

Minnesota grows more racially and ethnically diverse every year: according to the 2005 U.S. Census data, the non-white population in the state is now 12 percent; it is 23 percent in Hennepin and Ramsey counties; and 34 percent in the cities of Minneapolis and St. Paul. With this diversity comes the challenge to ensure that all Minnesotans enjoy optimal health, regardless of how they look, where they live, and which communities and cultures they identify with.

The challenge is acute because although Minnesota overall is one of the healthiest states in the U.S., racial minorities in our state do not enjoy the same levels of good health that the white majority does. The Minneapolis Foundation states that disparities in health affecting people of color are among Minnesota's most serious concerns, because the overall vitality of the state means that every individual must be healthy and vital enough to contribute to the whole. A less than healthy workforce means a less than healthy state.

Unfortunately, racial disparities in health are very real. Data provided by the Minnesota Office of Minority and Multicultural Health show that rates of cardiovascular disease are 10 percent higher for African Americans, Latinos, and American Indians compared to whites. African Americans and American Indians have the highest death rates from cancer. Although white women are more likely to get breast cancer, African American women are more likely to die from it. Asian American women are more likely than all other groups to get cervical cancer and are more than four times likely to die from it. Low birth-weight babies and babies who die within one year are much more commonly born to African American and American Indian women than to whites. And non-white pregnant women are less likely to receive adequate prenatal care.

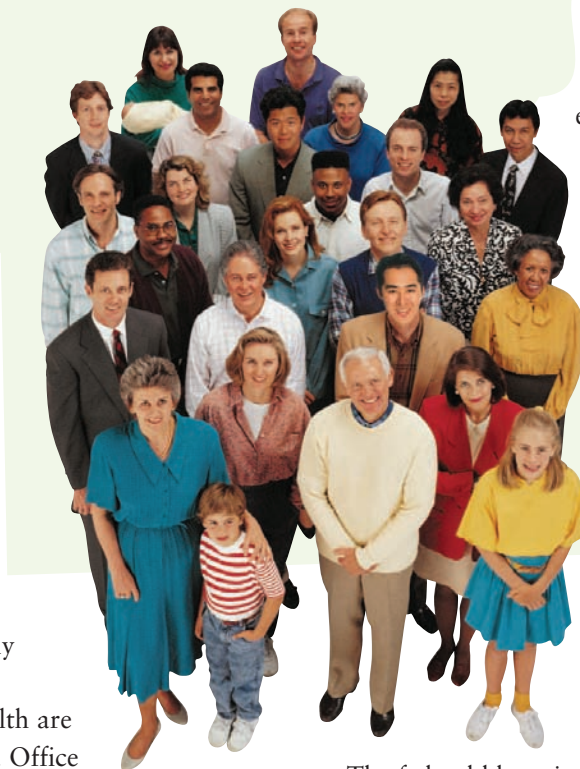
Causes of health care disparities

One explanation for these differences in health outcomes among minority groups is health insurance. In Minnesota, whites are up to five times more likely to have health insurance compared to all other racial and ethnic groups except Asians. Adults without health insurance are less likely to receive necessary preventive care and have difficulty obtaining continuous care for chronic disease. As a result, people without health insurance are more likely to have poorer health and to die prematurely. For example, uninsured people who get colon or breast cancer are 50 percent more likely to die compared to those

Disparities in health outcomes and care

Groups are organizing to eliminate the problem

By Yiscah Bracha, M.S.



who have insurance. However, even when all groups have the same insurance, national research shows that racial minorities receive less medical care than white Americans do. This may be caused by difficult cross-cultural communication between doctors and patients, unconscious stereotyping by physicians, and cultural beliefs and habits by patients that impede adequate care. Many frame these differences as problems of overall health care quality: if quality is erratic because of who people are, the whole system has lower quality.

Another reason for disparity among racial groups is that identical care does not always produce the same outcomes. For example, the same type and dosage of antihypertensive medication given to African Americans and whites may reduce blood pressure to safe levels in whites, but not in African Americans.

Efforts are underway

Confronting and eliminating disparities in health care access, treatment, and outcomes has been a major focus of attention at national, state, and local levels for much of this decade.

The federal blueprint for national health objectives, Healthy People 2010, targets the elimination of racial and ethnic disparities as one of two major goals. The state of Minnesota has a comparable plan called Eliminating Health Disparities Initiative, which aims to build and strengthen relationships among community members, faith- and culture-based community and social service organizations, community clinics and other health care providers, and the Minnesota Department of Health. Local units of government also are addressing disparities. The Minneapolis Department of Health and Family Support, in partnership with dozens of community-based agencies, works to eliminate health disparities with a focus on maternal and child health, teen health, and nutrition and physical activity.

These are focus areas for many researchers at the University of Minnesota as well. The winter 2006 issue of the University's School of Public Health magazine, *Advances*, was devoted to health disparities. The University's Office of Clinical Research, established in 2005 within the Academic Health Center, cites racial disparities in health outcomes and care as a major focus area, and the University's Medical School recently initiated a program in health disparities research.

The group that I work with, the Center for Urban Health, was established in May 2006 to help reduce disparities, mainly in chronic disease. It is located at Hennepin County Medical Center (HCMC). So far, the Center for Urban Health has sponsored efforts to determine how best to improve understanding of medication instructions

in Latino patients, and it is currently assessing how well the system communicates with patients, knowing that there may be cultural barriers to overcome. The Center for Urban Health is interested in how life circumstances can affect people's ability to self-manage chronic conditions like diabetes, and with that understanding, hopes to participate in the current business interest in paying for appropriate medical care. The center also stays abreast of the current movement toward electronic health records systems, anticipating that the privacy-protected data such systems produce can be instrumental in understanding reasons for disparities and figuring out how to eliminate them. The Center for Urban Health networks with the many other individuals and organizations in Minnesota that are committed to eliminating health disparities.



Racial disparities in health also are being targeted by many Minnesota philanthropies. The Minneapolis Foundation now focuses substantial time and energy around the issue of disparities, including racial disparities in health. The Medtronic Foundation has a focus on eliminating disparities in cardiovascular disease, infant mortality, diabetes, cancer, and HIV/AIDS.



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The Blue Cross and Blue Shield Foundation of Minnesota directs attention to social, economic, and environmental factors affecting health, noting that these are key to eliminating disparities. The Medica Foundation set one of its 2006 priorities as reducing racial and ethnic disparities in health care. The Healthier Minnesota Community Clinic Fund, an independent foundation created to improve the quality of health care for low-income people, provides grants to community clinics. Community clinics and public hospitals are important to this work because these organizations provide medical services to all individuals, regardless of their ability to pay.



Collaborative venture

A good example of a collaborative venture to reduce health disparities is the Minnesota Cancer Alliance, a coalition of the Minnesota Department of Health, health care organizations, university researchers, community-based groups, and individual volunteers. We know that African Americans are less likely to be screened for breast and prostate cancer than are whites, which means that when cancer is detected, it may be too late to treat it effectively. It also is known that the culture of the health care system may be so different from the

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culture of minority communities that individuals in minority communities have difficulty figuring out how to navigate the health system once they are in it. If a person's cancer screening test comes back positive, that person has to follow up in many different ways. Minority patients are less likely than whites to navigate this follow-up successfully.

In response to these problems, the Minnesota Cancer Alliance formed a Health Disparities Task Force with three project teams. One team works with a group of pastors' wives from 11 Minneapolis churches to increase cervical cancer screening rates among African American women. Another team trains community health workers to help underserved cancer patients navigate their way through the health care system. A third team focuses on ways to improve collection of data on patients' race and ethnicity in health care settings, in order to better identify populations at risk.

What can individuals do about disparities?

The single most valuable action each individual can take is to respond honestly if and when your health care provider asks you to identify your race or ethnicity. Without knowing the race and ethnicity of individuals in the health care system, it is impossible to know where the problems are, what the sources of the problems may be, what potential solutions could be implemented, and what progress is being made toward achieving the goal of reducing disparities. It is important to have the race and ethnicity of everyone, not just those experiencing worse health or health care.

Some people are concerned that the data they provide could be misused. Health systems take these concerns seriously and respond to them by imposing numerous protections on the data, starting by removing everything in the electronic record that could possibly identify individuals and working only with the pooled results. This is one way to resolve the tension between individual needs for privacy and the need to monitor population trends that provide information used to protect and improve health. While the tension will always exist, we are learning to balance it successfully in order to achieve the ultimate goal of good health and vitality for all—and every individual can help.



Results that count

Several important gains in eliminating health care disparities

have been made in Minnesota.

Compared to data from 1989–1993, Minnesota data from 2000–2004 show that rates of low birthweight babies for African Americans have declined; infant mortality rates for African Americans and American Indians have declined; rates of intensive or adequate prenatal care have increased dramatically for African Americans, American Indians, and Asians; and teen birth rates have declined for all racial groups except Hispanics.

It will take more time to determine whether improvements have occurred in chronic adult diseases, such as cardiovascular disease, cancer, and chronic obstructive pulmonary disease, which account for most of the adult racial differences in health. We hope the investment being made now in reducing disparities will demonstrate their effectiveness in data that appear several years down the road. ▣

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