers to differences in care that result from biases, prejudices, ste- reotyping, and uncertainty in clinical communication and decision-mak- ing. It should be emphasized that these definitions are not legal defini- tions. Different sources of federal, state and international law define discrimination in varying ways, with some focusing on intent and others emphasizing disparate impact. Patient prefer- ences that are not based on a full and accurate understanding of treatment options may therefore be a source of racial and ethnic disparities in care. These disparities are associated with socioeconomic differ- ences and tend to diminish significantly, and in a few cases, disappear altogether when socioeconomic factors are controlled. The majority of studies, however, find that racial and ethnic disparities remain even after adjustment for socioeconomic differences

and other healthcare access- related factors for more extensive reviews of this literature, see Kressin and Petersen, ; Geiger, this volume; and Mayberry, Mili, and Ofili, Studies of racial and ethnic differences in cardiovascular care provide some of the most convincing evidence of healthcare disparities. The most rigorous studies in this area assess both potential underuse and overuse of services and appropriateness of care by controlling for disease severity using well-established clinical and diagnostic criteria e. Several studies, for example, have assessed differences in treatment regimen following coronary an- giography, a key diagnostic procedure. These studies have demonstrated that differences in treatment are not due to clinical factors such as racial differences in the severity of coronary disease or overuse of services by whites e. Further, racial disparities in receipt of coronary revascularization procedures are associated with higher mortality among African Americans Peterson et al. Healthcare disparities are also found in other disease areas. Several studies demonstrate significant racial differences in the receipt of appro- priate cancer diagnostic tests e. As is the case in studies of cardiovascular disease, evidence suggests that disparities in cancer care are associated with higher death rates among minorities Bach et al. Similarly, African Americans with HIV in- fection are less likely than non-minorities to receive antiretroviral therapy Moore et al. These disparities remain even after adjusting for age, gender, education, CD4 cell count, and insurance cover- age e. In addition, differences in the quality of HIV care are associated with poorer survival rates among minorities, even at equivalent levels of access to care Bennett et al. In some instances, minorities are more likely to re- ceive certain procedures. As in the case of bilateral orchiectomy and am- putation, however which African Americans undergo at rates 2. Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable. Increase awareness of racial and ethnic disparities in healthcare among the general public and key stake- holders. African Americans, Hispanics, American Indians, and Pacific Islanders, and some Asian-American subgroups are disproportionately represented in the lower so- cioeconomic ranks, in lower quality schools, and in poorer-paying jobs. These disparities can be traced to many factors, including historic pat- terns of legalized segregation and discrimination. Unfortunately, some discrimination remains. These studies illustrate that much of American social and economic life remains ordered by race and ethnicity, with minorities disadvantaged relative to whites. Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic 7 SUMMARY inequality, and evidence of persistent racial and ethnic discrimina- tion in many sectors of American life. The Role of Preferences, Treatment Refusal, and the Clinical Appropriateness of Care Racial and ethnic disparities in care may emerge, at least in part, from a number of patient-level attributes. For example, minority patients are more likely to refuse recommended services e. These behaviors and attitudes can develop as a result of a poor cultural match between minority patients and their pro- viders, mistrust, misunderstanding of provider instructions, poor prior interactions with healthcare systems, or simply from a lack of knowledge of how to best use healthcare services. However, racial and ethnic differ- ences in patient preferences and care-seeking behaviors and attitudes are unlikely to be major sources of healthcare disparities. For example, while minority patients have been found to refuse recommended treatment more often than whites, differences in refusal rates are small and have not fully accounted for racial and ethnic disparities in receipt of treatments Hannan et al. Overuse of some clinical ser- vices i. Several recent stud- ies, however, have assessed racial differences relative to established crite- ria Hannan et al. Other studies find that overuse of cardiovascular services among whites does not explain racial differences in service use Schneider et al. Finally, some researchers have speculated that biologically based ra- cial differences in clinical presentation or response to treatment may jus- tify racial differences in the type and intensity of care provided. A small number of studies suggest that racial and eth- nic minority patients are more likely than white patients to refuse treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully ex- plain healthcare disparities. Language barriers, for example, pose a problem for many patients where health systems lack the resources, knowledge, or institutional priority to provide interpretation and translation services. Nearly 14 million Ameri- cans are not proficient in English, and as many as one in five Spanish- speaking Latinos reports not seeking medical care due to language barriers The Robert Wood Johnson Foundation, Similarly, time pressures on physicians may hamper their ability to accurately assess pre- senting symptoms of minority

patients, especially where cultural or lin- guistic barriers are present. Increasing efforts by states to enroll Medicaid patients in managed care systems, for example, may disrupt traditional community-based care and displace pro- viders who are familiar with the language, culture, and values of ethnic 9 SUMMARY minority communities Leigh, Lillie-Blanton, Martinez, and Collins, In addition, research indicates that minorities enrolled in publicly funded managed care plans are less likely to access services after mandatory en- rollment in an HMO, compared with whites and other minorities enrolled in non-managed care plans Tai-Seale et al. Unfortunately, little research has been conducted to elucidate how patient race or ethnicity may influence physician decision- making and how these influences affect the quality of care provided. In the absence of such research, the study committee drew upon a mix of theory and relevant research to understand how clinical uncertainty, bi- ases or stereotypes, and prejudice might operate in the clinical encounter. Clinical Uncertainty Any degree of uncertainty a physician may have relative to the condi- tion of a patient can contribute to disparities in treatment. Doctors must depend on inferences about severity based on what they can see about the illness and on what else they observe about the patient e. Doctors must balance new information gained from the patient some- times with varying levels of accuracy and their prior expectations about the patient to determine the diagnosis and course of treatment.

Chapter 4 : Changing contours of work (edition) | Open Library

Friendships forged across racial chasm Jump to media player Casey and Waj have forged a rare and deep friendship that cuts across Rotherham's ethnic divides.

At a news conference, Tools spoke with emotion about his second chance at life and the quality of his care. Tools has since lost his battle for life, but will be remembered as a hero for undergoing an experimental technology and paving the way for other patients to undergo the procedure. Moreover, the fact that Tools was African American and his doctors were white seemed, for most Americans, to symbolize the irrelevance of race in According to two recent polls, a significant majority of Americans believe that blacks like Tools receive the same quality of healthcare as whites Lillie-Blanton et al. Behind these perceptions, however, lies a sharply contrasting reality. A large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are white Americans. Relative to whites, African Americans â€" and in some cases, Hispanics â€" are less likely to receive appropriate cardiac medication e. Significantly, these differences are associated with greater mortality among African-American patients Peterson et al. Specifically, Congress requested that the IOM: Assess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care e. For the full findings and recommendations, and a more extensive justification of each, the reader is referred to the committee report. Below, findings and recommendations are preceded by text summarizing the evidence base from which they are drawn. For purposes of clarity, some findings and recommendations are presented in a different sequence than they appear in the full report; however, their numeric designation remains the same. Defining Racial and Ethnic Healthcare Disparities The study committee defines disparities in healthcare as racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences 1 , and appropriateness of intervention Figure 1. Discrimination, as the committee uses the term, refers to differences in care that result from biases, prejudices, stereotyping, and uncertainty in clinical communication and decision-making. It should be emphasized that these definitions are not legal definitions. Different sources of federal, state and international law define discrimination in varying ways, with some focusing on intent and others emphasizing disparate impact. Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare. These disparities are associated with socioeconomic differences and tend to diminish significantly, and in a few cases, disappear altogether when socioeconomic factors are controlled. The majority of studies, however, find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors for more extensive reviews of this literature, see Kressin and Petersen, ; Geiger, this volume; and Mayberry, Mili, and Ofili, Studies of racial and ethnic differences in cardiovascular care provide some of the most convincing evidence of healthcare disparities. The most rigorous studies in this area assess both potential underuse and overuse of services and appropriateness of care by controlling for disease severity using well-established clinical and diagnostic criteria e. Several studies, for example, have assessed differences in treatment regimen following coronary angiography, a key diagnostic procedure. These studies have demonstrated that differences in treatment are not due to clinical factors such as racial differences in the severity of coronary disease or overuse of services by whites e. Further, racial disparities in receipt of coronary revascularization procedures are associated with higher mortality among African Americans Peterson et al. Healthcare disparities are also found in other disease areas. Several studies demonstrate significant racial differences in the receipt of appropriate cancer diagnostic tests e. As is the case in studies of cardiovascular disease, evidence suggests that disparities in cancer care are associated with higher death rates among minorities Bach et al. Similarly, African Americans with HIV infection are less likely than non-minorities to receive antiretroviral therapy Moore et al. These disparities remain even after adjusting for age, gender, education, CD4 cell count, and insurance coverage e. In addition, differences in the quality of HIV care are associated with poorer survival rates among minorities, even at equivalent levels of access to care Bennett et al. Racial and ethnic disparities are found in a range of other disease and health service categories, including

diabetes care e. In some instances, minorities are more likely to receive certain procedures. As in the case of bilateral orchiectomy and amputation, however which African Americans undergo at rates 2. Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable. Increase awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders. African Americans, Hispanics, American Indians, and Pacific Islanders, and some Asian-American subgroups are disproportionately represented in the lower socioeconomic ranks, in lower quality schools, and in poorer-paying jobs. These disparities can be traced to many factors, including historic patterns of legalized segregation and discrimination. Unfortunately, some discrimination remains. These studies illustrate that much of American social and economic life remains ordered by race and ethnicity, with minorities disadvantaged relative to whites. Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life. The Role of Preferences, Treatment Refusal and the Clinical Appropriateness of Care Racial and ethnic disparities in care may emerge, at least in part, from a number of patient-level attributes. For example, minority patients are more likely to refuse recommended services e. These behaviors and attitudes can develop as a result of a poor cultural match between minority patients and their providers, mistrust, misunderstanding of provider instructions, poor prior interactions with healthcare systems, or simply from a lack of knowledge of how to best use healthcare services. However, racial and ethnic differences in patient preferences and care-seeking behaviors and attitudes are unlikely to be major sources of healthcare disparities. For example, while minority patients have been found to refuse recommended treatment more often than whites, differences in refusal rates are small and have not fully accounted for racial and ethnic disparities in receipt of treatments Hannan et al. Overuse of some clinical services i. Several recent studies, however, have assessed racial differences relative to established criteria Hannan et al. Other studies find that overuse of cardiovascular services among whites does not explain racial differences in service use Schneider et al. Finally, some researchers have speculated that biologically based racial differences in clinical presentation or response to treatment may justify racial differences in the type and intensity of care provided. For example, racial and ethnic group differences are found in response to drug therapies such as enalapril, an angiotensin-convertingâ€"enzyme inhibitor used to reduce the risk of heart failure Exner et al. A small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully explain healthcare disparities. Healthcare Systems-Level Factors Aspects of health systems â€" such as the ways in which systems are organized and financed, and the availability of services â€" may exert different effects on patient care, particularly for racial and ethnic minorities. Language barriers, for example, pose a problem for many patients where health systems lack the resources, knowledge, or institutional priority to provide interpretation and translation services. Nearly 14 million Americans are not proficient in English, and as many as one in five Spanish-speaking Latinos reports not seeking medical care due to language barriers The Robert Wood Johnson Foundation, Similarly, time pressures on physicians may hamper their ability to accurately assess presenting symptoms of minority patients, especially where cultural or linguistic barriers are present. Further, the geographic availability of healthcare institutions â€" while largely influenced by economic factors that are outside the charge of this study â€" may have a differential impact on racial and ethnic minorities, independent of insurance status Kahn et al. Perhaps more significantly, changes in the financing and delivery of healthcare services â€" such as the shifts brought by cost-control efforts and the movement to managed care â€" may pose greater barriers to care for racial and ethnic minorities than for non-minorities Rice, this volume. Increasing efforts by states to enroll Medicaid patients in managed care systems, for example, may disrupt traditional community-based care and displace providers who are familiar with the language, culture, and values of ethnic minority communities Leigh, Lillie-Blanton, Martinez, and Collins, In addition, research indicates that minorities enrolled in publicly funded managed care plans are less likely to access services after mandatory enrollment in an HMO, compared with whites and other minorities enrolled in non-managed care plans Tai-Seale et al, Unfortunately, little research has been conducted to elucidate how patient race or ethnicity may influence physician

decision-making and how these influences affect the quality of care provided. In the absence of such research, the study committee drew upon a mix of theory and relevant research to understand how clinical uncertainty, biases or stereotypes, and prejudice might operate in the clinical encounter. Clinical Uncertainty Any degree of uncertainty a physician may have relative to the condition of a patient can contribute to disparities in treatment. Doctors must depend on inferences about severity based on what they can see about the illness and on what else they observe about the patient e. When these priors â€" which are taught as a cognitive heuristic to medical students â€" are considered alongside the information gained in a clinical encounter, both influence medical decisions. Doctors must balance new information gained from the patient sometimes with varying levels of accuracy and their prior expectations about the patient to determine the diagnosis and course of treatment. The Implicit Nature of Stereotypes A large body of research in psychology has explored how stereotypes evolve, persist, shape expectations, and affect interpersonal interactions. Stereotyping can be defined as the process by which people use social categories e. Although functional, social stereotypes and attitudes also tend to be systematically biased. These biases may exist in overt, explicit forms, as represented by traditional bigotry. Both implicit and explicit stereotypes significantly shape interpersonal interactions, influencing how information is recalled and guiding expectations and inferences in systematic ways. They can also produce self-fulfilling prophecies in social interaction, in that the stereotypes of the perceiver influence the interaction with others in ways that conform to stereotypical expectations Jussim, Survey research suggests that among white Americans, prejudicial attitudes toward minorities remain more common than not, as over half to three-quarters believe that relative to whites, minorities â€" particularly African Americans â€" are less intelligent, more prone to violence, and prefer to live off of welfare Bobo, It is reasonable to assume, however, that the vast majority of healthcare providers find prejudice morally abhorrent and at odds with their professional values. But healthcare providers, like other members of society, may not recognize manifestations of prejudice in their own behavior. Medical Decisions Under Time Pressure with Limited Information Studies suggest that several characteristics of the clinical encounter increase the likelihood that stereotypes, prejudice, or uncertainly may influence the quality of care for minorities van Ryn, In most cases, they must do so under severe time pressure and resource constraints. These conditions of time pressure, resource constraints, and the need to rely on gestalts map closely onto those factors identified by social psychologists as likely to produce negative outcomes due to lack of information, to stereotypes, and to biases van Ryn, Mistrust and Refusal As noted above, the responses of racial and ethnic minority patients to healthcare providers are also a potential source of disparities. Little research has been conducted as to how patients may influence the clinical encounter. It is reasonable to speculate, however, that if patients convey mistrust, refuse treatment, or comply poorly with treatment, providers may become less engaged in the treatment process, and patients are less likely to be provided with more vigorous treatments and services. But these kinds of reactions from minority patients may be understandable as a response to negative racial experiences in other contexts, or to real or perceived mistreatment by providers. Survey research, for example, indicates that minority patients perceive higher levels of racial discrimination in healthcare than non-minorities LaVeist, Nickerson, and Bowie, ; Lillie-Blanton et al. In addition, it is clear that the healthcare provider, rather than the patient, is the more powerful actor in clinical encounters. Many sources â€" including health systems, healthcare providers, patients, and utilization managers â€" may contribute to racial and ethnic disparities in healthcare. Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare. While indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research. The disproportionate presence of racial and ethnic minorities in lower-end health plans is a potential source of healthcare disparities, given that efforts to control for insurance status in studies of healthcare disparities have not taken detailed account of variations among health plans. Such socioeconomic fragmentation of health plans engenders different clinical cultures, with different practice norms, tied to varying per capita resource constraints Bloche, Equalizing access to high-quality plans can limit such fragmentation. Public healthcare payors such as Medicaid should strive to help beneficiaries access the same health products as privately-insured patients. Avoid fragmentation of health plans along

socioeconomic lines. Strengthening Doctor-Patient Relationships Several lines of research suggest that the consistency and stability of the doctor-patient relationship is an important determinant of patient satisfaction and access to care. Having a usual source of care is associated, for example, with use of preventive care services Agency for Healthcare Research and Quality, In addition, having a consistent relationship with a primary care provider may help to address minority patient mistrust of healthcare systems and providers, particularly if the relationship is with a provider who is able to bridge cultural and linguistic gaps LaViest, Nickerson, and Bowie, Minority patients, however, are less likely to enjoy a consistent relationship with a provider, even when insured at the same levels as white patients Lillie-Blanton, Martinez, and Salganicoff, This is due in part to the types of health systems in which they are enrolled and the relative lack of providers located in minority communities.

Chapter 5 : Crossing Divides: Bridging Rotherham's racial chasm - BBC News

Race and ethnicity are related, but distinct. leading some scientists to describe all humans as belong to the same race â€" the human race. Ethnicity is the term for the culture of people in a.

Also the term "colored" entered the census nomenclature. In addition, a question stating "Number of foreigners not naturalized" was included. For the first time, free persons were listed individually instead of by head of household. There were two questionnaires: The question on the free inhabitants schedule about color was a column that was to be left blank if a person was white, marked "B" if a person was black, and marked "M" if a person was mulatto. Slaves were listed by owner, and classified by gender and age, not individually, and the question about color was a column that was to be marked with a "B" if the slave was black and an "M" if mulatto. Residents were still listed individually, but a new questionnaire sheet was used for each family. Additionally, this was the first year that the census distinguished between different East Asian races, such as Japanese and Chinese , due to increased immigration. This census also marked the beginning of the term "race" in the questionnaires. Also, there was an inclusion of an "Indian Population Schedule" in which "enumerators were instructed to use a special expanded questionnaire for American Indians living on reservations or in family groups off of reservations. Enumerators were instructed to no longer use the "Mulatto" classification. Instead, they were given special instructions for reporting the race of interracial persons. A person with both white and black ancestry termed "blood" was to be recorded as "Negro," no matter the fraction of that lineage the " one-drop rule ". A person of mixed black and American Indian ancestry was also to be recorded as "Neg" for "Negro" unless he was considered to be "predominantly" American Indian and accepted as such within the community. A person with both White and American Indian ancestry was to be recorded as an Indian, unless his American Indian ancestry was small, and he was accepted as white within the community. In all situations in which a person had White and some other racial ancestry, he was to be reported as that other race. Persons who had minority interracial ancestry were to be reported as the race of their father. For the first and only time, "Mexican" was listed as a race. Enumerators were instructed that all persons born in Mexico, or whose parents were born in Mexico, should be listed as Mexicans, and not under any other racial category. But, in prior censuses and in , enumerators were instructed to list Mexican Americans as white, perhaps because some of them were of white background mainly Spanish , many others mixed white and Native American and some of them Native American. It featured a question asking if the person was of full or mixed American Indian ancestry. Roosevelt promoted a "good neighbor" policy that sought better relations with Mexico. In , a federal judge ruled that three Mexican immigrants were ineligible for citizenship because they were not white, as required by federal law. Mexico protested, and Roosevelt decided to circumvent the decision and make sure the federal government treated Hispanics as white. The State Department, the Census Bureau, the Labor Department, and other government agencies therefore made sure to uniformly classify people of Mexican descent as white. This policy encouraged the League of United Latin American Citizens in its quest to minimize discrimination by asserting their whiteness. The Other print out race option was removed. East Indians the term used at that time for people whose ancestry is from the Indian subcontinent were counted as White. There was a questionnaire that was asked of only a sample of respondents. These questions were as follows: Where was this person born?

DOWNLOAD PDF RACIAL AND ETHNIC CHASMS

Chapter 6 : Racial segregation - Wikipedia

Race, ethnicity, and work: legacies of the past, problems in the present Histories of race, ethnicity, and work African American exceptionality.

Click here to listen to a recording of our interactive webinar on turning data into insights and action. In , the number of young people disconnected from both work and school declined for the sixth year in a row. The disconnected youth rate of A large group of young people saw their opportunities expand alongside the expanding economy; the youth unemployment rate was roughly half in what it was in But not all young people saw growth: More than a Million Reasons for Hope: Youth Disconnection in America Today analyzes youth disconnection in the United States by state, metro area, county, and community type, and by gender, race, and ethnicity. Disconnected youth, also known as opportunity youth, are teenagers and young adults between the ages of 16 and 24 who are neither in school nor working. Youth disconnection ranges from 7 percent in North Dakota to Young people in the Midwest are the least likely to be disconnected, with a rate of Among the nearly one hundred most populous metro areas, disconnection rates range from 6. Six European metro areas have rates lower than Des Moines, and Istanbul, the metro area with the highest rate of disconnection in Europe, has a rate just under that of Bakersfield, CA. Young people living in rural areas have the highest rate of youth disconnection, Disconnection rates in rural counties vary immensely, from essentially 0 percent to There is a chasm of nearly 20 percentage points in disconnection rates separating racial and ethnic groups. Asian youth have the lowest rate of disconnection 6. Youth disconnection has decreased over time for all major racial and ethnic groups; however, the gap between the groups with the highest and lowest rates has not narrowed appreciably. Overall, young women are less likely to be disconnected, with a rate of However, the rate of female disconnection varies widely by race and ethnicity, from 6. Disconnected young women face particularly high poverty rates and unique challenges like early marriage and motherhood that merit attention and resources. Racial and ethnic categories can mask diversity within groups. Among Asians, Vietnamese youth have the lowest rate of disconnection, 4. Among Latinos, rates range from 8. Disconnected young people are about two-and-a-half times as likely to be living with family other than their parents, about twice as likely to be living with a roommate, and eight times as likely to be living alone than their connected peers. Young people who do not have a stable living situation often lack the emotional and financial support of parents or other consistent, caring adultsâ€”an additional barrier in the transition to adulthood. An alarmingly high proportion of disconnected black boys and young menâ€”nearly a fifthâ€”is institutionalized, compared to just 0. About 40 percent of disconnected Asian youthâ€”and nearly half of disconnected Asian girlsâ€”are noncitizens. A third of disconnected Asian girls and about a fifth of disconnected Latinas are not English proficient. Thirty-eight states experienced a significant improvement since Over the past year alone, twelve states saw a significant improvement in their disconnection rates, but Washington, DC, and Nebraska had setbacks. For media and all other inquiries, contact Dewey Blanton:

Chapter 7 : Chasm - Definition for English-Language Learners from Merriam-Webster's Learner's Dictionar

As populations diversify and race relations intensify, the question "What is ethnicity?" is ever-present. Across social media, there are seemingly infinite ways to enter the conversation.

Chapter 8 : Race and ethnicity in the United States Census - Wikipedia

Saudi Arabia's Race Problem racial and ethnic chasm in his country and has pledged to bring unity to the country. The U.S. certainly has no room to look down upon the KSA for its racial and.