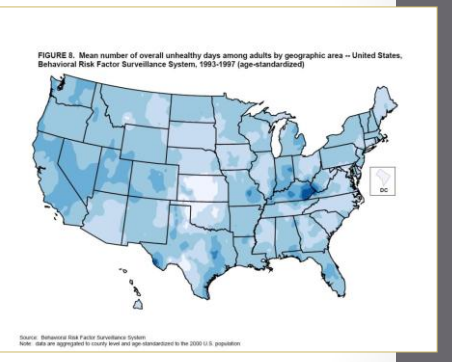
Health Disparities and Social Determinates of Health

Health Disparities: Objectives

- Overview of health disparities
- Define race, ethnicity and health disparities
- Critically examine racial/ethnic classifications – Considerations for health disparities
- Explore social determinants of health
- Examine the impact of discrimination and racism on health
- Identify key areas of for health disparities
  - Provide illustrative examples using, Cardiovascular disease, Cancer, Infant Mortality
  - At risk populations
    - Hispanics
    - African American/ Blacks
- Review national imperatives and implications for public health.

What are Health Disparities?

- Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases.
- Disparities– or inequalities – occur when members of certain groups do not enjoy the same health status as other groups.
- Disparities extend beyond race and ethnicity.



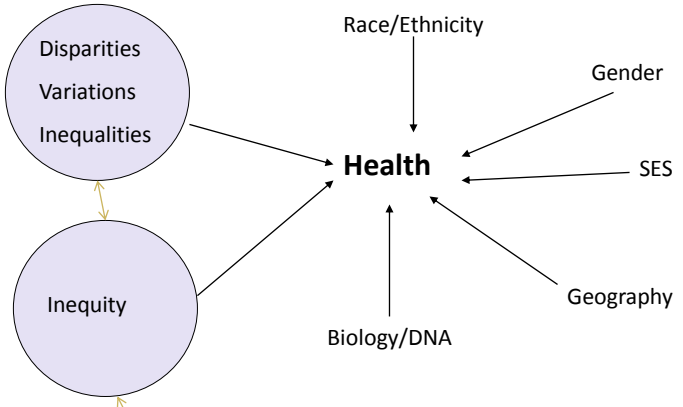
Source: http://crchd.nci.nih.gov/chd/
http://www.cdc.gov/gis/mg_age_adj_93_97.htm

Evidence of Racial and Ethnic Disparities in Healthcare

- Disparities consistently found across a wide range of disease areas and clinical services.
- Disparities are found even when clinical factors are taken into account.
- Disparities in care are associated with higher mortality among minorities .
- Disparities are measured relative to the group with the best rate.
- Gaps in health disparities data
  - Lack of data on disability
  - Lack of data regarding sexual orientation

National Institute of Medicine Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care
Truman et al, 2011

Disparity vs. Inequity



"Is it fair" or "Is it just"

"Should poor people die younger than rich people"

"Is it fair that smokers get more lung cancer"

Truman et al 2011

Individuals from at risk and underserved populations are more likely to:

- Die from preventable diseases
- Use fewer preventive and screening services
- Be diagnosed with late-stage disease
- Receive poorer quality care
- Die from curable diseases
- Endure greater pain and suffering
- Have problems navigating health care system
- Not seek needed care if they cannot pay for it.
- Have inadequate health insurance coverage
- Have lower annual earnings

http://www.cancer.gov/cancertopics/factsheet/cancerhealthdisparities

Racial and Ethnic Categories

- Race is defined as: originally defined as “shared biologic origin”
- Ethnicity: a label given to a group of people with a shared language, history, beliefs, culture and/or national origin
- Current racial/ethnic classification categories were developed by the Office of Management and Budget (OMB)
  - **Ethnic categories:**
    - Hispanic or Latino
    - Not Hispanic or Latino
  - **Racial Categories**
    - American Indian/Alaska Native
    - Asian
    - Native Hawaiian or Other Pacific Islander
    - Black or African American
    - White
    - More Than One Race
- The OMB noted the absence of "scientific or anthropological" foundations in its formulation.

Kagawa-Singer et al 2010

History of the concept of “race”

- 1790-1840: Enumeration based on status as free or slave and whether paid taxes.
  - Categories: Free white males and females, Anyone else who was free regardless of color, Slaves , Indians
- 1850-1920
  - Theory of polygenism
- 1930-1960
  - Classifications were simplified (White vs Non-white)
- Racial categories served as a means to distinguish and control other "non-white" populations in various ways.
- 1960 – present
  - Civil Rights Act of 1964

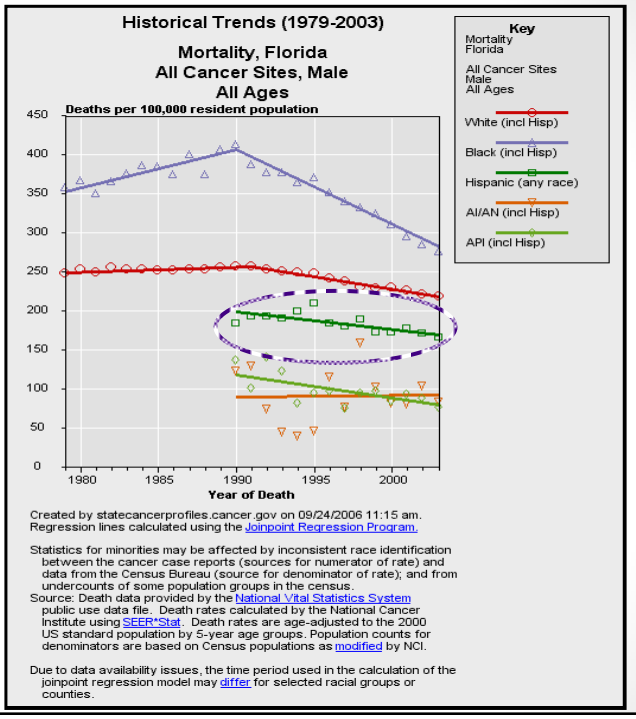
http://www.aaanet.org/gvt/ombdraft.htm, Wissow, Health Behavior and Society. Johns Hopkins School of Public Health

Problems with the concept of race and common mistakes

- Race is a socio-political construct - it does not exist biologically
- Treat all people of one racial, ethnic, national or other group as though they are all the same with respect to all important health determinants
  - Differences (genetic, cultural and otherwise) between individuals within groups are ignored
  - Groups are treated as distinct and mutually exclusive (genetically, culturally, etc)
  - Conflated ancestry, culture, socio-political categories

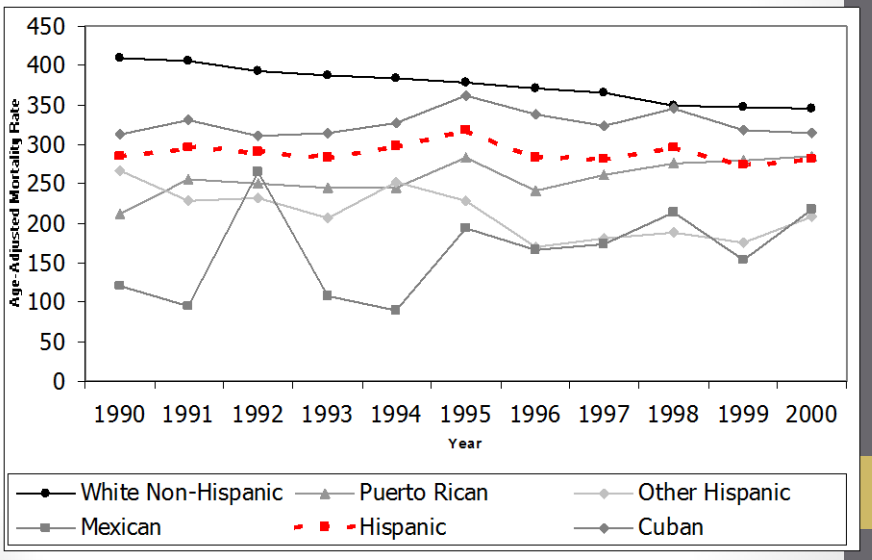
www.minority.unc.edu/institute/2006/materials/**slides**/2006sphrimh-**ossorio**-dis.ppt
http://www.aaanet.org/gvt/ombdraft.htm, Wissow, Health Behavior and Society. Johns Hopkins School of Public Health

Florida



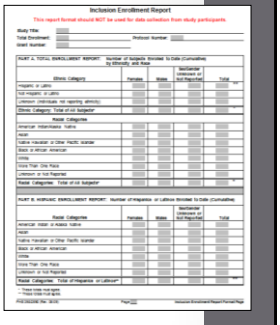
http://statecancerprofiles.cancer.gov/index.html - historical trends

Hispanic and white-non Hispanic male age-adjusted cancer death rates, **Florida** 1990-2000



Martinez Tyson et al 2009

Why do we use "race" as a variable in public health?



- Standardize the collection of information among state and federal agencies
- Race is perpetuated by the attempt to identify populations at risk
- Possibly appropriate
  - Experience or practice of discrimination is a relevant variable
  - Studies of populations that self-identify in this way
  - Studies linked to policies/laws that use this label
- Studies targeting populations with apparent differences in gene prevalence
  - Tay-Sachs (Eastern European Jews), Sickle cell disease (African-Americans)
- Probably not appropriate
  - Conscious or unconscious proxy for income, SES, place of residency
  - Studies that assume race has inherent biologic associations to broad characteristics like behavior or intelligence

www.minority.unc.edu/institute/2006/materials/**slides**/2006sphrimh-**ossorio**-dis.ppt
http://www.aaanet.org/gvt/ombdraft.htm, Wissow, Health Behavior and Society. Johns Hopkins School of Public Health

The Medicalization of Race: Scientific Legitimization of a Flawed Social Construct.

"---Ethnic boundaries are dynamic and imprecise, and it is dangerous to assume that any person possesses a certain health variable just because that person is a member of a particular ethnic group. The common thread between ethnicity and race is that both are social constructs and subject to ethnocentric biases."

Ritchie Witzig – Ann Int Med 1996;125:675-679
www.minority.unc.edu/institute/2003/materials/**slides/Rotimi**-20030610.pp

t

Social determinants of health:

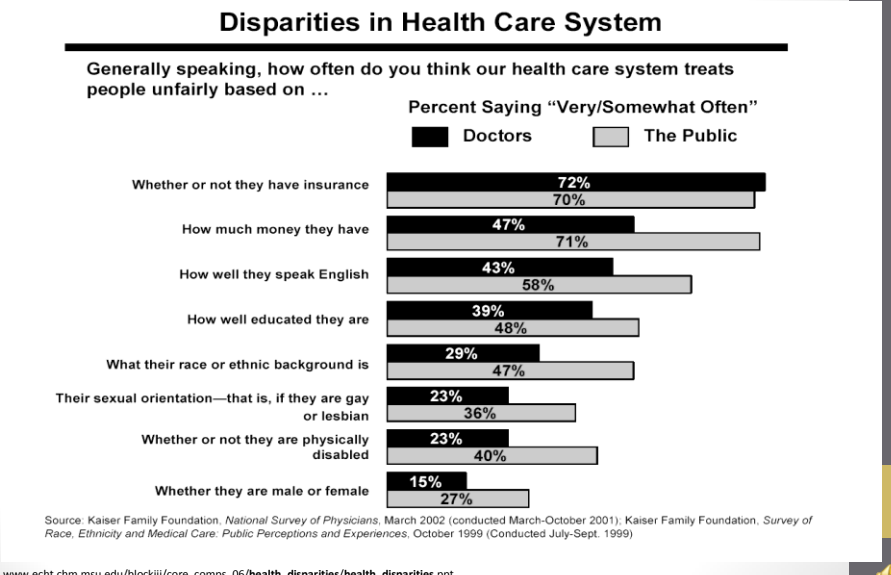
- **Childhood / Early Life Experience:**
- **Chronic Stress**
- **Education**
- **Food Security**
- **Housing and Neighborhood:**
- **Income and Socioeconomic Status**
- **Jobs and Work**
- **Racism and Discrimination**
- **Social Inclusion**
- **Health Services Access/ Insurance coverag**
- **Poor communication between patient/providers**

http://www.unnaturalcauses.org/assets/uploads/file/primers.pdf

Professional biases and discrimination also contribute to disparities:

- Prejudicial attitudes on the part of care-givers and providers also contribute to health disparities.
- There may be cross-cultural misunderstandings.
- Everyday little indignities - "unconscious discrimination."
  - ***"Not that I was poor, but I was made to feel poor"***
- Providers may have their own unconscious bias and stereotypes.
- Patients, clients and the community may show avoidant behavior based on fear of discriminatory treatment.

TWO DIFFERENT POINTS OF VIEW…



www.echt.chm.msu.edu/blockiii/core_comps_06/**health_disparities/health_disparities**.ppt

Shifting perspectives in health disparities research

- Context is important
- Consider "up stream" broader ecologic/ structural factors
- Sharing voice and power
- Causal pathways are complex
  - Racial genetic model
  - Health-behavior model
  - Socioeconomic model
  - Psychosocial stress model**
  - Structural-constructivist model**

Heurtin-Roberts and Philogene

Have we made much progress since the 1930s?

What do you think?

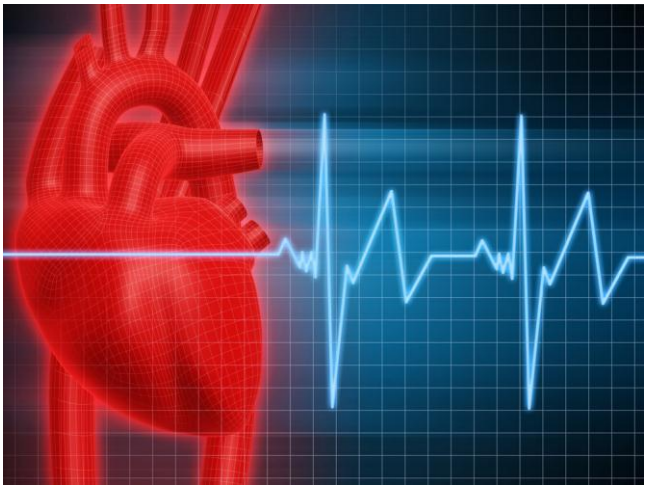
- In 1937
- The African American (AA) death rate exceeded that for European Americans (EA) at every age level and was more pronounced for females than for males.
- Between the ages of 15 and 25 years, AA males died at nearly 2.5 times the rate for EA males.
- AA female mortality rate was more than 3 times that for EA females.
- AA male who reached age 50 could expect 3.5 years less than an EA male
- An AA woman can expect to live 4.5 years less.

- In 2004
- AA mortality rates again exceeded those for EA at every age group, with the exception of those over the age of 85.
- Between the ages of 15 and 25, AA males in 2004 died at nearly 1.9 times the rate for EA males and AA females experienced a mortality rate that was 1.4 times that for EA females.
- An AA 50 yr old male can expect to live 4 years less than his EA male counterpart……
- An AA woman can expect to live 3.1 years less.

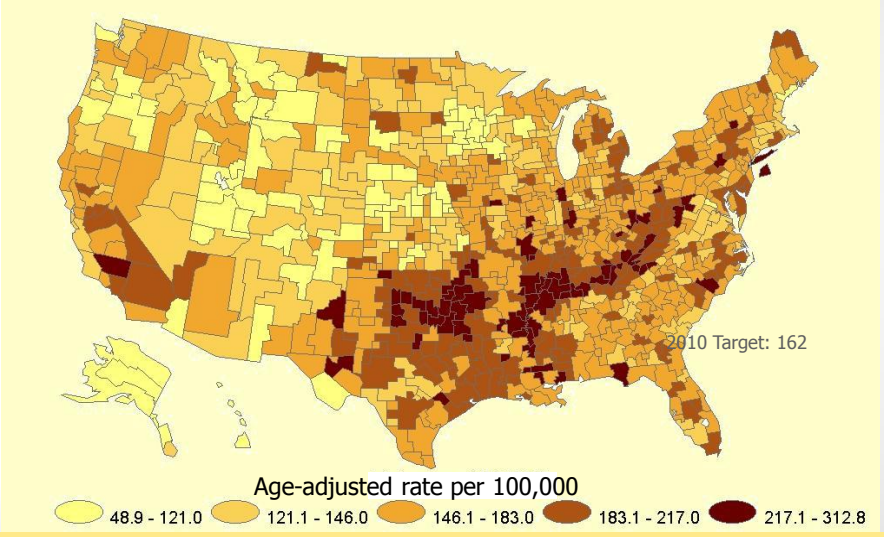
Healthy People 2010

- A comprehensive set of national health objectives for the decade
- Goals:
  - 1: Increase Quality and Years of Healthy Life
  - 2: Eliminate Health Disparities
- What's new for 2020
  - A renewed focus on identifying, measuring, tracking, and reducing health disparities through a determinants of health approach.
  - MAP-IT Framework

Cardiovascular Disease



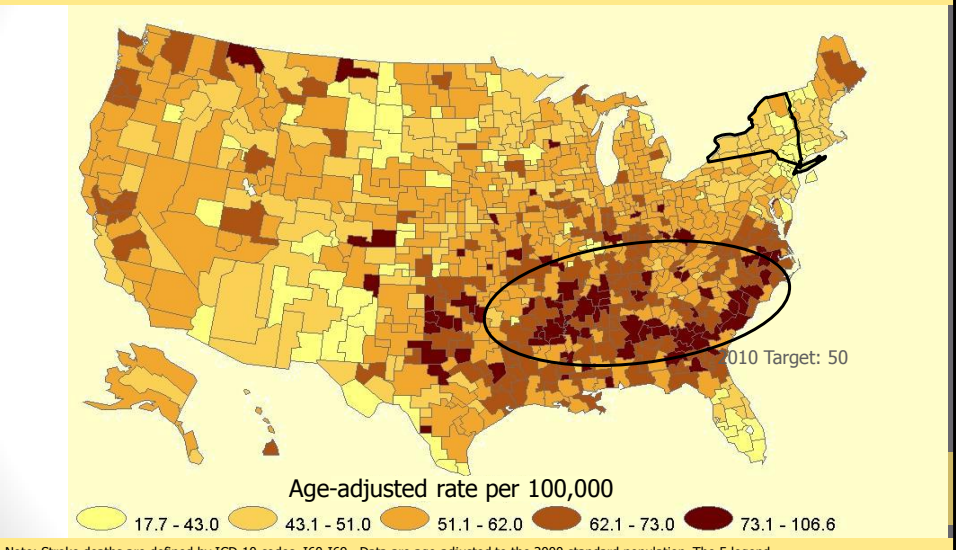
Coronary Heart Disease Deaths by Health Service Area, 2002-2004



Note: Coronary heart disease deaths are defined by ICD-10 codes I11, I20-I25. Data are age-adjusted to the 2000 standard population. The 5 legend categories represent the following percentage of Health Service Areas (from lowest to highest): 10%, 20%, 40%, 20%, 10%. Source: National Vital Statistics System—Mortality (NVSS-M), NCHS, CDC.

Obj. 12-1

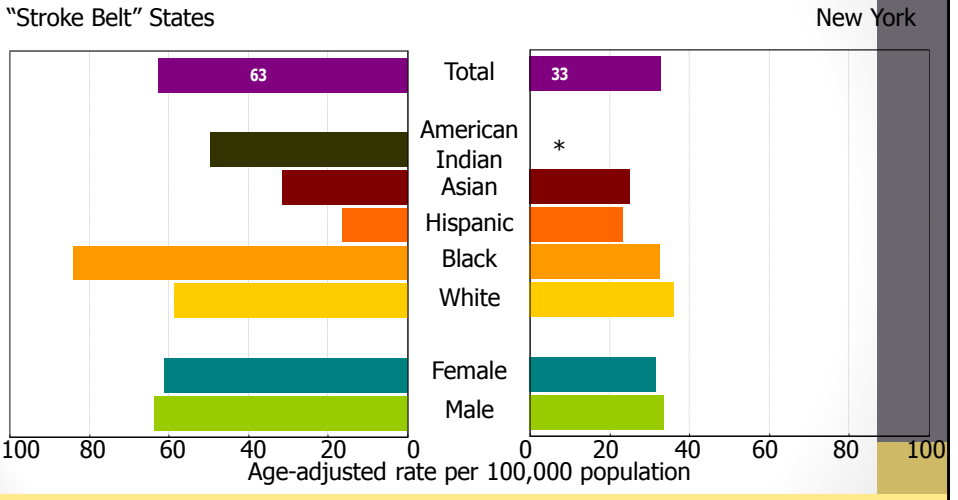
Stroke Deaths
by Health Service Area, 2002-2004



Note: Stroke deaths are defined by ICD-10 codes I60-I69. Data are age-adjusted to the 2000 standard population. The 5 legend categories represent the following percentage of Health Service Areas (from lowest to highest): 10%, 20%, 40%, 20%, 10%.
Source: National Vital Statistics System—Mortality (NVSS-M), NCHS, CDC.

Obj. 12-7

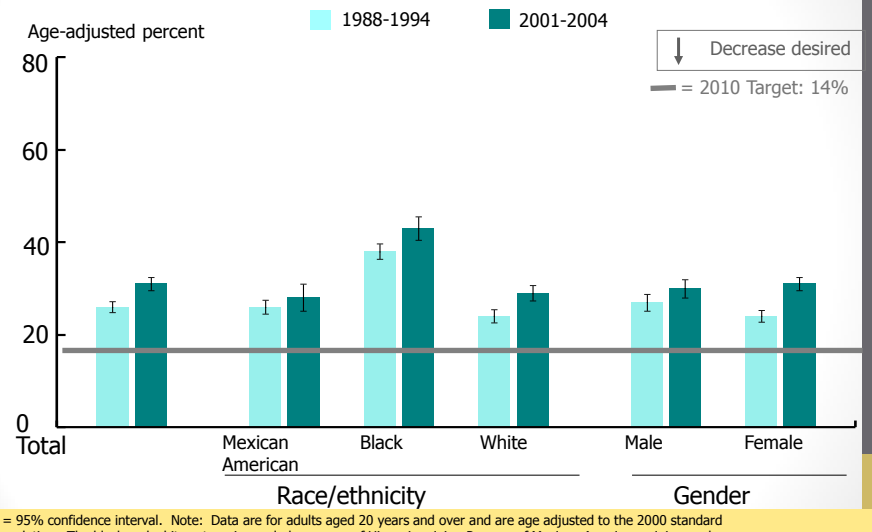
Stroke Deaths in Select Areas, 2004



* = Data are statistically unreliable.
Note: Stroke deaths are defined by ICD-10 codes I60-I69. Data are age adjusted to the 2000 standard population. "Stroke Belt" States are Alabama, Arkansas, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee. Asian includes Pacific Islander. The black and white categories exclude persons of Hispanic origin. Persons of Hispanic origin may be of any race. Source: National Vital Statistics System—Mortality (NVSS-M), NCHS, CDC.

Obj. 12-7

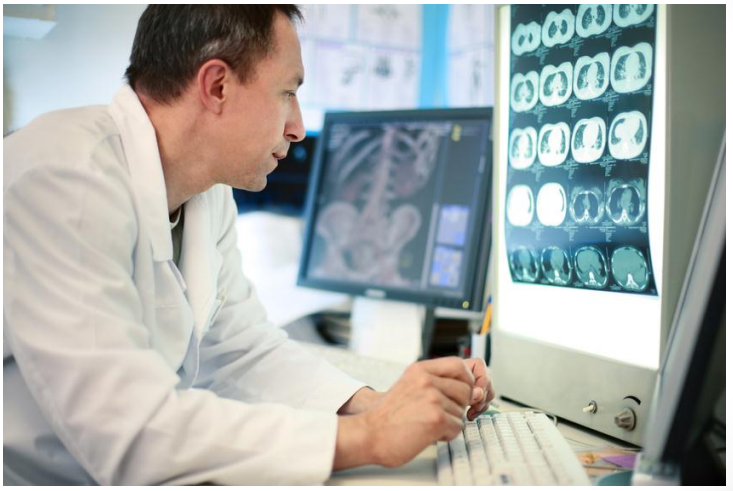
High Blood Pressure Prevalence



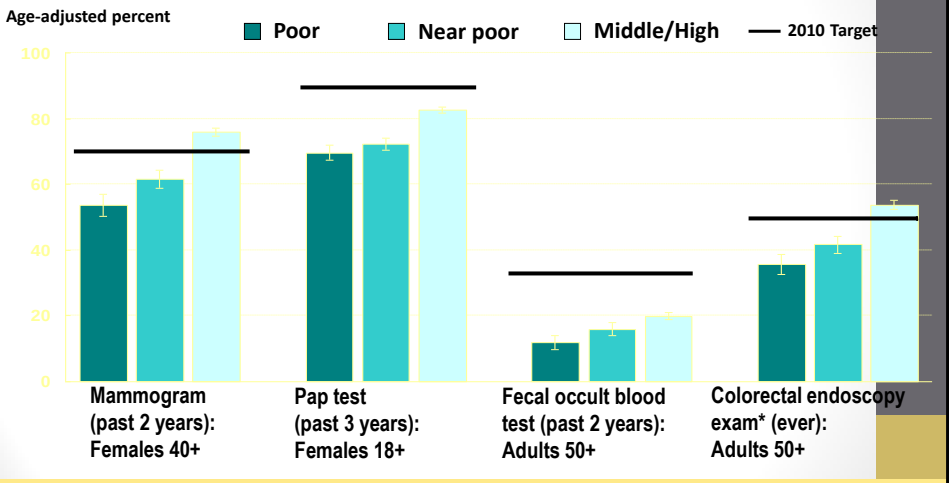
I = 95% confidence interval. Note: Data are for adults aged 20 years and over and are age adjusted to the 2000 standard population. The black and white categories exclude persons of Hispanic origin. Persons of Mexican American origin may be any race. Prior to 1999, respondents were asked to select one race category; selection of more than one race was not an option. For 1999 and later years, respondents were asked to select one or more races. Data for the single race categories are for persons who reported only one racial group. Source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Obj. 12-9

Cancer



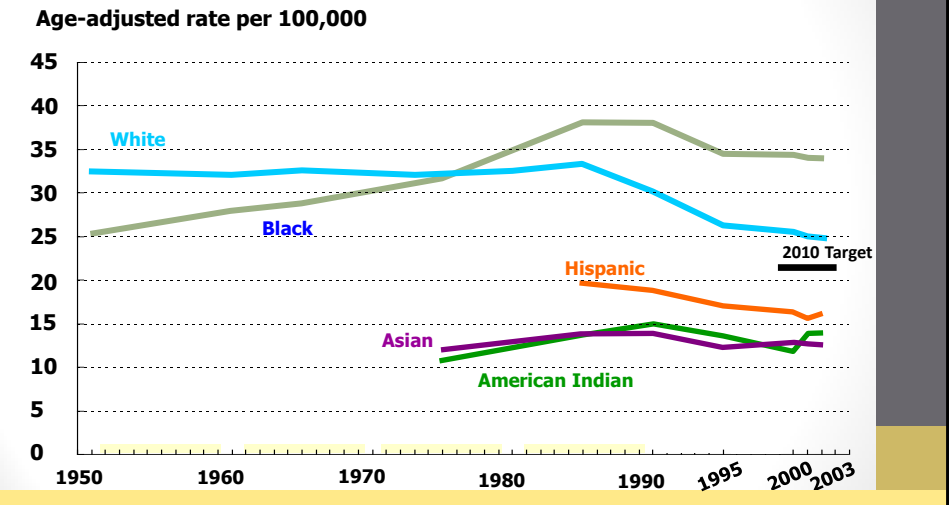
Early cancer detection procedures, by family income level, 2005



*Includes sigmoidoscopy, colonoscopy, and proctoscopy Note: Data are age adjusted to the 2000 standard population. Poor includes those below the Federal poverty level, Near poor includes those 100-199% of the Federal poverty level, and Middle/high income includes those 200% or more of the Federal poverty level.
SOURCE: National Health Interview Survey, CDC, NCHS.

Objs. 3-13, 3-11b, 3-12a, 3-12b

Female breast cancer mortality, by race and ethnicity

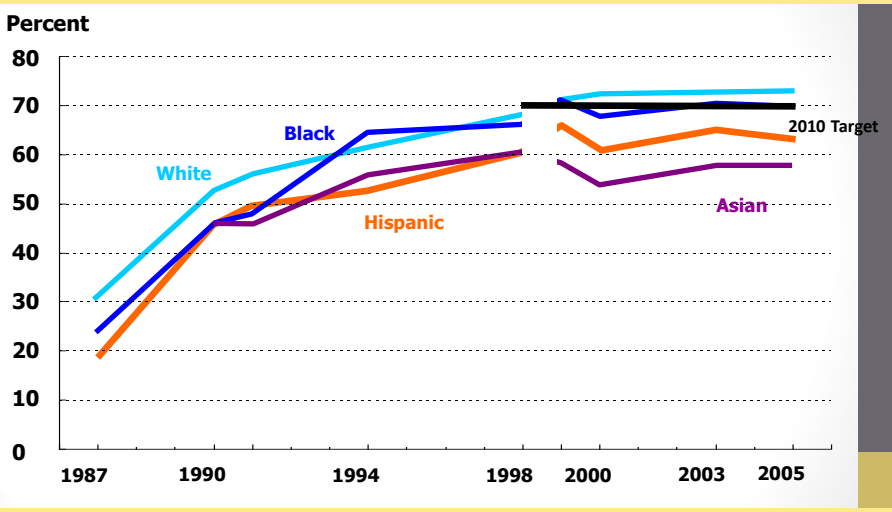


Disparities in Breast Cancer

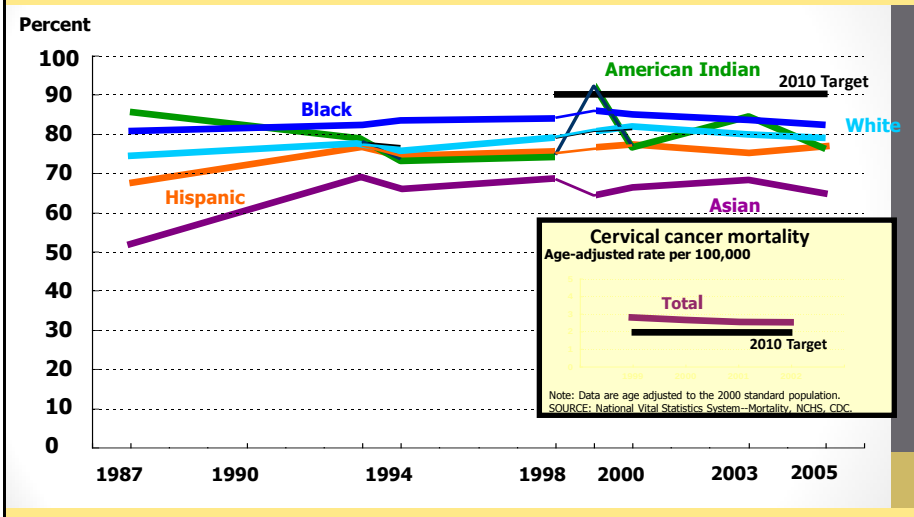
Population	*Incidence*	*Mortality*
Whites	**141.1**	25.9
Hispanic/Latina	89.9	16.7
African-Americans	119.4	**34.7**
Asian/Pacific Islanders	96.6	12.7
American Indians/Alaska Natives	54.8	13.8

Source: Surveillance, Epidemiology and End-Results Users Program, 2002. Numbers per 100,000 persons

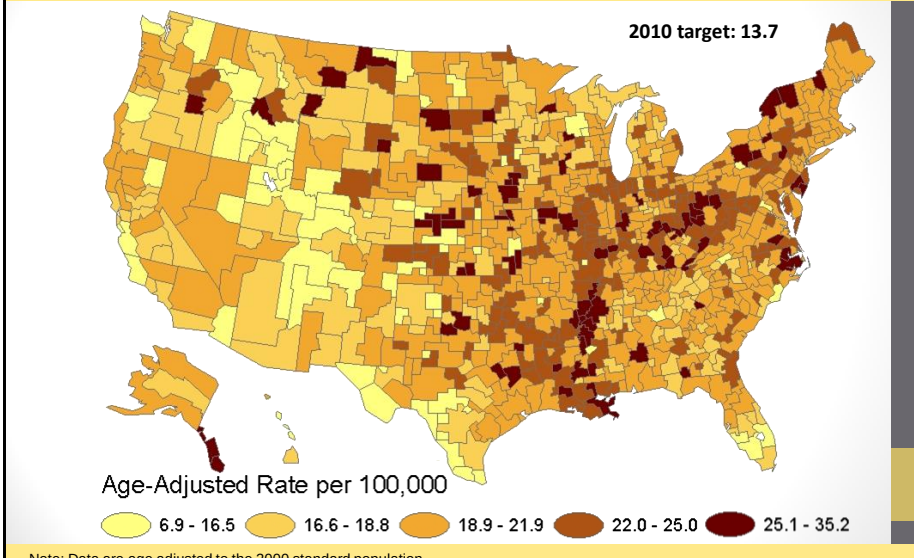
Women receiving a mammogram within past 2 years, aged 40 years and older



Women receiving Pap test in past 3 years, aged 18 years and older



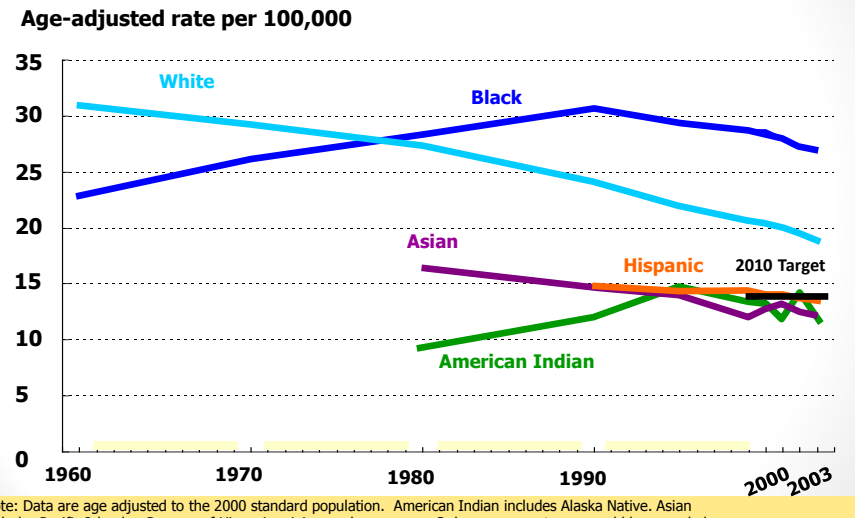
Colorectal cancer mortality, by Health Service Area, 1999-2003



Note: Data are age adjusted to the 2000 standard population.
SOURCE: National Vital Statistics System--Mortality, NCHS, CDC.

Obj. 3-1

Colorectal cancer mortality, by race and ethnicity

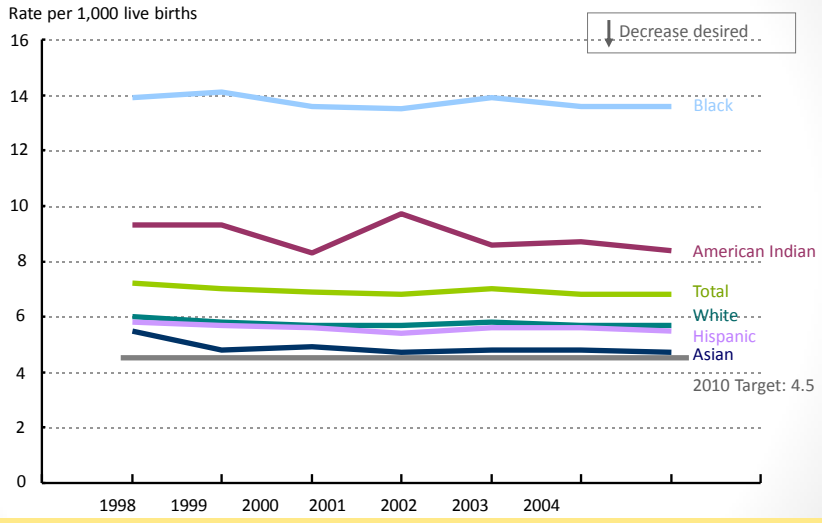


Note: Data are age adjusted to the 2000 standard population. American Indian includes Alaska Native. Asian includes Pacific Islander. Persons of Hispanic origin may be any race. Only one race category could be recorded. Recording more than one race was not an option.
SOURCE: National Vital Statistics System--Mortality, NCHS, CDC.

Obj. 3-5

Infant Mortality and Maternal Health

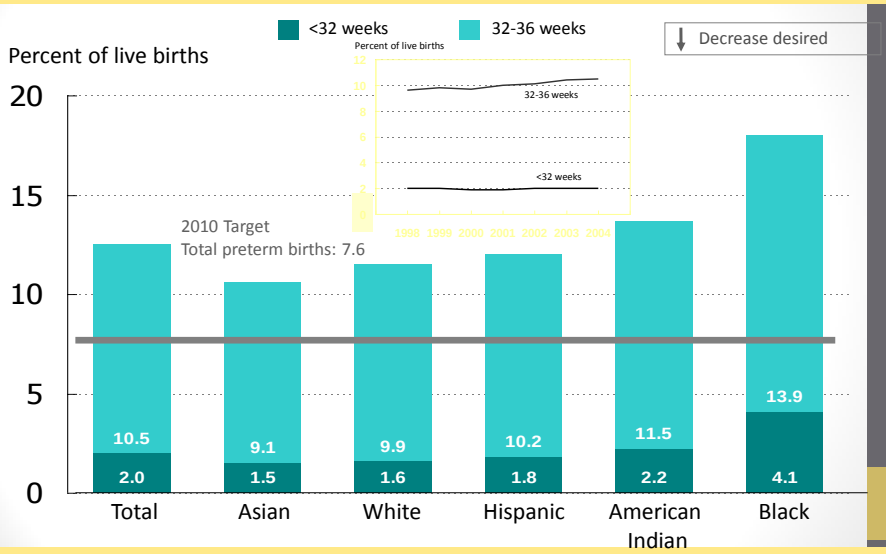
Infant Mortality



Note: Includes all deaths <1 year. American Indian includes Alaska Native. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. For 1940-79, infant deaths are classified by their race as reported on the death certificate. For 1980-2004, infant deaths are classified by race of mother.
SOURCE: National Vital Statistics System (NVSS), NCHS, CDC.

Obj. 16-1c

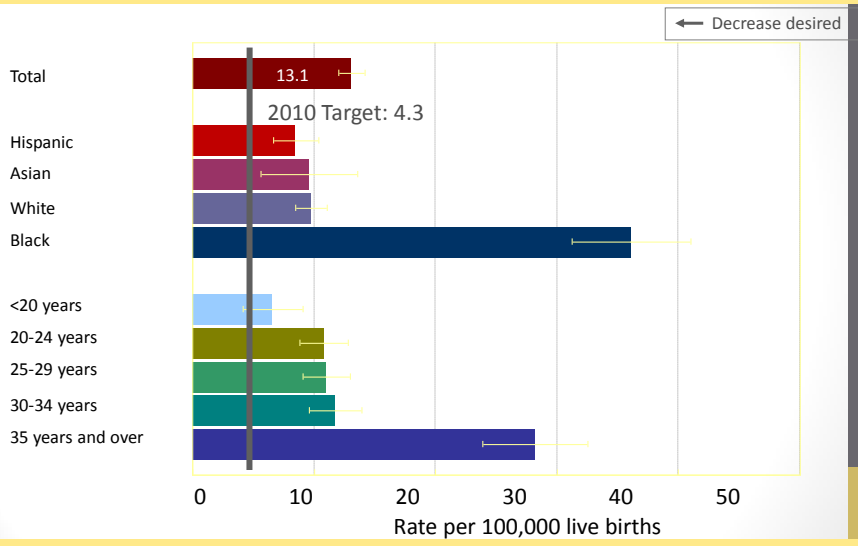
Preterm Births, 2004



Note: American Indian includes Alaska Native. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.
SOURCE: National Vital Statistics System (NVSS), NCHS, CDC.

Obj. 16-11 a, b, & c

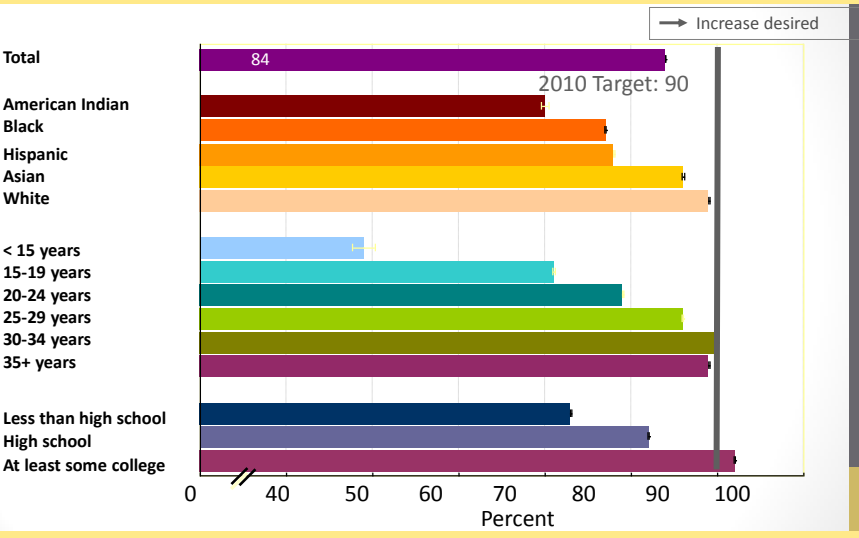
Maternal Mortality, 2004



⊢⊣ 95% confidence interval. Note: Data for the American Indian and Alaska Native population are statistically unreliable and are suppressed. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.
SOURCE: National Vital Statistics System (NVSS), CDC, NCHS.

Obj. 16-4

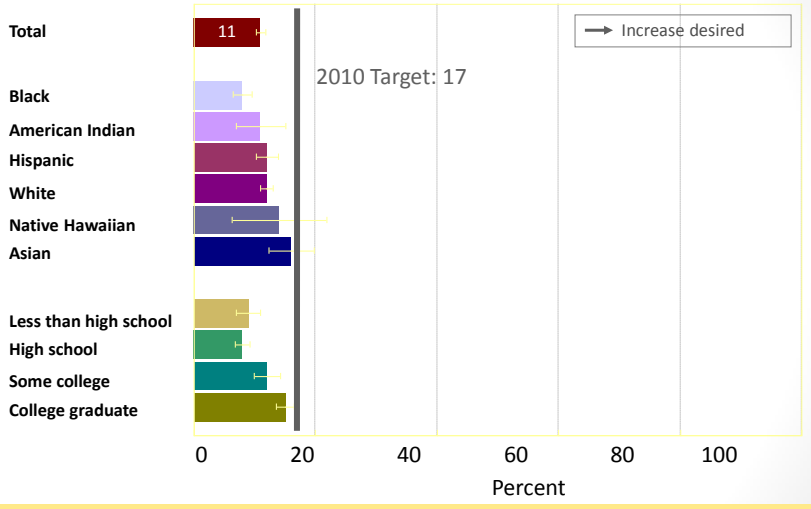
Prenatal Care
Beginning in First Trimester, 2004



⊢⊣ 95% confidence interval. Note: American Indian includes Alaska Native. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Excludes estimates for ID, FL, KY, NH, NY (not inc. NYC), PA, SC, TN, and WA. Data by education level are for mothers aged 20 years and over. Data for 2003 exclude PA and WA. SOURCE: National Vital Statistics System (NVSS), CDC, NCHS.

Obj. 16-6a

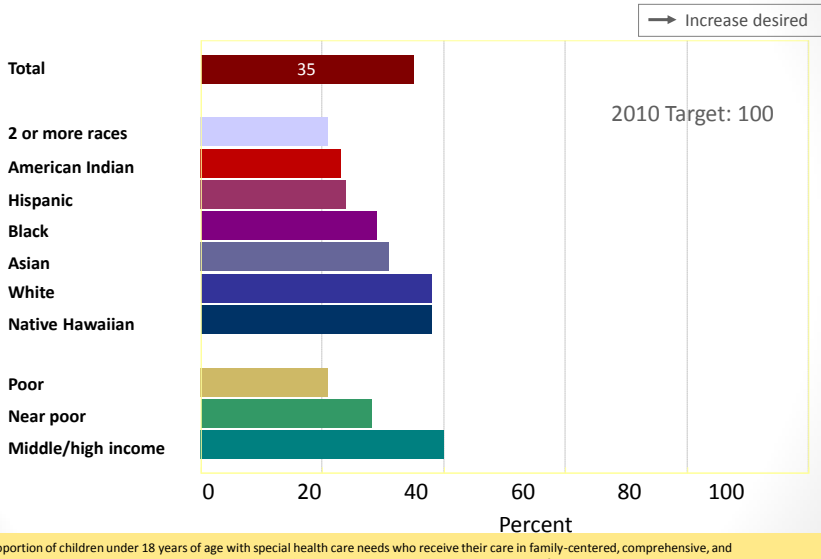
Exclusive Breastfeeding Through 6 Months, 2004



⊢+ 95% confidence interval. Note: Exclusive breastfeeding is defined as no food or drink other than breastmilk. Data are presented by birth year. Native Hawaiian includes other Pacific Islander. American Indian includes Alaska Native. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Respondents were asked to select one or more races. Data for races shown are not mutually exclusive.
SOURCE: National Immunization Survey (NIS), CDC, NCIRD and NCHS.

Obj. 16-19e

Children With Special Health Care Needs Who Have Comprehensive Care Systems*, 2001



*Proportion of children under 18 years of age with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems. Note: American Indian includes Alaska Native. Native Hawaiian includes other Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.
SOURCE: National Survey of Children with Special Health Care Needs, CDC, NCHS and HRSA, MCHB

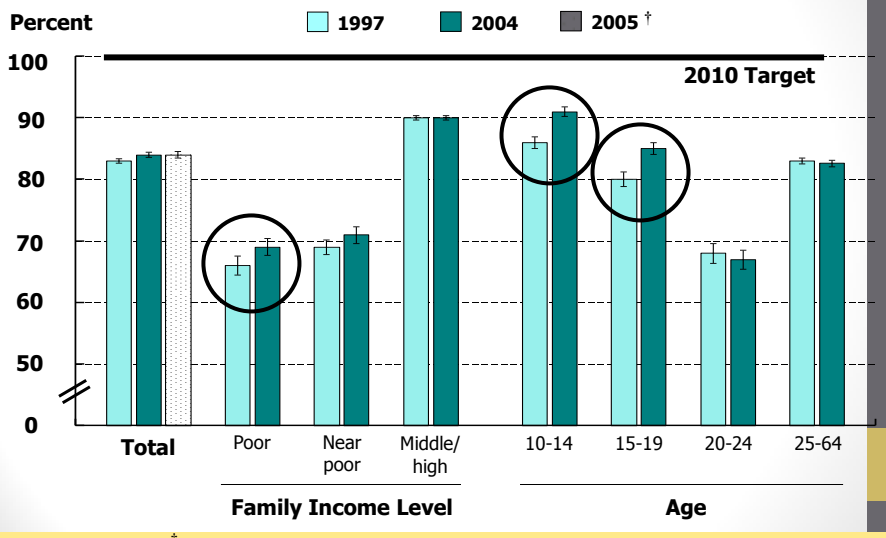
Obj. 16-23

Unraveling the Mystery of Black-White Differences in Infant Mortality

- http://www.unnaturalcauses.org/video_clips_detail.php?res_id=214

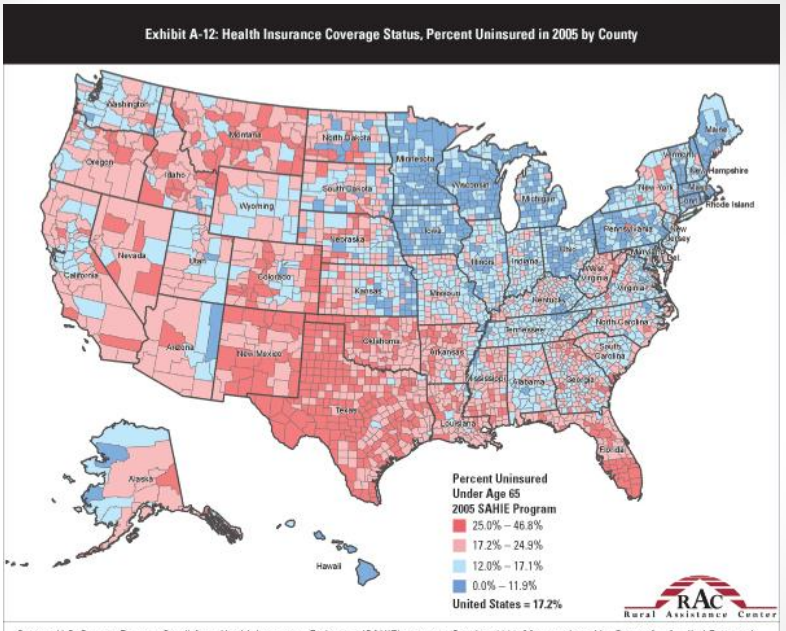
Access to Quality Health Care

Persons Under Age 65 with Health Insurance, by Income and Age, 2004

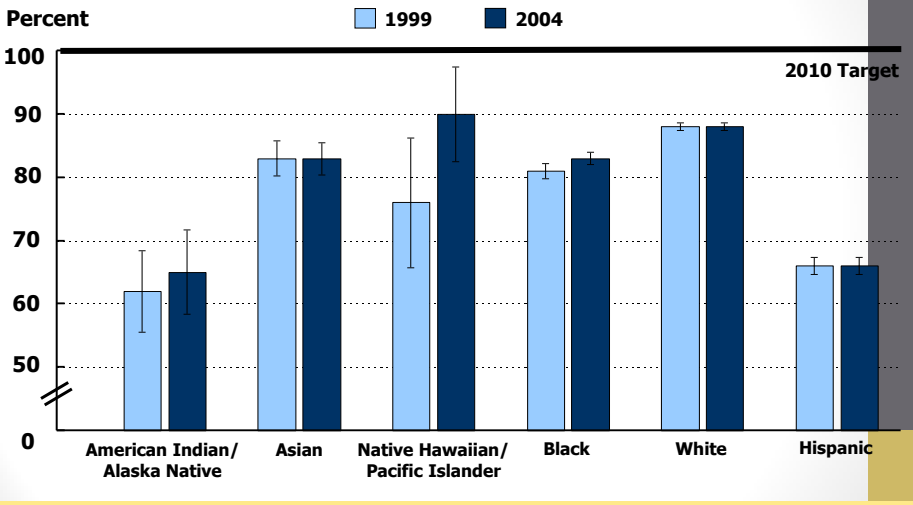


I = 95% confidence interval. † Preliminary data for January – September 2005.
Source: National Health Interview Survey, CDC, NCHS.

Obj. 1-1



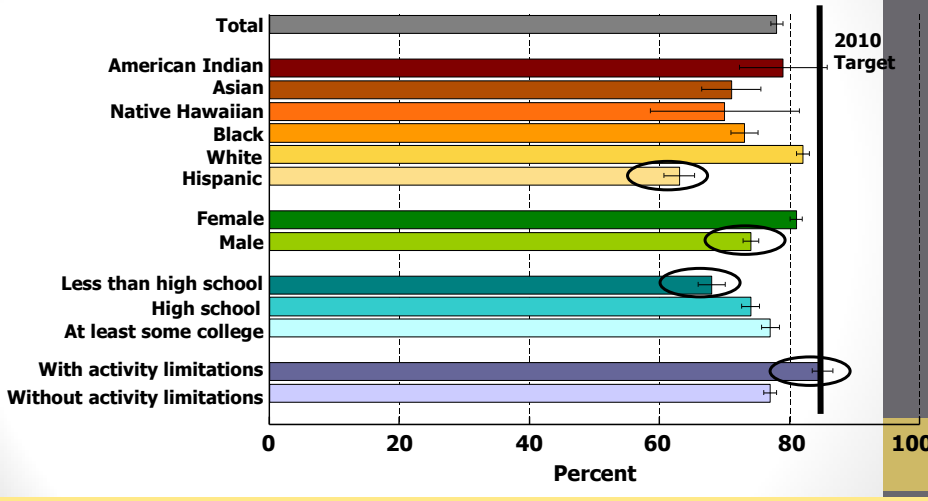
Persons Under Age 65 with Health Insurance, by Race/Ethnicity



I = 95% confidence interval.
Note: The black and white categories exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Respondents were asked to select one or more races. Data for the single race categories are for persons who reported only one racial group.
Source: National Health Interview Survey, NCHS, CDC.

Obj. 1-

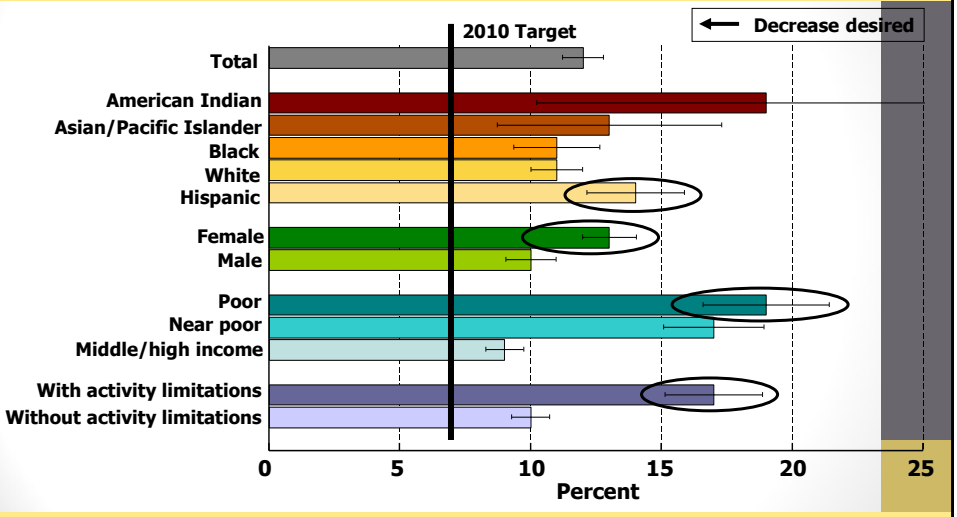
Persons with a Usual Primary Care Provider, 2003



Note: The American Indian category includes Alaska Natives. The Native Hawaiian category includes Pacific Islanders. The black and white categories exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.
Source: Medical Expenditure Panel Survey, AHRQ.

Obj. 1

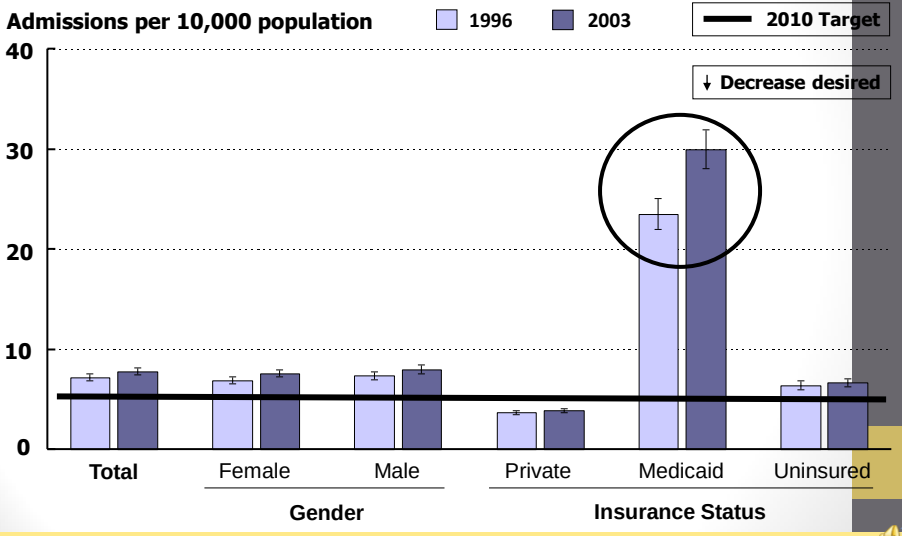
Persons Experiencing Difficulties or Delays in Obtaining Needed Care, 2001



Note: The American Indian category includes Alaska Natives. The black and white categories exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.
Source: Medical Expenditure Panel Survey, AHRQ.

Obj. 1

Hospitalizations for Uncontrolled Diabetes among Persons Aged 18-64 Years



SOURCE: Healthcare Cost and Utilization Project, AHRQ.

Obj. 1-9b

National Priorities

- Institute of Medicine Reports:
  Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care
  http://books.nap.edu/html/unequal/
- Health Literacy: A Prescription to End Confusion"
- Healthy People 2010
  http://www.healthypeople.gov/about/goals.htm
- Office of Minority Health - Culturally and Linguistically Appropriate Standards and Services
  http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf
- Trans HHS Plan to Reduce Cancer Health Disparities

The Discovery-Delivery Disconnect

Discovery ⇔ Development ⇔ Delivery

Critical Disconnect

The discovery to delivery "disconnect" is a key determinant of the unequal burden of cancer.

"Voices of a Broken System: Real People, Real Problems", President's Cancer Panel. (Freeman, H).

African Americans

- 13.5 percent of the USA population
- 56 % live in the South
- 24.5 % African-Americans in live in poverty compared to 8.2% of European Americans
- 23.8 % of African-Americans relied on public health insurance compared to just in comparison to 9% of European Americans
- Have lower 5-year cancer survival rates for lung and pancreatic cancer, compared to European American men.
- Diabetic African Americans are 1.7 times as likely as diabetic Whites to be hospitalized.
- Account for 49% of HIV/AIDS cases

http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=23

Hispanics/Latinos

- 15% of the US population
- One in three Hispanics are uninsured compared to one in eight European Americans
- Are only half as likely to have a usual source of care as European Americans.
- Puerto Ricans have a low birth weight rate that is 50 percent higher than the rate for European Americans
- Are 1.6 times as likely as European Americans to die from diabetes.
- Women have almost 5 times the AIDS rate as European American women.
- One-third less likely to be counseled on obesity than were European Americans.

http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=23

What could we be doing to reduce health disparities?

- Universal health care coverage for all people/ Access to quality health care
- Research that explores how human populations "really" differ
- Social policies and political commitment
  - (social policies are health policies)
- Investing in education
- Investing in poor communities and community organizing
- Cultural competence
- Community based approaches

http://www.unnaturalcauses.org/

What can we do locally to impact health disparities?

- What kind of differences in the health of our community could we make together?
- What could we create here locally that could be used in other communities?
- What does the community need and want?
  - What types of programs, services and projects are needed?
  - What types of education and training are needed?
  - What types of studies involving the community are needed?

National Institutes of Health (NIH)

- New Institute created at NIH:
- The National Institute on Minority Health and Health Disparities (NIMHD)
  - http://www.nimhd.nih.gov/

References and Resources

- http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_progress_reviews.htm
- http://www.cdc.gov/nchs/healthy_people.htm
- http://www.kff.org/minorityhealth/report_archives.cfm
- http://www.healthreform.gov/reports/healthdisparities/

Cultural Competence

- Cultural competence has gained attention from multiple stakeholders as a strategy to improve quality of health care and eliminate health care related racial/ethnic disparities.
- Cultural Competence emerged as a significant issue
  - Diversity of the population in the USA
  - Patient-provider communication is linked to patient satisfaction, understanding of medical instructions, and health outcomes.
  - Institute of Medicine (IOM) reports—*Crossing the Quality Chasm* and *Unequal Treatment*

Betancourt 2005

Some Characteristics of Cultural Competence

Within health care organizations

- Ability of health care organization to meet needs of diverse groups
  - Diverse workforce reflect patient/community population
  - Language assistance available
  - Ongoing staff training regarding culturally and linguistically appropriate services

Beach, The Intersection of health literacy, cultural competency, and patient-centeredness for quality improvement

Within interpersonal interactions

- Ability of a provider to bridge cultural differences to build an effective relationship
  - Explore and respect patient/community beliefs, values, meaning of illness, needs and preferences
  - Finds common ground/build trust
  - Is aware of own biases/assumptions
  - Is aware of health disparities and discrimination
  - Effectively uses interpreter services when needed

The CLAS standards

- National Standards on Culturally and Linguistically Appropriate Services
- Primarily directed at health care organizations,
  - List 14 Standards
- CLAS Standards 4, 5, 6, and 7 are current requirements for all recipients of Federal funds.
- Health care organizations must:
  - #4: offer and provide language assistance services…
  - #5: provide to patients/consumers in their preferred language verbal offers and written notices of their right to receive language assistance services.
  - #6 assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff
  - #7: make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15

Foundation of the Cultural Competence Model

- Stages of cultural competency as described by Cross et al 1989
  - Cultural destructiveness
  - Cultural incapacity
  - Cultural blindness
  - Cultural precompetence
  - Cultural competence
  - Cultural proficiency
- Considered dynamic and non-linear

Example: "Pocket Guide"

- Health care professionals should begin clinical visits by addressing the adult patient by titles such as Mr. Mrs. or Ms. Calling an adult patient by his or her first name
- demonstrates lack of respect and is demeaning.
- "Faith in God" is a strong predictor of how African American patients handle the understanding and diagnosis of cancer.
- When communicating with Latino/Hispanic families, "respecto" (respect) must be conveyed at first to the father, then to the mother, then to the other older adults and finally to the older and younger children. Informal use of language will also increase the level of suspicion and sharpen defenses.
- Because doctors, nurses and other health professionals represent sources of authority for Latinos/Hispanics, the clinician should allow the patient to avoid eye contact as a way of showing respect. Pacific Islanders, who consider direct eye contact with authority figures as rude, share this form of nonverbal communication.
- Out of a sense of "respecto," many Latino/Hispanic patients will avoid disagreeing or even asking the simplest questions.
- Most indigenous languages do not include a word for "cancer." Thus, when discussing prevention and early detection, specialists advise replacing the word "cancer" with "health," such as "breast health screening."
- Some Asian American patients and their families embrace the holistic approach to health. The use of tonics and herbs to strengthen resistance to disease and to improve overall health may be a barrier to cancer prevention and screening activities.
- Among the disadvantaged, such as the rural poor living in Appalachia, educational attainment, literacy and functional literacy are often barriers to cancer care. Not understanding what the health care professional is talking about during a clinic visit may contribute to some patients feeling ashamed about their literacy level and therefore, not admitting that they do not understand what is being said or what is in print. Accordingly, specialists recommend using plain language, defining the terms used in cancer care, and employing educational tools such as videos and DVDs to facilitate patient understanding among this population group.

Critique of cultural competence

- Suggest culture can be reduced to a technical skill or checklist
- Culture is made synonymous with ethnicity – e.g., the Chinese patient believes x,y,z Assumes all patients/clients will act behave the same way for the same reason… obstacle to seeing individual difference.
- Accepted assumption that it reduces health disparities – lack of outcome research or robust evaluation about whether attention to culture really improves clinical care
- May reinforce racial and ethnic biases and stereotypes - not address the social cultural context
- Emphasis on "culture" makes it easier not to focus on underlying issues of discrimination, racism, lack of access to care and poverty
- Most models espouse a unidirectional framework – focus on gaining knowledge and increasing awareness of "others" with out looking at own culture (e.g., organizational)

Kleinman and Benson 2006

Things to take into considerations… Suggestions for cultural competency

- The explanatory models approach – engage with others, understand the "other's" point of view
- It involves empathy, respect – transcends "culture"
- Acknowledge what matters most as it relates to health and the illness experience
- Assessment of our own biases and assumptions (positive and negative).
- While generalizations about cultural differences can serve as a starting point but not the final point.