RACISM AND DISCRIMINATION IN HEALTHCARE: PROVIDER AND PATIENTS

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ABSTRACT

Racism and discrimination in Healthcare must be understood within the perspective of racial discrimination in social institutes. Systemic bias is not the unusual behavior demonstrated by few but is mostly backed by the unconscious discrimination based upon destructive negative stereotypes and institutional guidelines. A novel initiative to make medical staff skillful and induction of providers from the background of disadvantaged backgrounds along with enhanced regulatory monitoring and better data system can effectively address inequalities in the quality of care. Designing and implementation efficient approaches to eradicate the racial discrimination in medical care and health status must be made a national priority.

Keywords: Racism, Discrimination in Healthcare, Racial Discrimination, Designing and Implementation

INTRODUCTION

Racial discrimination always remained a highlighted problem in the integration of various cultures around the globe. Adegbembo, et al., (2006) stated health care inequality as the involvement of non-white versus white in the USA and other regions of the earth, and patient versus healthcare providers. Inequality in the medical care is dated back to the time of racial inequalities when other non-whites and blacks were separated against in the USA prior to the fight for parity and acknowledge of blacks and other non-whites in the USA. A survey focusing on pediatric residents of Stanford university illustrated that more than fifteen percent of them had faced any kind of inequality from the patients or their concerning family members. The current status of racism and discrimination in the medical care system around the globe is summarized in this article, with a special emphasis on new trends, its effect, and approaches to resolve the racial matters in the health care field (Anderson, 2013 & Assari et al., 2017).

Physicians and other medical care practitioners take an oath that they will be protecting their patients without any discrimination of their status, condition, or their origin. The issue of discrimination is strongly rooted in our society, which leads to disproportionate admittance to various social benefits such as education and standard Healthcare. Movements such as "Black Lives Matter" have been started to highlight the discrimination against minorities and blacks. The United States has faced constant discrimination, particularly professionals associated with Indian heritage, Blacks, and Jewish origin. Few researchers proposed that ethnic/racial minorities were more prone to bear discrimination in society. It was also exhibited that Hispanics, *i.e.,* 13.5 percent and African-Americans, *i.e.,* 13.2 percent were more inclined to report discrimination associated with Healthcare in contrast with the white population. It was also noted that Asia Pacific Islanders, *i.e.,* 64.5 percent were less likely to report the healthcare quality as high in contrast with Hispanic and non-Hispanic whites (Ayotte et al., 2012).

Healthcare inequalities have distinct impacts on Black men and women. It is illustrated that Black men reported even greater discrimination when compared to Black women under the same conditions. The facet of racial inequalities takes the shapes of harassment and profiling, amongst other types. Poor health and racial discrimination are associated in connection with the enhanced physiological and mental stress that further disrupts the rehabilitation of sufferers. Discriminating

patients have adverse health consequences such as unhealthy, poor surviving behavior, and reduced care utilization (Bailey et al., 2017; Bécares & Zhang, 2018).

It is evident from the data of the past five decades that the health of the general public, irrespective of race and ethnicity, has improved, which is reflected in increased life expectancy as well as a sharp decrease in the mortality rate, both in infant and adults. Despite these facts, black people still have significantly higher morbidity and mortality rates when compared to white people on most of the health care indicators. It is worth mentioning here that this poor health status has nothing to do with the genetics of black people, as some people may perceive. Medical care may not be the only criteria as the determinant of health; however, medical care matters a lot in preventive medicine, timely involvement and response, proper supervision of chronic cases of the disease, and these factors determine the general health condition of a person, singly, and a community, collectively. Therefore, disparities and differential treatment of a community, either in terms of quantity or quality, depending on its race and ethnicity, matter a lot to determine its health status. It is noted that black people are unemployed, underrated, or hired mostly at lower wages compared to white folks. Sometimes, they are also devoid of health insurance as a component of the package in their job benefits (Ben et al., 2017 & Bernardo et al., 2017).

An alarming situation is continuously arising, which is also supported with quite a huge number of studies is that race is also influencing the health care facilities even in major therapeutic intervention techniques despite the fact that patients are insured for the procedures. Although there are certain health care facilities that target to minimize the differences on the basis of financial status and insurance, patients are still differenced on the base of their race. It is quite understandable that a physician cannot differentiate the pain felt by a black or a white man; however, studies point out that black people are not as analogized as white people. It is well documented that these differences and inequalities in the application of heath related procedures severely affect the minor groups of society. It is time to make sense in health care procedures and removing the differences among the patients based on race and creed. This can be attained by making a wise decision by the policymakers and researchers (Black et al., 2015; Bonilla-Silva, 1997).

Race, Racism, and Discrimination

The researchers and observers are astonished to find these disparities as they see the data without the proper context. But when we look into the historical perspective, the things that we see today can be explained in a logical way. For example, in the United States, there were three racial groups mentioned in the census conducted in the late eighties. Later on, more categories were introduced, and these categories were and are used to grab power, resources, and facilities in the society. The minorities were marginalized and were deprived of the power and resources. The minors were restricted either by law or by tradition to receive second-rate treatment and attention in all social institutions. Therefore, substandard treatment in health care is not the only exception (Braveman et al., 2010).

Hence, in order to comprehend the operation of disproportions in medical facilities and attention, one needs to fully appreciate the ways and means the dynamics of racism. Racism is a kind of systematized classification that is ingrained in the philosophy of subservience that classifies, orders, and partially assigns available resources in a human population. There may or may not be personal chauvinism. Racism, though a complex phenomenon, can be explained by looking into occupation and accommodation (Britt-Spells et al., 2018 & Busse et al., 2017).

By the end of the twentieth century, there is a positive change in social acceptance of black persons in a society of white persons at a broad spectrum, and they are considered equal, at least in principle, for housing and employment. However, in the early sixties, more than sixty percent of the

white population was ready to enjoy the right to keep the black people out of their locality on their choice, and black people should respect the right of white people. It took more than thirty years to shift this mentality of white people to reach around thirteen percent from sixty percent. A similar attitude was observed in employment opportunities. In mid-fifties, more than half of the white population considered it to be their right to half the first chance for any employment. It took three decades to shift this attitude in the majority of the white population when still three percent of the white population sticks to the previous statement. Now, more than ninety-seven of the white population considers that there should be an equal job opportunity for everyone, irrespective of race and social background. This shift in the attitude of white persons is supported by strong scientific reports (Carter et al., 2019; Carter et al., 2017; Chen & Yang, 2014).

Another positive move was made in mid-sixties when it was enforced by law that no one can refuse the rental or sale of property merely on the basis of race. Before this law, it was also implemented that no one can be hired, fired, or promoted just on the basis of his race, and employers were forced to follow the action (Clark et al., 1999 & Clark et al., 2018).

While considering the property sale, two-third of the white population consider it their right and would actually support such a law that may allow them not to sell their house to black if they like to. This ratio changed to one-third of the white population sample in the mid-twenties. Similarly, there is very poor support regarding policy-making and in favor of equality between black and white in terms of job opportunities. In mid-seventies, only thirty-eight percent of the people pointed out that there should be some serious legislation for the impartial treatment with the black people and, even at that point in time, thirteen percent of the white folks did not show even any interest in the question. Alarmingly, this trend did not shift in favor of black people with the passage of time, rather more and more white people opted the point of view of such no legislation is required, and an even higher number of white people became uninterested in the question (Cutler & Glaeser, 1997; de Freitas et al., 2018; Desalu et al., 2019).

Despite the general outlook, white people continue to not like black people in their neighborhood and colleagues. Even in the late nineties, approximately half of the white population consider that black people can live well without proper welfare, they are more likely involved in fierceness as well as they are believed to be lazy. Roughly one-third of white persons consider black folks as unintelligent as compared to them. Contrarily, they consider that even less than ten percent of white folks are lazy, unintelligent, and attracted to violence. Least they expect themselves to live without proper welfare facilities. In a nutshell, white persons consider themselves far better, and black persons far negative than themselves. Even they consider black more negatives as compared to Asians. Still, it may be quite possible that these values are well-understated because of the social judgment of one-self and actual stereotype, maybe even worse. Such stereotypes invited many psychological research groups to understand how such stereotype leads to social discrimination on minority groups in a white population dominant society. It is worth mentioning here that certain established stereotypes are so deeply rooted that breaking them is considered as disconfirmation in society. The activation and propagation become an automatic process where the public easily and spontaneously associate a certain stereotype with a certain group of people (Dolezsar et al., 2014; Doyle & Molix, 2014; Gaston & Alleyne-Green, 2013).

The stereotype effects are not limited to the general evaluation of minority groups; rather, it has a broad spectrum consequence in terms of residence preference and job opportunities. As black is rated negatively, therefore, a majority of white folks like to live in a community of their own or in a segregated quarter. This results in the marginalization of black people in the areas of cheaper

houses with poor facilities and access or in the areas of lower-income communities. On a border scale, there is a huge chance, about sixty percent that a black house-seeker, either for rent or for purchase, will end up away from the white community that unit, otherwise would be available to white persons. When the employers were asked, and data was analyzed, it revealed that a black applicant is more likely to be denied. This stereotype is not only limited to the locales; even the foreign investors consider racial discrimination and use it in their decision making while establishing new plants and market areas identification (Gee et al., 2007; Gilbert & Zemore, 2016).

Another finding reported in Wall Street Journal revealed that during the economic lockdown of 1990-1991, approximately sixty thousand black people lost their jobs while during the same duration, the same number of Latin extraction, almost fifty-five thousand Asians and more than seventy thousand white people were employed. These findings indicate relocation of the existing jobs from black to white persons. Moreover, it was found during the audit studies that black was discrimination from white folks in terms of application submission and actual job offer, and was offered a fewer number of chances. In five different audits, it was identified that when both white and black people with the same training and qualification appeared for the same job, discrimination favored the white (Glaeser & Vigdor, 2001; Held & Lee, 2017; Hopkins & Shook, 2017).

In order to summarize the discussion, the policies and acts drafted to limit the racial discrimination in the employment and housing sector failed miserably in their objectives. Racial isolation of black people from white in terms of housing was not far different between 1968 and 1990, after legislation. Like housing, the unemployment rate did not change much over the course of time from the 1950s to date; that is, black people were twice unemployed as compared to white people. In order words, it can be specified that such legislation is not enough to lower or eradicate racial discrimination in these sectors. It is worth mentioning that in spite of all these changes, the median income of black people didn't change much. There remained over the course of twenty years. Black persons earn only 59 cents for each dollar of white persons (Howard, 2018; Jones et al., 2016).

Lessons we Learnt from Racial Discrimination in Health Care

On pure literary terms, it can be assessed from a board body of knowledge that the general approach to racial discrimination of the white people has altered from a blunt to subtle at the present moment. It is a pathetic acknowledgment which we must recognize that discrimination is common and routine in all areas of society, including the health and medicine segment. With a few examples, a bulk of the medical sector is hesitant to agree that there is a clear disparity on the basis of race of the provider and the patient. Contrary to the general perception that there are only a few "bad apples," there is, unfortunately, a general subtle acceptance of racial justice in society (Kershaw et al., 2016; Kirkinis et al, 2021).

It is very dubious that there is only personal disparity from the providers of health care services. Although there are various causes of racial discrimination with wide-ranging effects in the health care segment of the society, as it is a very complex and multidimensional in origin, the outcome is, however, the same which is societal evaluation. Furthermore, the individual disparity is often more important than institutional disparity. Except for the race of the patient, there may be other explanations in medical care unit to avoid racial discrimination label like poor distribution of medical facilities in the different geographic region, personal preferences of the patients, the pathophysiology of the disease, financial standing, understanding, and awareness of a certain

medical procedure. Out of these, patient persona predilection would be a better explanation in the scenario of the presence of all other possible factors. However, recently it is discovered that personal inclination is not one of the factors of discrimination of the patients, which was considered as a pivot point of any medical and health-related disparity (Korous et al., 2017; Lewis et al., 2015).

It is very unfortunate that it is not the facilities which matter the general attitude rather. This attitude subconsciously perpetuates in the society by the dominant group of people and is deeply felt by the people affected. Most of the time, this behavior is unconscious, unintentional, and unplanned. This attitude spreads so slowly but consistently that even a non-believer of such race-based business gets taken away automatically. Such a person starts to follow the widely spread racial discrepancies. The current psychological data analysis revealed that even a non-believer and anti-racial division person's decision is effected in the presence of believers and advocators. In this scenario, people start to deprioritize and contribute less to the development of health care facilities for black unemployed people as compared to white unemployed people. When a negative stereotype is activated in real-life situations, it leads to unconscious biases in medical encounters. A lot of effort, which is put in drafting legislation, policy-making, and other intervention programs, are ruined because of intentional discrimination. It can be visualized in this review that one cannot fully rely just on the legislations and policies drafted to eradicate racial discrimination in health care setup and attitude of white persons towards black persons (Lewis et al., 2014; Liu & Kawachi, 2017).

Directions for Policies and Research in Healthcare

Enhancing the Equality for the Availability of Medical Care

A detailed approach to tackle injustice and discrimination in Healthcare must be initiated by ensuring equality in the availability of healthcare facilities. Disparities in Healthcare can be efficiently addressed by the constant and detailed efforts incorporated by the various sectors of society to tackle the other inequalities in major's community foundations. It is obvious we require the strong nationwide efforts to oppose and eradicate the discrimination in criminal justice, housing, employment, education, and various other sections of a society which will ultimately enhance the socioeconomic standing of the deprived populations existing in minorities and will indirectly deliver them more accessible medical care. The United States also requires making a political and moral promise to ensure medical care accessibility as basic citizenship right (Lockwood et al., 2018).

Moreover, struggles to guarantee equal rights to healthcare availability must go beyond the eradication of the financial constraints. A huge variety of system barriers like the inability to treat the patient with respect and dignity, complicated bureaucratic procedures, and long waiting times can cause patient isolation and contact avoidance unless extremely required. Previous research has been illustrated that racial minorities and poor persons are considered as desirable patients, and medical care providers provide poor Healthcare to the patients belongs to low socioeconomic status. The fact that patients of high socioeconomic status getting more positive communication and good quality interpersonal technical care as compare to the people of low socioeconomic status deteriorate the patient-provider communication among the patient of low socioeconomic status (Dover & Belon, 2019).

Continuous struggles are required to counter the forces that are potentially worsening racial disparities in healthcare accessibility. Such efforts are inevitable to ensure equality in access to Healthcare. First of all, it has been observed the closure of healthcare facilities is situated in

minority communities and areas of low-income people as compare to those healthcare facilities located in the other areas. Secondly and importantly, the migration from free for service systems to a well-managed care system seems to badly affect the accessibility to Healthcare for minority populations and other vulnerable sections of the society (World Health Organization, 2010).

Critics claim that managed care seems to worsen the existing racial discrimination in healthcare access in various ways. The novel competitive pressures in the delivery and financing of medical care can decrease the profits produced by the treatment of privately insured patients, which can cause a decline in the delivery of uncompensated care. Moreover, most of the time, managed care systems curb access to physicians who mainly care for disadvantaged communities and minority physicians (Churchwell et al., 2020).

In the managed care system, cost-efficient doctors are desired who write a few prescriptions, order fewer procedures, and make very few referrals. Conversely, patients in low-income communities and minorities are usually having higher disease severity, greater morbidity, and comorbidity, which require very intense disease management, which can be costly and involving more medical services. Hence, managed care services are seemed to consider doctors working with minority populations as undesirable and may further limit doctors that their enrollees, such as residents belong to lower communities and poor patients, can consult. Consequently, the physicians who are working in the minority populations may face little patients load, and some physicians may not be able to do an economically viable practice (World Health Organization, 2013).

Although it is not obvious that such concerns have been materialized, a previous survey in 1994 on black physical showed that 92 percent of the black physicians believed that in the managed care system, black physicians are more prone to contract termination as compare to the white doctors. As a matter of fact, 71 percent had lost patients to managed care organizations with which they were not affiliated and 88 percent had been declined a contract by the managed care system? Simultaneously, 75 percent revealed that their practice stayed stable or have grown in the previous years, and 71 percent had minimum on the contract of the managed care system. It was also noted by some observers that manage care system is not expected to worsen the access to health care for minorities. Health care providers serving the otherwise undesirable segment of the society can get a financial incentive due to the rise in the competition (World Health Organization, 2013).

Monitoring the Healthcare Quality and Improvement in the Data Systems

Systemic and daily data of occurrence is required for any strong struggle to eliminate the racial biases in the healthcare field. As observed, crucial modifications are being made in the delivery and organization of health care services in the US. It is vital to study the effect of such modifications on the accessibility and quality of healthcare services for the vulnerable section of society. Key efforts are being made to detect the elements of data to be incorporated in the country-wide standard data classes. It is inevitable that ethnic and racial status should be comprehensively and uniformly analyzed in such units of data sets. Detailed analysis shows that data sets should incorporate identifiers for main racial subgroups within the standard ethic/racial classes. For instance, it is mandatory to distinguish the three largest classes existing among Hispanics, which are Cubans, mainland Puerto Ricans, and Mexicans. Considering the strong association between socioeconomic status and ethnicity/race, and the major role of socioeconomic status in Healthcare,

it is crucial to incorporate socioeconomic status indicators in any uniform data set (Cookson et al., 2018).

The wide occurrence of discrimination illustrates that racial and ethnic data should be accessible to every healthcare counters. The National Committee of Vital and Health Statistics, an advisory committee to the Department of Health and Human Services, has called for the evaluation of socioeconomic status and ethnicity/race in the database of enrollment, which can ultimately be used for linkage of data on the healthcare counters. One of the most convenient and practical socioeconomic indicators suggested is the years of formal education. The existence of such identifiers in the database of enrollment will eradicate the resource-intensive ordeal of attempting the request racial data at every medical confront. Healthcare workers should be given essential training to ensure the uniform gathering of socioeconomic status and ethnic/racial data. Moreover, concerted efforts should be made to ensure the safety of a confidential and personal patient of the patient. It is observed by the assessment of the racial disparities in HCFA data files that helpful results can be taken from the administrative databases to highlight the magnitude and nature of the problem. But such assessments have just highlighted the white-black differences as the only existing racial identifiers were "black, white and other." At the beginning of the 90s, social security administration and HCFA put great effort together for the improvement in the ethnic/racial identifiers in the medicare data systems and social security administration. Currently, routine assessment and reporting of data for all ethnic and racial groups are required (Jencks & Wilensky, 1992; Wareham, 1994).

Routine reporting will detect the medicare institutes illustrating the racial parity in the context of health care delivery. It is possible that there is a significant difference in the racial disparities among various settings. Such data type can be utilized to build the benchmarks and observe the levels of excellence attained by industry leaders that can boost our knowledge of the best practices and facilitate their replication (Rodriguez-Lainz et al., 2018).

Further research is required to detect the useful specific strategies which can be used by the health care institutes, at least in episodes if not constantly, to identify and react to discrimination forms in medical treatment. It is proposed that hospitals can design anonymous working reporting systems to assist in the identification of events associated with biased medical decision making. Although, it will be critical to make an encouraging environment for reporting as an important part of a constructive problem-solving strategy. Generally, voluntary reporting, focus groups, computer screening, chart view, and direct observation are the main strategies to identify inappropriate medical treatment (Jencks & Wilensky, 1992).

Furthermore, the existence of Healthcare related to racial variation data can assist civil rights enforcement efforts. One of the barriers of present anti-discrimination regulations is that they mostly depend on proving subjective discriminatory intent. Providing that a huge population of white Americans support non-discrimination in principle, most of the time, it is hard to demonstrate discriminatory intent. In the legal context, the disparate effect claims need statistical data to report the differential impact of policies on racial classes (Blake & Hatzenbuehler, 2019).

In the legal context, disparate impact rights need statistical figures to report the disparity influence of the policy on racial/ethnic classes. This way is usually not used by the individuals who are looking for relief under civil rights laws as this way needs collection and assessment of huge data to demonstrate the biased impact. However, a gathering of data of daily routine assists the evaluation of racial/ethnic class disadvantage in public health (Feagin & Eckberg, 1980).

It is noted by Smith, et al., (1998) that focus on supervising both financial and clinical data in the managed care system delivers innovative prospects to boost monitoring of civil rights for the provision of medical care. He demonstrated that the incorporation of racial/ethnic identifiers to pre-existing data structure could assist in the production of reports which can be utilized to observe the inequalities in the communities, medical care institutions, and health care plans. Such reports can involve widely accepted pointers of health and health care delivery, like the utility of particular diagnostic tests and mortality rates, which have been suggested by many standards administration for the relative assessment of health care services. Smith also illustrates that the same documentation formalities in the banking sectors have caused a high rise in the loan number approved by racial minorities (Parkin, 2019).

Revised Regulatory Monitoring

Enhance monitoring of the regulatory system can be another method to tackle the issue of discrimination and disparity. Past examples of obvious inequality in the health care illustrate that federal laws and legal mandates were unproductive up until the institutional capacity and commitment were developed to enforce these laws. Some researchers associated with law practice claim that there are pre-existing rules and regulations that are not being imposed. For instance, to deal with the inequality in medical care provision, there is a law titled VI of the civil rights act of 1964. This act forbids any entity that gets financial support (federal) from discriminating on the ground of race in delivering services or goods to the federal program beneficiaries. As Federal financial support involves medical funds, this ban against inequality is related to virtually all health care facilities such as nursing homes and hospitals in the USA (Roberts, 2012).

Provided that the courts have ruled that Title VI bans both disproportionate negative consequences and deliberate discrimination, the accompanying documentation of negative consequences would deliver a potential ground for tackling and fixing discrimination in care (Hoffman & Podgurski, 2020).

Noah also highlights the fact that several unbiased strategies that might have a disproportionate effect on ethnic and racial minority groups in access to health care could also be taken into consideration if the unequal impact has been documented. For instance, some hospitals create barriers in the admission of patients like physicians having staff privileges at hospitals, refusal to deliver the babies if their mother did not get considerable prenatal care, and the requirement to deposit a considerable sum of payment before admission. Even though in this intent or context, policies are not race-oriented, but still minority patients seem to be more affected by such policies. Hence, the inequality impact assessment of such policies can be a useful arena to tackle these issues. It is also warned that as Title VI covers institutional policies creating inequality effect, these are not covering the personal behavior of the physicians who either unconsciously or intentionally discriminate until the medical care entity can reject its institutional policy status (Chin et al., 2007).

Another regulatory body is The Joint Commission on Accreditation of Health Care Organizations that can play its part in tackling the issue of racial discrimination in the medical care field. For instance, it can emphasize that constant accreditation of any health care entities will be under the term that they will take measures and form procedure to observe and correct unexplained inequalities in the provision of health care services. In past history, this commission has played a significant part in bringing an inspiring advance change in the industry related associated with

medical care. An example from recent timeline shows its struggles to boost the medical care facilities to create and enforce regulations to manage communication issues with the patient who has poor command on the English language, or even they are entirely unable to speak English. This commission may also reconsider its recent utilization review procedures to look if improved approaches can be formed to detect and revise the observation pattern of racial disparities and provision of services to the recipients of Medicaid and Medicare (Fiscella et al., 2000).

Tracking Managed Care

Enhanced governing efforts must particularly be focused on the managed care system as a managed care system form an environment favorable to business, and some researchers have emphasized that there will be further extensive discrimination under this system. In contrast with medical free for service where physician income rise with the rise in the number of the service provider, the managed care system usually emphasize to restrict the cost and quantity of services provided to the affiliates of the prepaid health plan. Numerous healthcare plans provide monetary benefits to providers for restricting referrals to specialists. Most of the time, a sum of amount is reserved for the diagnostic tests and specialists, with the provider input in the unexpended part of this sum. In managed-care systems, sometimes these systems blame the treating physician for the usage of higher cost than the average medical care cost of the hospital, even when these expenses are medically defensible. Such monetary benefits have been illustrated to outline decision making by the providers (Lyons et al., 1997).

Present research does not undoubtedly demonstrate either health care under free for service or managed health care system is better. Little previous evidence proposes that affiliates under the managed care system are expected to get cancer screening tests than patients enrolled under free for service medical care. Previous data on non-elder persons illustrated that there was no variation among health care maintenance organizations and other sorts of insurance services in term of using emergency surgeries and room, and inpatient care. Simultaneously, patients under health maintenance organizations showed higher unmet medical requirements, lower ratings of physicians' visits, low trust levels for physicians, and less satisfaction. It was demonstrated that health maintenance organizations delivered preventive and more primary services. They are carrying more administrative barriers to health care and less specialist care. Other researches propose that in the managed health care system, vulnerable populations like patients with chronic illnesses and older patients face worse health care (Peter, 1993).

Various solutions have been suggested to the potential risk to the minorities' medical care presented by the managed care systems. First of all, it is necessary to audit the managed care service providers in a further systemic way by professional medical organizations, consumer groups, and the government. Presently, there is very little monitoring and federal concern toward the significantly quick variations in the medical care provider. It is also required to create novel regulations or legislation that safeguard the optimal addition of physicians who practice in minority communities in the managed care system. To elaborate, with the example, the managed care system that inducts from minorities could be needed to hire a specific number of medical providers who practice there in the past. Likewise, legislations could be formed to guarantee that the categorical elimination of providers in poor communities does not happen. For instance, they can restrict the elimination of providers from managed health care plans on the basis of their parents' socioeconomic status, race, or health status (Doherty & Heinrich, 1996).

Lastly, sanctions can be used to avoid the discrimination activity being done by medical care organizations or entities. Systemic proof of current inequities could be encountered with the threat of loss in practicing license or by imposing a significant amount of fines.

It is emphasized by the researchers that the managed care system has the ability to enhance the medical care quality for minority communities. Providing higher bureaucratic oversight exists in medical care organizations; there is a chance for significant coordination of care, which can safeguard that individuals/patients took suitable health care. This was possible, if the substantial incentive were incorporated into the managed health care system, it could change the trends of minority communities getting less aggressive Healthcare and less number of medical procedures for a large number of medical conditions (Clouse & Osterhaus, 1994).

In the same way, groups like the National Committee for Quality Assurance that presently offer volunteer accreditation to nearly half of the health maintenance organizations in the USA could include racial disparities in care to the more than sixty standards that presently form the ground for the assessment of health care plans. This organization also manages the creation of the Health plans Employer Data and Information Set, which is a basic capacity and performance evaluation for the managed care system. It practices a number of standardized measures to relate to health plans. Presently, this system assesses what the medical plans essentially do in basic fields of care, like member satisfaction and immunization rates. The degree of racial/ethnic inequalities must be incorporated as an indicator of the performance (Beaulieu & Epstein, 2002).

Teaching and Training

In order to address and solve the problem of racial discrimination, it is need of the hour to educate the people at large and specifically, teaching the student at educational institutions to deal with biased behavior towards the black people. It is a must to significantly raise the general awareness level of all the people generally and the professional community specifically. There is a substantial dearth of literature on methodology on how to effectively increase awareness in public against racial discrimination in the medical profession. However, merely educating the public and professional community has its limits still educational campaigns can attain much over time. For instance, a massive media campaign has lowered the per capita consumption of tobacco on account of its harmful effects on smokers. Similarly, for professionals teaching and training, the medical syllabus must be revised and updated to highlight the issue of racial disparity and its sensitivity in its full form. Awareness of such issues to the practicing physicians should be part and parcel of their education and training (Sue et al., 2019).

No doubt, certain efforts are made to approach and emphasize the general and systemic problem of social and health care segregation, but it is still unclear how good they can do in this regard. There are certain cultural sensitivity programs that are designed, such as to address cultural sensitivity plans; however, unconscious and subconscious discrimination cannot be avoided to date. On the other hand, the course on cultural sensitivity may prove helpful to limit negative stereotypes (Cohen et al., 2002).

There are certain sensitivity training programmers that focus primarily on the odd behavior of medical help seekers. There is a requirement of more vigorous training and education of the medical health providers, with special emphasis on modification in their outlook and conduct with the patients. It will help to develop innovative strategies and apply them in an effective way to reduce subconscious and unconscious discrimination among different types of patients.

Last but not least, racial discrimination in medical care may be minimized by increasing the number of minority health providers. This is not merely to support the minority group on the basis of their race; rather, research data collected favors, black people. Black health professionals are more likely to take care of uninsured patients. Moreover, they are ready the serve in underprivileged rural and urban areas where most of their racial groups are stationed. Another study shows that in order to achieve racial population equality, the number of black residents needs to be doubled. Similarly, the white residents of first-year are required to be decreased by two-fifth and well as a significant reduction in Asian positioners is needed (Williams et al., 2019).

While looking at the current trends, it seems very unlikely that desired goals may be achieved in the near future. The data of the past thirty years favors our prediction as there has not been any significant increase in the fraction of underrepresented medical professionals, except just a little increase. Black physicians increased only slightly from 2.5 percent to 2.9 percent over the course of approximately thirty years. Although there was an initial increase in the representation of minority groups in the medical institutes starting from the late sixties, however, this proved to be temporary. In the mid-eighties, the enrollment of black people reached their peak and achieved approximately ten percent of the total intake of medical schools. As the lawsuits against discrimination were filed, this ratio started to lower. In order to cope with this declining percentage of black students in medical schools, medical college associations launch a pro-black campaign. The objective of the movement was to achieve three thousand minority group people in medical schools. This initiative reached its peak in mid-twenties with more than two thousand minority students in the medical schools, which accounted for approximately twelve percent of total student intake. Beyond this time, the number of applicants from minority groups started to decrease at a sharp rate. This decrease was most pronounced in the medical schools that did not fully follow rather banned the initial enrollment campaign (Williams et al., 2009).

As it can be seen that even the massive and aggressive approaches could not prove fruitful in the long run, therefore, still extensive research is required to recognize most suitable schemes for enrolment and sustainment of physicians from the minor and meager group of the society. One should not ignore the current research outcomes and in effect tactics because certain broad-ranged plans have been proved successful to some extent that promoted actions in favor of black health care professionals. There is an estimated figure that forty percent of assenting response was delivered by the black professionals or other underprivileged minority groups. It is true that there is a uniform trend, with a few exceptions, that most of the underrepresented groups failed to score similar marks as that of white people. However, their clinical performance was at par with the white people, which suggests that non-cognitive learning variable criteria should also be included in the selection of a competent medical professional (Williams & Mohammed, 2013).

Moreover, although they are unpopular, assenting action plans can be effectively defended on a number of bases, including considering it the responsibility of the society to meet the needs of all parts of the population. Furthermore, the current research data that highlights the racial chauvinism, principally subtle prejudice, is the signal and the essential source of antagonism to take affirmative movements. These reports suggest that there is a dire need to oppose and remove any kind of social racism so that this chapter of painful history may be closed forever from the face of the earth (Williams, 2012).

None the less, just be matching one kind of racial health professional with the patient of the same race is just enough. In the recent past, there have been cases where all black physicians' class behavior was noted. In this case study, the subjects were all poor and were not a threat to the

physician class, their family, and other close-ups. The study results argue that there is an emotional detachment of health care professionals from the group of their origin. Therefore, another kind of social discrimination starts to proliferate irrespective of the race of the professionals, and the patients become another stereotype for them research and investigation are required to locate the level at which these phenomenon function and what are the possible remedies to control such type of discrepancies most effectively (Feagin & Bennefield, 2014).

In spite of addressing the individual characteristics, energies to minimize the social, racial discriminations in the health care system should be brought about systematically in order to efficiently deliver the fruit of health care. It is an important question whether it is the potential to plan and apply schemes for the provision of medical attention, which may guarantee suitable behavior irrespective of subjective or out cold stereotype. Still, one cannot answer this question, and conclusive response to this query awaits further psychological and societal research. Still, some researchers consider that in the health profession, like many other occupations, microenvironment may be controlled, chores and procedures can be developed as well as the workforce can be skilled in the manner that can decrease the chances of unwanted results.

SUMMARY

It a general humiliation that there exists a large and wide-ranging racial difference in society, especially in the health sector. It a shame for humanity that the death rate in black people is significantly higher, approximately more than 1.5 times as compared to white people, and a more shocking fact is that this rate is the same for the last five decades. Furthermore, for the rate of numerous death-causing diseases, including heart conditions, cancer, liver conditions, and diabetes increased in certain periods of time in the black race. These figures are the mirror for the follow begins who publically advocate equal rights and services for everyone in the society. As a community, it is need of that hour we should make it our priority to racially back the under-representatives and cultivate plans to remove racial, social differences in the health care units.

The world leaders should put this agenda at their forefront. Some world leaders attained immense media coverage and public support by nationally and internationally advocating the severity of the problem and possible consequence, hence, educating the masses and provoking the concerned corners to make them leave no stone unturned to look into this problem. There are certain examples where the world leaders issued an executive order to address a certain problem. Such steps can be set as models for other leaders to take the lead. Such orders create an environment where the government, researchers, data analyzers, and policymakers are staged on the same table to develop guidelines for the relevant agencies. Similarly, a research and development group may be developed at national and international levels that should be able to monitor, regulate and coordinate the data from various sources, and hence, set short and long term goals to successively eradicate racial discrimination curse from the society. In continuation with the goal of alleviating racial differences, the establishment of intuitional capability is also necessary as well as enforcement of law and policies thus developed.

This discussion sums up that racial disparity acts like a technical threat in the exercise of the medical profession. A greater part of it may be the inconsiderate, thoughtless, and non-deliberate attitude of the society. But, irrespective of the motivation, racism has its hostile effects. To date, as a collective society, there is no data available to commendably lessen racism at single and collective levels. Although a number of books made racism their topic of discussion and there are many

programs running to promote cultural diversity and tolerance, none of them are good enough to provide a systematic approach regarding the underlying conditions and specific approaches that may be more or less nominal. Despite the increasing body of data that supports the racial consequences of health in numerous ways, an increasing number of systematic plans are required to be formulated and evaluated. Research and development centers for excellence need to be developed, backed by sizable funds aimed at interdisciplinary research on considering and alleviating racism in the health care department. Leadership has the courage, and practical approach is also required to initiate the essential footsteps to fully enforce all the available body of knowledge that we enjoy at the moment of will develop later on for minimizing race-based differences.

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