

## What We Know, Don't Know, and Should Be Doing about Disparities in Health Care

Speaker: H. Jack Geiger, MD

*“Equity in access does not guarantee equity in health status. Health is the complex result of multiple interacting factors, of which access to appropriate and timely care is a necessary but not sufficient component. Addressing the many non-financial barriers to care, as well as expanding financial coverage for all Americans, is essential if equity of access is to be achieved”*

— Joanne Lukomnik, “Non-Financial Barriers to Health Care,” 1992

The phrase “health disparities” refers to disparities in health status — the extra burden of illness and death among African-Americans, Hispanic Americans, Native Americans, and a variety of the Asian subgroups. But another meaning is racial and ethnic disparities in the quality of medical care itself. If you are minority, you have a strong probability of being treated differently, with less quality, than a white counterpart who is identical in all other variables of insurance status, income, education, severity of disease, co-morbidity, and hospital resources.

I will not repeat here the evidence of racial and ethnic disparities in medical care. The case has been proven over and over again. My colleagues and I have annotated close to a thousand peer-reviewed articles on racial and ethnic disparities in care. This report, “**The Right to Equal Treatment**,” and a bibliography are available at the Physicians for Human Rights web site ([www.phrusa.org](http://www.phrusa.org)). There is no longer any reasonable question that these disparities in treatment exist and have existed for a very long time in every major category of disease and of medical and surgical procedure.

We know that the causes are multi-factorial and complex. There is no single smoking gun. Broadly, we can group the causative elements for this differential treatment into three categories, in no rank order.

*\*This talk was given at a PNHP-NY Metro Chapter forum on April 27, 2004. An extended version of the talk is available at [www.pnhpnyc.org](http://www.pnhpnyc.org)*

Patient-level factors include patients’ knowledge and beliefs about health and illness, as well as the issue of patient trust in the physician and the health care system. The evidence is compelling. A recent survey of African-American respondents — we need  
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### The HIV/AIDS Epidemic and the Need for Health Care Reform

Speaker: Robert Fullilove, Ed.D.

HIV/AIDS, a sexually-transmitted disease, is cited in Institute of Medicine reports as one of the areas where we see significant health disparities by race. Half the cases of HIV/AIDS reported to the CDC most recently were among 12% of the population which is African-Americans.

What are we doing about this? National policy is: Get everyone tested and, for those who are found to be positive, quickly link them into care. Then we discover that there are not enough treatment places. We’re testing, but we can’t necessarily treat, for lack of money. Medicare Reform has made it worse. HIV/AIDS is now a chronic disease that can be treated with medications, but the Medicare Reform Act says that, if Medicaid is paying for your drugs, you are only allowed two drugs. Yet some combination of three types of drugs is needed to combat the ravages of the disease effectively.

We will see patients failing to complete their regimen for lack of money. When this happens, we will see the development, through mutation, of drug-resistant strains of the virus. We’re creating a scenario for disaster in which, in the worst case, a virus will be created that is not transmitted just sexually. We could face a large-scale epidemic in which everyone is vulnerable.

For those of us who deal with HIV/AIDS prevention and treatment, then, health care reform is not an abstraction or a subject for debate. The extent to which we have unequal access and do not provide the financing necessary to take care of those who are ill is the extent to which we are all in danger.

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similar studies of Hispanics and other groups — found that a significant plurality of respondents said that their own physician was capable of experimenting on them without their consent. This is yet another element that physicians, other health providers, and institutions of health care need to be aware of. Patient-level factors include, as well, out-of-pocket costs, fluency in English, health care literacy (knowing something about disease and the recommended regimen), and what are called “preferences” (what used to be called “compliance”). There is good evidence for the existence of these preferences, but in no case anywhere in the literature has that factor been anywhere near sufficient to account for the magnitude of the existing disparities.

**Provider factors** start with negative racial and ethnic stereotyping. The classic study of negative stereotyping by physicians, by Van Ryn and Burke, found in cardiac cases that clinicians, usually on the basis of an average 12-minute interview, decided that the African-American patient “doesn’t have the energy to do cardiac rehab, isn’t smart enough to stay with rehab, and really understand all the things that he or she needs to do to manage the disease, doesn’t have a good social support system, doesn’t have a stressful job.” This is a double violation, not only of what the society professes to be about, but also of medical ethics and the commitment of medicine to treat everyone equally.

Other provider factors include clinical uncertainty stemming from lack of cultural competence or linguistic competence, along with competing demands and cognitive overload leading to shorthand thinking and stereotyping.

**Institutional and community factors** contribute in familiar ways to racial and ethnic disparities in the quality of care. We all know about the location of physicians’ offices, the neighborhoods where resources are and are not. Institutional factors also include interactions with office staff where minority patients report differential treatment, along with what might be called the organizational culture of the health care institution (reading level and cultural appropriateness of written materials provided,

how co-pays and deductibles are handled, whether a quality improvement program is in effect).

**We need to know much more about the variations in disparities. We don’t really know what works for cultural competence**

training. Many of the early curricula were simply lists of the strange behaviors of other people, stereotype-reinforcing items one after the other, never addressing the idea that physicians and other health professionals bring their own culture and the culture of medicine to their work. Cultural competence begins with self-examination, rather than the idea that culture is something that is just an attribute of other people.

We don’t know very much about how to intervene in physician/patient communication styles. We do know that it is better when there is physician/patient racial or ethnic concordance and that African-Americans and Hispanics will almost always choose preferentially for physicians and providers of their own racial or ethnic or language group.

**What Can We Do Now?** First of all, we have to see that all clinical data is recorded by race and ethnicity. Minority group respondents are understandably skeptical of doing that, anticipating that the data will be used for some nefarious purpose. However, there is no way we can monitor what is happening by race and ethnicity unless we are collecting data in this way.

Second, we need to push every organized provider of care to have a quality improvement program and to use practice guidelines for all their patients. There is evidence that this works. About a hundred community health centers are part of a Health Disparities Collaborative in which quality improvement guidelines have reduced disparities in treatment and outcomes. One of the reasons quality improvement is useful, aside from the fact that it does seem to work, is that it is less challenging than going head-on with physicians about the issues of negative racial and ethnic stereotypes.

And that leads me to my final point: I don’t think change is going to happen if it’s all top-down. This effort has to involve community-based advocacy groups and community organizations. We’ve been researching this area for a decade, but this is a problem that we can and will solve.

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### **PNHP-NY Metro FORUM REPORT**

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### **THE LUKOMNIK FORUM SERIES**

This Forum was the third sponsored by the Joanne Lukomnik Fund for Health Care Reform. Joanne worked to improve health care for minorities for more than 20 years. Jack Geiger was her mentor in medical school, then her colleague and friend. He led her into the community health center movement where she did most of her work. The Lukomnik Fund was created to continue her activism toward the kind of compassionate health care she fought for and that we believe is a basic human right.

