Ensnared by Color Blindness: Discourse on Healthcare Disparities
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Background: Colorblindness is the dominant framework that White Americans and a growing number of Black Americans use to interpret and respond to racial inequality. Individuals who adhere to colorblind ideology minimize the role of racism in shaping institutional behavior, individuals’ beliefs, social interactions, and outcomes for racial minority populations. We use qualitative data to explore the ways in which aspects of colorblind ideology—its minimization of racism, cultural racism, abstract liberalism, and semantic moves—inform the ways in which health care personnel “make sense” of healthcare disparities.

Methods: As part of a larger project on “health equity climate” conducted in 2014 in a large Minnesota health care system, we conducted 21 semi-structured interviews with key informants and 7 focus groups with administrators, nurses, and physicians. Key informants were purposefully sampled based on their role in the health care system and included senior executives division heads intermediate-level managers and equity team members. The focus groups were held with senior administrators, clinical service line leaders, nurse executives; inpatient nurse managers; cancer care providers; cancer clinical staff (e.g., social workers, care coordinators, etc.); and primary care providers. Interviews and focus groups were audiotaped and transcribed. The transcripts were coded both inductively and deductively for themes using the constant comparative method. The PI and a second coder independently coded each transcript and then compared and reconciled their codes.

Results: In line with colorblindness, race was considered only one of many factors associated with health disparities, socioeconomic status being most important. Respondents believed that all patients were treated equally by the healthcare system, in part due to race-neutral care processes and guidelines. Because our respondents overwhelmingly disavowed differential treatment, calls to disaggregate quality data by race seemed antithetical to equality. When respondents discussed health care disparities, they focused on the interpersonal level, i.e., how providers and staff treat patients, and on patients’ beliefs and behaviors. Drawing on abstract liberalism, respondents strongly endorsed patient responsibility for outcomes. Respondents also used several semantic moves common to colorblindness to refute suggestions of racial inequality, such as referencing blind spots or the diversity of personal networks, to explain their awareness (or lack thereof) of racial disparities.

Conclusions: Like other Americans, health care professionals use the colorblindness frame as they seek to understand health care disparities. To reduce racial disparities in health and health care, it will be important to communicate to stakeholders the ways in which colorblindness upholds the racial status quo and inhibits efforts to promote health equity.