Statement on Racial & Ethnic Health Disparities

Student National Medical Association

Health Policy and Legislative Affairs Committee
Statement on Racial & Ethnic Health Disparities

First Revision

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Jasmine Douglas, HPLA Fellow
Edwige Dossou-Kitti, HPLA Fellow
Kimberly Adu-Gyamfi, HPLA Committee Member
Brandon Salimi, HPLA Committee Member
Antara Afrin, HPLA Committee Member
Justin Anderson, HPLA Committee Chairperson
Eloho E. Akpovi, HPLA Committee Chairperson

Originally authored in 2014 by:
Debra Dixon
INTRODUCTION

Founded in 1964 by medical students from Howard University College of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation’s oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color, as well as attempt to resolve healthcare issues of minority and underrepresented populations. Additionally, the SNMA is committed to practices leading to better healthcare for communities of color. With the decades-long endurance of many racial and ethnic health disparities and inequities amongst the United States (US) population that disproportionately impact the health and wellbeing of communities of color, the SNMA strongly opposes any policy or practice that creates or maintains barriers to achieving optimal healthcare for racial and ethnic minorities and supports policies and practices that decrease the racial health disparity gap.

BACKGROUND

Racial and ethnic minorities are among the fastest growing populations in the US. By the year 2040, the US Census Bureau has projected that minority groups which include Black/African American, Hispanic, Asian, Native Hawaiian and Other Pacific Islander, and American Indian and Alaska Native (AI/AN) will increase to more than 50% of the US population. Because of the expected growth of the non-White proportion of the population and the high proportion of racial and ethnic minorities in the US represented among the medically underserved, the future health of America as a whole will be influenced substantially by our nation’s success in improving the health status of racial and ethnic minorities. It is imperative to address these disparities for the sake of economics and equity. The US spends approximately $93 billion in excess medical care cost and $42 billion in loss of productivity. It is also evident given that communities of color and medically underserved populations continue to suffer disproportionately from disease. Black/African-Americans and AI/AN are more likely to report a range of health conditions including asthma and diabetes as well as exhibit higher mortality rates in AIDS and HIV. “Despite notable progress in the overall health of the Nation, such as implementation of the Affordable Care, 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.” The ACA expanded
coverage and increased funding to community health centers and created Offices of Minority Health within HHS to coordinate disparity reduction, however in the more recent years, there has been a reversal of policies. The federal government has decreased funds for outreach and enrollment assistance, Congress negated the ACA individual requirement to have coverage, and many more policy changes. Other notable barriers include limited capacities to address the social determinants of health, decline in funding and prevention and public healthcare initiatives, and gaps in data to measure and understand disparity. While some minorities are able to access care, more challenges exist during the physician-patient encounter. They include provider bias, cultural, or linguistic barriers of communication.

1. Burden of Diseases

Since 1980, there has been a public health imperative to reduce and eliminate racial health disparities in the US, as defined by the health goals and objectives outlined by the Healthy People Initiative.5–7 Though the health disparity gap between White and non-White populations has narrowed for some health indicators, for others, such as diabetes, the gap has actually widened since 1980, particularly among Native Americans.8,9 Other chronic health conditions, such as obesity, asthma, hypertension, heart disease, and cancer, also occur in Black/African American, Hispanic, Native Hawaiians and Pacific Islander, and American Indian and Alaska Native populations at much higher rate than in non-Hispanic Whites.10 Most recently, Healthy People 2020 reported in its midcourse progress report that most of its population-based trackable objectives for non-White and non-Asian populations had made “little or no detectable change” in progress. For White and Asian populations, those same objectives were reported as “target met or exceeded.”11 Thus, several decades of this nation-wide Healthy People Initiative has yet to achieve its intended outcome, and the burden of disease continues to fall on communities of color, despite greater reduction in behavioral risk factors than their White counterparts and improved access to healthcare through health insurance coverage.8,12

According to the CDC report, between 2012 and 2015, 24.5% of non-Hispanic Blacks, 23.1% of Hispanics, 19.1% of and American Indians/Alaskan natives (AI/AN) reported cost as a significant barrier to seeking healthcare, compared to 15.0% of non-Hispanic Whites.13 Multiple chronic condition were reported by 40.3% non-Hispanic Blacks and AI/ANs, compared to 36.0% non-Hispanic Whites, and 27.4% Hispanics who reported multiple chronic conditions.13
2. Mortality

Infant mortality, age-adjusted death rates, and life expectancy are three strong indicators of a population’s overall health. From 1975-2015, infant mortality decreased by 63%, the age-adjusted death rates for heart disease and cancer, the first and second leading causes of death, declined by 61% and 21%, respectively, and the life expectancy at birth increased by 6.2 years for the total US population. Despite those improvements, racial disparities in all three indicators continue to persist.

2.1. Infant Mortality

In 1975, the infant mortality rate was 16.1 per 1,000 live births. The infant mortality rate for White and “all other” race/ethnicity were 14.2 and 24.2, respectively. In 1985, the infant mortality rate for the US population was 10.6 per 1,000 live births. The infant mortality rates were 9.2 and 19.0 for Whites and Black/African Americans, respectively. In 1995, the infant mortality rate for the US population was 7.57 per 1,000 live births. The infant mortality rates were 6.3, 14.58, and 9.04 for Whites, Black/African Americans, and AI/AN, respectively. In 2005, the infant mortality rate for the US population was 6.86 per 1,000 live births. The infant mortality rates were 5.76, 13.63, and 8.06 for non-Hispanic Whites, non-Hispanic Blacks, and AI/AN, respectively. In 2016, the infant mortality rate for the US population was 5.87 per 1,000 live births. The infant mortality rates were 4.87, 11.21, and 8.61 for non-Hispanic Whites, non-Hispanic Blacks, and AI/AN, respectively.

2.2. Age-Adjusted Death Rates

In 1975, the age-adjusted death rate for the US population was 1,094.4 per 100,000. The age-adjusted death rate was 1,069.4 for Whites and 1,327.5 for Blacks. In 1985, the age-adjusted death rate for the US population was 988.1 per 100,000. The age-adjusted death rate was 963.9 for Whites and 1,261.2 for Blacks. In 1995, the age-adjusted death rate for the US population was 918.5 per 100,000 people. The age-adjusted death rate was 890.0 for non-Hispanic Whites and 1,224.5 for non-Hispanic Blacks. In 2005, the age-adjusted death rate for the US population was 798.8 per 100,000 people. The age-adjusted death rate was 796.6 for non-Hispanic Whites and 1,034.5 for non-Hispanic Blacks. The age-adjusted total death rate in
2014 was a record low, at 724.6 per 100,000, but racial differences in death rates still persist. In 2017, the age-adjusted death rate for the US population was 731.9 per 100,000. The age-adjusted death rate was 885.1 for non-Hispanic White males, 642.8 for non-Hispanic White females, 1,083.3 for non-Hispanic Black males, and 728.0 for non-Hispanic Black females. Each year, the all-cause, age-adjusted death rate for Whites was lower than the national population, which that of Blacks was consistently higher than both the national population and the White population.

2.3. Life Expectancy at Birth

Though the life expectancy for Whites crossed 70 years of age towards the end of the Civil Rights Movement (between 1960 and 1970), the same did not occur for Blacks/African Americans until the end of the 20th century, between 1995 and 2000 (Table 1).

Table 1: Life Expectancy at Birth by Race/Ethnicity from 1975-2015.

<table>
<thead>
<tr>
<th>Year</th>
<th>US Population</th>
<th>White Americans</th>
<th>Black/African Americans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>72.6 years</td>
<td>73.4 years</td>
<td>66.8 years</td>
</tr>
<tr>
<td>1985</td>
<td>74.4 years</td>
<td>75.3 years</td>
<td>69.3 years</td>
</tr>
<tr>
<td>1995</td>
<td>75.8 years</td>
<td>76.5 years</td>
<td>69.6 years</td>
</tr>
<tr>
<td>2005</td>
<td>77.6 years</td>
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<td>73.0 years</td>
</tr>
<tr>
<td>2015</td>
<td>78.8 years</td>
<td>79.0 years</td>
<td>75.5 years</td>
</tr>
</tbody>
</table>

3. Obstetric Outcomes

The leading causes of infant death in 2017 were congenital malformations, low birth weight, maternal complications, sudden infant death syndrome, and unintentional injuries. Low birth weight and preterm birth are both important factors that predict infant morbidity and mortality. Just like infant mortality, rates of both low birth weight and preterm birth differ between racial and ethnic groups. In 2015, the overall rate of low birthweight was 8.07% of live births and very low birthweight was 1.40%. For Black/African Americans, rates for both were highest amongst all groups at 13.03% and 2.81%. For Whites, rates were below the national rates, at 7% and 1.12%. In 2014, the overall rate of preterm birth was 7.7% of singleton births. For non-Hispanic Blacks, AI/AN, and non-Hispanic Whites, the rates were 11.1%, 9%, and 6.9%, respectively.
In the same time frame that infant mortality has declined, maternal mortality has unfortunately increased in the US – from 7.2 deaths per 100,000 live births in 1987 to 18.5 per 100,000 in 2013.\textsuperscript{23} This comes in sharp contrast to other industrialized nations. The Maternal Health Task Force noted that the US has “failed to meet prior national goals for maternal mortality reduction and is not on track to meet the modest Healthy People 2020 goal of reducing maternal mortality by 10% between 2007 and 2020.” Factors contributing to such poor outcomes for mothers not only include access to and utilization of adequate prenatal care and social determinants of health, but also lack of a nationwide standard for reporting maternal mortality data in all 50 states in the country.\textsuperscript{24}

There are also notable differences by race and ethnicity. Specifically, from 2005-2014 the ratio of maternal mortality in non-Hispanic White, non-Hispanic Black, and Native American mothers were 11.3, 40.2, and 25.1 per 100,000 live births, respectively, with a total of population ratio of 17.2 per 100,000 live births.\textsuperscript{25} Black/African American women are 3-4 times more likely to die from pregnancy-related causes than White women.\textsuperscript{23} In fact, a recent study demonstrated that a state’s percentage of deliveries to non-Hispanic Black mothers had the strongest association with its maternal mortality ratio.\textsuperscript{25} In addition, Black/African American women experience complications due to pregnancy at about the same rate as the national average when corrected for confounders such as comorbidities, yet they are more likely to die from such complications.\textsuperscript{26}

4. Obesity

Obesity has been shown to be a significant risk factor for morbidity and many chronic conditions and its high rates in the US over the past few decades have made it a major public health concern. Since 1988, the percent of children (ages 2-19) and adults (age 20 and over) with obesity has increased from 10% to 17.2% for children and 22.9% to 37.8% for adults.\textsuperscript{12} Racial and ethnic minorities are affected by obesity disproportionately. Hispanic and non-Black Hispanic children have the highest prevalence of obesity at 21.9% and 19.5%, respectively, from 2011-2014. A similar pattern is seen with extreme obesity, with the prevalence in the US population at 5.8%, and the prevalence amongst Hispanic and non-Black Hispanic children at 7.6% and 8.6%, respectively.\textsuperscript{27} One study examining the proper diagnosis of obesity in children by providers based on BMI recorded in the medical record found that Black (63.3%) and
Hispanic (58.7%) children were more likely to be told they were obese than White children (21.6%) and all children (49.3%). Besides demonstrating underdiagnosis of obesity in children, this also demonstrates a potential bias that encourages providers to more readily associate high BMI with disease in children of color more often than in White children. In adults, the opposite pattern has been observed. From 2003-2004, the percentage of obese adults told that they were overweight was significantly lower for non-Hispanic Blacks (57.3%) and Mexican Americans (54.4%) compared with non-Hispanic Whites (66.3%); and for adults with less than a high school education (59.8%) compared with adults with a high school education or more (64.6%).

5. Diabetes Mellitus

Like obesity, diabetes is a chronic condition associated with many adverse outcomes and morbidity. Type I diabetes results from an autoimmune process, while the incidence of type II diabetes is often associated with lifestyle factors, such as weight, diet, and exercise. In children ages 0-19, the prevalence of type I diabetes from 2011-2012 was significantly higher in non-Hispanic Whites (27 per 100,000) than in non-Hispanic Blacks (19 per 100,000), Hispanics (14.8 per 100,000), Asian/Pacific Islanders (9.7 per 100,000) or American Indians (6.5 per 100,000). In children ages 10-19, the prevalence of type II diabetes from 2011-2012 demonstrated the opposite pattern, with the burden on non-White populations, especially American Indians: non-Hispanic Whites, 3.9 per 100,000; non-Hispanic Blacks, 32.6 per 100,000; Hispanics, 18.2 per 100,000; Asian/Pacific Islanders, 12.2 per 100,000; American Indians, 46.5 per 100,000.

In 2015, the prevalence of diabetes was 9.4% or 30.3 million people in the US. For adults ages 18 or older, the prevalence was 12.2%. Many of these adults were unaware of their diagnosis. From 2013-2015, the age-adjusted incidence of diagnosed diabetes among adults was disproportionately higher in Hispanics (8.4 per 1,000) and non-Hispanic Blacks (9 per 1,000) than in non-Hispanic Asians (6 per 1,000) and non-Hispanic Whites (5.7 per 1,000). Regional disparities can also be seen, with Puerto Rico and the southeastern states having significantly higher prevalence than the rest of the country.

Extent of glycemic control is a clinical indicator of a patient’s risk of developing complications of diabetes, including renal and vascular disease, loss of eyesight, lower-extremity amputations. Between the 2007-2008 and 2013-2014 periods, the and percentage of adults
with diabetes with HbA1c under good glycemic control (< 7%) did not change. In 2013-2014, only 54.42% of adults with diabetes had their HbA1c under optimal control. From 2007 to 2014, the disparity between glycemic control in non-Hispanic Whites and non-Whites (“Mexican American, other Hispanic, non-Hispanic Black, other race, including multiracial”) increased, with the rate of good HbA1c control in non-Whites being lower than in non-Hispanic Whites.³²

6. **Cardiovascular Disease (CVD)**

Despite decades of advancement in reduction and control of age-standardized cardiovascular disease (CVD) death rates, heart disease remains the leading cause of mortality and morbidity in the United States.³¹ CVD is a disease of the heart and circulatory system, and includes coronary heart disease, congenital heart disease, non-congenital heart disease, and hearth rhythm problems.³⁴,³⁵ There are over 610,000 CVD-related deaths in the US annually,³⁶,³⁷ with approximately 630,000 CVD-related deaths in the U.S. in the year 2015 alone.³⁸ CVD accounts for more than $330 billion in direct and indirect healthcare cost annually.³⁹ Approximately 630,000 individuals die each year from heart disease in the US, which is roughly one in four deaths. It has been estimated that someone suffers a heart attack every 40 seconds in the United States. Every minute, one or more person dies from an event related to heart disease in the United States.

CVD-related morbidity and mortality is a major public health challenge. CVD costs the United States about $200 billion every year.³⁴,³⁶,⁴⁰,⁴¹ This amount includes cost related to medications, healthcare services and lost workforce and productivity. The worsening trends in the prevalence of diabetes and obesity, as well as an increasing elderly population, have contributed to persistently elevated national CVD burden.³⁶ These trends portray a future increase in CVD-related mortality, with a high rate of poor outcomes in younger adults.

CVD is also one of the leading causes of mortality among the Hispanic population in the United States, who comprise the largest and one of the most rapidly growing minority populations in the country.⁴⁰ Of the CVD cases that occur annually in the US, 47.7% of NH Black females and 46.0% males have at-least one form of cardiovascular disease.⁴¹ CVD and stroke risk factors include hypertension, diabetes, BMI, cholesterol, physical inactivity, smoking, alcohol consumption.³⁵ According to the American Heart Association and the American Stroke Association, NH Blacks over the age of twenty experience significantly higher burden of all risk
factors for CVD and stroke including diabetes, hypertension, cholesterol, physical inactivity, overweight and obesity, smoking, and alcohol consumptions.\textsuperscript{42,43}

6.1. Stroke

Stroke results from decreased delivery of oxygen and nutrients to the brain when there is a blocked vessel.\textsuperscript{40,44} There are approximately 795,000 cases of new (620,000) and recurrent (185,000) strokes, which results in 140,000 deaths annually.\textsuperscript{45} More than 87\% being ischemic stroke that results from the loss of blood flow to the brain, the remaining 13\% are a combination of intracerebral (10\%) and subarachnoid hemorrhage (3\%).\textsuperscript{40} Stroke accounts for $34$ billion in healthcare expenditure annually.\textsuperscript{45} Non-Hispanic (NH) Blacks are disproportionately affected by stroke, with an annual incidence rate of 3.9\% and 4.0\% in NH black males and females, respectively;\textsuperscript{12} a rate that is twice that of other racial groups.\textsuperscript{40,45,46} Approximately 45,000 NH Blacks experience a new stroke, and 60,000 experience a reoccurring stroke, annually.\textsuperscript{45}

6.2. Heart Failure

According to the American Heart Association, the prevalence of heart failure for males 20 or older between years 2013 to 2016 was higher for Blacks/African Americans than for Whites (3.5\% compared with 2.2\%). Black/African American females had the highest prevalence of heart failure at 3.9\% of any racial or sex group.\textsuperscript{40} In a study done to studying the likelihood of receiving care by a cardiologist in the intensive care unit (ICU), it was found that 15\% of White patients received care by cardiologist compared to 14.8\%. Care by cardiologist was attributed to higher mortality rates irrespective of White or Black/African American race.\textsuperscript{47}

7. Cancer

7.1. Breast Cancer

Breast cancer is the most common cancer in women in the United States, accounting for 30\% all new cancer diagnoses in women. The estimated number of new cases of breast cancer cases in 2018 is 268,670 and deaths from breast cancer is 41,400, in both men and women, representing a significant increase in recent years.\textsuperscript{48} From 1999 to 2005, the disparities between Blacks and Whites remained the same. In 2005, Black patients with breast cancer were less likely than Whites to receive radiation therapy to the breast within 1 year of diagnosis (68.1\%
compared with 75.3%). From 1999 to 2005, the disparities between Hispanics and non-Hispanic Whites increased. In 2005, Hispanic patients with breast cancer were less likely than non-Hispanic Whites to receive radiation therapy to the breast within 1 year of diagnosis (61.5% compared with 76.0%).

7.2. Colorectal Cancer

Colorectal cancer (CRC) is the third most common cancer in adults in the United States. Though screening, incidence, and mortality rates have improved over the years, racial disparities between non-White and White adults ages 50 years or over can be seen across the board. Overall, the percentage of adults ages 50 years or over who received CRC screening increased from 2013 to 2015. However, non-Hispanic Black, Hispanic, non-Asian, and non-American Indian/Alaska Native patients were all less likely than non-Hispanic White patients to receive a fecal occult blood test (FOBT)/fecal immunochemical test (FIT) or an endoscopy to screen for CRC (61.8%, 49.9%, 49.4%, and 54.3%, respectively, compared with 65.4%). From 2009 to 2013, the overall incidence rate of CRC declined significantly by 1.4% for those 50-64 years old and 4.6% for those 65 years and over to an overall rate of 46.9 per 100,000 population. From 2010-2014, the overall mortality rate of CRC declined significantly by 2.5%. Non-Hispanic White patients saw a 2.7% decline in incidence rate and 2.4% decline in mortality rate during the respective time periods. Both non-Hispanic Black and Hispanic patients saw a 3% decline in incidence rates. Non-Hispanic Black patients saw a 2.9% decline in mortality rate, while Hispanic patients saw a 1.9% decline. However, non-Hispanic Black patients were still 20% (49.2 per 100,000) more likely to be diagnosed with CRC than non-Hispanic White patients (40.2 per 100,000), and 40% (20.5 per 100,000) more likely to die from CRC than non-Hispanic White patients (14.6 per 100,000). Non-Hispanic Black (24%) and American Indian/Alaska Native (24%) patients were also much more likely to be diagnosed with distant-stage disease and to have the lowest survival rates at every stage of CRC. Hispanic patients were also more likely than non-Hispanic White patient to be diagnosed at a distant stage with CRC (21% compared with 19% for non-Hispanic White patients).

8. Pulmonary Disorders
The two types of pneumococcal vaccines, pneumococcal conjugate vaccine (PCV13) and pneumococcal polysaccharide vaccine (PPSV23) are given to adults age 65 and over to protect against invasive pneumococcal disease and pneumococcal pneumonia. In 2017, the percentage of adults age 65 and over who ever had any pneumococcal vaccination was significantly lower for Black/African Americans than for Whites (45.0% compared with 61.2%). The largest differences in PPSV23, PCV13 or both vaccines were between White and Hispanic/Latinx Medicare beneficiaries. The percentage of Hispanic/Latinx adults age 65 and over who ever had pneumococcal vaccination was still less than that of non-Hispanic Whites (42.2% compared with 61.2%). Despite reduced barriers to access through the Affordable Care Act, the current recommendations for the pneumococcal vaccination in US adults aged 65 years and older were found to be economically unfavorable with or without a program to improve vaccine uptake compared to an alternative strategy proposed by the Advisory Committee on Immunization Practices of the US Centers for Disease Control where PPSV23 was used in non-immunocompromised individuals especially in Black/African Americans.

In 2018, the highest prevalence of current asthma by race/ethnicity was seen in Black/African American (9.6%) and Puerto Rican (14.2%) adults, with a lower prevalence in non-Hispanic White (8.2%) adults. The prevalence of asthma also varies by income level with a prevalence of 10.8% in people 100% below the poverty line versus a prevalence of 6.5% in those at 450% of poverty threshold or higher Adults age 65 and over had death rates of 29.0% which was higher than any other age group. In 2013, using data from a large retrospective cohort study, it was found that Black/African Americans with asthma/COPD were less adherent to their medications than Whites with asthma (18.4% compared with 33.2%) and Hispanics were the least adherent to their asthma/COPD medications with 15.6%. A further literature review in 2018, showed that racial/ethnic minority patients were less adherent to their asthma medications due to factors on an individual level, provider level, and systemic level. The individual level factors included cultural differences in beliefs about traditional medications and mental health concerns such as depressive symptoms. Provider-level factors included health care provider biases and communication about controller medication use in a culturally sensitive manner. Systemic factors included health care coverage, cost, and features of the community environment such as exposure to violence. It also showed that people with asthma who had a median income between $0-$53k (30.9%) were less adherent to their medications than those with a median
income >$78k (31.2%). Black/African-Americans had the highest death rate at 21.8% versus 9.5% in non-Hispanic whites and 6.3% in Hispanics.55

9. End-Stage Renal Disease (ESRD)

From 1996 to 2019, the incidence of ESRD declined for Blacks/African Americans, Native Americans, and Asians, however, Blacks/African Americans continue to be disproportionately impacted, making up approximately 30% of ESRD cases.58,59 From 1994-2015, the disparity in the rates of dialysis patients meeting clinical care guidelines for dialysis adequacy decreased between Blacks/African Americans and Whites such that Kt/V measures are now comparable (1.5 versus 1.6, respectively),60 however, facilities that served predominantly Black/African-American patients and were located in low-income communities, had higher rates of Black/African-American patients with suboptimal dialysis adequacy, worse expected survival, and lower rates of wait-listing for kidney transplantation.61 Kt/V is a ratio that compares the amount of fluid that passes through the dialyzer with the amount of fluid in the patient’s body and to meet dialysis adequacy guidelines, the patient’s Kt/V should be above 1.2.62 The new Kidney Allocation System (KAS) was implemented by the United Network for Organ Sharing in December 2014. After the implementation of KAS, the rate of wait-listing declined amongst both incident and prevalent ESRD patients. However, the disparity in the percentage of dialysis patients registered for transplantation between Blacks/African Americans and Whites remained the same (25.1% versus 51.0%, respectively).63–65 Additionally, USRDS data from shows that the use of peritoneal dialysis and preemptive kidney transplants were less common in Blacks/African-Americans (20.5% and 5.6%, respectively) and Hispanic/Latinx (27.2% and 6.4%, respectively) patients with ESRD than in non-Hispanic White patients with ESRD (7.7% and 34.1%, respectively).58

10. Human Immunodeficiency Virus (HIV)

Although the overall number of new cases of HIV infection decreased from 2008 (18.8 per 100,000) to 2018 (13.6 per 100,000), the number of new cases for Native Hawaiians and other Pacific Islanders increased, as well as the number of new cases among several subgroups.66,67 Racial/ethnic disparities continue to be seen, with non-White and non-Asian populations experiencing disproportionately higher rates of infection as of 2018: 47.5 per
100,000 for Black/African American, 21.2 per 100,000 for Hispanic/Latinx, 20.1 per 100,000 for persons of multiple races, 13.7 per 100,000 for Native Hawaiians/Other Pacific Islander, 9.4 per 100,000 for American Indians/Alaska Natives, 5.6 per 100,000 for White, and 5.4 per 100,000 for Asian.\textsuperscript{67} The highest rate of deaths (16.3\%) for persons with diagnosed HIV infection was among Blacks/African Americans, yet 2.5\% for Whites.\textsuperscript{66} HIV infection also continues to have are having an increasing impact on Black/African-American women and men who have sex with men (MSM). Black/African American women made up 13\% of the US population, yet 58\% of estimated HIV infection diagnoses in female adults and adolescents in 2018. Within the 13-24 years old age group, Black/African American (52\%) and Hispanic/Latinx MSM (27\%) accounted for more than 75\% of HIV infection diagnoses. From 2014 (31 per 100,000) to 2018 (53 per 100,000), HIV infection diagnoses increased 71\% among Native Hawaiian and other Pacific Islander MSM alone. The number of new cases among Hispanic/Latinx gay and bisexual men and Hispanic/Latinx transgender adults and adolescents also increased during this period.\textsuperscript{66}

Women, MSM, and transgender people with HIV face particular challenges to accessing care. Behaviors such as drug use and sex trading put women, MSM, and transgender people at higher risk of HIV infection, as well as depression, violence, family problems, and inadequate social support. Women are often the primary caregivers in their families, thus making their own health a lesser priority. Additionally, stigma often serves as a barrier for seeking care for HIV infection, thus increasing the risk of developing AIDS (acquired immunodeficiency syndrome).\textsuperscript{68–72} From 2000 to 2018, the rate of new AIDS cases decreased for overall from 16.6 per 100,000 to 6.2 per 100,000. Although the rates also decreased for Blacks/African Americans (from 67.6 to 23.8 per 100,000) and Hispanics/Latinx (from 29.1 to 8.6 per 100,000), they still remained disproportionately higher than they did for Whites (from 6.3 to 2.4 per 100,000) at a rate of 10 times higher for Blacks/African Americans in 2018.\textsuperscript{67}

\textbf{II. Mental Health and Substance Use Disorders}

From 2015-2018, there was a significant increase in major depressive episodes amongst young adults age 18-25 in Blacks/African Americans (6.1\%-9.4\%), Hispanics/Latinx (8.0\%-12.8\%), American Indians/Alaska Natives (4.8\%-12.1\%), and Asians/Native Hawaiians and other Pacific Islanders (8.9\%-10.1\%). Additionally, there was a significant increase in major depressive episode with severe impairment amongst young female adults age 18 to 25 in
Blacks/African Americans (4.9%-7.8%), Hispanics/Latinx (6.6%-8.9%), American Indians/Alaska Natives (4.0%-12.3%), and Asians/Native Hawaiians and other Pacific Islanders (6.3-9.7%). Also, there was a significant increase in marijuana use amongst adults age 26 and over in Blacks/African Americans (8.7%-10.4%), Hispanics/Latinx (4.6%-6.5%), and Asians/Native Hawaiians and other Pacific Islanders (0.3%-1.1%). As of 2018, there are still large treatment gaps that need to be addressed in these groups. Amongst those age 12 and over with substance use disorder 88.7% of Blacks/African Americans, 89.7% of Hispanics/Latinx, and 96.1% of Asians/Native Hawaiians and other Pacific Islanders went without treatment. Additionally, amongst those age 18 and over with any mental illness, 69.4% of Blacks/African Americans, 67.1% of Hispanics/Latinx, and 73.1% of Asians/Native Hawaiians and other Pacific Islanders went without treatment.

**Scope of the Problem & Recommendations**

*Structural Racism and the Social Construct of Race*

A discussion on racial and ethnic health disparities is not complete or accurate without a discussion on the social construct of race and the underlying structures and systems that create and perpetuate inequality. Racial categories are historically created and not biologically derived, thus differences in outcomes based on race must be discussed within the societal context rather than the biological. Whenever there is a consistent difference in health outcomes based on race, it is by definition a health inequity, because there is no genetic basis for race. However, because of the US legacy of slavery, imperialism, and mass massacre and internment of racially minoritize groups and the ideology that was used to justify such policies and practices, perceived racial category dictates a person’s walk through life. This includes their interactions with the healthcare system and social services, and thus, their health outcomes. As a result, structural racism, as outlined within the official SNMA Statement on Racism as a Public Health Issue, is the primarily driver of health disparities and inequities and must frame all further discussion.

*Income, Insurance Coverage, and Healthcare Access*

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1 https://snma.org/hpla
Communities of color are more likely to receive healthcare later in the progression of disease and thus more likely to suffer greater mortality as a result of disease as demonstrated by the racial/ethnic disparities in age-adjusted mortality rates. Since access to adequate healthcare is tightly associated with an individual’s economic and insurance status, communities of color are sicker than their majority counterpart. Level of income is also associated with access to health insurance, with those with lower income being less likely to have health insurance than the general population. In households with annual incomes of less than $25,000, 13.9% were without health insurance, while 7.9% and 4.3% of households with incomes of $75,000-$99,000 and $125,000 or more were without health insurance in 2017, respectively. However, the poor and uninsured are disproportionately and inequitably Black/African American and Hispanic/Latinx, despite improved access to health insurance coverage for all Americans through the Patient Protection and Affordable Health Act of 2014. In 2017, Blacks/African Americans and Hispanics/Latinx had the highest rates of coverage by government health insurance\(^2\) (44.1% and 39.5%, respectively), lowest rates of coverage by private insurance (56.5% and 53.5%, respectively), and highest rates of lack of any coverage (uninsured; 10.6% and 16.1%, respectively).\(^8\) Not only are Black/African American and Hispanic/Latinx communities disproportionately impacted by poverty or near poverty,\(^8\) these statistics demonstrate that they are also disproportionately experiencing lack access to adequate and affordable healthcare through the receipt of health insurance coverage. In 2017, non-Hispanic Whites made up 60.5% of the US population but only 42.8% (17 million people) of the entire population experiencing poverty. The poverty rates for Blacks/African Americans and Hispanics/Latinx were 21.2% (9 million people) and 18.3% (10.8 million people), respectively.\(^8\) This lack of access to care, compounded by the overwhelming poverty rates, allows preventable and manageable diseases to go untreated, eventually leading to disastrous health outcomes, including mortality for communities of color.

**Recruitment and Retention of Physicians of Color**

An uneven distribution of physicians is a barrier to both access to care and to the elimination of health disparities.\(^8\) Historically, communities with high proportions of

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\(^2\) Medicare, Medicaid, TRICARE, CHAMPVA, and care provided by the Department of Veterans Affairs and the military.
Black/African American and Hispanic/Latinx residents have been described as four times as likely as other populations to have a shortage of physicians, regardless of community income. Studies show that physicians of color are at least twice as likely as White physicians to practice in underserved areas and also more likely to provide care to underserved communities, communities of color, and/or patients from their own ethnic group.

Not only are physicians of color more likely than White physicians to care for minority, low income, underinsured, and uninsured patients, patients also feel more comfortable with the decision-making style of physicians from their own ethnic group (race-concordant). Patients seeing physicians of their own race have also been found to rate their physicians’ decision making styles as more participatory. Thus, physicians from racial and ethnic minority groups can help improve care provided to underserved communities and communities of color by serving these populations in a way that is most sensitive and attuned to their lived experiences and needs. Therefore, the continued failure of racial/ethnic representation among US medical students and resident physicians to reflect the demographic characteristic of the US population further exacerbates the disparity in healthcare access and delivery among minority and low income patient populations.

Even though there is a clear need for physicians of color, people of color are underrepresented at all levels of medicine. The number of Black/African American, Hispanic/Latinx, and Native American students enrolled in US health professions schools and entering the workforce has not reached parity with the increasing diversity of the US population. As a result, significant numbers of people are not receiving high quality care. In light of these facts, increasing the number of physicians of color is an obvious and imperative step. Therefore, “…a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health and minority medical education…” must be developed.

Although addressing the representation of patients in medical professionals should play a key role in solving the health disparities problem, it cannot be fully addressed until every healthcare professional is prepared to care for all patients regardless of race, ethnicity, culture, gender, language, religion, education level or socioeconomic status in a respectful, culturally-humble, and structurally-competent way. Therefore, health professional training and
education must integrate the learning of and engagement with implicit bias, cultural competency, structural competency, and antiracism into the curriculum at all segments and levels.\textsuperscript{97}

\textbf{Antiracism within the Medical Curriculum}

“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.”\textsuperscript{98} Culturally humble providers have the academic and personal skills that allow them to appreciate and identify the healthy practices and behaviors of their patients across cultural and language barriers.\textsuperscript{99} The structural competency framework emphasizes the consideration of social structures as key elements of cultural process, and thus, drivers of health outcomes.\textsuperscript{100} It is important that medical students, healthcare professionals, and the healthcare system consider institutions, communities, policies, etc., that operate above the level of the individual but still determine the individual’s health. Both frameworks provide health professionals the tools to dismantle false beliefs of race as a biological entity, which has permeated medicine for centuries, and appropriately and adequately address the health needs of communities of color. “Creating a socially conscious educational environment for students in health care professions is of vital importance if providers are to have a significant impact on racial inequities in health.”\textsuperscript{101} As such, it is imperative that implicit bias and antiracism be incorporated into the development of culturally humble and structurally competent healthcare providers who will adequately address the atrocious health inequities that persist within the US population.\textsuperscript{102,103}

\textbf{Recruitment, Retention, and Mentoring of Medical of Color}

Increasing the minority student applicant pool to medicine begins with recruiting “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.”\textsuperscript{104} Building a strong science and math foundation throughout the educational lifespan is thus vital. The racial/ethnic diversity of physicians should be increased and can be achieved in part through cultivating and nurturing the preexisting and potential interest of minority students in math and science beginning in grade school. If the minority medical student applicant pool is increased, then this
will facilitate the acceptance of more qualified students to health professional training programs. Additionally, mentorship for students who are underrepresented in medicine is crucial, and necessarily throughout all stages of the process: pre-medical student, medical student, and resident physician. 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. Mentoring deserves to be more highly valued and to become a structured component of programs dedicated to a larger presence of health professionals of color. Once matriculated, medical schools need to provide an atmosphere conducive to social acclimation and academic success for medical students who are underrepresented in medicine. Medical schools must develop policies and strategies that facilitate “ongoing, two-way process of critical (self-)reflection] in all stakeholders on dominant social norms in academic medicine that involves the curriculum, as well as the medical school culture and structure.”

**STATEMENT OF POSITION & RECOMMENDATIONS**

We, the members of the SNMA, are dedicated to addressing the needs of underserved communities – communities which are disproportionately of color. We acknowledge that we must first address the role that healthcare systems and the medical community has played in constructing and/or perpetuating systems that produce and/or uphold health disparities and inequities. The medical community is a social and structural determinant of health, and acknowledging this is necessary in the pursuit of health equity. Therefore, the SNMA urges the following recommendations to address health disparities:

1. Increasing access to healthcare must be addressed in order to decrease racial/ethnic health disparities by creating:
   - Universal healthcare with equal access to care,
   - More programs to address the gap in healthcare 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.

2. Mandate the incorporation of cultural and structural competency into training and life-long learning of health professionals through:
○ Cultural and structural competency instruction at all levels of education, including continuing education, as outlined within the official SNMA Statement on Cultural and Structural Competency,³

○ 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 and structural competency training in the medical school curriculum to help cultivate physicians who are critical aware of and prepared to address the needs of all of their patients.

3. The number of students of color who enjoy or have an interest in math and science at the elementary and secondary levels should be nurtured. Interests can be cultivated through 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 science and math teachers in schools;

○ 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

○ 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.

4. The availability of financial assistance to underrepresented minorities throughout all levels of education should be assured through public and private sector scholarships and loans. Existing programs, such as the National Health Service Corp (NHSC),⁴ 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 with the intention of attending medical school;

³ https://snma.org/hpla
⁴ https://nhsc.hrsa.gov/
○ Funding for obligatory summer experiences approved by the National Health Service Corps which give pre-medicine students valuable clinically oriented experiences, research geared toward eliminating minority health disparities, and/or preparation for the Medical College Aptitude Test (MCAT);
○ Funding for programs that accept NHSC undergraduate scholarship recipients for the aforementioned 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; and
○ Funding for scholarships for underrepresented minority medical students to matriculate into medical school, graduate from medical school, and prepare for and successfully pass the required United States Medical Licensing Examination (USMLE) and/or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) licensing examinations.

5. The number of programs that give children of color access to minority physicians and other healthcare workers in a mentoring/shadowing capacity should be increased by providing:
   ○ A community service initiative embedded within the medical school curricula,
   ○ Assisting in the creation of programs where pre-medical students at undergraduate institutions work with medical school students in their areas to do volunteer mentoring, and
   ○ Funding to reimburse or provide incentives for physicians and health profession students who participate in the above programs.
REFERENCES


doi:10.1146/annurev-publhealth-031811-124658


57. McQuaid EL. Barriers to medication adherence in asthma: The importance of culture and context. Ann Allergy, Asthma Immunol. 2018;121(1):37-42. doi:10.1016/j.anai.2018.03.024


59. Adjusted Prevalence of Treated End Stage Renal Disease (ESRD).


69. Lyons CE, Schwartz SR, Murray SM, et al. The role of sex work laws and stigmas in
doi:10.1038/s41467-020-14593-6

doi:10.1097/QAI.0000000000001072

doi:10.1089/trgh.2016.0018

doi:10.1080/09540121.2018.1492696


doi:10.1093/hsw/hlv038


