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Short Communication

Healthcare Disparities: Skin Color and Accessibility to Healthy Food

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The call to remove unfair disparities rings louder this year than any time before. With our current state of affairs, the theme of diversity is intertwined deeply in not only medicine but public health and the day-to-day life of pretty much everyone. It should be noted that healthcare, and more importantly health stems from more than just the services delivered in the clinic, but the accumulation of all the societal influences that someone experience seach day. For the reasons above, this writing will discuss the associations between the clinician's implicit attitude about race while analyzing neighborhood disparities. First, we will analyze the multitude of attitudes underlined by the prevailing clinician view point regarding individual race through discussion of both medical and humanities aspects. Then, this writing will explore the multitude of influences that affect neighborhoods with lower socio economical statuses. These two topics are discussed specifically due to the confounding factors that affect both these topics, as neighborhoods are often composed of individuals from similar socioeconomic backgrounds and who receive similar types of medical treatments.

A clinician's implicit attitude regarding race and its effect on healthcare delivery – from communication to interpersonal relationships to diagnosis – is one of the most discussed topics regarding the gap of healthcare disparity among different races. The consensus is that Hispanic and African American patients in particular receive a different level of care from that provided to Caucasian individuals. Dr. Inui[1].objectively examined clinicians' implicit attitude through a cross-sectional study of 269 patients within an urban community-based practice. The study concluded that there are implicit race biases against Black patients, which can be associated with markers including poor visit communication and poor ratings of care in general[1].The current prevalent topic concerns the heuristic and anchoring errors with respect to how African American patients from low socioeconomic backgrounds are treated differently. The steps to addressing this problem will have to come from a systemic approach as opposed to an individual approach. "Traditional" medical practices, including estimated glomerular filtration rate (eGFR) and differences in blood pressure associated with African Americans, for example, areentrenched in not only the medical curriculum but also the practice of medicine and its guidelines[2,3]. On the other hand, biases that individual practicing physicians have regarding African Americans will unfortunately be difficult to change considering that these biases are often deeply ingrained. The shift in clinician biases regarding African Americans and minorities in general should be focused on changing existing biases in the next generation of physicians, who have not yet been exposed to the depth and breadth of existing stereotypes.

Healthy foods, particularly the access to healthy food, is a controversial, yet important discussion. For example, the amount of healthy food consumed is actually higher among lower socioeconomically stratified individuals due to the limitations of EBT and its regulations against the purchase of processed food, compared to the next higher socioeconomic level that does not qualify for EBT and therefore actually consumes a larger proportion of processed and fast food. This exemplifies the theme of systematic change that can influence access to healthy foods. Not to mention that for middle class individuals, the choice between organic food and processed food often comes down to cost, with organic food typically being more expensive. Dr. Hilmer's article "Neighborhood disparities in access to healthy foods and their effects on environmental justice" reviewed studies of differences in accessibility of fast-food outlets by socioeconomic and racial or ethnic characteristics of neighborhoods[4].

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The study concludes that "the impact of neighborhood design on resident's health" is reflected through the "low-income and racial/ethnic minority populations" experiencing a "disproportionate distribution of food sources that contributes to the development of unhealthy behaviors among the communities, and the consequent disease burden deeply affects not only individuals and families, but also society as a whole."[4]Other factors include accessibility of convenience stores among different neighborhoods. Furthermore, according to Roni Neff's review article "Food systems and public health disparities," the lack of access can lead to a feedback loop in which the perceived lack of demand for health foods within a community can lead to storekeepers being reluctant to stock healthier food choices[5]. Such feedback loops also work in the opposite direction, with increased food education leading to an increase in demand for healthy food and an increase in accessibility thereof in a college setting[5] .Therefore, public education about the health benefits of organic, sustainable food is a key factor in mitigating healthcare disparities due to differential access to healthy food[6].The reasons behind why an individual would choose organic versus processed food for their family goes back to a systematic problem, and more importantly, a systematic solution [7].

Prevailing physician beliefs and neighborhood access to healthy food have large components ingrained in our system. Systemic approaches come down to adjusting the way medical education is taught regarding patients of different races, and the way that organic food markets are organized and subsidized regarding their pricing. Regulating organic food markets would be much more complicated, as adjusting the way specific foods are subsidized will have a widespread effect on supply and demand of these foods, ultimately incurring cost on the system trying to put the regulations in place. Systemic changes will also take place on a prolonged timeline that requires changes in an inverse pyramid model. Therefore, educating people on the health benefits of certain foods will also play a strong role in equalizing healthcare[8].The purpose of this paperis to discuss the entwinement of underlying racial biases in physicians and healthcare disparities stemming from disparity in access to organic or processed fast food [9]. The overarching themes of medical humanities – how physicians approach patients – and consumption of healthy foods are themselves, a form of preventive medicine, and comprise many of the themes discussed during our second-year education. The public health education we receive, in many ways, is a systematic approach to addressing the healthcare disparity issues discussed in this writing.

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