National Women's Health Report
NWHRC
PUBLISHED BY THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER

Health & Wellness for Women of Color

Politicians and health care analysts are good at listing the problems in our health care system. Cost. Quality. Access. We have more than 47 million uninsured, another 25 million underinsured.[1,2] Even Americans with great health insurance often find their pocketbooks hurting when it's time to pay the bill. Taken individually, each of these issues is a crisis on its own. But taken together, these issues form the underpinnings of an even greater crisis in health care: significant disparities in disease and death rates between whites and people of color. Bottom line: African Americans, Hispanics and Native Americans have far worse health and health outcomes than whites.[3]

In fact, disparities in health care are such a major problem that the U.S. Department of Health and Human Services has made eliminating such disparities by 2010 one of its overarching goals. It's highly unlikely, however, that it will meet that goal.[4]

For instance, despite improved diagnosis and treatment for cancer, the gap in the death rate from cancer between whites and blacks is just as high today as it was 25 years ago. It is one-third higher for African-American men and 16 percent higher for African-American women. As the American Cancer Society starkly noted: "African Americans have the highest death rate and shortest survival of any racial and ethnic group in the U.S. for most cancers."[5] Most disturbing: The difference in death rates for cancers that can be prevented or diagnosed very early with screening has actually increased since 1975.[6]

For instance, only half of breast cancers diagnosed in African-American women are found in the earliest stages, while 62 percent of those in white women are found at this stage. This is one reason that just 77 percent of African-American women live five years after diagnosis compared with 90 percent of white women. The underlying reason for these differences: lack of mammograms. Women of color are less likely to receive regular mammograms and more likely to receive inadequate screenings than white women.[7] There are many reasons why they fail to pursue screenings. Cost and location may be the biggest reasons for many women, but lack of education about breast cancer and the most current treatment options also play a role. Cultural bias and myths perpetuated in the African-American community, which include fear of the test or fear of the results, also are responsible, according to the 2008 Breast Cancer Awareness Survey conducted by the National Women's Health Resource Center.[8] When African-American women do receive regular screenings, one study found, there is no difference between black and white women regarding the stage of the tumor when detected.[7]

continued on page 2

INSIDE

Volume 31
Number 2

Published three times a year by the National Women's Health Resource Center

157 Broad Street, Suite 106
Red Bank, NJ 07701

1-877-986-9472 (toll-free)

www.HealthyWomen.org

National Women's Health Resource Center
www.healthywomen.org

For subscription inquiries, address changes or payments, call 1-877-986-9472 or email: info@HealthyWomen.org.
Write: National Women's Health Report,
157 Broad Street, Suite 106, Red Bank, NJ 07701

 continued from page 1

Similarly, just 54 percent of breast cancers in Hispanic women were diagnosed in the earliest stages between 2000 and 2003 compared with 63 percent of white women. In addition, Hispanic women are 20 percent more likely to die from breast cancer than other women diagnosed at the same age and stage.[9] Meanwhile, regardless of economic status, African-American women and American Indian/Alaskan Native women have lower five-year survival rates for cancer overall than whites.[10]

But cancer is hardly the only area of major health-related disparities between people of color and whites. Blacks also have far higher death rates for heart disease, stroke and diabetes,[11] while Hispanics, who make up the nation's largest minority with 14 percent of the population, are almost twice as likely to die from diabetes as whites and have far higher rates of high blood pressure and obesity.[12]

Such disparities are rarely related to any genetic underpinnings. Instead, their roots lie in social and ethnic disparities in everything from income to education and housing, in racial bias and discrimination, and in barriers to quality health care.[3,5]

For instance, Hispanic women have a 50 percent higher death rate from cervical cancer than non-Hispanic women. This is probably because they are far less likely to be screened for cervical cancer and, if a problem is identified, to follow up with their health care professional.[13] In fact, about 8 out of 10 deaths from cervical cancer in Hispanic women could be avoided if they had regular Pap screening and follow-up.[9,13]

A Problem with Many Parts

"We've been dealing with racial disparities for a very long time," says Kevin L. Thomas, MD, an assistant professor of medicine in Duke University Medical Center's cardiovascular disease division. Dr. Thomas is a coinvestigator on a Robert Wood Johnson Foundation-funded program designed to improve the quality of cardiovascular care for minority populations.

He notes that civil rights activist and historian W. E. B. Dubois first described health-related disparities in blacks in the early 1900s: "One reason we haven't made a lot of headway (in reducing disparities) is that we haven't understood why they exist. It's so complex that there is not one magic bullet to fix it."

But there *are* ways to fix it, says Joseph Betancourt, MD, Director of the Disparities Solutions Center at Massachusetts General Hospital. Dr. Betancourt served on the Institute of Medicine (IOM) committee that produced the landmark 2002 report, *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care*. The report revealed the existence of disparities even for minority patients with the same access to care and similar socioeconomic backgrounds as white patients.[3]

It was while traveling the country to speak about the report that Dr. Betancourt realized that the nation didn't need another center to study the problem, but needed one to focus on solutions. That formed the motivation for the Disparities Solutions Center, created nearly four years ago. Today the center funds fellowships to train health care leaders in the area of cultural competence, community-oriented research and elimination of racial and ethnic disparities. It creates toolkits and hosts Web seminars for hospital leaders on the importance of addressing disparities in their organizations, along with guidance on how to do it.

Beyond the ethical and societal reasons for addressing disparities, says Dr. Betancourt, there is a clear financial

incentive. Take the patient with limited English who arrives at the emergency department with head and face pain. "If the doctor can't take a full medical history, he or she is more likely to order an expensive test like a CT scan for what may be sinusitis." Minority patients tend to have longer hospital stays than white patients, higher readmission rates for conditions such as congestive heart failure and more avoidable admissions. Patients with limited English experience greater medical errors than those without.[14]

Data, Data, Data

Addressing health care disparities begins and ends with knowing the race and ethnicity of patients. While this might seem like a relatively easy thing to do, the reality is that while 82 percent of hospitals collect information on patients' race and ethnicity, the data is often not collected in a systematic manner or shared among departments.[3]

That's what South Nassau Communities Hospital on Long Island in New York discovered when it formed a Cultural Initiatives Committee shortly after the release of the IOM report. The hospital didn't even ask patients about their ethnic or racial background; if someone had dark skin, they were assumed to be black, even if they had a white parent. So the first thing the hospital did was train staff to collect demographic information in a sensitive manner. The findings shocked everyone. More than one in five patients (22 percent) in this previously white, middle-class, Jewish community were either African American or Hispanic.

That information led to numerous changes throughout the hospital, said Sheila D'Nodal, MD, the hospital's chief diversity officer. It created bilingual signs, translated all patient documents into Spanish and added a Spanish-language channel to the in-hospital television network. When staff realized that the religious services they provided—primarily Jewish and Catholic—did not meet the needs of many African-American patients, who were primarily Baptist and Episcopalian, they reached out to community churches for resources.

Today, administrators continue to hold focus groups with patients and doctors to identify barriers to equitable care. "We found that if you don't ask the questions, you don't know what issues you should address," Dr. D'Nodal said.

Measuring Outcomes Important

In addition to asking the right questions and changing systems, you have to measure change. That's what Michael W. Painter, MD, learned when he headed a project to improve diabetes care for Native Americans in Seattle. After entering patient data into a central registry and measuring the care and outcomes of patients by race and ethnicity, he and the rest of the staff at the clinic where he worked got a rude surprise: Hemoglobin A1C blood levels (a marker of diabetes control that measures average blood sugars over six to 12 weeks) averaged 11 percent among their Native American patients, far higher than the recommended 7 percent. "We thought we were providing culturally competent care, but it was not enough," he said.

The clinic developed a multidisciplinary diabetes team that included a podiatrist to provide foot care and an optometrist to provide eye care. That eliminated transportation and time barriers for patients who didn't have cars.

The team also included nurses who specialized in patient education and outreach who visited high-risk patients in their homes to identify problems such as access to healthy foods or other situations that could affect diabetes control. And clinic staff developed relationships with community specialists to improve the transition of care for patients who required a higher level of care. That's important, given evidence showing that people with Medicaid or no health insurance (like Dr. Painter's clinic population) have a difficult time getting appointments with specialists.[15]

The result? After 18 months, the average hemoglobin A1C level for Native Americans dropped to a healthy 7 percent.

Today Dr. Painter is a senior program officer for the Robert

African Americans have the highest death rate and shortest survival of any racial and ethnic group in the U.S. for most cancers, according to the American Cancer Society.

Health Issues for Women of Color At-a-Glance

- Only half of breast cancers diagnosed in African-American women are found in the earliest stages, while 62 percent of those in white women are found at this stage.
- African-American women and American Indian/Alaskan Native women have lower five-year survival rates for cancer overall than whites.
- Women of color are less likely to receive regular mammograms and more likely to receive inadequate screenings than white women.[7]
- Hispanic women have a 50 percent higher death rate from cervical cancer than non-Hispanic women.
- Hispanics are almost twice as likely to die from diabetes as whites and have far higher rates of high blood pressure and obesity.

continued on page 4

 continued from page 3

When African-American women do receive regular screenings, one study found, there is no difference between black and white women regarding the stage of the tumor when detected.

Wood Johnson Foundation's quality/equality team, working to disseminate the lessons he learned in Seattle throughout the country.

The foundation funds programs in 15 communities designed to improve the quality of care and address racial and health care disparities. Thus, every quality indicator is reported in terms of race and ethnicity.

From the Patient Perspective

Tracking data, of course, is just one part of resolving the disparities problem. Another has to do with addressing some of the root causes of health disparities where they occur: in neighborhoods. For instance, one reason for higher rates of obesity in women and children of color, experts say, is their lack of access to safe neighborhoods for walking and playing and to grocery stores with fresh fruits and vegetables.[16-18]

People of color are also far more likely to live in neighborhoods close to hazardous waste sites, landfills and other toxins and have far higher exposure to lead and PCBs, all of which have been linked to higher rates of asthma, neurological deficits, heart disease and other health conditions.[19] In fact, a study published last year found that neighborhood accounted for between 15 percent and 76 percent of disparities (depending on the outcome measured) between African Americans and whites.[16]

Dr. Painter would like to see such discrepancies addressed in the current debate over health care reform.

The Role of Health Insurance

One component of the disparity gap that may get some attention in the near future is health insurance. Over and over, studies find that lack of health insurance contributes significantly to the disparities gap, primarily because of a lack of access to quality care. And, not surprisingly, black and Hispanic adults are much more likely to be uninsured than whites.[20] A recent government report examining access to care over time found that 60 percent of the core measures used to track access remained unchanged or got worse for African Americans and Asians, while 80 percent of those measures remained unchanged or got worse for Hispanics.[21]

Once people of color turn 65 and are eligible for Medicare, however, the disparity gap narrows considerably.[22]

So researchers in the area of health disparities are cautiously optimistic about the potential for health care reform to reduce disparities. Simply providing universal coverage would make a big difference.

The key point, Dr. Betancourt says, is that "this is an issue we can solve if we are attentive to it. There are plenty of tools that work and resources out there."[14]

Resources

Indian Women's Health
www.indianwomenshealth.com

Medline Plus Trusted Health Information for You: Hispanic-American Health
1-888-346-3656
www.nlm.nih.gov/medlineplus/hispanicamericanhealth.html

SAWNET: Health Issues of South Asian Women
www.sawnet.org/health/

Women's Health.Gov
1-800-994-9662
www.womenshealth.gov

NAWHO: Health Partnership for Asian Women and Families
925-468-4120
www.nawho.org

Black Women's Health Imperative
www.blackwomenshealth.org
202-548-4000

We Speak Loudly
www.wespeakloudly.com

National Alliance for Hispanic Health
202-387-5000
www.hispanichealth.org

Think Cultural Health
www.thinkculturalhealth.org

References

1. *Fact sheets. Cover the Uninsured. Available at: covertheuninsured.org.*
2. *Schoen S, Collins SR, Kriss JL, et al. How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007. Health Affairs Web Exclusive. 2008:w298–w309.*
3. *Institute of Medicine. Unequal Treatment: Confronting the Racial and Ethnic Disparities in Health Care. Washington, DC: Institute of Medicine of the National Academies; 2002.*
4. *US Department of Health and Human Services. What is Healthy People 2010? Oct 2005. www.healthypeople.gov*
5. *American Cancer Society. Cancer Facts & Figures for African Americans, 2009-2010 Atlanta; 2009.*
6. *DeLancey JOL, Thun MJ, Jemal A, et al. Recent Trends in Black-White Disparities in Cancer Mortality. Cancer Epidemiol Biomarkers Prev. 2008;17(11):2908-2912.*
7. *Smith-Bindman R, Miglioretti DL, Lurie N, et al. Does utilization of screening mammography explain racial and ethnic differences in breast cancer? Ann Intern Med. 2006;144(8):541-553.*
8. *National Womens Health Resource Center. 2008 Breast Cancer Awareness Survey 2008.*
9. *American Cancer Society. Cancer Facts & Figures for Hispanics/Latinos. 2006. www.cancer.org*
10. *Ward E, Jemal A, Cokkinides V, et al. Cancer disparities by race/ethnicity and socioeconomic status. CA Cancer J Clin. 2004;54(2):78-93.*
11. *Heron M, Hoyert DL, Murphy SL. Deaths: Final Data for 2006. National Vital Statistics Reports. CDC. April 2009.*
12. *US Department of Health and Human Services. Healthy people 2010: Understanding and improving health, 2nd ed Washington, DC: US Government Printing Office; 2000.*
13. *Reynolds D. Cervical cancer in Hispanic/Latino women. Clin J Oncol Nurs. 2004;8(2):146-150.*
14. *US Department of Health and Human Services. National Healthcare Disparities Report2003.*
15. *Blanchard J, Ogle K, Thomas O, et al. Access to appointments based on insurance status in Washington, D.C. J Health Care Poor Underserved. 2008;19(3):687-696.*
16. *Do DP, Finch BK, Basurto-Davila R, et al. Does place explain racial health disparities? Quantifying the contribution of residential context to the black/white health gap in the United States. Soc Sci Med. 2008;67(8):1258-1268.*
17. *Dubowitz T, Heron M, Bird CE, et al. Neighborhood socioeconomic status and fruit and vegetable intake among whites, blacks, and Mexican Americans in the United States. Am J Clin Nutr. 2008;87(6):1883-1891.*

Overcoming Cultural and Language Barriers

Two contributors to health care disparities in this country are cultural and language barriers between health care professional and patient. Put simply, you and your doctor (or nurse or dentist or physician assistant) may not understand each other, even if you speak the same language.

A hot topic in health care these days, cultural competence is designed to create a health care system that delivers the highest-quality care to every patient regardless of race, ethnicity, culture or language.

For instance, in one study in which more than 6,000 people were asked about their interactions with physicians, more than 14 percent of African Americans, 19 percent of Hispanics and 20 percent of Asians said their doctor had treated them with disrespect, typically because of race or language. They also believed they would have received better care if they belonged to a different race.[23]

Whether they really were treated with disrespect or looked down upon isn't the issue; perception is what matters. The fact is, women of color, particularly black women, simply mistrust the medical system more than other people, a perception that directly relates to low levels of screenings such as mammograms.[24]

Enter cultural competence. A hot topic in health care these days, cultural competence is designed to create a health care system that delivers the highest-quality care to every patient regardless of race, ethnicity, culture or language.[25] Some health insurers are beginning to tie reimbursement to cultural competence, and The Joint Commission, a national organization that accredits health care organizations, is developing cultural competency standards.[26]

Cultural competence takes many forms, including understanding—not judging—patients' fears and misperceptions about health care. For instance, Jan A. Huston, MD, medical director of the Connie Dwyer Breast Center at Saint Michael's Medical Center in Newark, NJ, lectures at area museums, churches and schools to overcome some of the mistrust and myths that African-American women have about mammograms and breast cancer.

"Women tell me they don't want to have a mammogram because we might find something," she said. Or, "They don't want to have a biopsy because letting air get to the cancer could cause it to spread." Dr. Huston also understands the barriers that prevent women from getting in for mammograms or for follow-up care if they are diagnosed with cancer—things like money, child care or transportation. "It's largely through no fault of their own" that these women miss appointments, she said. "It's just priority based." And for many such women, their own health is simply not a priority.

To overcome some of those barriers, Saint Michael's provides transportation for appointments at the Breast Center. If an uninsured woman is diagnosed with breast cancer, for example, the hospital works to get her on Medicaid, the state and federal health insurance program for the poor. And, as a nonprofit hospital, Saint Michael's—and Dr. Huston—provide a fair amount of charity care.

How to Get Health Care to Meet Your Cultural Needs

- Explain your perspective about your medical condition to your health care professional. If you are afraid to have surgery for your cancer, for example, tell your health care professional.
- Tell your health care professional if you're using herbal or other treatment approaches you've heard about from other sources. Explain why and how you use them.
- Ask for a translator, if necessary. Under federal law, all health-care facilities receiving federal funds (that includes Medicare and Medicaid) are required to provide translation services. They may be offered on-site or by phone. You have a right to understand your medical condition in your own language–without expecting your children to translate.
- Write down your questions. You're less likely to forget to ask your questions if you write them down in your own language and take them with you to your medical appointment.
- Bring someone with you to medical appointments. This should be someone who will support you, help explain your needs to your health care team, ask questions and take notes.
- Educate yourself about your condition. Most hospitals have public libraries with consumer-oriented information. You can also learn about medical conditions and treatments online using free computers at public libraries. A good starting site with English and Spanish resources is *www.hhs.gov.*
- Ask if the health center you're using provides any kind of transportation, if you need it.

Getting Personal: Health Conditions *You* Need to Know About

If you are a woman of color, there are certain health conditions for which you have a higher risk. This chart describes the conditions, the risk differences for women like you compared with white women and steps you can take to minimize your risk.

Condition	Increased Risk	Steps to Reduce Your Risk
Breast cancer	African-American women are 1.5 to 2.2 times more likely to die from breast cancer than white women, while Hispanic women are 20 percent more likely to die from the disease as other women diagnosed at the same age and stage.[9]	Get regular mammograms and follow-up care. The American Cancer Society recommends women have an annual mammogram beginning at age 40. Visit your health care practitioner at least once a year for a clinical breast exam. See your health care practitioner as soon as you notice any changes in your breasts. One study found that Hispanic women wait longer to receive care for breast cancer, making their disease harder to treat.[27]
Diabetes	African-American women are 100 percent more likely to develop diabetes than white women,[28] while the rate of developing diabetes is two to four times higher among Hispanic-American, American Indian and Asian/Pacific Islander women.[29] Rates of blood sugar control are significantly lower and average hemoglobin A1C levels significantly higher for blacks and Hispanics than for whites with diabetes.[22] Blacks, American Indians and Hispanics have higher death rates from diabetes. Blacks also have higher rates of serious complications from diabetes, including higher rates of kidney failure and leg amputation due to diabetes.[11]	Lose weight, increase your daily physical activity level, change your diet and see your health care professional at least every three months for regular testing and evaluation. All have been shown to prevent diabetes in high-risk women. For more tips, see page 8.[30] Test your blood sugar throughout the day and adjust your diet, exercise and medication accordingly. Studies find such monitoring can improve blood glucose control,[31] which can, in turn, reduce the risk of complications such as cardiovascular and renal disease, blindness and neuropathy. Make sure you receive all recommended medications and testing for people with diabetes. These include a statin and a daily low-dose aspirin (although this recommendation is being questioned as it relates to women), as well as regular testing and treatment for high blood pressure, cholesterol levels and eye and foot examinations, all of which are often less likely to be provided to people of color.[32]
High blood pressure	African Americans and Hispanics have significantly higher blood pressure and worse blood pressure control than whites.[22] In addition, American Indian/ Alaska Natives were 22 percent more likely than whites to have been told they had hypertension.[33]	Cut out as many processed foods as possible (think canned soups and vegetables, frozen dinners, packaged rice and ready-to-eat meals). These foods are filled with sodium, which increases blood pressure. Limiting sodium could reduce systolic blood pressure 2–8 mm Hg.[34] Instead, add in fresh fruits, vegetables, beans and whole grains. You can also add frozen vegetables—plain with no sauces! Limit alcohol. One drink or less a day for women, can reduce systolic blood pressure 2–4 mm Hg.[34] Follow the DASH (Dietary Approaches to Stop Hypertension) diet. This eating program is high in fruits, vegetables and low-fat dairy, and low in saturated and total fat. Studies find it can reduce systolic blood pressure 8–14 mm Hg.[34] View the DASH diet at www.nhlbi.nih.gov/health/public/heart/hbp/dash/dash_brief.pdf. Talk to your health care professional about the best medication for you, not for hypertension overall. There is evidence that certain classes of antihypertensives (calcium channel blockers and diuretics) work better in African Americans than other classes, and that they respond better to an ACE inhibitor in combination with a diuretic[35] than to an ACE inhibitor alone.[36,37]
Colorectal cancer	African Americans are more likely to have their colorectal cancer diagnosed at a later stage than whites and to die of colorectal cancer.	Beginning at age 50 (earlier if you have a family history of colorectal cancer), get regular screenings for colorectal cancer. Blacks are less likely than whites to receive such screenings.[21]

References *continued*

18. *Do DP, Dubowitz T, Bird CE, et al. Neighborhood context and ethnicity differences in body mass index: a multilevel analysis using the NHANES III survey (1988-1994). Econ Hum Biol. 2007;5(2):179-203.*
19. *Powell DL, Stewart V. Children. The unwitting target of environmental injustices. Pediatr Clin North Am. 2001;48(5):1291-1305.*
20. *Ayanian JZ, Weissman JS, Schneider EC, et al. Unmet health needs of uninsured adults in the United States. JAMA. 2000;284(16):2061-2069.*
21. *US Department of Health and Human Services. National Healthcare Disparities Report 2008.*
22. *McWilliams JM, Meara E, Zaslavsky AM, et al. Differences in control of cardiovascular disease and diabetes by race, ethnicity, and education: U.S. trends from 1999 to 2006 and effects of medicare coverage. Ann Intern Med. 2009;150(8):505-515.*
23. *Blanchard J, Lurie N. R-E-S-P-E-C-T: patient reports of disrespect in the health care setting and its impact on care. J Fam Pract. 2004;53(9):721-730.*
24. *Gardner A. Minorities Distrust Medical System More. Health Day. 2009. www.healthday.com.*
25. *Betancourt JR, Green AR, Carrillo JE, et al. Cultural competence and health care disparities: key perspectives and trends. Health Aff (Millwood). 2005;24(2):499-505.*
26. *The Joint Commission. Developing Culturally Competent Patient-Centered Care Standards. 2009. www.jointcommission.org.*
27. *Park M. Research shows Hispanic women get breast cancer treatment late. CNN.com. 2009. www.cnn.com.*
28. *Lipton RB, Liao Y, Cao G, et al. Determinants of incident non-insulin-dependent diabetes mellitus among blacks and whites in a national sample. The NHANES I Epidemiologic Follow-up Study. Am J Epidemiol. 1993;138(10):826-839.*
29. *American Diabetes Association. Total Prevalence of Diabetes & Pre-diabetes. www.diabetes.org*
30. *Diabetes Prevention Program Research Group. Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin. N Engl J Med. 2002;346(6):393-403.*
31. *Trinacty CM, Adams AS, Soumerai SB, et al. Racial differences in long-term self-monitoring practice among newly drug-treated diabetes patients in an HMO. J Gen Intern Med. 2007;22(11):1506-1513.*
32. *Peek ME, Cargill A, Huang ES. Diabetes health disparities: a systematic review of health care interventions. Med Care Res Rev. 2007;64(5 Suppl):101S-156S.*
33. *American Heart Association. American Indians/Alaska Natives and Cardiovascular Diseases–Statistics. 2009. www.heart.org.*
34. *Lenfant C, Chobanian AV, Jones DW, et al. Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7): Resetting the Hypertension Sails. Hypertension. 2003;41(6):1178-1179.*

Commonly Asked Questions & Answers about Health & Wellness for Women of Color

Q As a woman of color, what can I do to reduce my risk of becoming a health statistic?

A It is so important to take responsibility for your own health. That means being aware of the screenings you need (even if you feel fine), following a healthy diet or working to improve your current diet to make it healthier and getting regular physical activity. These are all things you can do regardless of your health insurance status. Even if you have no health insurance, many hospitals offer free or reduced-cost mammograms and Pap smears. Just ask!

It is also important that you find a health care professional you trust. If that means someone who has the same color skin as you, or speaks with the same accent, then so be it. Because if you don't trust your health care professional, you are unlikely to return to him or her for the routine care you need or to follow their recommendations.

–Joanne W. Flowers, PhD
Associate Dean
School of Health Sciences
Walden University
Minneapolis, MN

Q Does a health care provider's personal bias affect the care they deliver?

A The issue of bias and stereotyping affecting the way care is delivered makes a lot of people uncomfortable but it is an important point. This was clearly demonstrated in a landmark article published in 1999 in the *New England Journal of Medicine*. In that study, 720 physicians completed an interactive program involving videos of "patients" (actually, actors following a script) describing symptoms of chest pain.[38] The patients had identical medical histories and symptoms; the main differences were their age, race and gender. Yet men and white patients were 40 percent more likely to be referred for cardiac catheterization to unblock arteries than were women and black patients even after adjusting for the severity of symptoms, physician estimates of the probability of coronary disease and other risk factors. The authors noted that "a patient's race and sex may influence a physician's recommendation with respect to cardiac catheterization regardless of the patient's clinical characteristics."

So, yes, physician bias can affect the type of care you receive. However, I don't think this bias is malicious; rather, there are certain subtle, preconceived notions that seep into the decision-making process. Decisions made under time pressure are more likely to reflect bias and preconceptions.

That's why it is so important to provide care based on evidence, not on personal opinion or past history, and to measure the outcomes of that care. If all eligible patients with chest pain and stress test findings suggesting coronary heart disease were sent to the cath lab, and all patients with diabetes received recommended care based on national guidelines, then race, ethnicity and gender would fall out of the picture.

–Kevin L. Thomas, MD
Assistant Professor of Medicine
Division of Cardiovascular Disease
Duke University School of Medicine
Durham, NC

35. Ferdinand KC, Armani AM. The Management of Hypertension in African Americans. Critical Pathways in Cardiology. 2007;6(2):67-71 10.1097/HPC.1090b1013e318053da318059.
36. Douglas JG, Bakris GL, Epstein M, et al. Management of High Blood Pressure in African Americans: Consensus Statement of the Hypertension in African Americans Working Group of the International Society on Hypertension in Blacks. Arch Intern Med. 2003;163(5):525-541.
37. Sica D. Optimizing hypertension and vascular health: focus on ethnicity. Clin Cornerstone. 2004;6(4):28-38.
38. Schulman KA, Berlin JA, Harless W, et al. The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization. N Engl J Med. 1999;340(8):618-626.
39. Centers for Disease Control and Prevention. Obesity Among Adults in the United States–No Statistically Significant Change Since 2003-2004. Data Brief Number 12007.
40. AMERICAN HEART ASSOCIATION. Hispanic Women at Higher Risk for Heart Disease. 2007. www.heart.org.
41. Gary TL, Baptiste-Roberts K, Gregg EW, et al. Fruit, vegetable and fat intake in a population-based sample of African Americans. J Natl Med Assoc. 2004;96(12):1599-1605.
42. Prevalence of fruit and vegetable consumption and physical activity by race/ethnicity–United States, 2005. Morb Mortal Wkly Rep. 2007;56(13):301-304.
43. Gaston MH, Porter GK, Thomas VG. Prime Time Sister Circles: evaluating a gender-specific, culturally relevant health intervention to decrease major risk factors in mid-life African-American women. J Natl Med Assoc. 2007;99(4):428-438.
44. Davis-Smith YM, Boltri JM, Seale JP, et al. Implementing a diabetes prevention program in a rural African-American church. J Natl Med Assoc. 2007;99(4):440-446.
45. Kim KH, Linnan L, Campbell MK, et al. The WORD (wholeness, oneness, righteousness, deliverance): a faith-based weight-loss program utilizing a community-based participatory research approach. Health Educ Behav. 2008;35(5):634-650.
46. Yanek LR, Becker DM, Moy TF, et al. Project Joy: faith based cardiovascular health promotion for African American women. Public Health Rep. 2001;116 suppl 1:68-81.
47. Davis Martin P, Rhode PC, Dutton GR, et al. A primary care weight management intervention for low-income African-American women. Obesity. 2006;14(8):1412-1420.

What *You* Can Do to Improve Your Health

I want to talk about the things you can do to improve and protect your health, and take the focus off the health care system, for just a minute. Surely, there must be things we can do on our own to reduce the many health-related gaps between women of color and white women.

By Pamela Peeke, MD, MPH
NWHRC Medical Advisor

Dr. Peeke is a Pew Foundation Scholar in Nutrition and Metabolism, and Assistant Clinical Professor of Medicine at the University of Maryland in Baltimore. She writes about health and lifestyle issues important to all women.

Did you know that approximately 53 percent of non-Hispanic black women and 51 percent of Mexican-American women 40 to 59 years of age are obese compared with about 39 percent of white women of the same age?[39] These higher rates of obesity contribute to the fact that blacks are more likely to be diagnosed with and die from coronary heart disease (clogged arteries) than whites, that Hispanic women develop cardiovascular disease an average of 10 years earlier than white women[40] and that the prevalence of coronary heart disease among blacks is rising even as it is falling among whites.[14]

So let's focus on your weight, physical activity and diet as three steps you can take to reduce your personal health care disparities.

For instance, a diet high in fruits and vegetables is linked with lower rates of cancer, heart disease, diabetes and nearly every other major chronic condition. Yet only 8 percent of African Americans report getting at least a cup a day of fruit (two servings), and just 16 percent say they get one-and-a-half cups a day of vegetables (three servings).[41] The recommendations for how much you should get varies based on your age and gender, but should be about eight or nine cups a day total. And those veggies, of course, should be steamed or raw, not fried!

So I challenge you to see how many more servings a day of fruits and vegetables you can add to your diet and to your family's diet.

I also challenge you to increase your daily physical activity levels, another area of disparity. While half of all white women claim to be physically active on a regular basis, that figure drops to 36 percent of black and 42 percent of Hispanic women.

To help you get started, I did a quick search to see what types of programs have been shown to work well for women of color. Check out the recommendations below. Ladies, it's time to get out there and move!

Small Steps to Better Health for Women of Color

- Join a support group composed of women from a similar background. In one study, middle-aged, middle-income African-American women who attended ten 90-minute weekly, culturally sensitive support groups significantly increased their physical activity levels and ate more nutritious foods.[43] Women in the study participated in Prime Time Sister Groups. See if you can find one near you.
- Get the church involved. Form a walking group with members of your church, bring in nutritionists and other experts to coach you on healthy diet and physical activity and support one another in your efforts to lose weight. Church-based weight-loss programs built around physical activity and a healthy diet show great success in helping African-American women lose weight, reduce their risk of heart disease and diabetes and lower hypertension.[44-46]
- Involve your doctor. Ask your health care professional to guide and support you, not lecture you, in your effort to lose weight, eat healthier and/or increase your physical activity. Studies find getting your primary care involved increases the likelihood of success.[47]

Learn more: Visit www.HealthyWomen.org/wellness.