Health equity/ health inequity

Session 1 (Part 3)
Health Equity & Health Literacy
C. Parvanta
May 8, 2008
Part I

- Health equity, health disparities, health inequities
- National (& some local) data on health disparities
- IOM Report on Unequal Health Care
- Ecological perspective
- Other explanatory frameworks
- Teaching resources
Part 2

- Health literacy and health outcomes
- The National Assessment of Adult Literacy
  health literacy tasks
  - On a scale of 0-500, what was measured?
  - How did people do?
- What tasks are involved in your patients’ health care?
- Participants provide examples of prose, document, and quantitative tasks.
Health Equity: Key ideas

- Health disparities are measurable differences in health and sickness across social groups.
- Health inequities involve circumstances that may be controlled by a policy, system, or institution so that the disparity is avoidable.
- A society must use moral and ethical judgment to determine which disparities are unfair, or inequitable.
Health equity

• **Social Justice** is the fair distribution of society’s benefits, responsibilities and their consequences.

• It focuses on the relative position of one social group in relationship to others in society as well as on the root causes of disparities and what can be done to eliminate them.
UNNATURAL CAUSES
...is inequality making us sick?

A seven-part documentary series exploring racial & socioeconomic inequalities in health.

Do we ALL have an EQUAL chance for HEALTH?

True health equity means answering this question, YES!
<table>
<thead>
<tr>
<th>Year</th>
<th>All Races</th>
<th>White</th>
<th>Black</th>
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<td></td>
<td>Both Sexes</td>
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<td>Female</td>
</tr>
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<td>75.5</td>
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Source: New Jersey Department of Health and Senior Services, Center for Health Statistics
How an anthropologist might view this

• **Cultural patterns** of male competitiveness, sociality and dispute settlement
  – violence, drinking, poor social support, respect, etc.

• **Cultural patterns of risk behavior**
  – smoking, drinking, promiscuity, dangerous work, etc.
• Why do men smoke cigarettes and drink alcohol at higher rates than women?
  – because they have access to cash to spend on themselves
  – because these are expected behaviors of men (reward for a day’s work)
• The health consequences of this privilege are negative
• The social construction of gender and cultural identity, and how it contributes to health related behavior is discussed below in ‘explanatory frameworks’
• They also heavily impact patient-provider communication, which we will take up later in the seminar series.
Data on Racial and Ethnic Disparities

Source: Health, United States, 2006. [http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary](http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary) Table 19.
Age-Adjusted Death Rates per 100,000 Persons by Race and Hispanic Origin for All Causes: U.S., 2004

Source: Health, United States, 2006. [http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary](http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary) Table 29.
Age-Adjusted Mortality Rates per 100,000 Persons by Race/Ethnicity for 3 Health Focus Areas: U.S., 2003

Source: Health, United States, 2006. [http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary](http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary) Table 29.
Age-Adjusted Death Rates per 100,000 Persons by Race, & Hispanic Origin for Diabetes Mellitus: U.S., 2004

Source: Health, United States, 2006. [http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary](http://www.cdc.gov/nchs/data/hus/hus06.pdf#summary) Table 29.

Age-Adjusted Death Rate per 100,000 Persons

- All Races: 19.8
- White: 19.6
- African American: 22.3
- American Indian/Alaska Native: 17.6
- Asian/Pacific Islander: 16
- Hispanic: 17.1
Obvious health disparities

- Infant mortality
- Death by all causes
- Death from heart disease, cancer and stroke
- [prostate cancer]
- Diabetes
- HIV Infections/AIDS
- Suicide/homicide

Are they health inequities? Are they attributable to public policies, resource allocation, social discrimination—preventable causes?

- Disparities exist even when insurance status, income, age, and severity of conditions are comparable.
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, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities in care are associated with higher mortality among minorities.
Among Medicare Beneficiaries Enrolled in Managed Care Plans, African Americans Receive Poorer Quality of Care (Schneider et al., *JAMA*, March 13, 2002)
Caveats – Unequal Treatment

- Access (e.g., insurance status, ability to pay for healthcare) is the most important predictor of the quality of healthcare across racial and ethnic groups.

- It is difficult – even artificial – to separate access-related factors from social categories such as race and ethnicity.

- The bulk of research on healthcare disparities has focused on black-white differences – more research is needed to understand disparities among other racial and ethnic minority groups.
Suggested proportion of Disparity to Inequity in Quality of Health Care for Populations with Equal Access to Health Care

From IOM, based on Gomes C, and McGuire TG. (2001). Identifying the sources of racial and ethnic disparities in health care use.
What are potential sources of disparities in care?

- Health systems-level factors – financing, structure of care; cultural and linguistic barriers to navigation and access.
- Patient-level factors – including patient preferences, refusal of treatment, poor adherence, biological differences, health literacy.
- Disparities arising from the clinical encounter, including patient-provider communication.
Efforts to eliminate disparities in medical care are essential to reducing socioeconomic and racial or ethnic disparities in health, but are not sufficient.
Other entry points

- Ecological model
- Accumulation of small effects (mind-body, bio-physiological model)
Upstream perspectives

- Ecological model
- Systems approach

What can be modified here

To enhance health here
Contrast to ‘personal choices’ perspective that many Americans share.

- Character
- Upbringing
- Education
- Mindset
- Priorities
- Knowledge

Good choices → Positive outcomes

Bad choices → Negative outcomes

Axel Aubrun, Andrew Brown, Joseph Grady
Not All Americans Have Equal Opportunities To Be Healthy
Robert Wood Johnson Foundation
Commission to Build a Healthier
America

A Short Distance to Large Disparities in Health

Life span disparities reflect differences in wealth, education and environment across all community residents. The differences are even more dramatic—sometimes double—if you compare black and white residents.
Health Varies by Income and Across Racial or Ethnic Groups

Lower income generally means worse health. Racial or ethnic differences in health status are also evident: Poor or fair health is much more common among black and Hispanic adults than among white adults.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
*Age-adjusted
Income Is Linked With Health Regardless of Racial or Ethnic Group

Differences in health status by income do not simply reflect differences by race or ethnicity; differences in health can be seen within each racial or ethnic group. Both income and racial or ethnic group matter.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
*Age-adjusted
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Racial or Ethnic Differences in Health Regardless of Income

Racial or ethnic disparities do not simply reflect differences in income. Racial or ethnic disparities in the likelihood of poor or fair health are seen within each income group. Both income and racial or ethnic group matter.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
*Age-adjusted
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Less Education, Worse Health

Less education is linked with worse health. Compared with college graduates, adults who have not finished high school are more than four times as likely to be in poor or fair health.
Social differences in health can be reduced, but only if solutions can be identified to address their root causes. The greatest potential lies in solutions that will help people choose health. That means both strengthening individuals’ ability to make healthy choices and removing obstacles to choosing health. It also means creating more opportunities to be healthy.
Reducing Health Disparities: Broadening the Focus

Medical care and personal responsibility for behaviors are important. But finding promising strategies to reduce disparities will require broadening the focus to include the social and economic contexts in which Americans live.
Race, Chronic Stress, Poor Health Behaviors, and Physical and Mental Disorder Disparities
Exploring the Intersections

James S. Jackson
Institute for Social Research
University of Michigan

Conference on Understanding and Reducing Health Disparities: Contributions from the Social and Behavioral Sciences. NIH, Bethesda, MD, October 23-24, 2006
Law of Small Effects in Race Related Outcomes (Jackson, 2004)

- There is no one single factor that produces observed physical health disparities among race/ethnic groups in U.S.
- Group of small differences which may accumulate over the life-course to produce observed differences in adulthood and older ages among different race/ethnic groups
Some Candidates

- Gene/gene and gene/environment interactions
- Discrimination and perceived racism (stress process)
- Accumulated stress (weathering, allostatic load, etc.)
- Life course selection
- Cultural factors
- Behavioral differences
- SES and institutional arrangement
- Accumulated Treatment Differences

- Social & Psychological Factors (e.g. John Henyism, Self-efficacy, mastery, etc).

- Culturally & Environmentally Mediated Behavioral Coping Strategies

- We cannot easily parse these potential effects into their constituent parts and assign individual contributions
Major Culprits For Producing Stressful Effects May be Chronic Environmental Stressors and Discrimination

- Discrimination and perceived racism as a class of stressors have been shown to have health and mental health effects among racial and ethnic minorities

- Discrimination operates in the context of social, political, economic, and cultural influences over the individual and group life-course

- Discrimination and perceived racism, as well as other stressors related to poor structural life conditions probably play a role in health and mental health processes, but the role is complex
Negative Neighborhood Characteristics

- Differentially Stressful (e.g. Roux et al, 2001; 2002; Geronimous & Thompson, 2004; Massey, 2004)
- Afford Differential Opportunities, e.g. food, services, jobs (e.g. Morland, et al, 2001; 2002; Wing et al, 2002; )
- Afford Differential Coping Resources (e.g. Fast Food Outlets, Liquor Stores, Illegal Drug Distributors, etc. Roux, 2002)
Health Disparities by Age, Aging and the Life-Course

- There are links from childhood (infancy, neonatal, pregnancy, etc.) social conditions to race/ethnic disparities in adulthood and older age (e.g. Warner & Hayward)

- Over the life course blacks more than any other group live the fewest years and a high proportion of these years is in poor health (e.g. Hayward & Heron)

- Health, race, ethnicity and mobility (SES) are linked in complex ways across childhood, adolescence, adulthood, and old age (e.g. Hayward et al; Whitfield & Hayward, 2003; Crimmins et al, 2000; Crimmins & Saito, 2001)
Household surveys of mental disorder prevalence estimates since the 1980s have all revealed equivalent, or higher, rates (especially MDD) for whites in comparison to blacks

- Weissman & Myer (1978) - Community
- Somervall et al (1989) - ECA
- Jackson et al (2003) NSAL

At the same time these and other studies have shown higher rates of dysthymic disorder and psychological distress among blacks in comparison to whites
Relationships Among Structural Life Inequalities, Chronic Stress, Negative Behaviors and Physical and Psychiatric Health Disparities

Structural Life Inequalities

Chronic Stressors/Stress

Behaviors

Physical Health Disparities

Psychiatric Health Disparities
Figure 4: Possible Interrelationships Among Environment, Stressors, Negative Health Behaviors and Physical and Mental Health Disorders

*hypothalamic-pituitary-adrenal*
Summary

- Disparities in physical health and mental health statuses and services do exist - but we do not know exactly why - Law of Small Effects
- The differences between physical & mental health disparities by race/ethnicity are not easy to understand
- But one route by which these differences may be mediated is through behaviors used by some race/ethnic groups to cope with the psychological consequences of stressful life conditions
- These behaviors are influenced by gender, culture and environmental opportunities (affordances)
Summary

- Specifically, behavioral coping strategies, in the face of chronic stressful conditions, that may be effective in “preserving” African American mental health, may simultaneously contribute, along with structural inequalities and stressful life conditions, to observed physical health disparities in morbidity and mortality among some race and ethnic groups (Jackson, 2002; Jackson & Knight, 2006; Jackson, Knight & Rafferty, under review).

- And this effect may be mediated by the stress response network (Dallman et al., 2003)
Summary

- Blacks have early-learned, environmentally mediated, effective coping strategies to deal with stressful conditions of life.
- These behaviors may be effective, perhaps through the chronic stress-response network, in impeding the biological cascade to mental disorders, resulting in positive mental health disparities for Blacks in comparison to non-Hispanic Whites.
- These behaviors contribute, however, along with poor living conditions, lack of resources, and environmentally produced stress, over the life-course, to negative race disparities in physical health morbidity and mortality.
Conclusions

- Physical health and psychiatric disorder disparities are not reducible in any simplistic way to differences in social and economic statuses among groups (Report of the Surgeon General, 2001)

- Complex, multi-faceted -- racial, ethnic, culturally, environmentally, gendered, and life-course, influenced

- Succinctly and perversely, blacks in comparison to whites may buy their reduced rates of psychiatric disorders with higher rates of physical health morbidities and early mortality, contributing to the consistent disparities observed
Part I

✓ Health equity, health disparities, health inequities
✓ National (& some local) data on health disparities
✓ IOM Report on Unequal Health Care
✓ Ecological perspective
✓ Other explanatory frameworks
❑ Teaching resources
Recommendations for Teaching about Racial and Ethnic Disparities in Health and Health Care

Wally R. Smith, MD; Joseph R. Betancourt, MD, MPH; Matthew K. Wynia, MD, MPH; Jada Bussey-Jones, MD; Valerie E. Stone, MD, MPH; Christopher O. Phillips, MD, MPH; Alicia Fernandez, MD; Elizabeth Jacobs, MD, MPP; and Jacqueline Bowles, MD, MSCE

Racial and ethnic minorities often receive lower-quality health care than white patients, even when socioeconomic status, education, access, and other factors are used as controls. To address these pervasive disparities, health care professionals should learn more about them and the roles they can play in eliminating them, but few curricula are focused on understanding and addressing racial and ethnic health disparities, and well-accepted guidelines on what and how to teach in this complex area are lacking.

The Society of General Internal Medicine Health Disparities Task Force used a review and consensus process to develop specific recommendations and guidelines for curricula focusing on health disparities. Learning objectives, content, methods for teaching, and useful resources are provided. Although the guidelines were developed primarily for teaching medical students, residents, and practitioners in primary care, the Task Force’s general recommendations can apply to learners in any specialty.

The Task Force recommends that a curricula address 3 areas of racial and ethnic health disparities and focus on the following specific learning objectives: 1) examining and understanding attitudes, such as mistrust, subconscious bias, and stereotyping, which practitioners and patients may bring to clinical encounters; 2) gaining knowledge of the existence and magnitude of health disparities, including the multifactorial causes of health disparities and the many solutions required to diminish or eliminate them; and 3) acquiring the skills to effectively communicate and negotiate across cultures, languages, and literacy levels, including the use of key tools to improve communication. The broad goal of a curriculum on disparities should be for learners to develop a commitment to eliminating inequalities in health care quality by understanding and assuming their professional role in addressing this pressing health care crisis.

For author affiliations, see end of text.

The health and life expectancy of Americans has dramatically improved during the past several decades, but racial and ethnic minorities have not benefited equally from this progress. Differences in health outcomes between majority and minority populations, commonly referred to as racial or ethnic disparities in health, are the result of several factors operating in complex sociologic, cultural, political, economic, and health care contexts. Until recently, curricula addressing racial and ethnic health disparities focused on factors outside the health care system, including socioeconomic disadvantage and lack of health insurance (1), but some publications (2–5), culminating in 2002 with the Institute of Medicine report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health that without new and more effective interventions, health disparities will be difficult to eliminate (9), and they may become an even larger problem as racial and ethnic minorities become a larger proportion of the U.S. population (10). Key stakeholders need to engage at many levels to eliminate disparities, including at the community and societal levels. However, considering the significance of the physician–patient relationship in health care delivery, interventions by individual physicians will be an important component of an overall strategy to reduce health care disparities.

Several surveys show that many physicians remain unaware of health care disparities nationally and in their own practices (11–13). The Institute of Medicine’s report rec-
Curriculum goals

• Help learners examine and understand attitudes such as ..
  – Mistrust
  – Subconscious bias
  – Stereotyping

..that both patients and practitioners may bring to the clinical encounter

• Impart knowledge of the existence and magnitude of health disparities, including
  – Multifactorial causes
  – Range of solutions to eliminate them/create health equity
Curriculum goals, cont.

• Provide learner with skills required to effectively communicate and negotiate across cultures, languages and literacy levels
  – Including use of key tools to improve communication. [Ah ha. Why we’re here.]

• Learning Objectives, Sample questions, Resources:
  – To address Attitudes, Knowledge and Skills
More Systemic Changes

Health Policy

Eliminating Racial and Ethnic Disparities in Health Care: What Is the Role of Academic Medicine?
Joseph R. Betancourt, MD, MPH

Abstract

Research has shown that minority Americans have poorer health outcomes (compared to whites) from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, and cancer. In addition to racial and ethnic disparities in health, there is also evidence of racial and ethnic disparities in health care. The Institute of Medicine Report Unequal Treatment remains the preeminent study of the issue of racial and ethnic disparities in health care in the United States. Unequal Treatment provided a series of general and specific recommendations to address such disparities in health care, focusing on a broad set of stakeholders including academic medicine. Academic medicine has several important roles in society, including providing primary and specialty medical services, caring for the poor and uninsured, engaging in research, and educating health professionals. Academic medicine should also provide national leadership by identifying innovations and creating solutions to the challenges our health care system faces in its attempt to deliver high-quality care to all patients.

Several of the recommendations of Unequal Treatment speak directly to the mission and roles of academic medicine. For instance, patient care can be improved by collecting and reporting data on patients’ race/ethnicity; education can minimize disparities by integrating cross-cultural education into health professions training; and research can help improve health outcomes by better identifying sources of disparities and promising interventions. These recommendations have clear and direct implications for academic medicine. Academic medicine must make the elimination of health care disparities a critical part of its mission, and provide national leadership by identifying quality improvement innovations and creating disparities solutions.

These patients have the same condition, but their treatment may be different.

Help Understand Why

Speaker’s Kit

Thank you for your interest in leading a local discussion about racial and ethnic disparities in cardiac care. By presenting information and leading a discussion, you are increasing visibility of the issue and providing opportunities for other physicians to share their thoughts.

Physicians have a key role to play in addressing disparities in medical care. As a first step in what ultimately must be a multifaceted effort, the Henry J. Kaiser Family Foundation and The Robert Wood Johnson Foundation have undertaken this initiative to raise physician awareness about disparities in medical care, beginning with cardiac care.

Included in this speaker's kit are materials that may assist you with your dialogue.

New initiative by RWJ and KKF to tackle care differences head on.
Health Equity

Welcome to our online collection of health equity resources

This database contains articles, Web sites, video clips, chart and data, interviews, transcripts, interactivities, case studies, and educational and outreach materials. Check back often as we will continue to add resources on a regular basis.

Select an option on the left to explore resources by topic, keyword or type.

Our Top 10 Resources

We’ve assembled ten documents that were influential in the development of this series. These articles will provide information about the key concepts covered in the series and this web site.

Commission for a Healthier America