

# Understanding and Addressing Social Disparities in Health and Healthcare

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# **Key Fact #1**

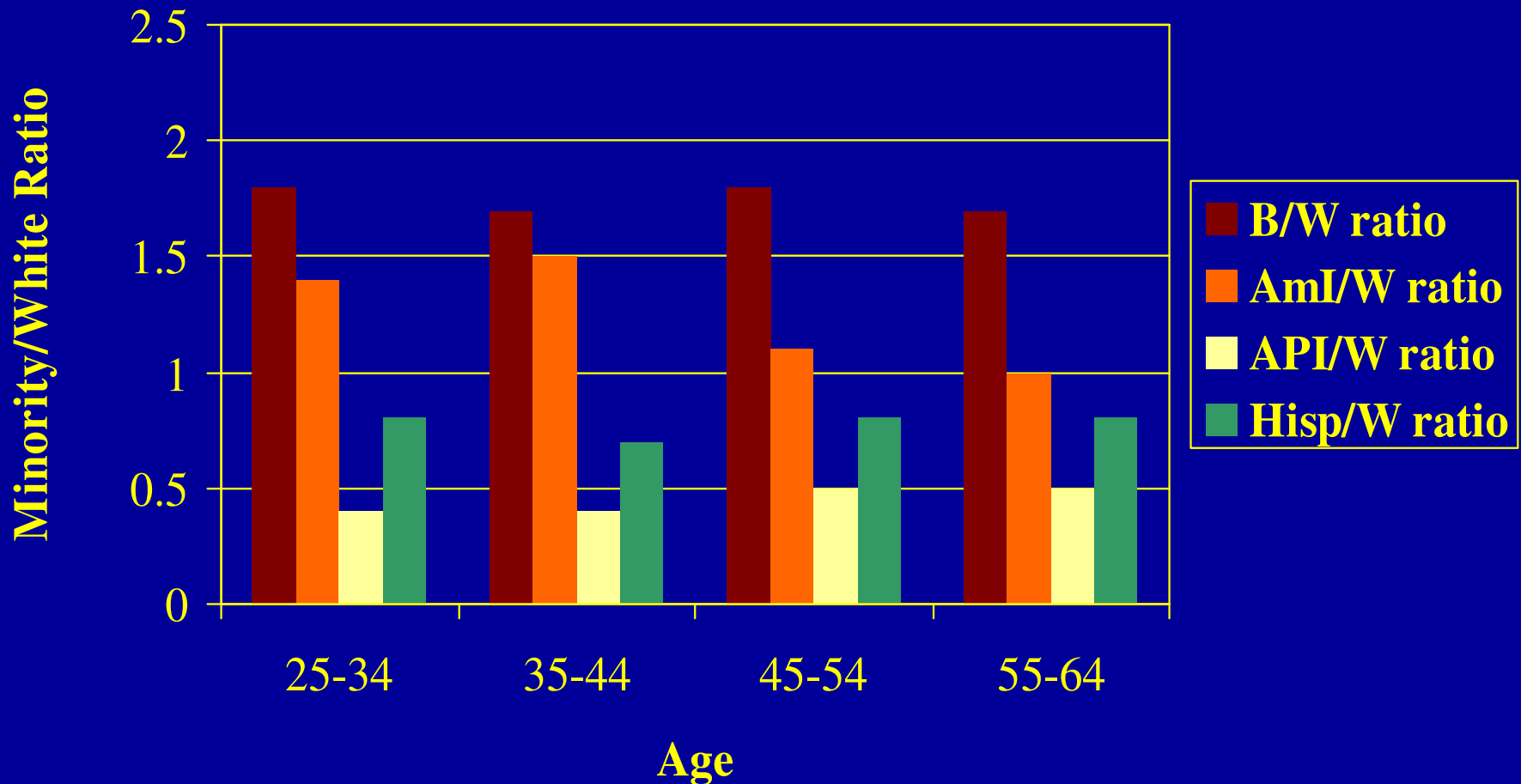
**Racial/Ethnic differences in health are large**

# Racial Disparities in Health

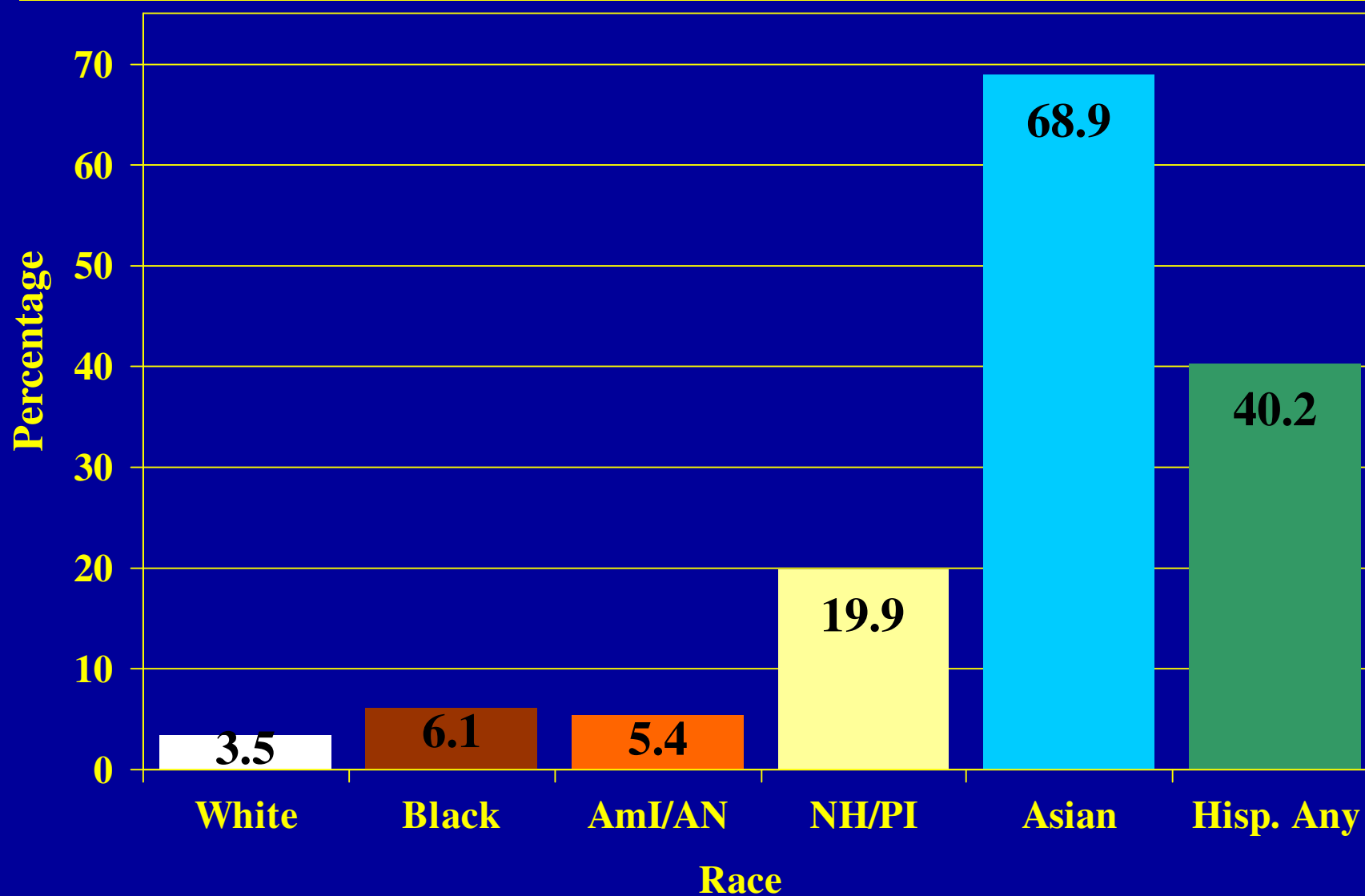
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- In 2001, African Americans had higher death rates than Whites for 12 of the 15 leading causes of death.
  - Blacks and American Indians have higher age-specific mortality rates than Whites from birth through the retirement years.
  - The death rate for Blacks today is equivalent to that of Whites some 30 years ago.
  - Hispanics have higher death rates than whites for diabetes, hypertension, liver cirrhosis & homicide
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# There Is a Racial Gap in Health in Mid Life: Minority/White Mortality Ratios, 2006



# Percent Foreign-Born by Race/Ethnicity



U.S. Census 2000

# Immigration and Health

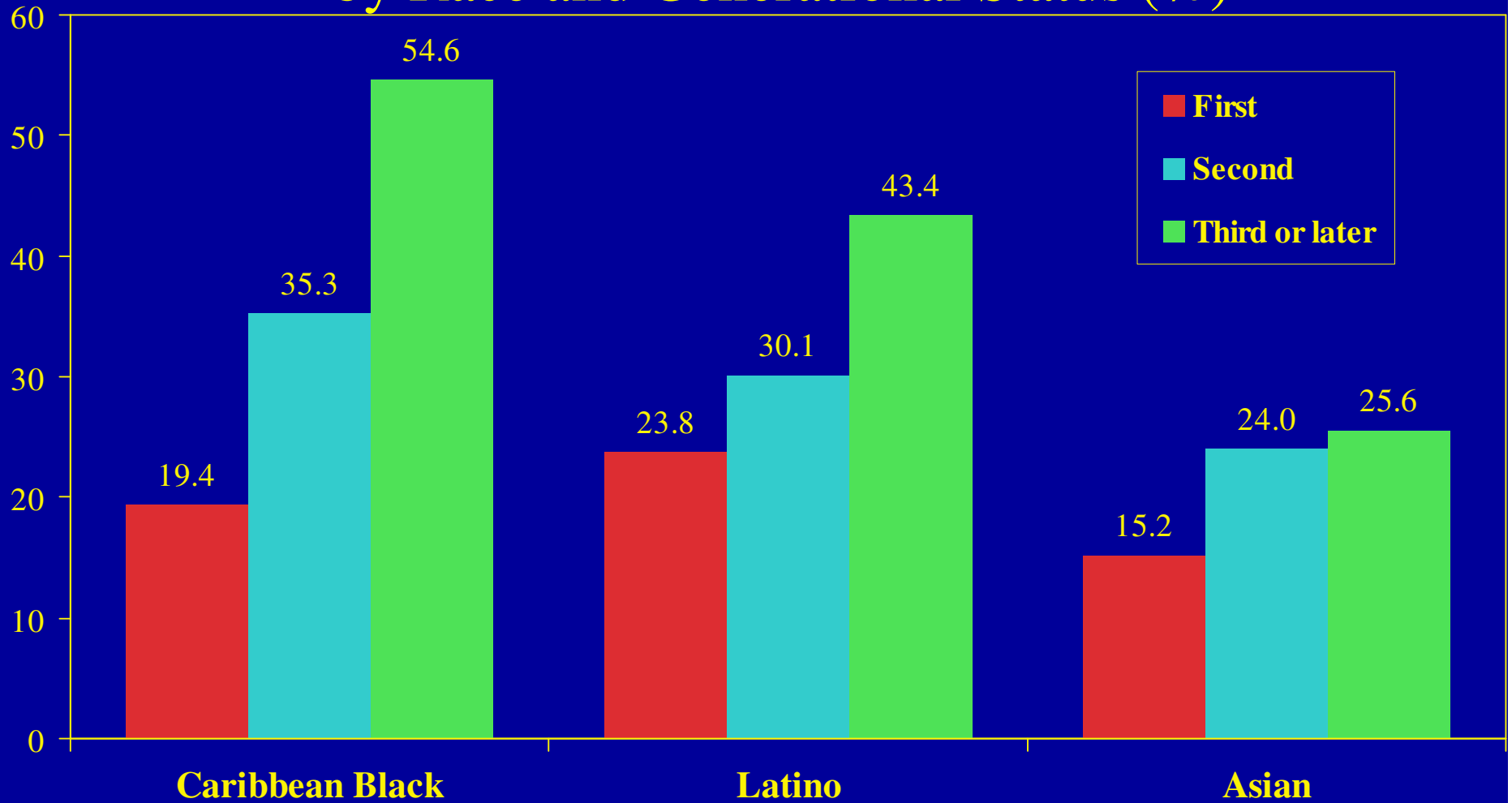
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Immigrants of all racial/ethnic groups enjoy better health (adult & infant mortality) than their native-born counterparts.

As length of residence in the U.S. increases, the health of immigrants declines.

For example, infant and adult mortality, low birth weight, poor health practices, & multiple indicators of morbidity increase for Latinos with length of stay in the U.S.

## Lifetime Prevalence of Psychiatric Disorder, by Race and Generational Status (%)



Source: Williams et al. 2007; Alegria et al 2007; Takeuchi et al. 2007

# Research & Policy Challenge

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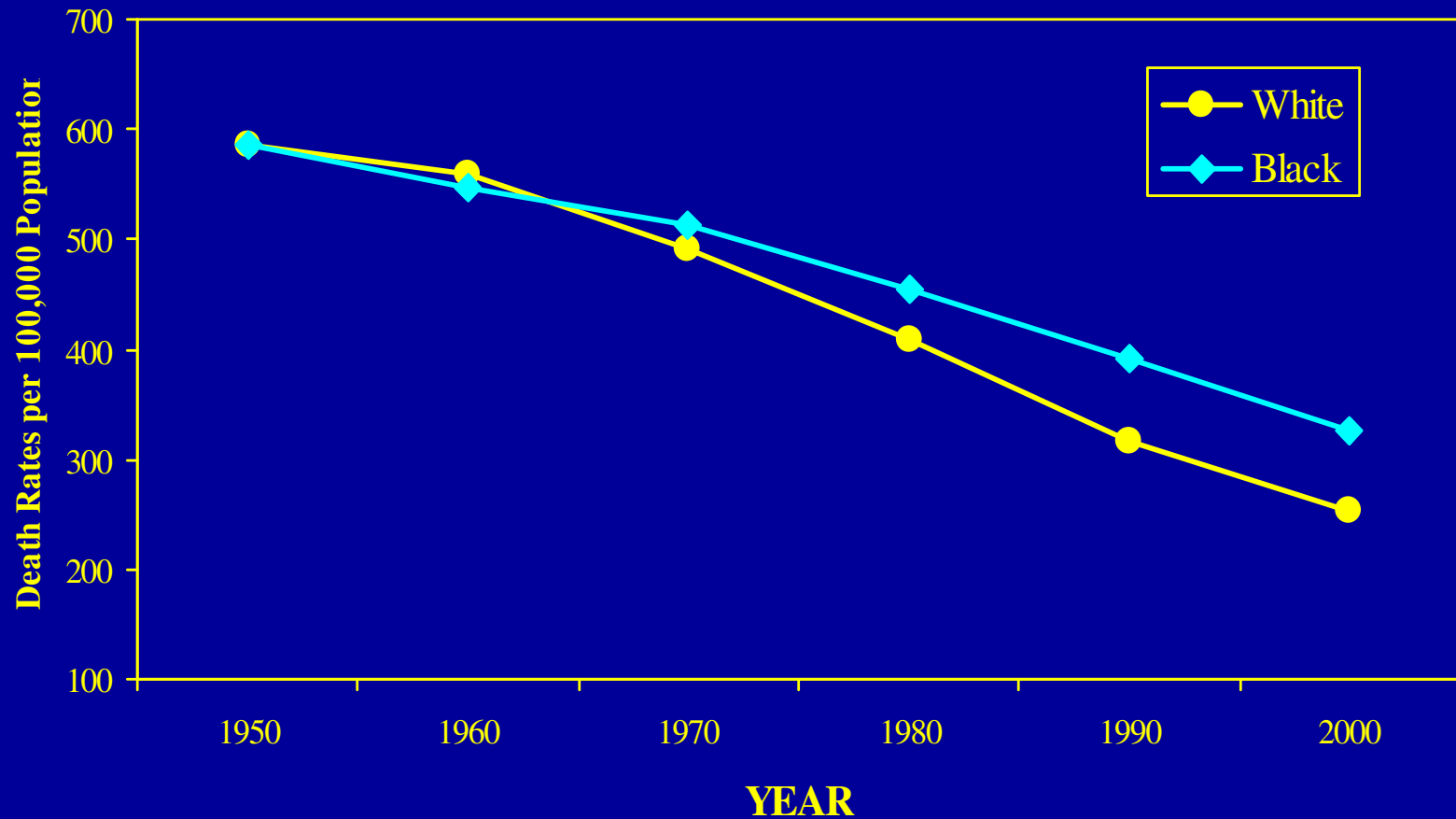
What interventions, if any, can reverse the downward health trajectory of immigrants with length of stay in the U.S.?

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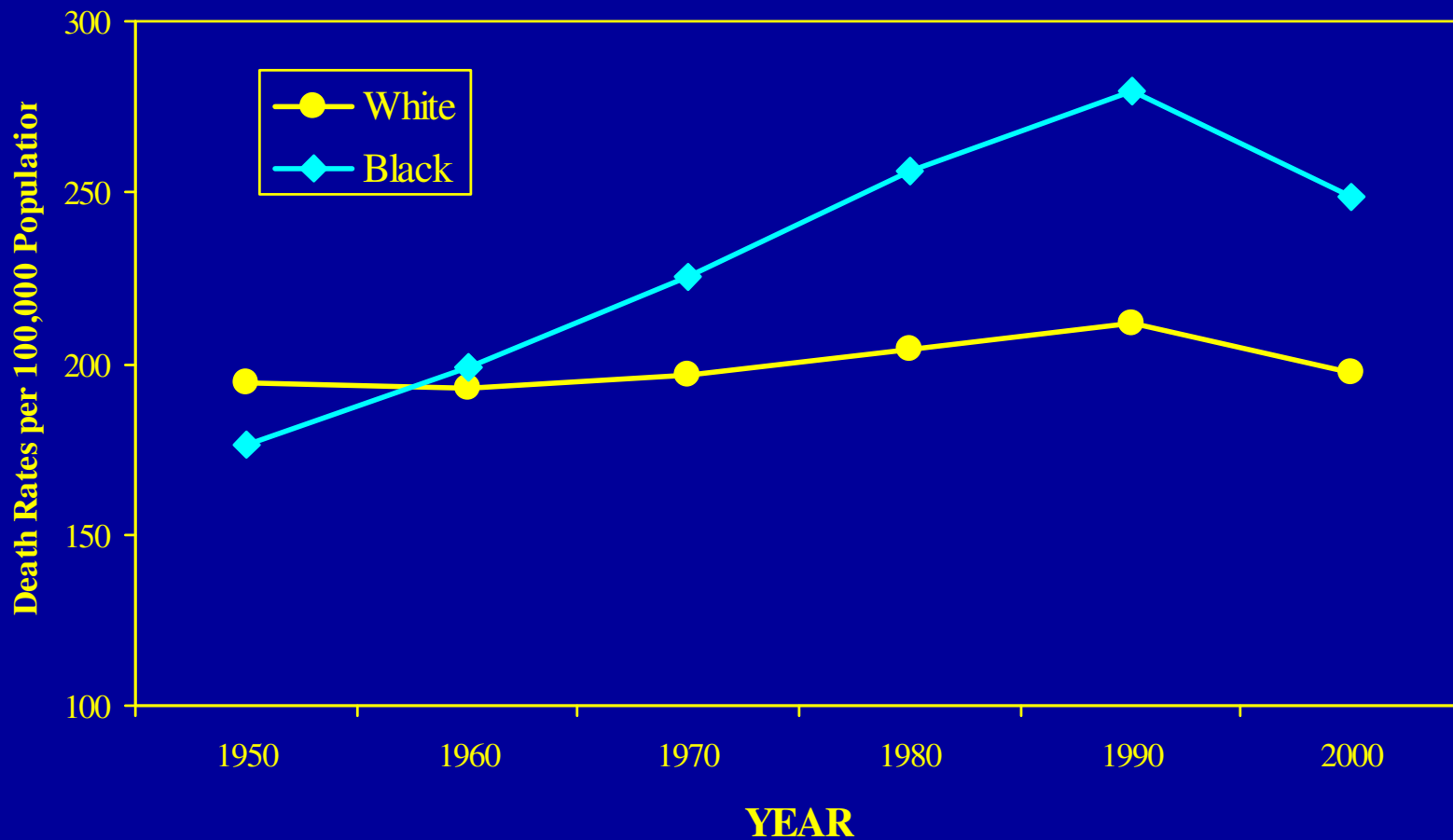
## **Key Fact #2**

**In the last 50 years, although overall health has improved, racial differences in health are unchanged or have widened.**

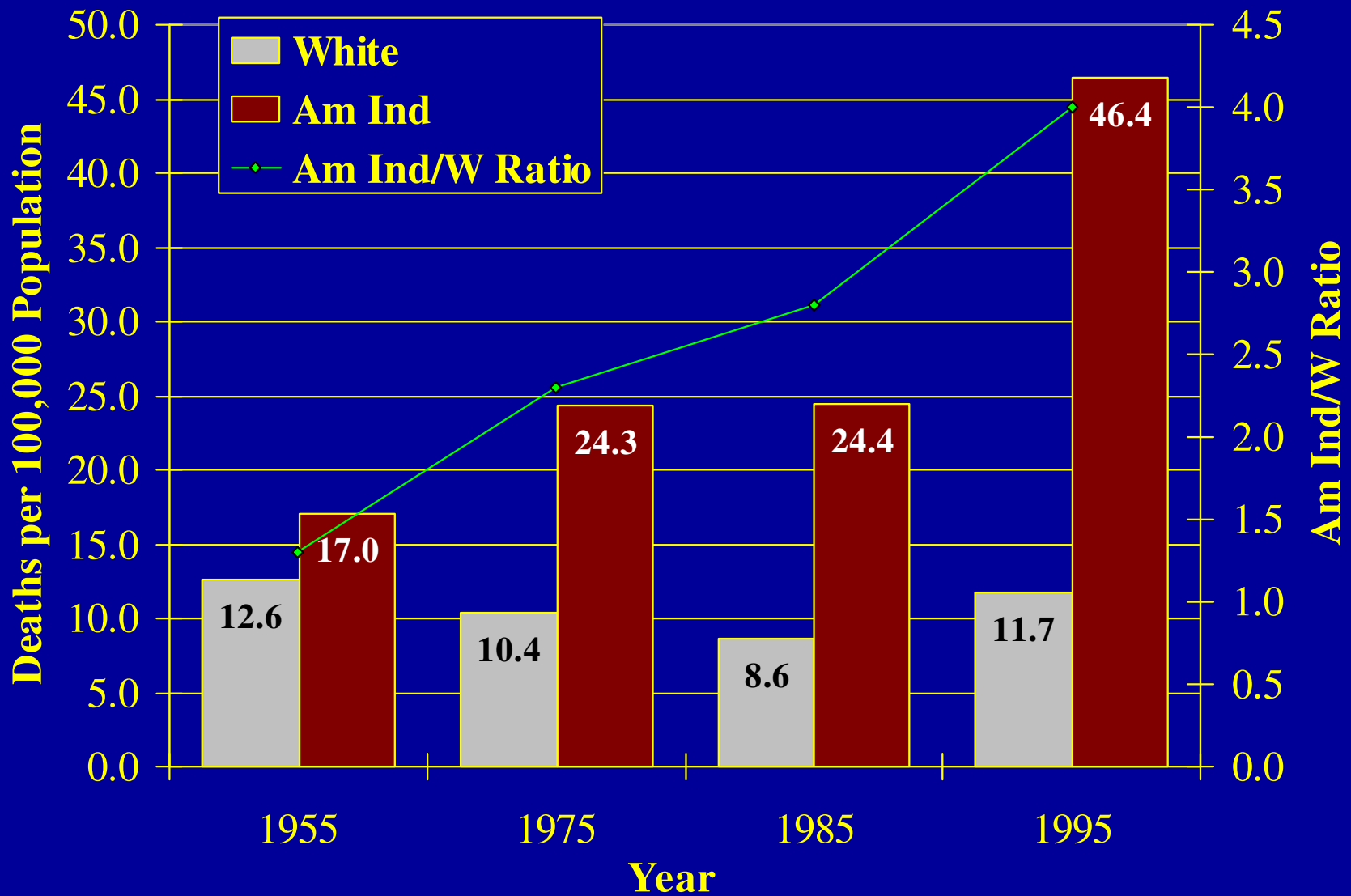
## Age-Adjusted Heart Disease Death Rates for Blacks and Whites, 1950-2000



# Age-Adjusted Cancer Death Rates for Blacks and Whites, 1950-2000

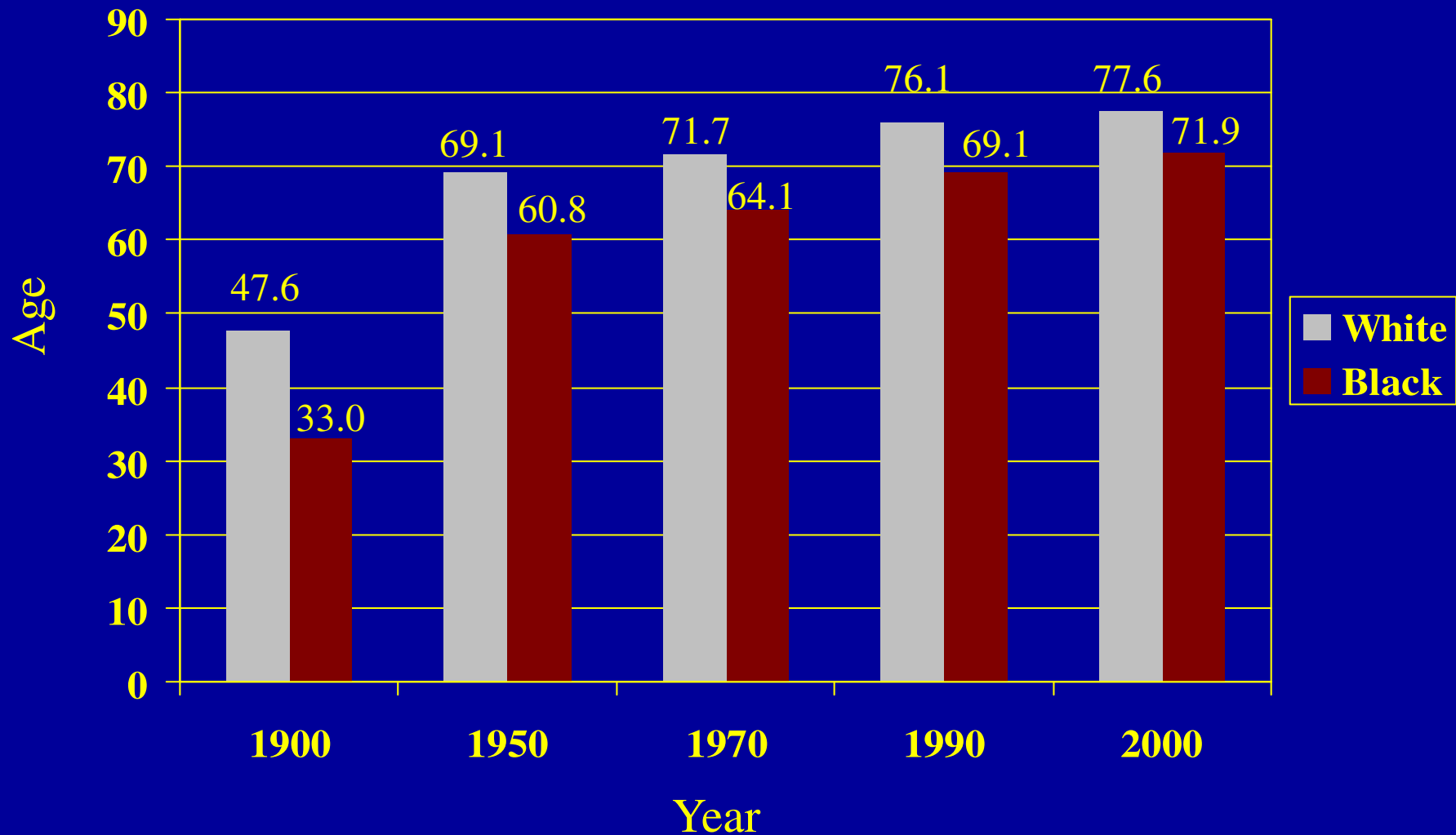


# Diabetes Death Rates 1955-1995



Source: Indian Health Service; Trends in Indian Health 1998-99

# Life Expectancy at Birth, 1900-2000



# Excess Deaths for Black Population

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Year	Avg.No/Day	Avg.No/Year
1940	183	66,900
1950	144	52,700
1960	139	50,900
1970	198	72,200
1980	221	80,600
1990	285	103,900
1998	265	96,800

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TOTAL Premature Deaths, 1940-1999 = 4,272,000

# The Persistence of Racial Disparities

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- We have FAILED!
- In spite of:
  - a War on Poverty
  - a Civil Rights revolution
  - Medicare & Medicaid
  - the Hill-Burton Act
  - Major advances in medical research & technology

We have made little progress in reducing the elevated death rates of blacks and American Indians relative to whites.

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## **Key Fact #3**

**Racial differences in health are not primarily caused by genetic factors**

# The Limits of Biology

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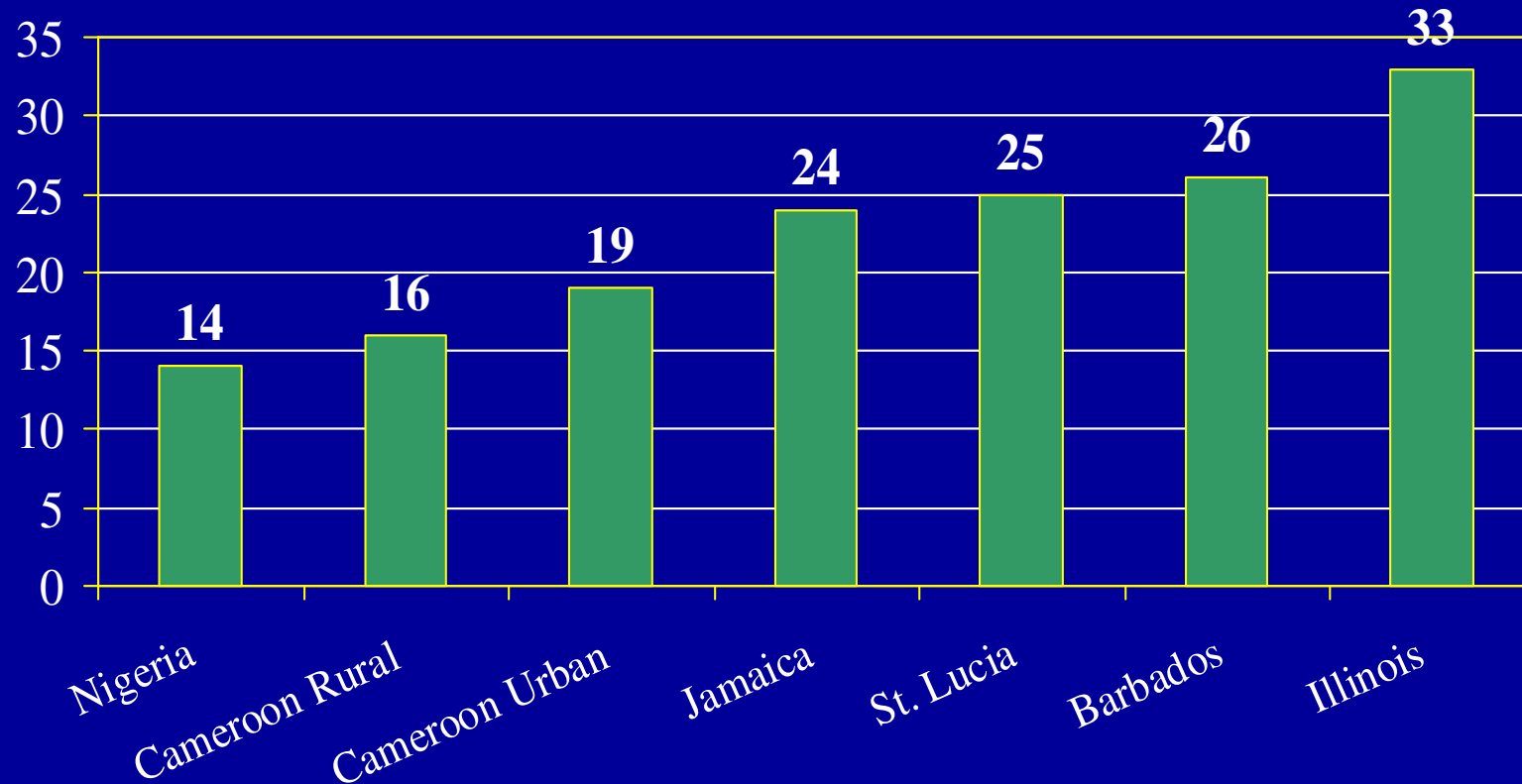
- Our racial categories predate scientific theories of genetics and modern genetic studies and do not capture well the distribution of genetic characteristics across populations
- Groups with similar physical characteristics can be very different genetically
- “The fact that we know what race we belong to tells us more about our society than our biological makeup”<sup>1</sup>
- “Race is a pigment of our imagination”<sup>2</sup>
- We need to understand how risk factors/resources in the social/physical environment interact with biological predispositions to affect health

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<sup>1</sup>Krieger and Bassett, 1986; <sup>2</sup>Ruben Rumbaut

# Hypertension, 7 West African Origin Groups (%)

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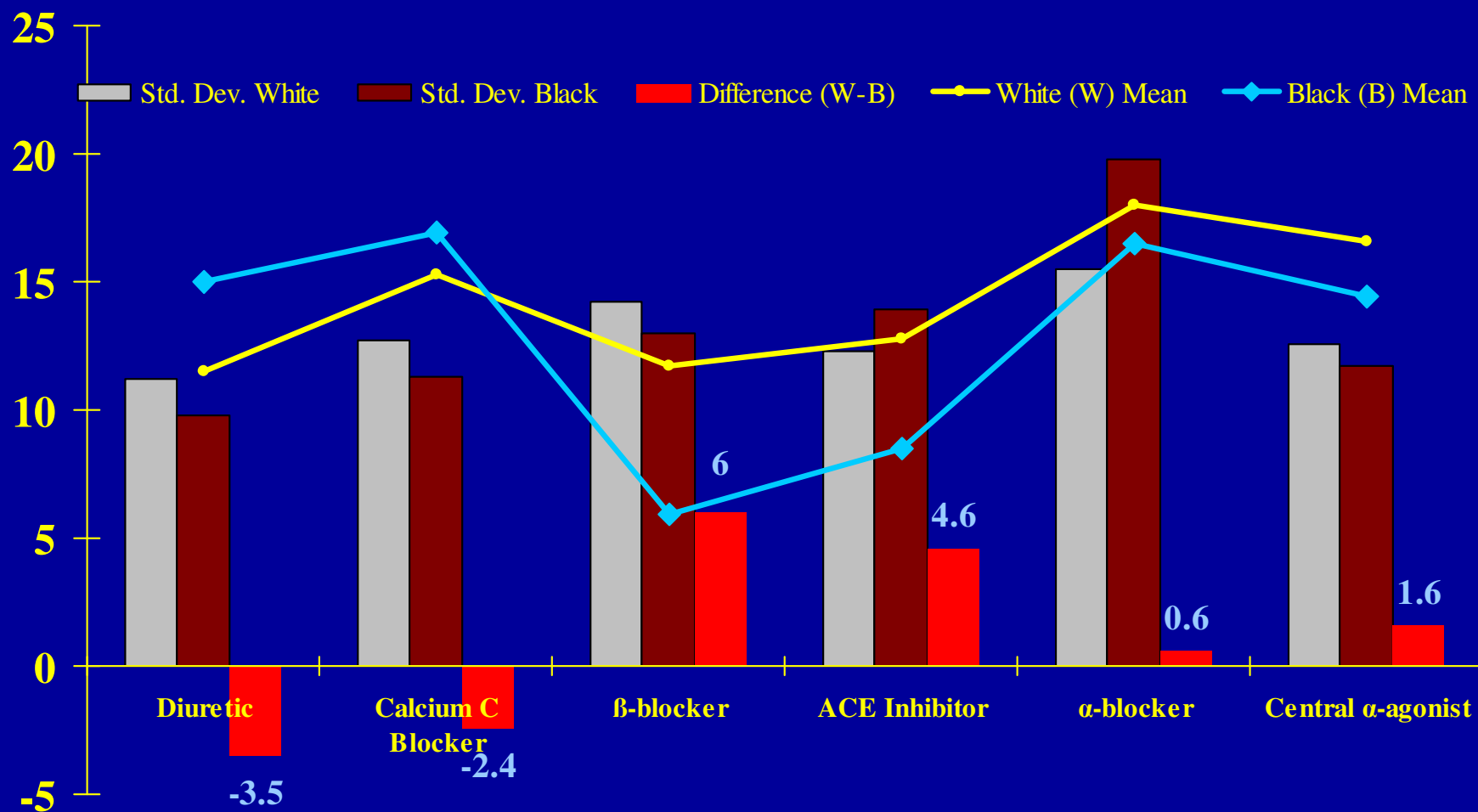
**Source: International Collaborative Study of Hypertension in Blacks, 1995**

# A Closer Look at Conventional Wisdom

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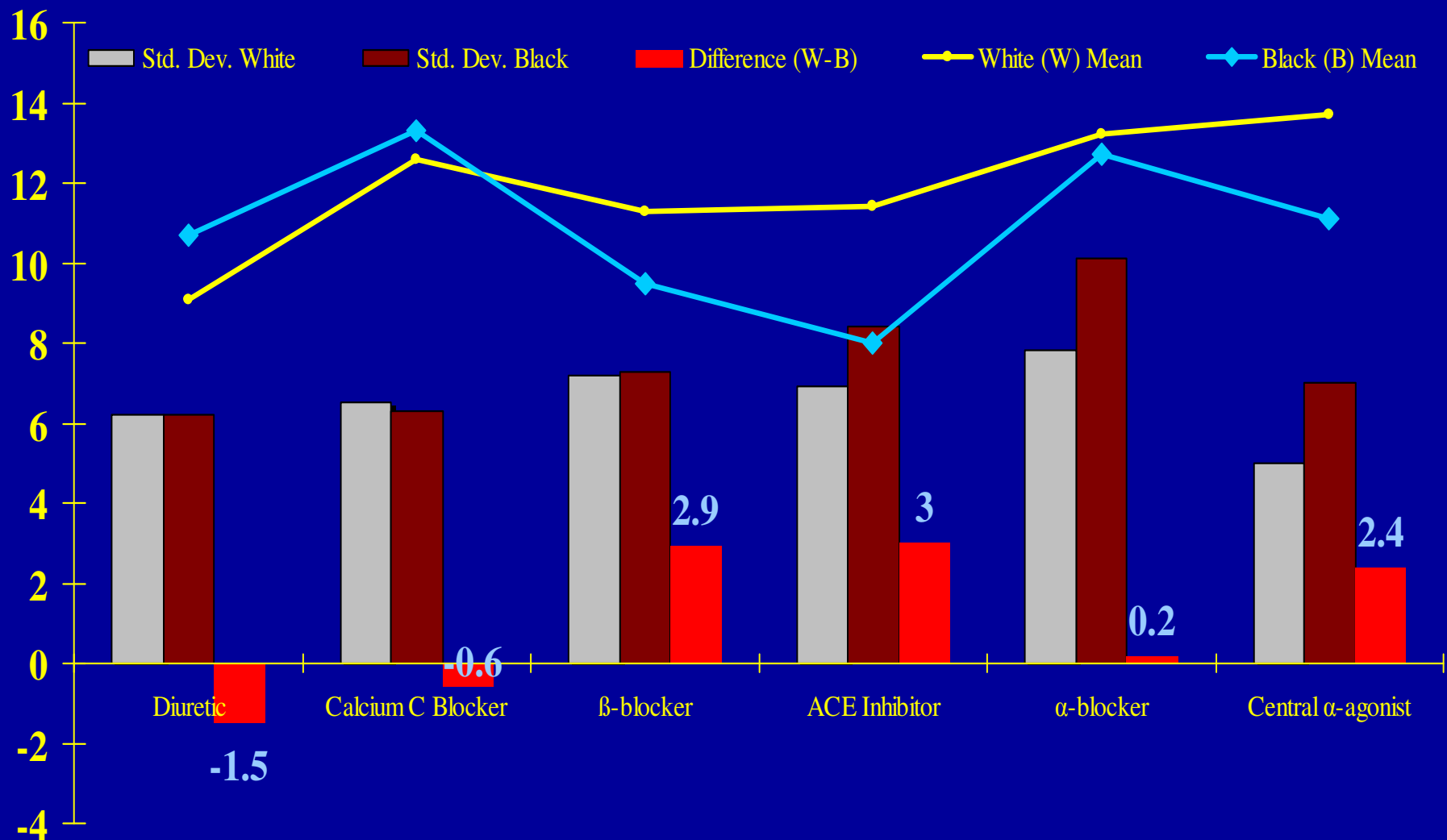
- Blacks and whites differ in their responses to antihypertensive medications
  - White patients respond better to beta Blockers and ACE inhibitors
  - Black patients respond better to Diuretics and Calcium Channel Blockers
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# Decrement in Systolic B.P. with Antihypertensive Tx



Source: Sehgal, Ashwini R. (2004). Hypertension. Vol. 43:566-572

# Decrement in Diastolic B.P with Antihypertensive Tx



Source: Sehgal, Ashwini R. (2004). Hypertension. Vol. 43:566-572

# Overlap in Antihypertensive Drug Response

## Percent of Blacks & Whites with Similar Responses to Medications

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<b>Medication</b>	<b>Systolic</b>	<b>Diastolic</b>
<b>Diuretics</b>	<b>86%</b>	<b>90%</b>
<b>Calcium C Blocker</b>	<b>93%</b>	<b>95%</b>
<b><math>\beta</math>-Blocker</b>	<b>83%</b>	<b>90%</b>
<b>ACE Inhibitor</b>	<b>86%</b>	<b>81%</b>
<b><math>\alpha</math>-Blocker</b>	<b>88%</b>	<b>87%</b>
<b>Central <math>\alpha</math>-Agonist</b>	<b>92%</b>	<b>78%</b>

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Source: Sehgal, 2004. Meta Analysis of 15 Clinical Trials.

# Skin Color in the Clinical Context

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- This meta analysis of 15 clinical trials reveals that the overwhelming majority of blacks and whites have similar responses to all of the common antihypertensive medications
  - Thus, simply knowing a patient's race provides precious little guidance to a clinician in the selection of antihypertensive medications
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## **Key Fact #4**

**Socioeconomic Status (SES) is a central but incomplete explanation of racial differences in health.**

# SAT Scores by Income

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<b>Family Income</b>	<b>Median Score</b>
<b>More than \$100,000</b>	<b>1129</b>
<b>\$80,000 to \$100,000</b>	<b>1085</b>
<b>\$70,000 to \$80,000</b>	<b>1064</b>
<b>\$60,000 to \$70,000</b>	<b>1049</b>
<b>\$50,000 to \$60,000</b>	<b>1034</b>
<b>\$40,000 to \$50,000</b>	<b>1016</b>
<b>\$30,000 to \$40,000</b>	<b>992</b>
<b>\$20,000 to \$30,000</b>	<b>964</b>
<b>\$10,000 to \$20,000</b>	<b>920</b>
<b>Less than \$10,000</b>	<b>873</b>

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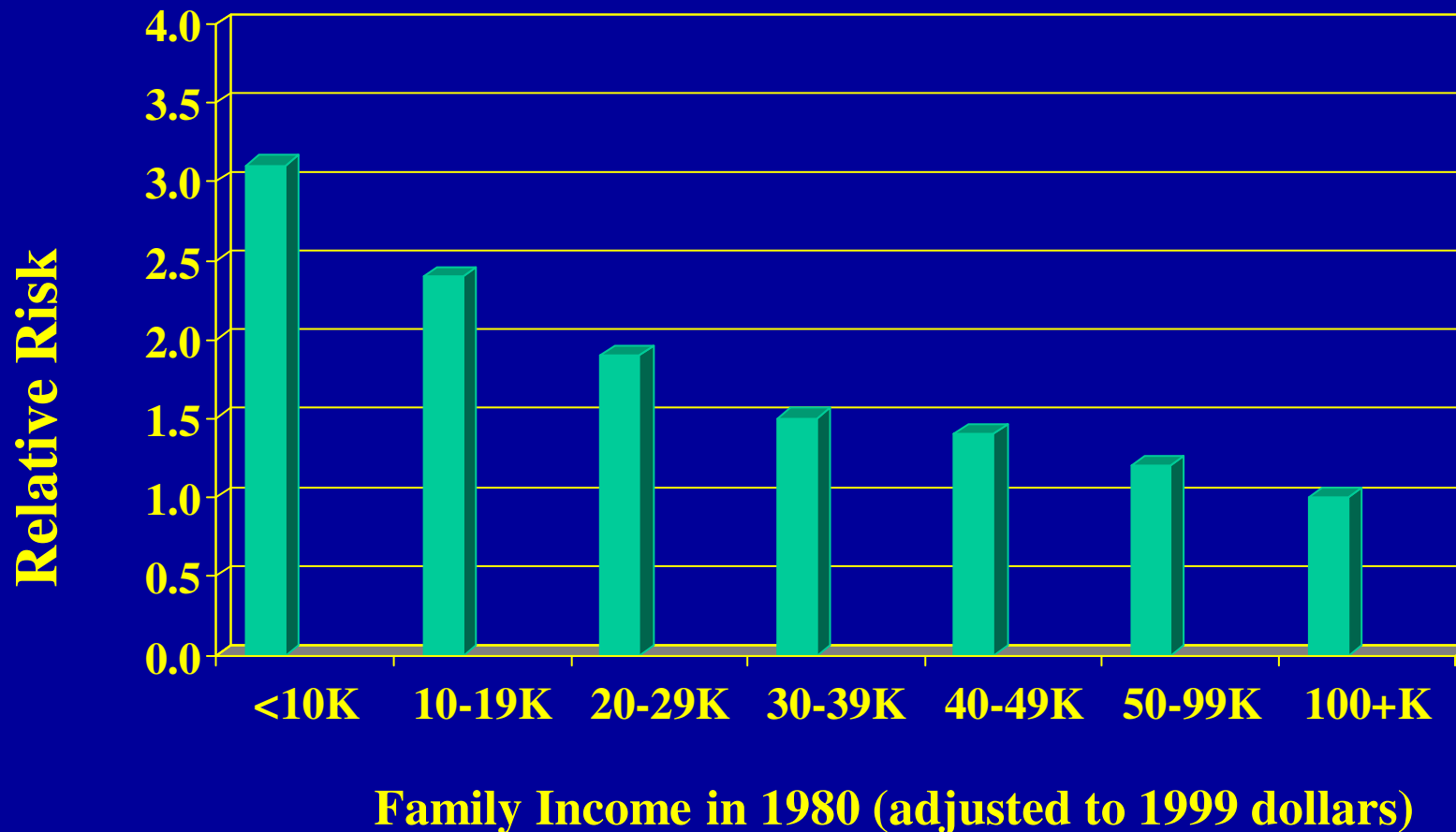
Source: (ETS) Mantsios; N=898,596

# SES: A Key Determinant of Health

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- **Socioeconomic Status (SES) usually measured by income, education, or occupation influences health in virtually every society.**
  - **SES is one of the most powerful predictors of health, more powerful than genetics, exposure to carcinogens, and even smoking.**
  - **The gap in all-cause mortality between high and low SES persons is larger than the gap between smokers and non-smokers.**
  - **Americans who have not graduated from high school have a death rate two to three times higher than those who have graduated from college.**
  - **Low SES adults have levels of illness in their 30s and 40s that are not seen in the highest SES group until after the ages of 65-75.**
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# Relative Risk of Premature Death by Family Income (U.S.)



9-year mortality data from the National Longitudinal Mortality Survey

# SES: Multiple Disadvantages

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- Poor education in childhood and adolescence
- Insecure employment
- Stuck in hazardous or dead-end jobs
- Living in poor housing
- Trying to raise a family in difficult circumstances
- Living on an inadequate pension

# SES and Health Risks

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SES is linked to:

- \*Exposures to health enhancing resources
- \*Exposures to health damaging factors
- \*Exposure to particular stressors
- \*Availability of resources to cope with stress

Health practices (smoking, poor nutrition, drinking, exercise, etc.) are all socially patterned

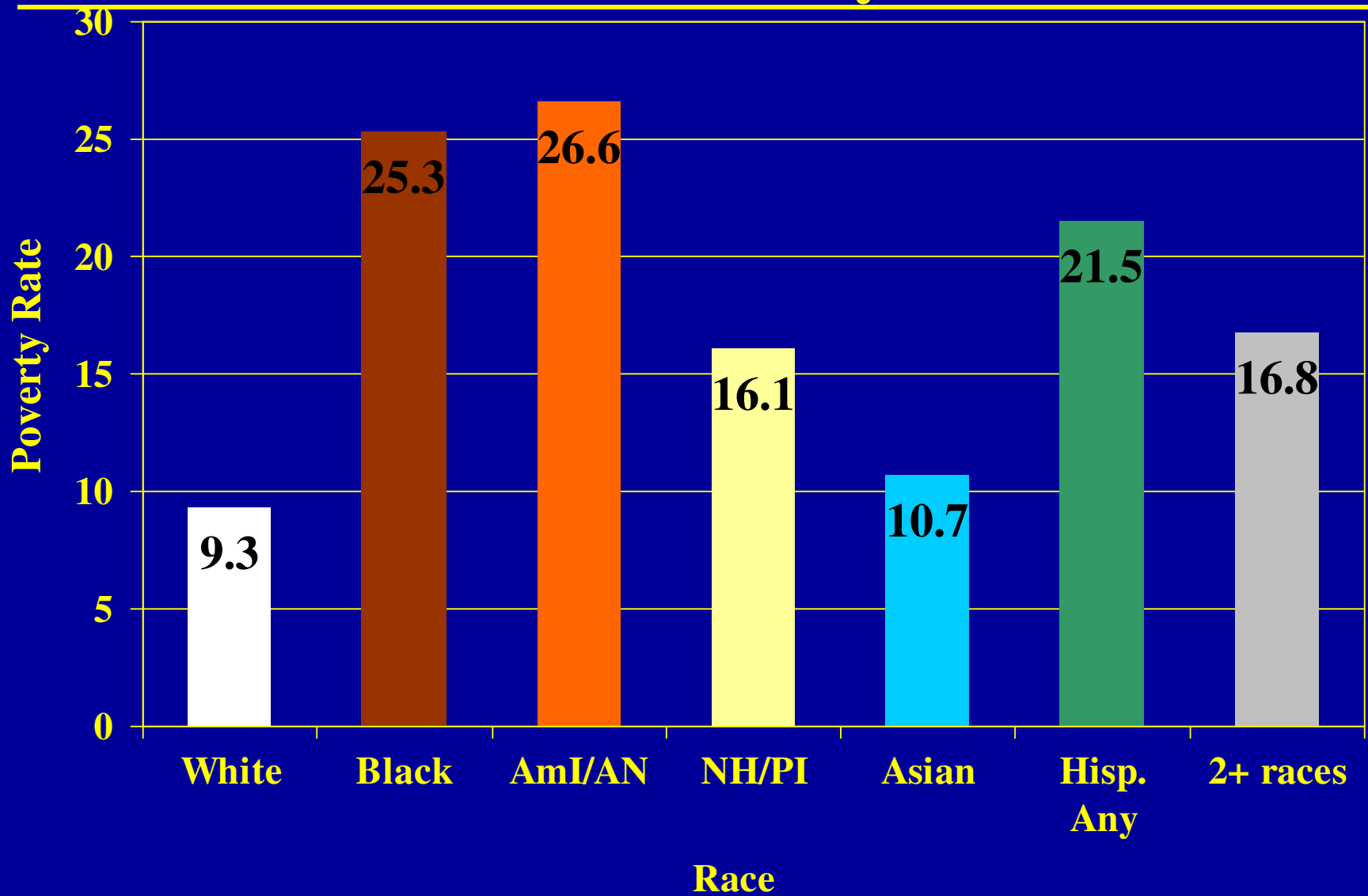
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## SES and Race

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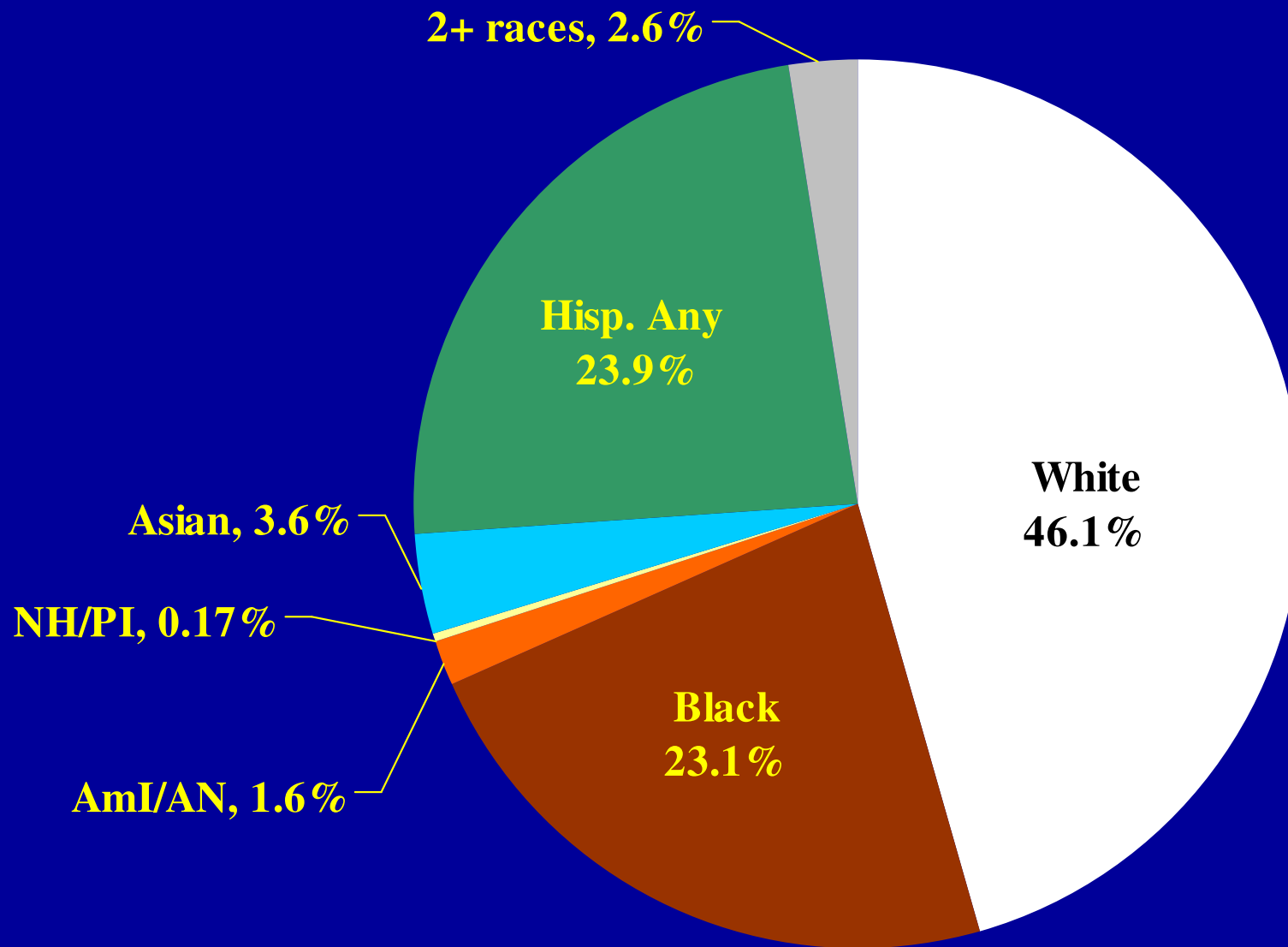
- African Americans and multiple other minorities have lower levels of education, income, professional status, and wealth than whites. These racial differences in SES are the major reason for racial differences in health.
  - Education and income are generally more strongly associated with health status than race.
  - Racial differences in health status decrease substantially when racial groups are compared at similar levels of SES.
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# Percentage of Persons in Poverty Race/Ethnicity



# Racial/Ethnic Composition of People in Poverty in the U.S.

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## Race/Ethnicity and SES

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- Race and SES reflect two related but not interchangeable systems of inequality
  - In national data, the highest SES group of African American women have equivalent or higher rates of infant mortality, low birth-weight, hypertension and overweight than the lowest SES group of white women
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# Life Expectancy At Age 25, 1998

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<b>Group</b>	<b>White</b>	<b>Black</b>	<b>Difference</b>
<b>All</b>	<b>53.4</b>	<b>48.4</b>	<b>5.0</b>

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Murphy, NVSS 2000; Braveman et al. in Press, NLMS 1988-1998

# Life Expectancy At Age 25, 1998

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<b>All</b>	<b>53.4</b>	<b>48.4</b>	<b>5.0</b>
<b>Education</b>			
<b>a. 0-12 Years</b>	<b>50.1</b>		
<b>b. 12 Years</b>	<b>54.1</b>		
<b>c. Some College</b>	<b>55.2</b>		
<b>d. College Grad</b>	<b>56.5</b>		
<b>Difference</b>	<b>6.4</b>		

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<b>a. 0-12 Years</b>	<b>50.1</b>	<b>47.0</b>	
<b>b. 12 Years</b>	<b>54.1</b>	<b>49.9</b>	
<b>c. Some College</b>	<b>55.2</b>	<b>50.9</b>	
<b>d. College Grad</b>	<b>56.5</b>	<b>52.3</b>	
<b>Difference</b>	<b>6.4</b>	<b>5.3</b>	

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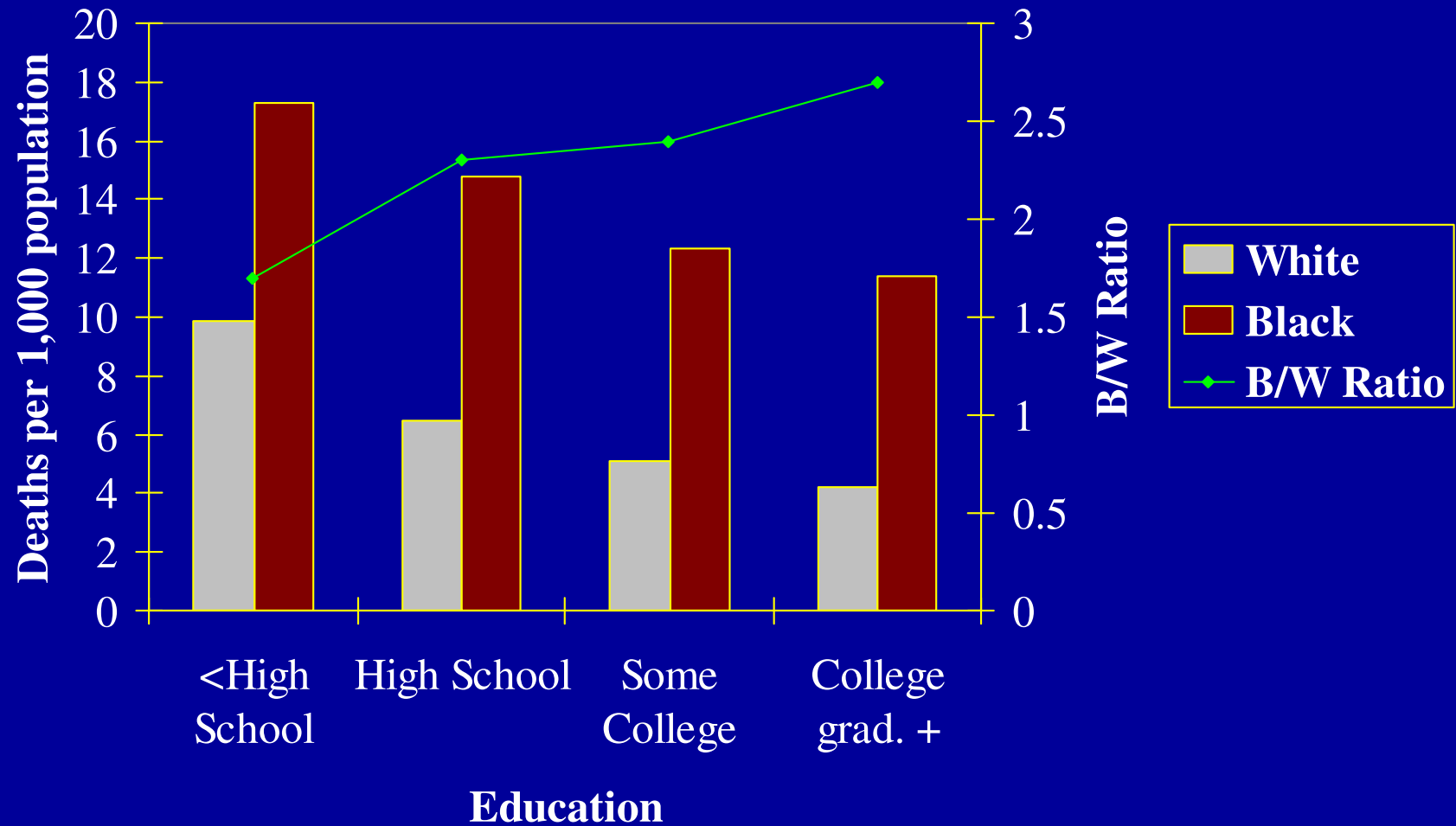
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<b>All</b>	<b>53.4</b>	<b>48.4</b>	<b>5.0</b>
<b>Education</b>			
<b>a. 0-12 Years</b>	<b>50.1</b>	<b>47.0</b>	<b>3.1</b>
<b>b. 12 Years</b>	<b>54.1</b>	<b>49.9</b>	<b>4.2</b>
<b>c. Some College</b>	<b>55.2</b>	<b>50.9</b>	<b>4.3</b>
<b>d. College Grad</b>	<b>56.5</b>	<b>52.3</b>	<b>4.2</b>
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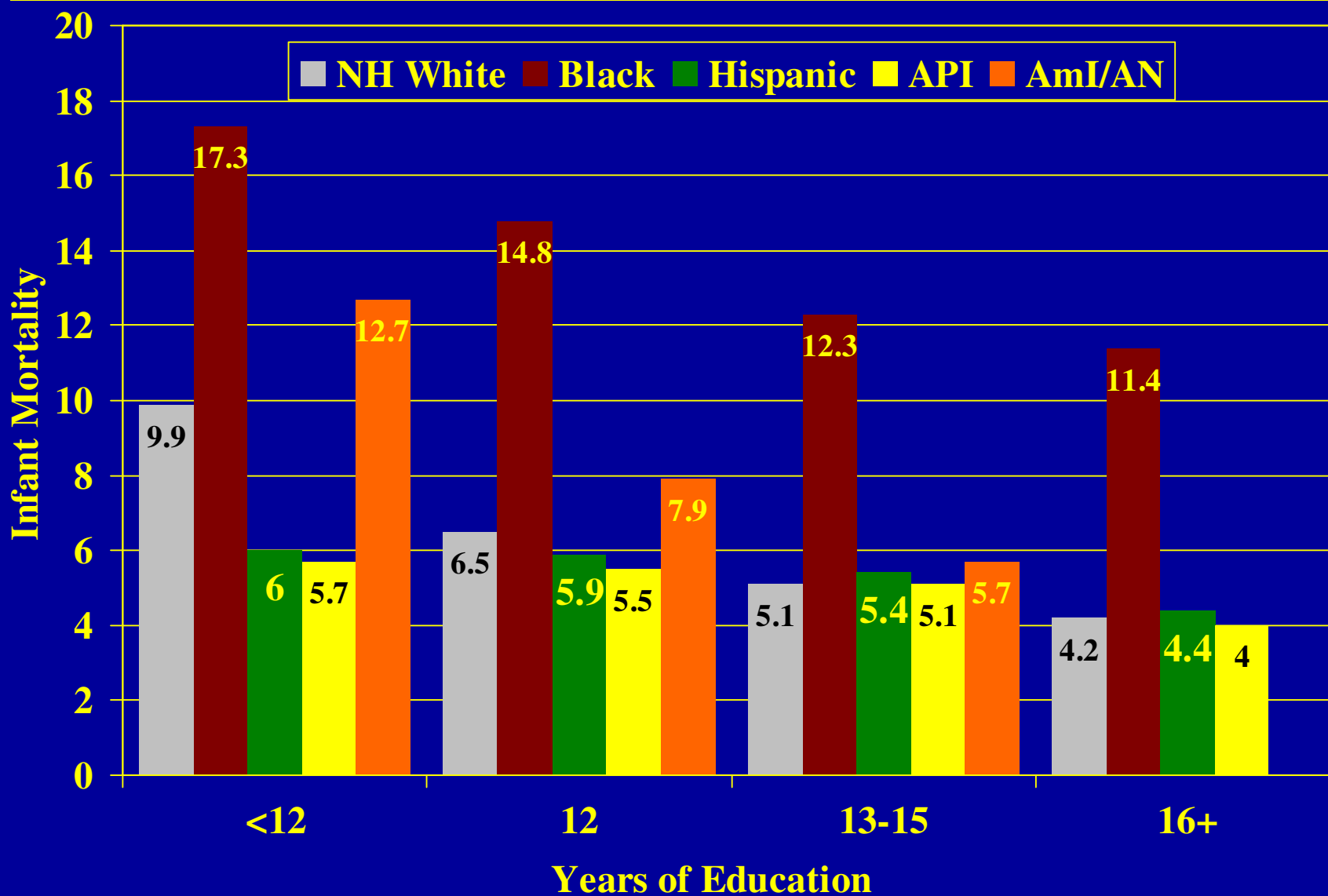
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Murphy, NVSS 2000; Braveman et al. in Press, NLMS 1988-1998

# Infant Death Rates by Mother's Education, 1995



# Infant Mortality by Mother's Education, 1995



# Why Race Still Matters

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1. All indicators of SES are non-equivalent across race. Compared to whites, blacks receive less income at the same levels of education, have less wealth at the equivalent income levels, and have less purchasing power (at a given level of income) because of higher costs of goods and services.
  2. Health is affected not only by current SES but by exposure to social and economic adversity over the life course.
  3. Personal experiences of discrimination and institutional racism are added pathogenic factors that can affect the health of minority group members in multiple ways.
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## **Key Fact #5**

**All indicators of SES are not the same across racial/ethnic groups.**

# Race/Ethnicity and Wealth, 2000

## Median Net Worth

<b>Income</b>	<b>White</b>	<b>Black</b>	<b>Hispanic</b>
<b>All</b>	<b>\$79,400</b>	<b>\$7,500</b>	<b>\$9,750</b>
<b>Excl. Hm. Eq.</b>	<b>22,566</b>	<b>1,166</b>	<b>1,850</b>
<b>Poorest 20%</b>	<b>24,000</b>	<b>57</b>	<b>500</b>
<b>2<sup>nd</sup> Quintile</b>	<b>48,500</b>	<b>5,275</b>	<b>5,670</b>
<b>3<sup>rd</sup> Quintile</b>	<b>59,500</b>	<b>11,500</b>	<b>11,200</b>
<b>4<sup>th</sup> Quintile</b>	<b>92,842</b>	<b>32,600</b>	<b>36,225</b>
<b>Richest 20%</b>	<b>208,023</b>	<b>65,141</b>	<b>73,032</b>

Source: Orzechowski & Sepielli 2003, U.S. Census

## Wealth of Whites and of Minorities per \$1 of Whites, 2000

<b>Household Income</b>	<b>White</b>	<b>B/W Ratio</b>	<b>Hisp/W Ratio</b>
<b>Total</b>	<b>\$ 79,400</b>	<b>9¢</b>	<b>12¢</b>
<b>Poorest 20%</b>	<b>\$ 24,000</b>	<b>1¢</b>	<b>2¢</b>
<b>2<sup>nd</sup> Quintile</b>	<b>\$ 48,500</b>	<b>11¢</b>	<b>12¢</b>
<b>3<sup>rd</sup> Quintile</b>	<b>\$ 59,500</b>	<b>19¢</b>	<b>19¢</b>
<b>4<sup>th</sup> Quintile</b>	<b>\$ 92,842</b>	<b>35¢</b>	<b>39¢</b>
<b>Richest 20%</b>	<b>\$ 208,023</b>	<b>31¢</b>	<b>35¢</b>

Source: Orzechowski & Sepielli 2003, U.S. Census

# **Race and Economic Hardship 1995**

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**African Americans were more likely than whites to experience the following hardships <sup>1</sup>:**

- 1. Unable to meet essential expenses**
- 2. Unable to pay full rent on mortgage**
- 3. Unable to pay full utility bill**
- 4. Had utilities shut off**
- 5. Had telephone shut off**
- 6. Evicted from apartment**

<sup>1</sup> After adjustment for income, education, employment status, transfer payments, home ownership, gender, marital status, children, disability, health insurance and residential mobility.

## **Key Fact #6**

**In addition to SES, racism is an added burden.**

# Racism Mechanisms

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- Institutional discrimination can restrict socioeconomic attainment a group differences in SES a health.
  - Segregation can create pathogenic residential conditions.
  - Discrimination can lead to reduced access to desirable goods and services.
  - Internalized racism (acceptance of society's negative characterization) can adversely affect health.
  - Racism can create conditions that increase exposure to traditional stressors (e.g. unemployment).
  - Experiences of discrimination may be a neglected psychosocial stressor.
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# MLK Quote

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"...Discrimination is a hellhound that gnaws at Negroes in every waking moment of their lives declaring that the lie of their inferiority is accepted as the truth in the society dominating them."

Martin Luther King, Jr. [1967]

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# Discrimination Persists

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- Pairs of young, well-groomed, well-spoken college men with identical resumes apply for 350 advertised entry-level jobs in Milwaukee, Wisconsin. Two teams were black and two were white. In each team, one said that he had served an 18-month prison sentence for cocaine possession.
- The study found that it was easier for a white male with a felony conviction to get a job than a black male whose record was clean.

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Source: Devan Pager; NYT March 20, 2004

# Percent of Job Applicants Receiving a Callback

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<b>Criminal Record</b>	<b>White</b>	<b>Black</b>
<b>No</b>	<b>34%</b>	<b>14%</b>
<b>Yes</b>	<b>17%</b>	<b>5%</b>

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Source: Devan Pager; NYT March 20, 2004

# Recent Review

- 115 studies in PubMed between 2005 and 2007
- Broader outcomes (fibroids, breast cancer incidence, Hb A1c, CAC, stage 4 sleep, birth weight, sexual problems)
- Studies of effects of bias on health care seeking and adherence behaviors
- Some longitudinal data
- Attention to the severity and course of disease
- International studies:
  - national: New Zealand, Sweden, & South Africa
  - Australia, Canada, Denmark, the Netherlands, Norway, Spain, Bosnia, Croatia, Austria, Hong Kong, and the U.K.
- Discrimination accounts, in part, for racial/ethnic disparities in health

# Every Day Discrimination

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In your day-to-day life how often do the following things happen to you?

- You are treated with less courtesy than other people.
  - You are treated with less respect than other people.
  - You receive poorer service than other people at restaurants or stores.
  - People act as if they think you are not smart.
  - People act as if they are afraid of you.
  - People act as if they think you are dishonest.
  - People act as if they're better than you are.
  - You are called names or insulted.
  - You are threatened or harassed.
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# Everyday Discrimination and Subclinical Disease

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In the study of Women's Health Across the Nation (SWAN):

- Everyday Discrimination was positively related to subclinical carotid artery disease (IMT; intima-media thickness) for black but not white women
- chronic exposure to discrimination over 5 years was positively related to coronary artery calcification (CAC)

# Arab American Birth Outcomes

- Well-documented increase in discrimination and harassment of Arab Americans after 9/11/2001
- Arab American women in California had an increased risk of low birthweight and preterm birth in the 6 months after Sept. 11 compared to pre-Sept. 11
- Other women in California had no change in birth outcome risk pre-and post-September 11

# **Key Fact #7**

**Place makes an added contribution  
to health.**

# Understanding Elevated Health Risks

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**“Has anyone seen the SPIDER  
that is spinning this complex  
web of causation?”**



# Racial Segregation Is ...

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1. Myrdal (1944): ... "basic" to understanding racial inequality in America.
  2. Kenneth Clark (1965): ... key to understanding racial inequality.
  3. Kerner Commission (1968): ... the "linchpin" of U.S. race relations and the source of the large and growing racial inequality in SES.
  4. John Cell (1982): ... "one of the most successful political ideologies" of the last century and "the dominant system of racial regulation and control" in the U.S.
  5. Massey and Denton (1993): ... "the key structural factor for the perpetuation of Black poverty in the U.S." and the "missing link" in efforts to understand urban poverty.
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# How Segregation Can Affect Health

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1. Segregation determines quality of education and employment opportunities.
2. Segregation can create pathogenic neighborhood and housing conditions.
3. Conditions linked to segregation can constrain the practice of health behaviors and encourage unhealthy ones.
4. Segregation can adversely affect access to high-quality medical care.

# Race and Job Loss

## Economic Downturn of 1990-1991

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<b>Racial Group</b>	<b>Net Gain or Loss</b>
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<b>BLACKS</b>	<b>59,479 LOSS</b>
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<b>WHITES</b>	<b>71,144 GAIN</b>
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<b>ASIANS</b>	<b>55,104 GAIN</b>
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<b>HISPANICS</b>	<b>60,040 GAIN</b>
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Source: *Wall Street Journal* analysis of EEOC reports of 35,242 companies

# Race and Job Loss

## Percent Black

Company	Work Force	Losses	Reason
Sears	16	54	Closed distribution centers in inner-cities; relocated to suburbs
Pet	14	35	Two Philadelphia plants shutdown
Coca-Cola	18	42	Reduced blue-collar workforce
American Cyanamid	11	25	Sold two facilities in the South
Safeway	9	16	Reduced part-time work; more suburban stores

Source: Sharpe, 1993: Wall Street Journal

# Residential Segregation and SES

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A study of the effects of segregation on young African American adults found that the elimination of segregation would erase black-white differences in

- Earnings
- High School Graduation Rate
- Unemployment

And reduce racial differences in single motherhood by two-thirds

# Segregation and Medical Care -I

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- Pharmacies in segregated neighborhoods are less likely to have adequate medication supplies (Morrison et al. 2000)
  - Hospitals in black neighborhoods are more likely to close (Buchmueller et al 2004; McLafferty, 1982; Whiteis, 1992).
  - MDs are less likely to participate in Medicaid in racially segregated areas. Poverty concentration is unrelated to MD Medicaid participation (Greene et al. 2006)
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## Segregation and Medical Care -II

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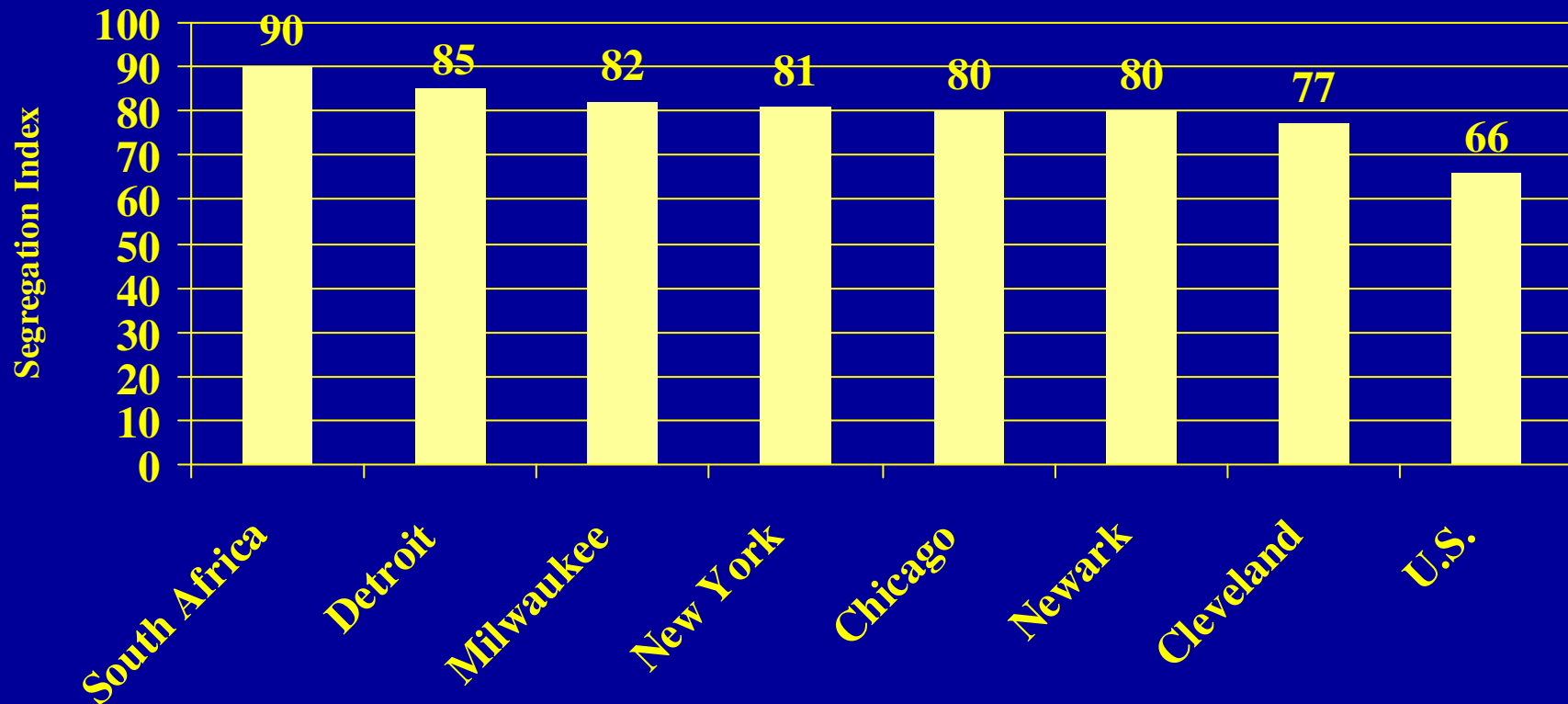
- Blacks are more likely than whites to reside in areas (segregated) where the quality of care is low (Baicker, et al 2004).
  - African Americans receive most of their care from a small group of physicians who are less likely than other doctors to be board certified and are less able to provide high quality care and referral to specialty care (Bach, et al. 2004).
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# Racial Differences in Residential Environment

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- In the 171 largest cities in the U.S., there is not even one city where whites live in ecological equality to blacks in terms of poverty rates or rates of single-parent households.
- “The worst urban context in which whites reside is considerably better than the average context of black communities.”  
p.41

# American Apartheid: South Africa (de jure) in 1991 & U.S. (de facto) in 2000



Source: Massey 2004; Iceland et al. 2002; Glaeser & Vigdor 2001

## **Key Fact #8**

**There are racial/ethnic differences in access to care and the quality of care**

# The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

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- 720 physicians viewed recorded interviews
- Reviewed data about a hypothetical patient
- The physicians then made recommendations about that patient's care



## The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

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- **Women (OR =0.60) and blacks (OR =0.60) were less likely to be referred for cardiac catheterization than men and whites, respectively.**
- **Black women were significantly less likely to be referred for catheterization than white men (OR= 0.4)**

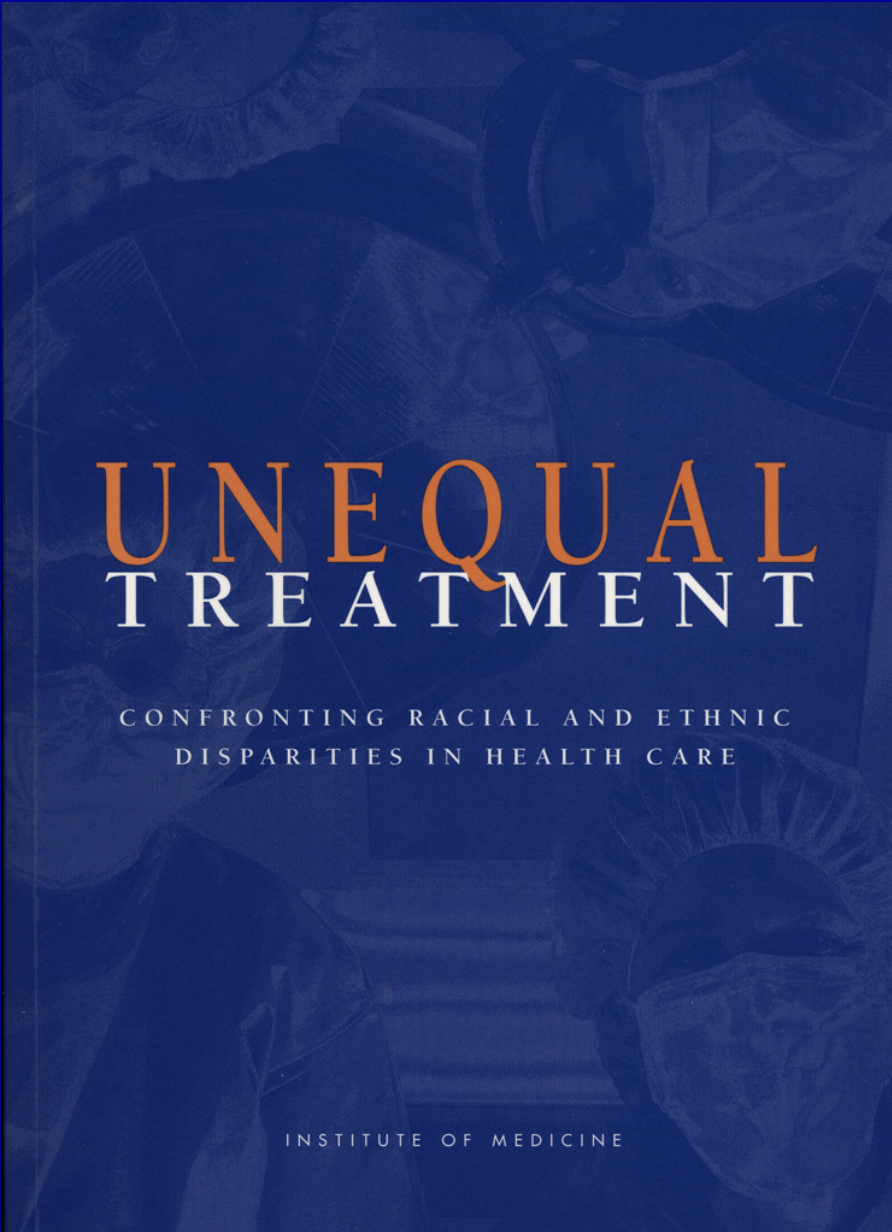
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Source: Schulman et. al., *NEJM*  
1999;340:618.

# STUDY CHARGE

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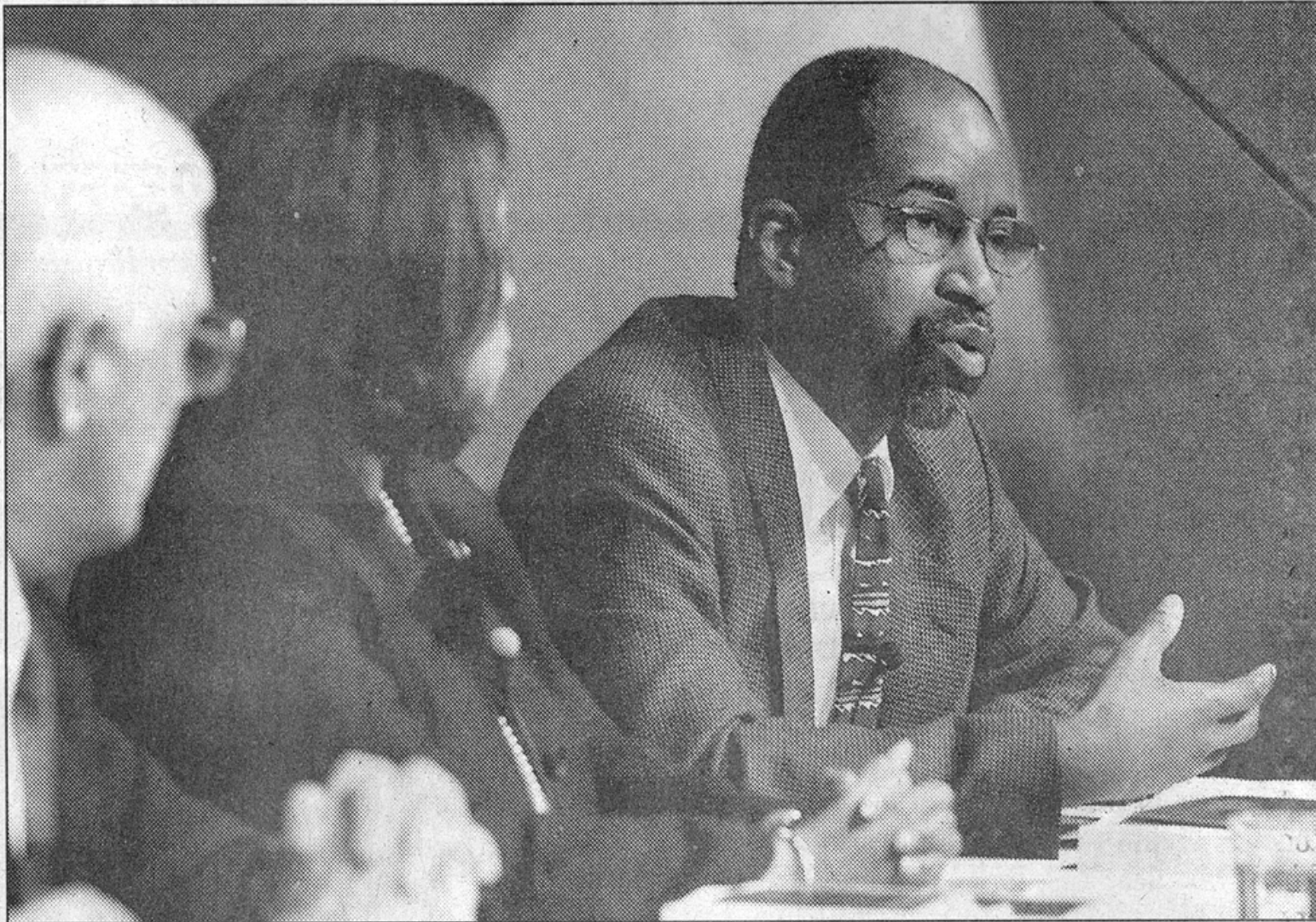
- **Assess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage);**
  - **Evaluate potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels; and,**
  - **Provide recommendations regarding interventions to eliminate healthcare disparities.**
-



# UNEQUAL TREATMENT

CONFRONTING RACIAL AND ETHNIC  
DISPARITIES IN HEALTH CARE

INSTITUTE OF MEDICINE



BY SUSAN WALSH—ASSOCIATED PRESS

**David Williams, a University of Michigan professor, right, says: “We have a health care system that is the pride of the world, but this report documents that the playing field is not even.”**

# Race and Medical Care

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- Across virtually every therapeutic intervention, ranging from high technology procedures to the most elementary forms of diagnostic and treatment interventions, minorities receive fewer procedures and poorer quality medical care than whites.
- These differences persist even after differences in health insurance, SES, stage and severity of disease, co-morbidity, and the type of medical facility are taken into account.
- Moreover, they persist in contexts such as Medicare and the VA Health System, where differences in economic status and insurance coverage are minimized.

# Race and Heart Disease

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- **White Medicare patients were four times more likely than blacks to receive bypass surgery.**
- **Mexican Americans with definite or possible MI received 38% fewer medications (antiarrhythmics) than whites.**
- **Blacks with acute MI were less likely than whites to:**
  - 1) be admitted to a hospital with revascularization services**
  - 2) receive revascularization if admitted**
  - 3) receive revascularization if transferred or on subsequent readmission.**

# Race and Cancer

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**Compared to Whites, Black breast cancer patients were:**

- **Less likely to have health insurance**
- **Less likely to be treated by experienced board-certified MDs**
- **More likely to be treated in large public hospitals**

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Source: Diehr et al. 1989. Study of 7,781 in 107 hospitals

# **Race and Cancer (cont.)**

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**Adjusting for these factors, blacks were less likely than whites to receive:**

- **The appropriate prognostic test (progesterone receptor assay)**
- **radiation therapy in combination with radical/modified mastectomy**
- **rehabilitation support services after a mastectomy**

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**Source: Diehr et al. 1989. Study of 7,781 in 107 hospitals**

## Ethnicity and Analgesia

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**A chart review of 139 patients with isolated long-bone fracture at UCLA Emergency Department (ED):**

- **All patients aged 15 to 55 years, had the injury within 6 hours of ER visit, had no alcohol intoxication.**
- **55% of Hispanics received no analgesic compared to 26% of non-Hispanic whites.**
- **With simultaneous adjustment for sex, primary language, insurance status, occupational injury, time of presentation, total time in ED, fracture reduction and hospital admission, Hispanic ethnicity was the strongest predictor of no analgesia.**
- **After adjustment for all factors, Hispanics were 7.5 times more likely than non-Hispanic whites to receive no analgesia.**

## Procedures with Higher Rates for Blacks than Whites Medicare Beneficiaries Age 65 or Older, 1992

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	Procedure Rates	Mortality Rates
Procedure	B/W Ratio	B/W Ratio
1. Amputation (lower limb	3.62	0.79
2. Excisional Debridement	2.65	1.22
3. Arteriovenostomy	5.17	0.66
4. Bilateral Orchiectomy	2.21	0.99

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Source: McBean and Gornick, 1994

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1 = Usually a consequence of diabetes

2 = Removal of tissue, usually related to decubitus ulcers

3 = Implanting shunts for chronic renal dialysis

4 = Removal of both testes, generally performed because of cancer

# **Disparities in the Clinical Encounter: The Core Paradox**

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**How could well-meaning and highly educated health professionals, working in their usual circumstances with diverse populations of patients, create a pattern of care that appears to be discriminatory?**

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# **Stereotyping: A Definition**

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**Stereotyping can be defined as the process by which people use social categories (e.g. race, sex) in acquiring, processing, and recalling information about others.**

*Stereotyping beliefs may serve important functions - organizing and simplifying complex situations and giving people greater confidence in their ability to understand, predict, and potentially control situations and people.*

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## Whites Stereotypes of Blacks (and Whites) %

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### 1. Lazy

Blacks are lazy	44	(5)
Neither	34	(36)
Blacks are hard working	17	(55)

### 2. Violent

Blacks are prone to violence	51	(16)
Neither	28	(42)
Blacks are not prone to violence	15	(37)

### 3. Unintelligent

Blacks are unintelligent	29	(6)
Neither	45	(33)
Blacks are intelligent	20	(55)

### 4. Welfare

Blacks prefer to live off welfare	56	(4)
Neither	27	(22)
Blacks prefer to be self-supporting	13	(71)

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Source: 1990 General Social Survey

# Whites Stereotypes of Hispanics (and Whites) %

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## 1. Lazy

Hispanics are lazy	34	(5)
Neither	34	(36)
Hispanics are hard working	24	(55)

## 2. Violent

Hispanics are prone to violence	38	(16)
Neither	34	(42)
Hispanics are not prone to violence	18	(37)

## 3. Unintelligent

Hispanics are unintelligent	29	(6)
Neither	43	(33)
Hispanics are intelligent	18	(55)

## 4. Welfare

Hispanics prefer to live off welfare	42	(4)
Neither	31	(22)
Hispanics prefer to be self-supporting	18	(71)

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Source: 1990 General Social Survey

# Unconscious Discrimination

- **When one holds a negative stereotype about a group and meets someone who fits the stereotype s/he will discriminate against that individual**
  - **Stereotype-linked bias is an**
    - **Automatic process**
    - **Unconscious process**
  - **It occurs even among persons who are not prejudiced**
-

# *“I am not racist: I know I don’t stereotype”*

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- **Conclusive evidence that stereotypes are activated automatically (without intent).**
  - **Individuals frequently are not aware of activation nor impact on their perceptions, emotions and behavior.**
  - **They are activated more quickly and effortlessly than conscious cognition.**
  - **Many cognitive processes result in confirmation of expectancies (we process information in ways that support our beliefs).**
- 

Source: van Ryn, 2003

# Factors that Increase Stereotype Usage

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- **Time Pressure**
- **Need for Quick Judgments**
- **High Cognitive demands**
- **Task Complexity**
- **Resource constraints**
- **Anger or Anxiety**

**Medical Encounter: Time pressure, brief encounters, need to manage complex cognitive tasks.**

# Generalizability of Unconscious Bias

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- An important characteristic of social interaction across a broad range of cultures and societies where individuals are characterized into social groups
  - In the U.S., race, sex and age are the three primary characteristics of individuals that are attended to across a broad range of social contexts
-

# Possible Solutions

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- Individuals who hold egalitarian beliefs are less likely to activate negative stereotypes (implicit beliefs) when exposed to neutral (but not negative) stimuli.
- Under certain conditions individuals can consciously replace automatically activated stereotype with egalitarian response:
  - Must be aware of potential for judgment, emotions and behaviors to be biased.
  - Have awareness of stereotype activation
  - Have high level of motivation
  - Have sufficient cognitive resources (time and cognitive capacity).

# Possible Solutions

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- The promotion of counter-stereotypes may have beneficial effects.
- Counter-stereotype mental imagery (e.g. imagining a strong woman) can influence the activation of implicit gender stereotype
- Requires time, effort, cognitive resources

# Possible Solutions

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- Perspective-taking can reduce stereotypes and prejudice. (Compared to a no-instruction control group and a “stereotype suppression group” that was instructed to actively try to avoid thinking about the person in a stereotypic manner.)
- For example, whites who wrote about a day in the life of an elderly or black person, showed less *explicit* and *implicit stereotyping*.
  - “imagine a day in the life of this individual as if you were that person, looking at the world through his eyes and walking through the world in his shoes.”

# Personal Application

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- **Become an agent of change by being conscious of, and speaking out against, both subtle and blatant forms of bias in health care delivery**
  - **Consciously monitor deep-seated personal stereotyping, whether bias is conscious or unconscious its adverse impact on patients is real**
  - **Avoid judging “the book by its cover.” Be cautious about applying ‘skin color’ or other social or physical characteristics for measuring sociocultural variables**
  - **Seek out opportunities for becoming better informed about the specific attributes of other cultures, but remember that there is great diversity within each cultural group.**
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# **Recommendations: Actions Must be Sustained and Comprehensive**

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Increase awareness of racial and ethnic disparities in health care among the general public and key stakeholders, and increase health care providers' awareness of disparities.

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# Recommendations: Legal, Regulatory, And Policy

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- Avoid fragmentation of health plans along socioeconomic lines
  - Strengthen the stability of patient-provider relationships in publicly funded health plans
  - Increase U.S. racial and ethnic minorities among health professionals
  - Apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees
  - Provide greater resources to the U.S. DHHS Office of Civil Rights to enforce civil rights laws
-

# Recommendations: Health Care System

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- Promote the consistency and equity of care through the use of evidence-based guidelines;
  - Structure payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities;
  - Provide incentives for practices that reduce barriers and encourage evidence-based practice;
  - Promote the use of interpretation services where community need exists.
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# Recommendations: Education

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- Patient education programs
    - To increase patients' knowledge of how to best access care
    - To participate in treatment decisions.
  - Integrate cross-cultural education into the training of all current and future health professionals.
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# Recommendations: Data Collection And Monitoring

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- Collect and report data on health care access and utilization by patients'
    - race
    - ethnicity
    - socioeconomic status
    - where possible, primary language
  - Include measures of racial and ethnic disparities in performance measurement;
  - Monitor progress toward the elimination of health care disparities;
-

## **Key Fact #9**

**Minorities are still under-represented among health professionals.**

# Enrollment in Dental School: Blacks, Other Races, Women

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	1970-71	2000-01
	Percentages	
Black	4.5	4.7
White	91.4	64.4
Hispanic	1.0	5.3
American-Indian	0.1	0.6
Asian	2.6	25.0
All Women <sup>1</sup>	3.1	37.6

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Source: National Center for Health Statistics, 2003; <sup>1</sup> Comparison years for women are 1971-72 with 1999-2000.

## Enrollment in Medical School: Blacks, Other Races, Women

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	1970-71	2000-01
	Percentages	
Black	3.8	7.4
White	94.3	63.8
Hispanic	0.5	6.4
American-Indian	0.0	0.8
Asian	1.4	20.1
All Women <sup>1</sup>	13.7	44.4

---

Source: National Center for Health Statistics, 2003; <sup>1</sup> Comparison years for women are 1971-72 with 1999-2000.

## **Key Fact #10**

**African Americans have much better mental health than expected.**

# Disparities in Mental Health

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Blacks have lower rates than whites of :

1. Any Affective Disorder
2. Any Anxiety Disorder
3. Any Substance Abuse/Dependence
4. Any disorder

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Source: Kessler et.al. (1994)

## **Key Fact #11**

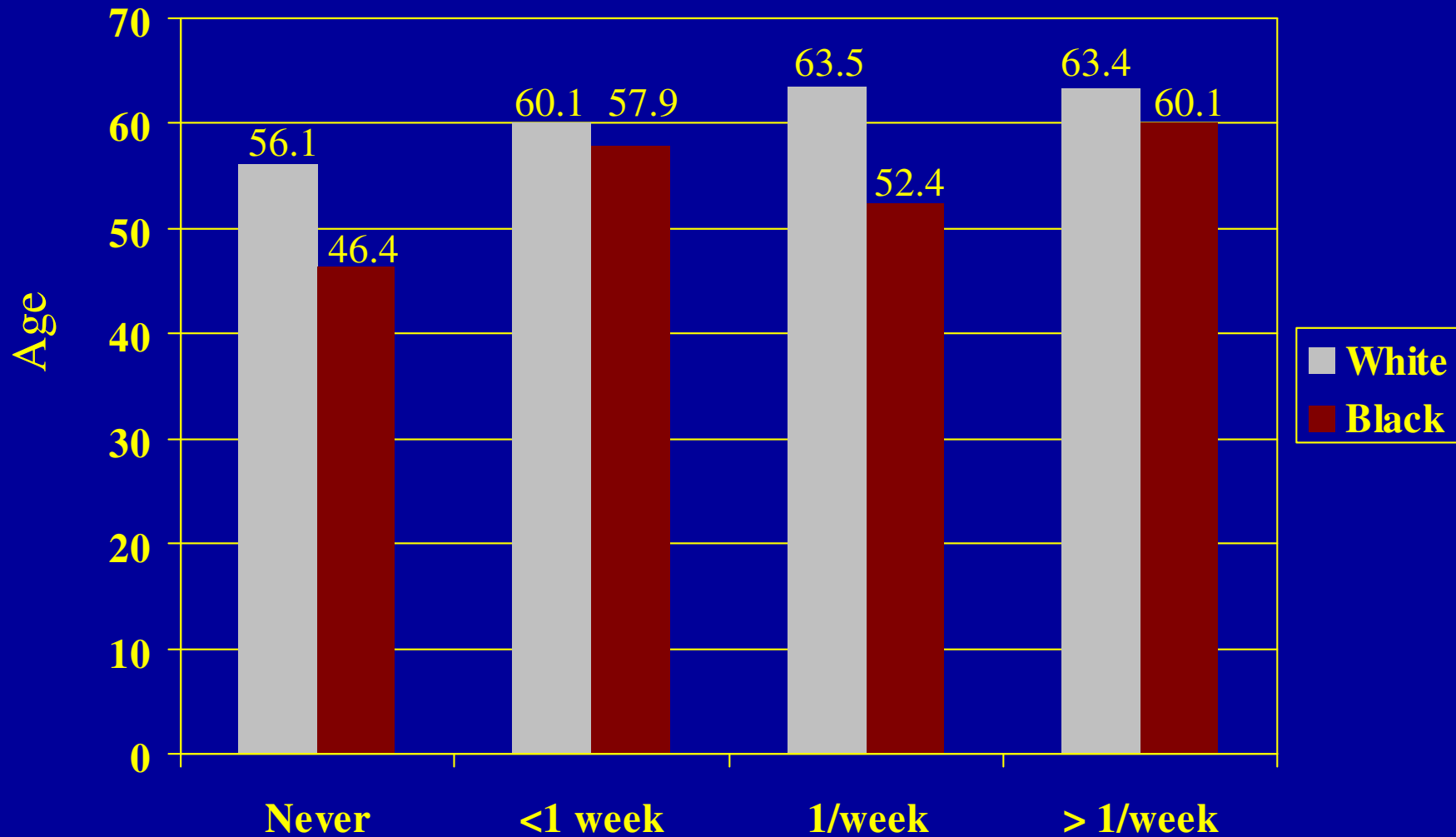
*We Need to Better Understand  
How Resilience Factors and  
Processes Can Affect Health and  
how to Build on the Strengths  
and Capacities of Communities*

# Religion and Adolescent Risk Behavior

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- **Religious high school seniors are less likely than their non-religious peers to**
  - **Carry a weapon (gun, knife, club) to school**
  - **Get into fights or hurt someone**
  - **Drive after drinking**
  - **Ride with driver who had been drinking**
  - **Smoke cigarettes**
  - **Engage in binge drinking (5 or more drinks in a row)**
  - **Use marijuana**
- **Religious seniors were more likely to**
  - **Wear seat belts**
  - **Eat breakfast, green vegetables and fruit**
  - **Get regular exercise**
  - **Sleep at least 7 hours per night**

# U.S. Life Expectancy at Age 20 by Religious Attendance



# Religious Services as Therapy?

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1. Several aspects of some religious services are distinctive in the provision of opportunities to articulate and manage personal and collective suffering.
2. The expression of emotion and active congregational participation can promote “collective catharsis” in ways that facilitate the reduction of tension and the release of emotional distress.
3. There are parallels between all the key elements of formal psychotherapy and the rituals of some religious services.

## **Key Fact #12**

**Policies to reduce inequalities in health must address fundamental non-medical determinants.**

# Reducing Inequalities

## Address Underlying Determinants of Health- I

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- Improve living standards for poor persons and households
  - Increase access to employment opportunities
  - Increase education and training that provide basic skills for the unskilled and better job ladders for the least skilled
  - Invest in improved educational quality in the early years and reduce educational failure
-

# Reducing Inequalities

## Address Underlying Determinants of Health- II

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- Improve conditions of work, re-design workplaces to reduce injuries and job stress
  - Enrich the quality of neighborhood environments and increase economic development in poor areas
  - Improve housing quality and the safety of neighborhood environments
-

# Reducing Inequalities Health Care

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- Improve access to care and the quality of care
    - Give emphasis to the prevention of illness
    - Provide effective treatment
    - Develop incentives to reduce inequalities in the quality of care
-

# Reducing Inequalities: Engage Multiple Communities

- Knowledge of the extent of disparities and their causes is a prerequisite for effective action
    - In the U.S., over 50% of whites, blacks and Hispanics are unaware that racial disparities in health exist.
  - Partnerships needed with government, industry, and other private organizations
  - Important role for community involvement in the identification and management of interventions
  - Strengthen the capacity of community organizations to take action
-

## **Key Fact #13**

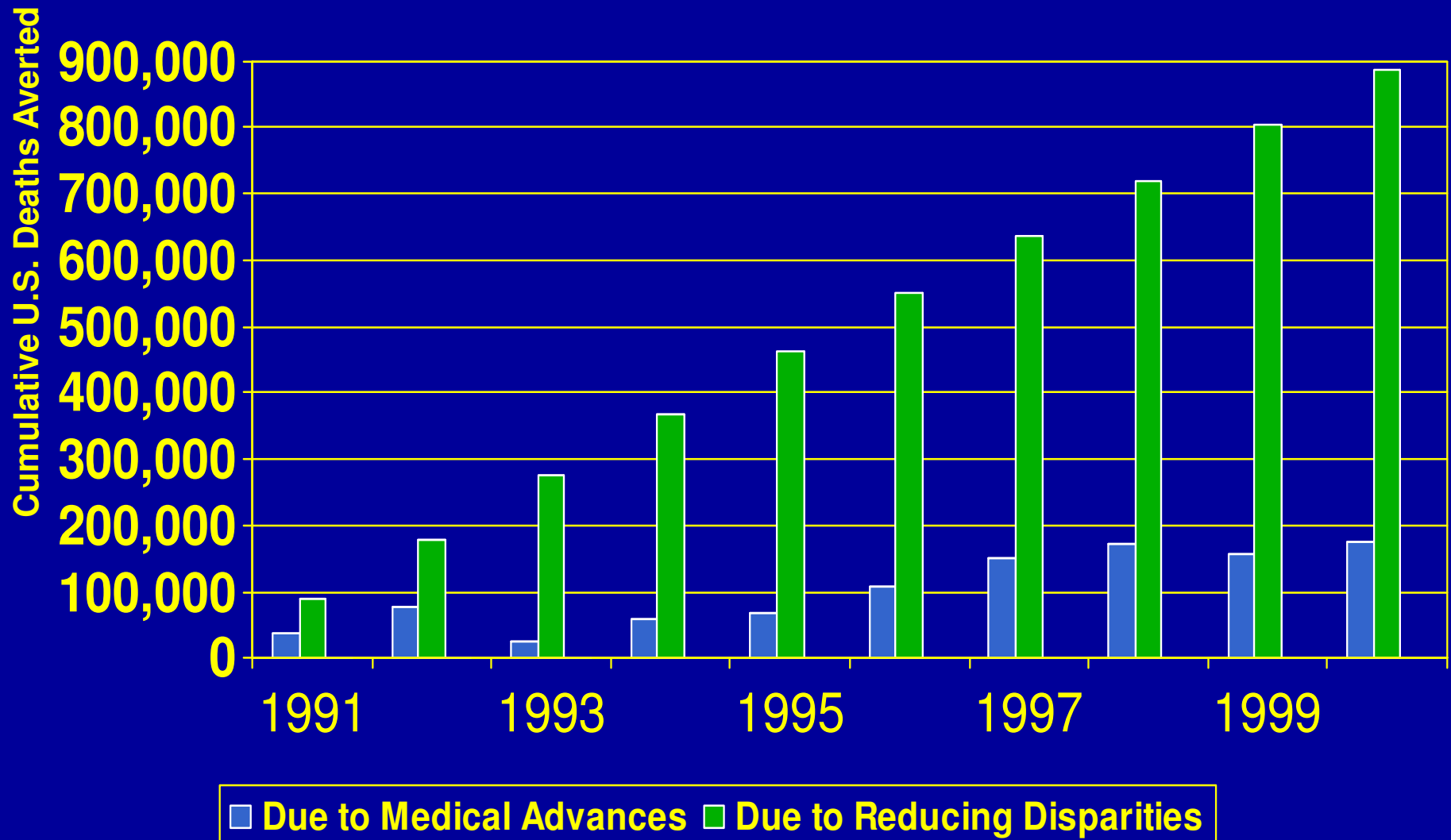
**Racial Disparities in health are  
really costly to our society**

## Medical Advances Vs. Disparities, 1991 - 2000

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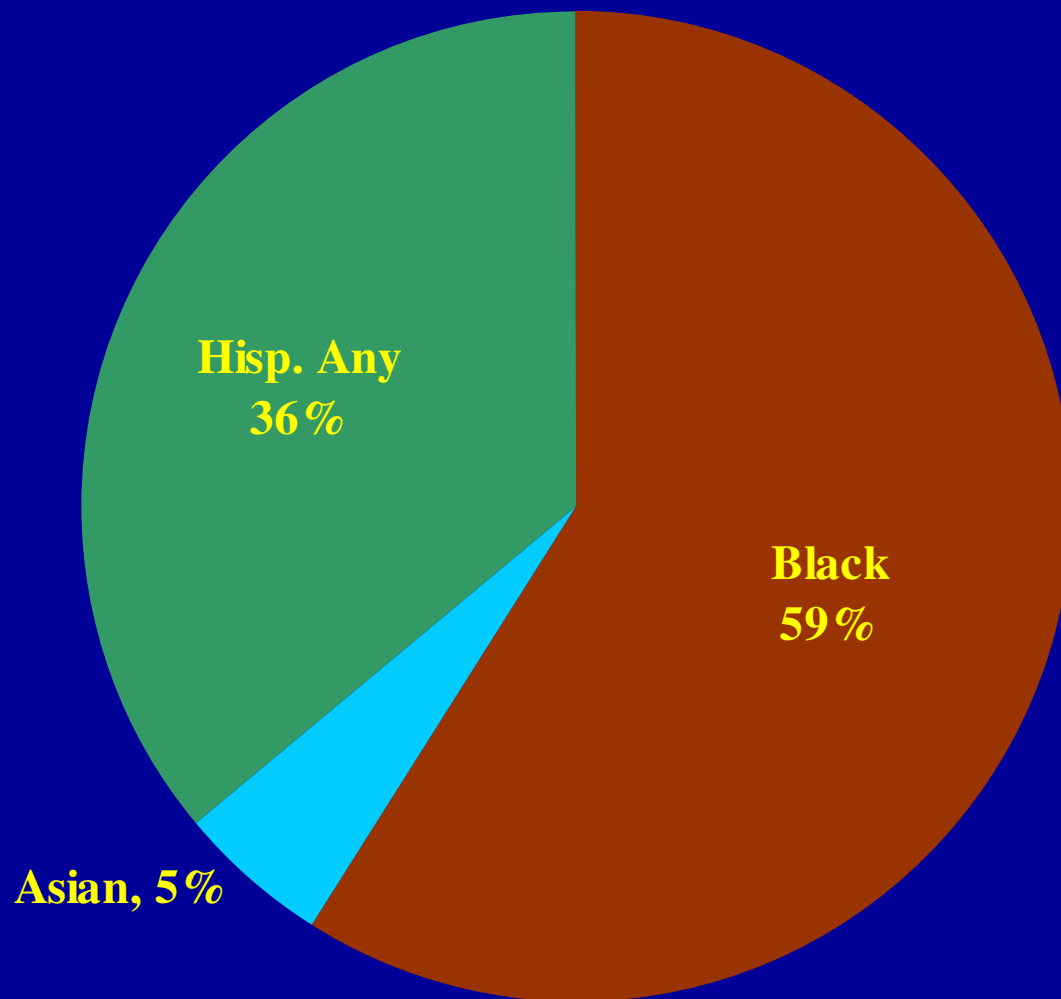
- ❖ 176,633 deaths averted due to declines in mortality
- ❖ Assume all the decline is due to medical advances
- ❖ If the death rates of blacks and whites were identical, 886,202 deaths would have been averted
- ❖ 5 deaths could be averted by reducing disparities for every life saved by medical advances
- ❖ ~~Eliminating disparities in health would save~~  
Woolf, S. et al 2004, AJPH  
more lives than current advances in medical technology

# Medical Advances Vs. Disparities, 1991- 2000



# Medical Care Costs of Racial Disparities: \$229.4 Billion, 2003-2006

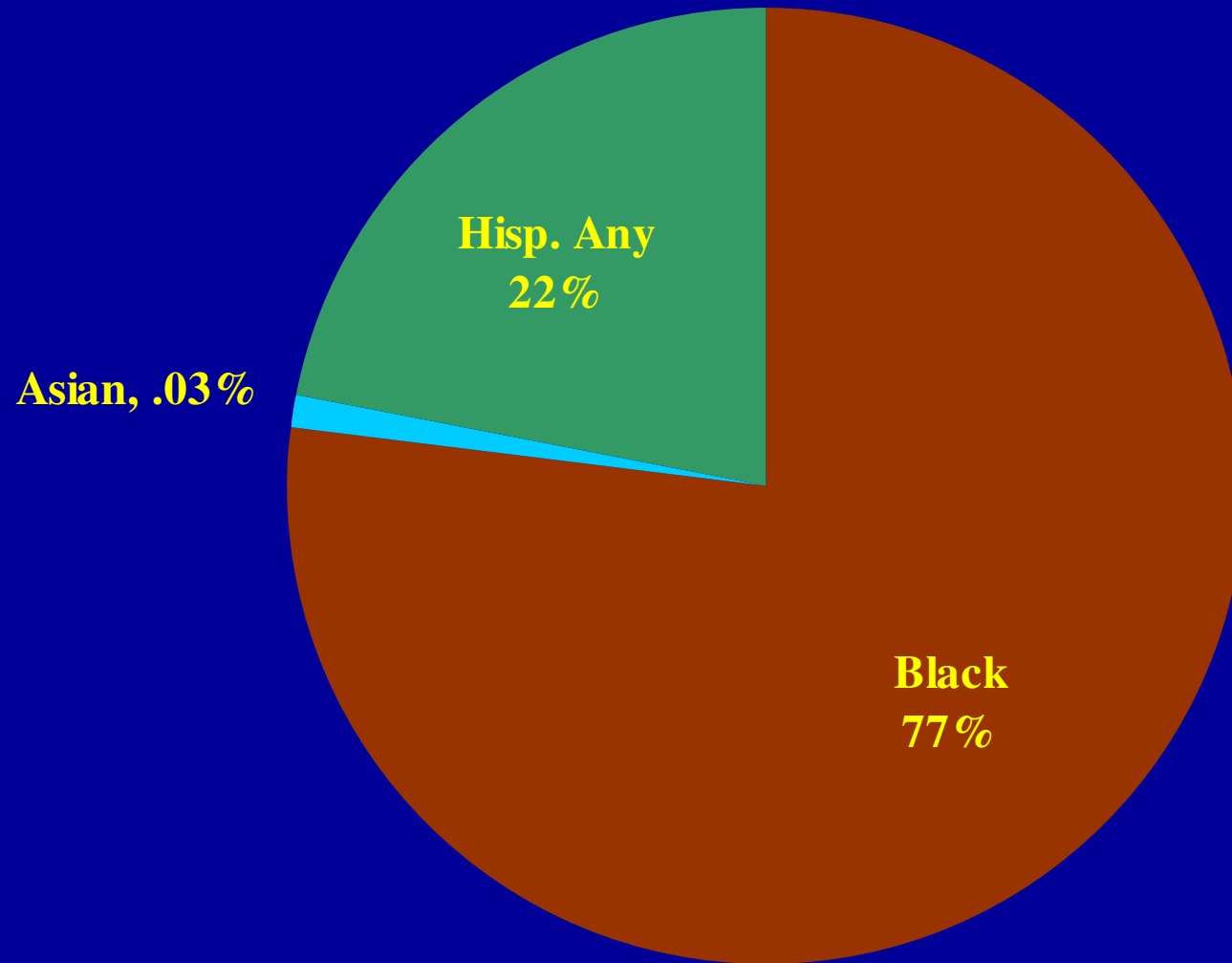
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# Indirect Costs of Racial Disparities: \$1.008 Trillion, 2003-2006

## Costs of lower worker productivity and premature death

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# Total Costs of Racial Disparities

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- \$1.24 Trillion, 2003-2006
- More than the Gross Domestic Product of India (world's 12<sup>th</sup> largest economy in 2008)
- \$309.3 Billion annual loss to the economy
- Social Justice can be cost effective
- Doing nothing has a cost that we should not continue to bear

# MLK Quote

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**"Of all the forms of inequality, injustice in health care is the most shocking and inhumane"**

**--Martin Luther King Jr.**

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# A Call to Action

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“The only thing necessary for the triumph [of evil] is for good men to do nothing.”

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Edmund Burke, Irish Philosopher