status report

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Eliminating Health Disparities:
Addressing Minority and Rural Community Issues

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Eliminating Health Disparities: Addressing Minority and Rural Community Issues

Background

Healthy People 2010 is an ongoing U.S. Department of Health and Human Services program designed to identify and improve national health objectives. One of the two primary goals of Healthy People 2010 is to "eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation."

Currently, a divide exists in the quality of health care delivered to the typical white male population and the health care delivered to minorities, women, and members of rural or lower socioeconomic communities. Women are less likely than men to receive aggressive therapy for heart conditions. In the gay and lesbian population, conditions such as HIV/AIDS and incidences of suicide occur in a disproportionate number, while religious beliefs and social prejudices can create barriers that prevent proper treatment. Disabled and lower socioeconomic populations face many obstacles to the delivery of medical services, including the lack of facilities designed to cater to their specific time and geographic needs. For the purposes of this report, we will examine the shortcomings in medical service delivery to the minority and rural communities specifically.

Minorities and members of rural populations can expect to have shorter life expectancies, lower rates of delivery for necessary medical services, and poorer results when those services are rendered. Factors such as cultural differences, lack of insurance or underinsurance, and difficulties associated with access to health care are some of the main obstacles to improvement. While the issues behind these disparities are many, they aren't insurmountable. The public health community is committed to the elimination of health disparities and has created an outline of steps that can be taken to accomplish this goal.

The World Health Organization (WHO) defines health as "the state of complete physical, mental, and social well-being, and not merely the absence of disease or injury." However, the vast majority of the $1.3 billion spent on health care annually goes not toward the maintenance of the healthy state, but on resource-intensive measures designed to cure disease that might have been prevented in the first place.

Marilyn Hughes Gaston, MD, former assistant surgeon general, suggests that the bulk of health care expenditures should be spent on primary care services aimed at prevention, education, and ensuring access to care. By doing so, we can have "better care for more people at less cost"—a situation that few could argue against.

Minority Issues

A recent report by the Institute of Medicine found that disparities in health outcomes exist between white and minority populations, even in the absence of differences in income or insurance coverage. Minorities are less likely to receive preventative care for conditions such as diabetes. Minorities are also less likely to receive aggressive care for conditions such as heart disease and breast or prostate cancer. Surgical rates are significantly higher in white populations, despite the fact that heart disease affects a greater percentage of minorities.

The University Center for Social and Urban Research (UCSUR) created a series of reports for the Urban League of Pittsburgh and the Center for Minority Health (CMH) known as The Black Papers, which documented health disparities specific to Allegheny County. Five conditions were studied: life expectancy at birth, leading causes of death for county African Americans, infant mortality, firearm injuries and deaths, and sexually transmitted diseases.

The life expectancy for African American males was 5.7 years less than white males and 7.8 years less than the overall life expectancy. Prostate cancer mortality rates exceeded those for white males by a factor of three. The homicide rate for African American males between the ages of 15 and 19 was determined to be 39 times higher than for white males in the same age group. The gonorrhea rate for African American females is 48 times the white female rate. More alarming news indicates that in some areas, the

divide is increasing. Gaston reports that nationally, rates pertaining to obesity, diabetes, end-stage renal disease, amputation, and depression are increasing for minorities as compared to white populations.

There are a number of factors affecting minority communities that prevent adequate delivery of health care. Language barriers can discourage non-English speaking people from seeking care. While strides have been made toward the creation of multilingual public health materials, dissemination is not widespread. Cultural issues also affect the health care delivery process. Historical incidences such as the Tuskegee Syphilis Study have created an atmosphere of mistrust of the medical community. Stephen Thomas, PhD, director of the CMH at the University of Pittsburgh, asserts that underlying discrimination by healthcare professionals also serves to create mistrust.

Solutions to these problems mostly revolve around increasing communication between the minority and healthcare communities, as well as within minority communities. More likely than not, healthcare advice is solicited from friends, relatives, and neighbors rather than official sources of medical information. One proposed method of increasing education is the dissemination of healthcare information through barbershops and jitney drivers, two common sources of advice in minority communities. Faith-based organizations are another avenue through which anecdotal medical advice can be delivered.

Thomas cites the need for "culturally appropriate strategies for specific communities." Rather than relying on traditional technology-based medical solutions that usually require the patient to make the first step, Thomas suggests "we can no longer wait for people to come into the healthcare system to intervene." Specific efforts must be made toward the inclusion of those outside the current scope of care, in a manner that recognizes and allays the unique concerns of each community.

Ron Porter, president and CEO of RDP Consulting Services, advocates the development of financial incentive programs as well. Citing an inevitable waning of interest in volunteer-dependent organizations, he recommends the creation of funded positions in the community geared around organization and coordination of disenfranchised populations.

Rural Issues

Similar to minority communities, rural populations fare worse than the general public in several health areas. Rural communities have significantly higher rates of heart disease, motor vehicle related trauma, and mental health problems, specifically, depression and teen suicide. As in minority communities, there are a number of problems associated with delivery of healthcare services among rural populations. Smaller population densities and the greater geographic areas served by rural healthcare facilities and providers make access to care difficult.

The lack of county health departments in Pennsylvania's rural communities makes coordination of care and public health delivery initiatives problematic—only 10 counties in Pennsylvania have health departments, mostly in the urban and suburban areas surrounding Pittsburgh and Philadelphia. Retention of healthcare professionals in rural areas is low due to the low pay associated with these positions and the relative unattractiveness of these areas as permanent destinations for most physicians.

Michael Meit, MA, MPH, director of the Center for Rural Health Practice at the University of Pittsburgh at Bradford, makes several suggestions for improvement. He suggests less focus on traditionally based medical services and more focus on public health techniques, including health education and disease surveillance. Critical to the development of organized care is the funding of professional coordinators as a replacement to the volunteers currently in place, through both local and hospital dollars. This will help to create a dedicated entity responsible for a particular area, unburdened by other position requirements.

Bioterrorism and emergency response programs should be developed. Unguarded and unmonitored, rural communities are realistic targets for a smallpox or similar attack that has the potential to be as life threatening as a similar urban attack. Currently, there are few professionals responsible for responding to such a threat on a rural population. Ownership by the community is essential; participation by all is necessary for successful rural health management.

Lisa Davis, MHA, director for the Pennsylvania Office of Rural Health (PORH), concurs with Meit and further defines the lack of medical service to the rural community. She points out the fact that two-thirds of Penn-

sylvania physicians practice in Allegheny, Montgomery, and Philadelphia counties. This has created a physician vacuum in the central and northern areas of the state. She recommends that specific efforts be established toward the coordinated recruitment of physicians filling rural service positions. Davis also recommends that increased attention be paid to the provision of specialty medical care, which is often unavailable to rural populations.

Framework for Improvement

Nearly all public health experts agree on several key steps that can be taken to eliminate Pennsylvania's health disparities. Increased attention must be paid to providing access to care, whether physically, such as emphasizing outpatient services or transportation, or culturally, such as creating faith-based motivational and educational programs. Funding for dedicated public healthcare professionals should be a priority. While examples of volunteer-based initiatives have shown success to date, true community-wide coordination will never occur without full-time staff trained in delivery of public health services.

Research presented in The Black Papers cites several already established programs, the first of which is conducted by the Centers for Healthy Hearts and Souls. Its smoking cessation program involves congregation participants and "experts in smoking cessation, a review of best practices, and discussions with health ministry leaders." The purpose has been to take an already cohesive faith-based community, offering both support and trust, and bring it a healthy message. The program started with 160 participants and produced an initial quit rate exceeding 40 percent.

The African-American Cancer Program uses cancer prevention education and early screening to reduce the over proportional cancer rates in the African American community. Associated with University of Pittsburgh Cancer Institute, the program sponsors health fairs and self-help groups. No data is available on the success of this program.

The Witness Project in Little Rock, Arkansas, was established in conjunction with the Arkansas Cancer Research Center with funding from the Centers for Disease Control and Prevention. Another faith-based project, this program uses testimonials from cancer survivors to increase credibility and communication amongst the target audience. African American women participating in the program show a significant increase in self-examination and mammography.

The common theme among all these programs is community development and an increased emphasis on communication. All programs attempt to get the community-wide buy-in of a particular group. A similar common theme is the association with faith-based organizations. While this method is currently effective, coordinators should be careful not to rely on this method for extended periods. Unfortunately, other common themes among the programs involve a lack of documentation, a lack of across-the-board standards, and an ad-hoc approach.

Eventually, for success to continue, volunteer coordinators must become full-time employees with dedicated organizations behind them. Porter points out the tendency for interest to wane in an organization comprised of volunteers, whose primary goal is not the address of the health disparity in question. For a tertiary information-trading network to be established, professional personnel must be involved, and standards must be created.

While it is important for the community leader to coordinate the volunteer force and funding sources, it is also important that participation come from the state legislative level. Legislators must become involved to establish government-based health departments or other similar resources. With a legislative commitment to coordinating and motivating the underserved to seek health care, the effort will achieve stability. Given the long-term benefits of community-based preventative care, increased support should go to programs delivering these services.

A Pennsylvania Initiative

The Pennsylvania Department of Health created its State Health Improvement Plan (SHIP) in July 2001. It was established as a conduit through which Pennsylvania's communities could work together toward the improvement of public health. Among its goals are the creation of partnerships between local and state governments and the providers of public health services. It allows for communities to customize the approaches used to their specific populations while sharing resources and information. It is a significant step toward the creation of a statewide network responsible for the delivery of basic healthcare services.

SHIP published the *Special Report on the Health Status of Minorities in Pennsylvania* in April 2002. According to Secretary of Health Robert Zimmerman Jr., the publication was designed to be a "catalyst in our efforts to eliminate health disparities affecting racial and ethnic minority populations throughout the state."

Conclusions

While we know some of the characteristics and techniques of successful programs aimed at eliminating health disparities, the road ahead may still be long. The solutions proposed are simple, but unappealing. The healthcare community's traditional reliance on invasive and complex life-saving techniques is not as cost effective as the grassroots approaches to delivering health care proposed here. It is unrealistic to ask healthcare institutions to decrease revenue or for healthcare workers to take pay cuts in order to deliver these necessary services. The development of economic models that will permit the healthcare industry to earn profits while providing care in the most cost-effective manner is the only true path to the elimination of health disparities.

Resources

The entirety of the Healthy People 2010 documents published by the U.S. Department of Health and Human Services can be found at www.health.gov/healthypeople/Document/tableofcontents.htm. This program has outlined the top priorities in public health for the near future, including the elimination of health disparities, and suggests steps to achieve the stated goals. Progress toward the accomplishment of these goals can also be tracked at this site.

The PORH Web site can be found at porh.cas.psu.edu. Directed by Lisa Davis, the PORH was established in 1991 as a collaborative effort between Pennsylvania State University's College of Health and Human Development and the Penn State Outreach and Cooperative Extension. The PORH works in conjunction with the Pennsylvania Rural Health Association, whose Web site can be found at porh.cas.psu.edu/prhaweb/prhahome.htm.

The Institute of Medicine Web site, www.iom.edu, allows visitors to view its recent publication *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The mission of the Institute of Medicine is "to advance and disseminate scientific knowledge to improve human health. The Institute provides objective, timely, authoritative information and advice concerning health and science policy."

The Black Papers can be found at the Web site for the UCSUR, www.ucsur.pitt.edu/default.htm. Established at by the University of Pittsburgh, UCSUR "promotes a research agenda focused on the social and economic issues most relevant to our society, including children, youth, and families; regional economic analysis and forecasting; the psychosocial impacts of aging; intergenerational relations; and environmental resource management."

The CMH at the University of Pittsburgh can be found at www.cmh.pitt.edu/home1.html. Director Stephen Thomas believes "the successful elimination of health disparities depends upon our ability to establish trusting community partnerships designed to increase the participation of minority populations."

The Pennsylvania Department of Health Web site provides access to its recent publication titled the *SHIP Special Report on the Health Status of Minorities in Pennsylvania* at webserver.health.state.pa.us/health/site.

Additional information on health disparities can be found in recent issues of the Institute of Politics' *Report*:

- Issue 24, Fall 2001, contains an overview of the Fifth Annual Elected Officials Retreat held at Hidden Valley in July 2001, which focused on the elimination of health disparities specific to Pennsylvania.
- Issue 26, Spring 2002, contains summaries of both the Deepening Community Health Partnerships to Eliminate Health Disparities conference held in Pittsburgh on March 13, 2002, and the Eliminating Health Disparities Forum: Policy Options for Pennsylvania conference held in Harrisburg on April 29, 2002.

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