



*MSS Health Disparities Presentation
Speaker Notes*

1:

2:

- Public health literature uses the term “disparity” to mean an inequity or inequality, and “health disparity” as a “chain of events signified by a difference in access to, utilization of and quality of care.” Use of the term inequity implies not only that there is a measurable difference, but that it is *unjust* and *avoidable* (Carter-Pokras and Baquet 2002).
- Healthy People 2010 defines health disparities as “differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.” (US Department of Health and Human Services, 2000)
- Institute of Medicine’s 2002 report specifically focused on the issue of racial and ethnic healthcare disparities and narrows the definition to “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention” (Smedley, Stith et al. 2003).

3:

- Disparities exist both in *health*, that is, a higher burden of illness or higher mortality in minority populations and in *health care*, which refers to access or quality of care that is not due to health needs (Lillie-Blanton & Lewis, 2005).
- Disparities have been well-researched and documented in almost all areas of medicine including health outcomes, health status and access to care. Disparities have been studied among most minority groups (Hispanics Americans, Native Americans, Asian Americans), but they have been best studied in African Americans.

4:

- Infant mortality is nearly 2.5 times greater among African Americans than among whites (Agency for Healthcare Quality and Research, 2002)
- Hispanic Americans are twice as likely to die of diabetes as non-Hispanic whites (US Department of Health and Human Services, 2000)
- African American women are more likely to die of breast cancer than white women, despite having comparable screening rates (US Department of Health and Human Services, 2000)

5:

- In a Kaiser Family Foundation survey, Latinos, Asians, African Americans and Native Americans were more likely to be without a health care visit in the last year, compared with whites (Kaiser Family Foundation, 2003). These differences, however, are not as great as differences in the *source* of care.
- In a Commonwealth fund study, 80% of whites reported that their usual source of care was a doctor’s office, compared with 70% of African Americans, 68% of Asian Americans and 57% of



- Hispanics. Also, 14% of Hispanics and 13% of African Americans either rely on emergency rooms or report *no* source of care (compared with 6% of whites and 8% of Asian Americans) (Collins, Hughes et al. 2002)
- 28% of Hispanics, 24% of Asian Americans and 22% of African Americans reported that they had “very little choice” or “no choice” in where they get health care, compared with 15% of whites (Collins, Hughes et al. 2002)
- 6:
- Bach et al. (2000) reported that, among Medicare patients, African American patients with early stage non-small cell lung cancer were half as likely as white patients to undergo surgical resection (64% vs. 77%). African American patients also had lower five year survival rates, while black patients who had surgery showed similar survival rates as whites.
- 7:
- There is a growing body of evidence that indicates that even when factors such as socioeconomic status, insurance coverage and ability to pay for healthcare are controlled, the race gap in healthcare persists. The evidence is especially strong in the area of cardiac care.
 - Vaccarino, et al. reviewed data on treatment strategies following myocardial infarction for almost 600,000 patients from 1994-2002. Among patients who were “ideally suited” for each treatment strategy, they found that African Americans were less likely than whites (and females less likely than males) to undergo reperfusion therapy and angiography. Among patients treated between 2000 and 2002, 86.8% of ideal white male candidates underwent reperfusion therapy vs. 82.6% of white females, 80.7% of black men and 78.8% of black women. For coronary angiography, 65% of ideal white male candidates underwent this procedure vs. 52.7% of white women, 61.1% of black men and 51.1% of black women (Vaccarino, et al. 2005).
 - Schulman, et al. (1999) studied the effects of age and race on rates of referral for cardiac catheterization. A set of “patients” were video recorded describing a scripted set of chest pain characteristics and history and evaluated by physicians for possible coronary disease. The study found that men and whites were more likely to be referred for cardiac catheterization, with black women being significantly less likely than white men to be referred.
- 8:
- Pictured are the four 55 year old “patients” used in the Schulman et al. study. (A second group of 70 year old “patients” was also used.)
- 9:
- In 2002, the Institute of Medicine issued a landmark report on disparities in quality of care. After reviewing over 100 studies, they found that the data was extremely consistent in concluding that racial and ethnic disparities are significant even when confounding factors such as insurance status, income, severity of illness, presence of co-morbid illness, etc. were controlled for.
 - To state it simply, when a minority patient enters the health care system, he or she receives lower quality care than an equivalent white patient.



10:

- Not everyone recognizes racial and ethnic disparities as a problem, and these differences fall along racial and ethnic lines. Minorities are more likely to feel that they are worse off in terms of access to health care than whites, face more discrimination and have fewer opportunities in life. (Washington Post, Kaiser Family Foundation and Harvard University, 2001; Institute for Ethics at the AMA and AMA Minority Affairs Consortium, 2003).

11:

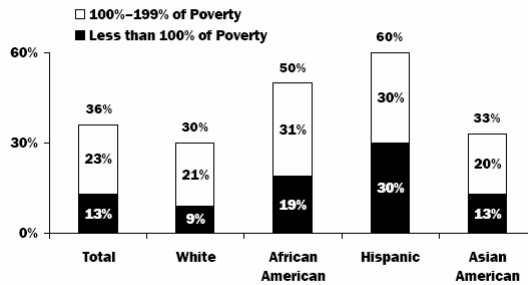
- According to a 2001 survey by the Kaiser Family Foundation, physicians' perceptions of racial and ethnic differences in health care tend to parallel that of the general population. A minority of white physicians thought that the health care system "very often" or "somewhat often" treated patients unfairly based on race or ethnicity. The overwhelming majority of African-American and a majority of Hispanic physicians agreed with this statement. Total, only 29% of physicians thought that disparities based on race and ethnicity existed in the health care system (Kaiser Family Foundation, 2002)
- The AMA Institute on Ethics conducted a survey of 2000 physicians in 2004, on behalf of the Commission to End Health Disparities. Their early results show that 55% of physicians agreed that "minority patients generally receive lower quality care than white patients", while 21 percent were unsure of this claim and about the same number (24 percent) disagreed with it. Also, 62% of physicians reported they had personally witnessed a patient receive poor quality health care because of the patient's race or ethnicity.
- This survey also found that physicians were interested in or actively participating in activities to address disparities. Within the last month, 32% of physicians surveyed had spoken with colleagues about ways to address specific health care needs of their minority patients and 44% had spoken with a community health worker about the health needs of patients in their practice community. Within the last six months, 19% had attended an educational event and 54% had read a journal article on improving the health of minority patients. (AMA/NMA/NHMA Commission to End Health Disparities, 2005)
- *Awareness is increasing!*

12:

- *Patient factors*
 - Minorities (especially African Americans, Native Americans and Hispanic Americans) are more likely to be of a lower socioeconomic status than white Americans. In a 2001 survey, nearly one out of five African American and one out of three Hispanic Americans report incomes below the federal poverty level (\$18,000 for a family of four), compared to one in ten white Americans (Collins, Hughes et al. 2002).

Chart 1

Poverty Status, by Race/Ethnicity



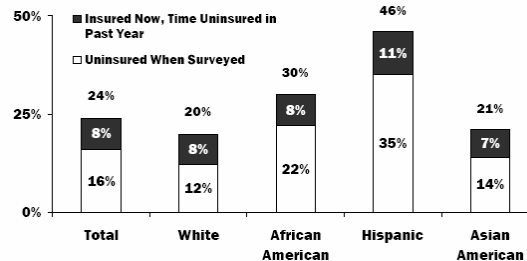
Source: The Commonwealth Fund 2001 Health Care Quality Survey.

- 46% of Hispanic Americans and 30% of African Americans were uninsured at some point during the last year, compared with 20% of white Americans and 21% of Asian Americans

Chart 2

African Americans and Hispanics Most Likely to Be Uninsured During the Past Year

Percent of adults ages 18-64



Source: The Commonwealth Fund 2001 Health Care Quality Survey.

- Economic and insurance status are well correlated with poor health outcomes and health status.
- A few studies have found that African American patients are more likely to reject provider recommendations, however only a 3-6% difference between black and white patients has been seen and it is unlikely that this factor alone accounts for the racial and ethnic disparities seen. These differences could also be related to mistrust or negative perceptions of the health care community and physicians. (Smedley, Stith et al. 2003).
- *Institutional factors*
 - Cultural and linguistic barriers such as lack of trained interpreters or a healthcare staff that does not reflect the racial/ethnic make-up of the patient population can contribute to minority patient marginalization (Brach and Fraser 2002).
- *Provider factors*
 - Physicians are not *more* likely than the general population to operate based on racial bias, however, they are also not *less* likely! The complexity of the decisions physicians must make, combined with time constraints and high pressure situations may cause physicians to rely on stereotypes or subconscious bias (van Ryn and Burke 2000).
- **Access is the main predictor in quality of health care across racial and ethnic groups.** However, **access does not account for disparities in their entirety** and this is where provider



and institutional factors come into play (Institute of Medicine, *Presentation, Unequal Treatment, Confronting Racial and Ethnic Disparities in Healthcare*, 2002). Because physicians and healthcare workers contribute to a portion of the disparity problems, they stand in a position to ‘close the gap’ caused by these provider and institutional factors.

13:

14:

- A study of 164 medical students found that students were more likely to evaluate a white male “patient” with cardiac symptoms as having a higher health status relative to a black female “patient” with objectively similar symptoms. (Rathore, Lenert et al. 2000).
- In the van Ryn & Burke study, blacks were only half as likely to be considered “very” intelligent compared to whites, even when controlling for socioeconomic status and other covariates. The physicians felt less affiliation with the black patients (were less likely to agree that black vs. white patients are “the kind of person they could be friends with”) and ranked black patients as more likely to be at risk for noncompliance (van Ryn and Burke 2000).
- African Americans and low income patients were less likely to report receiving advice during to primary care visit to quit smoking, less likely to discuss diet and exercise and less likely to receive prenatal care advice on alcohol use, breastfeeding and smoking (van Ryn and Fu 2003).

15:

- Patients report feeling the effects of poor provider-patient communication. Although all patient groups report problems communicating with their doctor, minority patients are more likely to experience miscommunications and. These findings are likely due largely to language barriers, but Asian Americans and Hispanic Americans whose primary language is English are still more likely to report problems interacting with their physician (Collins, Hughes et al. 2002).

16:

- If providers communicate lower expectations to certain patients, those patients’ own expectations for their condition or progress may be adversely impacted (van Ryn and Fu 2003).
- When medical decisions must be made under time and resource constraints, physicians may fall back on stereotypes concerning a patient’s condition and treatment and make decisions based on inadequate information (Institute of Medicine, 2002).
- Patient and provider actions and attitudes can interact to create a sort of cycle of mistrust leading to poorer health. Though most individual patients trust their personal physician, certain minority communities may have an underlying mistrust of the medical community. For example, African Americans are much more likely to mistrust hospital care and are often very suspicious of research in the medical community (Institute for Ethics at the AMA and AMA Minority Affairs Consortium, 2003). This pre-existing mistrust can affect patient adherence, which in turn can cause the physician to become frustrated and lower expectations for that patient. The physician may be less likely to recommend treatments or services that require greater patient adherence. As



patients sense that the doctor doesn't trust them, their own mistrust is increased, and the cycle continues (Institute of Medicine, 2002).

17:

- More than half of the general public and many physicians are still unaware of racial and ethnic health disparities (Lillie-Blanton, Brodie et al. 2000; Kaiser Family Foundation, 2002). Though doctors are considerably more aware of health care inequities, further education to eliminate this “awareness” barrier will open the way for efforts to address the problem.
- In 2004, underrepresented minorities (African Americans, Native Americans and Hispanic Americans) made up 13.8% of matriculates in American medical schools while making up approximately 27% of the general population. Not only will increasing the diversity of the medical student population contribute positively to medical education as a whole, but studies have also shown that minority physicians are more likely to be sensitive to the needs of underserved minority populations and practice in underserved areas (Association of American Medical Colleges, 2005).

18:

- The goal of cultural competency is to teach health care providers how to improve communication and the patient-physician relationship across cultural barriers. Since it was first suggested that cultural competency may be a means to reduce health disparities, there has been a decent amount of evidence that it does improve communication and health outcomes among racial and ethnic minorities (Williams 2005)
- Cultural awareness means that providers are sensitive to the values and beliefs of their patients and the ways they approach and solve problems and understand how sociocultural factors affect health behaviors and quality of care. It also means that providers understand their own cultural values and beliefs and how this can influence interactions with patients.
- Cultural knowledge is understanding a few of the basic principles of patients' worldview – their beliefs, values, lifestyle, etc.
- Cultural skills refer to the ability of the provider to communicate effectively and deal with conflicts cross-culturally (Camphina-Bacote, 1999; Betancourt, 2003).
- It should also be noted that if the goal of cultural competency training is to master certain information about certain minority communities (i.e. all African Americans think this, or all Hispanic Americans tend to respond to this, etc.), it may actually serve to *enforce* stereotypes and hinder progress towards culturally appropriate care. The goal of training should emphasize cultural skills which will allow the provider to deal with the kinds of conflicts and challenges that may arise in a cross-cultural clinical encounter. Rather than memorizing “facts” about specific racial or ethnic groups, the focus is understanding the culture of individual patients and appropriately responding to their unique needs (Williams 2005; Carrillo, Green et al. 1999).

19:

- This mnemonic “LEARN” illustrates some key skills in cross-cultural communication. Use of these principles allows the provider to understand how the patient understands their own illness and allows decision-making to be more participatory (Berlin and Fowkes, 1983; University of Michigan Health System, 2005)



20:

- In 1978, Kleinman (a medical anthropologist) developed eight questions that could allow providers to develop an “explanatory model” – a framework for understanding how the patient’s sociocultural context affects the way they (and their family) view their illness. Here are the eight questions (Kleinman, Eisenberg and Good, 1978).
 1. What do you call the problem?
 2. What do you think has caused the problem?
 3. Why do you think it started when it did?
 4. What do you think the illness does? How does it work?
 5. How severe is the sickness? Will it have a short or long course?
 6. What kind of treatment do you think the patient should receive? What are the most important results you hope he/she receives from this treatment?
 7. What are the chief problems the illness has caused?
 8. What do you fear most about the illness?

21:

- Present or distribute information to your fellow students that focuses on minority health disparities

Presentation resources

- [*Why the difference?*](#) Kaiser Family Foundation and Robert Wood Johnson Foundation. Speaker’s kit on racial and ethnic disparities in cardiac care
- [*Take the challenge! Student action for zero health disparities.*](#) American Medical Student Association. Outlines current health disparities and student driven solutions
- [*Unequal Treatment: Confronting racial and ethnic disparities in health care.*](#) Institute of Medicine. Two-part presentation on the IOM’s report
- [*Race, Trust, and Tuskegee: Professional Ethics, Broken Trust and Health Disparities.*](#) Institute for Ethics at the AMA and AMA Minority Affairs Consortium.

Fact sheets

- [*Racial Ethnic Difference in Cardiac Care: The Weight of the Evidence.*](#) Kaiser Family Foundation fact sheet
 - [*Health disparities fact sheets.*](#) American Public Health Association.
 - [*Physicians for Human Rights fact sheets.*](#) Physicians for Human Rights.
- Invite a speaker or assemble a panel discussion



- Organize a book, reading or film discussion

Suggested readings

- *"The Spirit Catches You and You Fall Down: a Hmong child, her American doctors and the collision of two cultures."* Anne Fadiman
- [Unequal treatment: what healthcare providers need to know about racial and ethnic disparities in healthcare.](#) Institute of Medicine

22:

- The University of Illinois at Chicago Medical School's cultural competency curriculum was implemented as a result of an initiative by medical students to create an extra-curricular educational program on cultural competency (Physicians for Human Rights, 2005)

23:

- Partner with local schools to create a "doctor day" or health career fair to expose minority and low income children to the health careers.
- Set up a mentoring program between medical students and high school students interested in the health professions.
- The University of Minnesota Medical School Twin Cities worked with a local high school science department to create a "health care and career fair." Medical students taught high school students to take blood pressures, read x-rays, and had displays on different areas of health care (AMA-MSS 2005).

24:

- Identify local community leaders interested in health disparity issues and partner with them to raise awareness and advocate local, state and national governments to address health disparities.

25:

H-350.967 Eliminating Health Disparities

Our AMA will engage in activities, including but not limited to: educating members on Healthy People 2010 through sponsored Continuing Medical Education events and publications; encouraging state medical societies to engage in promoting activities that address the elimination of health disparities; and investigating the development of a partnership with the Department of Health and Human Services to work to accomplish the goal of eliminating disparities on the basis of race and ethnicity. (Res. 414, A-00)

H-350.974 Racial and Ethnic Disparities in Health Care

Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.



The AMA emphasizes three approaches that it believes should be given high priority:

- (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
- (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
- (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. (CLRPD Rep. 3, I-98; Appended and Reaffirmed:: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03)

H-295.897 Enhancing the Cultural Competence of Physicians

The AMA will:

- (1) continue to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula;
- (2) continue research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings;
- (3) form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database;
- (4) assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; and
- (5) seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women Association, the American Public Health Association, the American Academy of



Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. (CME Rep. 5, A-98)

26:

27:

- Numerous healthcare and government organizations have made the elimination of racial and minority health disparities one of their top priorities. The issue is also one of the AMA's top advocacy issues.
- The second annual National Healthcare Disparities Report from the Agency for Healthcare Research and Quality showed that disparities are "slow to change," but found progress in a few specific areas (Troutman 2005).

28:



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