Student National Medical Association
MINORITY HEALTH DISPARITIES POSITION STATEMENT

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THE STUDENT NATIONAL MEDICAL ASSOCIATION
MINORITY HEALTH DISPARITIES POSITION STATEMENT

The Student National Medical Association (SNMA), established in 1964 by medical students of Meharry Medical College and Howard University, is the nation's oldest and largest organization focused on the needs and concerns of medical students of color. Additionally, the SNMA is dedicated to practices leading to better health care for minority and underrepresented communities.

Within the next 50 years, physicians will have to provide health care to a steadily growing underrepresented minority population,[1] which suffers disproportionately from disease, has markedly different characteristics than those of the population in the United States today, and has significantly different patterns of disease and health care needs.[2] Therefore, the health of America as a whole will be influenced substantially by our Nation's success in improving the health status of minorities. Access to health care is a key part of this issue. For example, communities with large numbers of Black and Hispanic residents have been identified as being four times as likely as other populations to have a shortage of physicians, regardless of community income.[3] Because minority physicians show a greater tendency to practice in their communities or other underserved areas[4] and to provide care to minority populations,[5] it is imperative that there be greater representation of minority medical and health professionals to address current minority health disparities and to prevent a future health crisis. Additionally, all health care professionals must become culturally competent so that the health status of all Americans can be improved.

We, the members of the SNMA, recognize the threat to American health posed by minority health disparities and believe that increasing the number of minority physicians and health care professionals will play a key role in addressing these issues. Minority health disparities have reached such epic proportions that it is imperative that we address this as both a medical and public health issue.

1. Access to health care must be increased in order to decrease minority health disparities.

2. The preexisting and potential interest that elementary and secondary students especially minority students have in math and science should be cultivated and nurtured through exposure to these areas.

3. The number of programs that give minority children access to minority physicians and other health care workers in a mentoring/shadowing capacity should be increased.

4. Existing programs such as the National Health Service Corps should be broadened and utilized as a vehicle to increase financial aid to minority students interested in medicine and other health professions.

5. Teaching methods and experiences that assure cultural competency in medicine should be incorporated as essential parts of the curricula of medical schools, residency programs, medical specialty organizations, and continuing medical education programs.[6]

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Appendix

Racial and ethnic minorities are among the fastest growing populations in the United States.[3] By the year 2050, the U.S. Census Bureau has projected that minority groups which include Black Americans, Hispanic Americans, Asian Pacific Americans, and American Indians will increase to 47.2 percent of the United States population.[1] Because of the expected growth of the minority proportion of the U.S. population and the high proportion of racial and ethnic minorities in the United States represented among the medically underserved,[7] the future health of America as a whole will be influenced substantially by our Nation's success in improving the health status of minorities.

Ethnic minority and medically underserved populations continue to suffer disproportionately from disease. "Despite progress in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, and Asian Pacific Islanders, compared to the United States as a whole."[7]

There is a public health imperative to decrease minority health disparities which was clearly defined by many of the health objectives outlined in Healthy People 2000[8] and Healthy People 2010[9]. Examples of health disparities can be seen in infant mortality rates, age-adjusted total death rates, and the number of tuberculosis cases. Infant mortality is an important indicator and measure of the health status of a society. In 1990 the infant mortality rate for infants of Black non-Hispanic women was 2.6 times the rate for infants of Asian or Pacific Islanders and 2.3 times the rate of White non-Hispanic women.[10] Though infant mortality among Blacks was a special objective of Healthy People 2000, there has only been a slight decrease in the rate of infant mortality among Black, non-Hispanic women to 2.5 times the rate for Asian or Pacific Islanders and 1.9 times the rate of White non-Hispanic women in 1998.[10]

Age adjusted total death rate is a health status indicator useful for comparing mortality among race/ethnicities. In 1990, the total deaths for the U.S. population was 518.0/100,000 people.[10] However, the White non-Hispanic total death rate was 483.7/100,000 while the Black non-Hispanic total death rate was 785.2/100,000.[10] In 1998 the total deaths for the U.S. population was 471.7 while the total deaths rates were 452.7/100,000 for White non-Hispanic and 710.7/100,000 for Black non-Hispanics.[10] Although a decrease has been shown over this eight year period, the enormous number of Black non-Hispanics dying in proportion to White non-Hispanics is virtually unchanged.

Causes of death use to measure in the age adjusted total death rate are heart disease, stroke, lung cancer, female breast cancer, motor vehicle crash, suicide, and homicide.[10] Of the seven specific causes of death included in the age-adjusted total death rate, Black non-Hispanics have the greatest numbers of deaths within 5 of the indicators -- heart disease, stroke, lung cancer, female breast cancer, and homicide.[10]

In some cases, the health gaps initially identified in the 1985 Report of the Secretary's Task

Force on Black and Minority Health[11] or Healthy People 2000[8] have widened. For example, the number of tuberculosis cases among non-Hispanic Whites actually decreased by 42 percent during 1985-1997 while the number of reported tuberculosis cases increased 54 percent for Asians or Pacific Islanders, and 36 percent for Hispanics.[12] Surprisingly, the number of American Indian or Alaskan Native deaths from lung cancer increased from 19.8/100,000 in 1990 to 25.1/100,000 in 1998 indicating a 28.1% rise.[10] Additionally, the number of suicides committed by American Indian or Alaskan Natives has increased from 12.4/100,000 in 1990 to 13.4/100,000 in 1998 which indicates an 8.1% increase.[10]

Because appropriate health care is often associated with an individual's economic and insurance status, many minorities are sicker then their majority counterparts. "The poor and near poor are less likely to have health insurance than the total population."[1] In households with annual incomes of less than $25,000, 20.1% were without health insurance while 8.3% of households with incomes of $75,000 or more were without health insurance.[10] Out of a total of 35.5 million Blacks, 21.1% of Blacks are insured by Medicaid and 21.2% of Blacks are uninsured.[1] Additionally, 18.1% of Hispanics are insured by Medicaid while 33.4% of Hispanics are uninsured.[1] This shows that a significant portion of the Black and Hispanic communities are poor or near poor. Of the 42.6 million uninsured people in the United States in 1999, minorities made up a total of 89% of the uninsured with 33.4%, 21.2%, 20.8% contributed by Hispanics, Blacks, and Asian Pacific Islanders, respectively.[1] In 1998 the poverty rate for Black non-Hispanic and Hispanic children under the age of 18 were 36.7% and 34.4%, respectively.[10] This lack of access to care allows preventable disease to go untreated, eventually leading to worse health status.

An uneven distribution of physicians is a barrier to both access to care and to the elimination of health disparities.[13] Minority physicians are more likely than White physicians to practice in underserved areas.[2] "Communities with high proportions of Black and Hispanic residents have been described as four times as likely as other populations to have a shortage of physicians, regardless of community income."[3] "Black physicians have been found to practice in areas where the numbers of Black residents were nearly five times as high as where other physicians practice. Likewise, Hispanic physicians worked in communities with twice the number of Hispanic residents when compared to their non-Hispanic colleagues."[3]

Studies show that minority physicians are more likely to provide care to minority populations and/or serve patients from their own ethnic group."[5] Nearly half of patients seen by African American physicians and one-third of patients seen by Asian and Pacific Islander and Hispanic physicians are Medicaid or uninsured patients."[3] Therefore, "[t]he [recent] decrease in the number of minority physicians exacerbates health care access and delivery problems in both minority and low socioeconomic patient populations."[14]

Not only are minority physicians more likely than White physicians to care for minority, poor, underinsured, and uninsured persons[2], but patients feel more comfortable with the decision-making style of physicians from their own ethnic group. "Researchers also found that patients seeing physicians of their own race rate their physicians' decision making (PDM) styles as more participatory."[15] This article states, "that all patients prefer participatory visits because patient satisfaction was linked to physicians' decision making scores for patients across all ethnic

groups."[15] Physicians from racial and ethnic minority groups can help improve access to care for minority groups by serving minority populations in a way that is more sensitive to patients' needs.

Although minorities should play a key role in solving the health disparities problem, it cannot be fully addressed until every health care professional is prepared to deal with any patient regardless of race, gender, ethnicity, culture, or socioeconomic status in a respectful, culturally-competent way. In the future, " ... physicians ... will provide care to a population whose characteristics will differ markedly from those of the population in the United States today, and who may have significantly different patterns of disease and health care needs."[2] Therefore, "[i]mproving the health status of all Americans depends in some degree on ensuring access to physicians who reflect the nation's increasingly diverse population."[14]

Even though there is a clear need for minority physicians, "[m]inorities are underrepresented at all levels of medicine."[2] "The number of African Americans, Hispanics, and American Indians and Alaska Native enrolled in health professions schools and entering the workforce has not reached parity with the population. As a result, significant numbers of people are not receiving the most effective care."[3] "African American, Hispanic, and American Indian graduates of U.S. medical schools represented approximately six percent of practicing physicians in this country in 1998."[5] "Medical school enrollment is not keeping pace with this increasing diversity in the population."[14] Therefore, it is imperative that there be greater representation of minorities in medical schools to deal with current minority health disparities in order to prevent a future health crisis.

In light of the facts stated above, increasing the number of minority physicians just makes sense. Therefore, " ... a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health and minority medical education..."[14] must be developed.

Minorities are more likely to receive health care later in the progression of disease and to suffer greater mortality as a result of diseases as shown by the 1998 age adjusted death rates.

> Increasing access to health care must be addressed in order to decrease minority health disparities by creating:
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> > -universal healthcare with equal access to care,
> > -more programs to address the gap in health care access seen in the poor and near-poor populations, and
> > -incentives to encourage physicians and other health professionals to donate their services to treat the uninsured.

A major goal should be " to recruit minority students to science early and to maintain and support them as they pass through the pipeline so that they are better prepared for admission to professional training, thus ensuring that they will graduate and be well established toward a professional career."[4] Therefore, this bill stresses building a strong science and math foundation throughout the educational lifespan. If the minority medical student applicant pool is increased,

then this will facilitate the acceptance of more qualified students to health professional training programs.

The number of students especially minority students who enjoy or have an interest in math and science at the elementary and secondary levels should be nurtured, have their interests cultivated and have increased exposure to the field of medicine and other science careers by providing:

-funding for programs to increase minority participation in math and science classes through the use of innovative approaches to teaching,
-funding for more hands on science and math teaching in school,
-funding for the inclusion of creative uses of math and science oriented teaching during after school programs,
-funding for special math and science summer programs to be held in medically underserved and/or areas with large minority populations, and
-matching funding and financial incentives to academic medical centers that collaborate with other institutions to create and implement programs that increase the number of academically prepared minority students.

With its proven track record of helping minorities pursue their aspirations and achieve their career goals, mentoring plays a critical role in increasing the number of minority physicians and health professional and deserves to be more highly valued and to become a structured component of programs dedicated to a larger presence of minorities in the health professions.[4]

The number of programs that give minority children access to minority physicians and other health care workers in a mentoring/shadowing capacity should be increased by providing:

-funding to reimburse or give incentives to physicians and health professions students who participate in the above programs.

The availability of financial assistance to underrepresented minorities throughout all levels of education should be assured through public and private sector scholarships and loans."[2]

Existing programs such as the National Health Service Corp should be broadened and utilized as a vehicle to increase financial aid to minority students interested in medicine and other health professions by receiving:

-funding for scholarships for undergraduate minority students majoring in biology, biochemistry, or pre-medicine with the intention of attending medical school with obligatory summer, experiences approved by the National Health Service Corps which give them valuable clinically oriented experiences, research geared toward eliminating minority health disparities, and/or preparation for the Medical College Aptitude Test, and

-funding for programs that accept National Health Service Corps undergraduate scholarship recipients for the abovementioned obligatory summer experiences which will go toward the expenses created by the said recipient as well as money to be distributed to the scholarship recipient as a stipend during the duration of the obligatory summer experience.

"Medical schools, residency programs, medical specialty organizations, and continuing medical education programs should incorporate, as essential elements of their required curricula, teaching methods and experiences that assure cultural competency in medicine."[2] Additionally, medical schools should provide an atmosphere conducive to social acclimation and academic success.

These goals can be achieved through mandates for:

-cultural competency instruction at all levels of education,

-the development of educational tools and programs that will sensitize health professionals to a variety of health belief systems and enhance provider communication skills, and

-medical schools to include a cultural competency course in the medical school curriculum to help create physicians sensitive to the needs of all their patients.

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