

Breaking Barriers



**Breaking Barriers Module I:
Introduction to Barriers to
Health Care**

**Breaking Barriers II:
Racial and Ethnic Minorities**

A multimedia
project on CD-ROM...

Breaking Barriers

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if you are reading this, you probably already recognize the barriers to health care problems in the United States. If so, these “Breaking Barriers” modules were created just for you. You have the knowledge and desire to do something about this serious problem; now one of the first things you can do to address it is to help educate other physicians-in-training.

These modules were created to help medical students stimulate discussion among their peers, and more importantly, to take action to break the barriers to health care in the United States.

This peer educator guide is important to read before using the accompanying CD-ROM. It provides a short overview of barriers to health care, gives you information about the “Breaking Barriers” modules (e.g. technical information and tips on presentation), and will help you generate discussion when you present the modules to a group of your peers.

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Overview of Barriers to Health Care

Several barriers to health care access are present in the U.S. health-care system. One of the goals of Healthy People 2010, the HHS health promotion initiative, is to eliminate health disparities among different populations.¹ Unfortunately, many future physicians are unaware of the conditions affecting access to health care. And for those who are aware of the situation, they may not know what actions to take to combat these obstacles and deliver effective health care to the American population.

This section provides an overview of some of the disparities and explores some of the commonly encountered barriers such as culture, socio-economic class, geographical location, sexual orientation, disability, and health insurance coverage. Although the results are organized under separate barrier types, many people are affected by more than one.

Race and Culture


African Americans, Latinos and Asians all face barriers to care that lead to poorer health outcomes. The disparities in health outcomes among the different races illustrates that there must be barriers faced by these sub-populations.

Studies have shown that African Americans receive fewer lung operations for cancer, cardiovascular procedures, organ transplants, orthopedic surgeries, C-sections, etc.² For example, although there has been a reduction in age-adjusted death rate from heart disease, stroke and cancer between 1985 and 1995 for African Americans, the discrepancy between African Americans and Caucasians continues to increase.³ Forty percent more African Americans die of heart disease each year than Caucasians, and African Americans with HIV/AIDS are more than seven times more likely to die than Caucasians are.¹ There is also a disparity in the five-year survival rate from breast cancer between African-American women and Caucasian women.⁴

The barriers causing these health outcomes stem from education, physician biases and health insurance. Although differences in health-care outcomes may be partly based on genetic predisposition, barriers to care are also a cause. For example, the lifetime risk of prostate cancer developing in African-American men and the mortality rate is double that of Caucasian men, but this is also related to less preventive care sought and received by African-American men, causing delays in diagnosis and treatment because of lack of knowledge and access to health care.³ A study based on this hypothesis showed that after the African-American male patients participated in a prostate cancer educational and screening program, they reported significant improvement in their knowledge about the topic.⁵

Cultural differences also affect participation levels in hospice care. Only 5 to 7 percent of hospice patients are of ethnic and racial minority backgrounds.⁶ A survey of African-American pastors found the problem was that their congregation disagreed with the hospice philosophy. To overcome these barriers, the authors suggest looking for areas of agree-





ment between the African-American community and the hospice philosophy, teaching African-American pastors about hospice care and appointing African-American pastors as directors of hospice programs.⁶

Similarly, cultural beliefs stand in the way of abused Latinas and Asian women seeking health care. It has been shown that these women aren't always aware of their rights and resources as immigrants, fear deportation to their country of origin, perceive physician disinterest in their needs, believe in family loyalty and fear getting a divorce, limiting their efforts to seek care.⁷

Physician bias may also act as a barrier, as reported in a recent article which showed that the patients' race and sex influenced whether physicians decided to refer patients with chest pain for cardiac catheterization.⁸

The most prevalent barriers to preventive care for minority populations in the rural south are first, a perception that health services are not needed, and second, inability to pay.⁹ It has been shown that patients have difficulty accessing services because of complex instructions for eligibility of entitlement programs/Medicaid, difficulty in scheduling doctor appointments, and unclear advertisements about preventive services. More than a third of those interviewed also reported transportation as an obstacle due to the fact that half do not own a car.⁹

It has also been shown that American Indian and Alaskan Native women in the United States have a higher risk of death from cervical cancer, due to low screening with Papanicolaou tests. The barriers to low screening are a lower level of education, lower household income and no health insurance.¹⁰

Rural and Migrant Workers

Rural populations are faced with many barriers to health care access. Nearly 20 percent of the 40 million uninsured population resides in rural areas, and as a result is 20 percent less likely than urban residents to receive regular physician check-ups and preventative screenings.¹¹

According to the Centers for Disease Control and Prevention, adults residing in rural areas have a 31-44 percent higher mortality rate than those living in suburban areas. Rural children were found to have a 50 percent higher mortality rate than suburban children.¹²

Socio-economic status, education levels, and lack of transportation are some barriers that make it more difficult for rural residents to obtain health care. But major disparities in physician supply further aggravate the problem. The majority of U.S. physicians are still disproportionately located in metropolitan areas, with an estimated 1,879 rural counties designated as "medically underserved," due to the shortages of primary-care health professionals. To bring these counties above the minimum criterion of 1 provider for every 2,000 people, an additional 2,370 primary-care practitioners are needed.¹³

In 1997, there were a total of 603,656 patient care physicians in the nation; however, only 64,912 (10.8 percent) practiced in

rural counties. This problem is heightening as many rural area hospitals are forced to close due to insufficient funding and physician shortages. Between 1990 and 1998 a net reduction of 438 hospitals in rural areas took place, leaving more and more residents without access to adequate care.¹³

Migrant workers represent an especially vulnerable population to health care inequities. On average, a migrant family earns \$5,000 a year and fewer than half speak English or have had more than eight years of formal education. Studies have shown that 61 percent of the migrant farm workers' children have had at least one disease and 43 percent had multiple ailments. Infant mortality was reported as 29 per every 1,000 live births compared to 14 per 1,000 in the general population. Only 12 to 15 percent of the migrant farm worker families are seen at the 400 migrant health clinics annually. Disability rates are three times higher than in the general population. And, tuberculosis is found six times more often in a migrant farm worker than in an average working adult.¹⁴

These poor health outcomes are a direct result of these families moving after every season. Some other causes are poor living conditions (without proper sanitation), malnutrition, pregnant women working long hours doing manual labor, farm injuries, lack of transportation to health clinics, lack of insurance, isolation, exposure to insecticides and language barriers.¹⁴

Sexual Orientation

Homosexual males and females are at risk for poor health outcomes due to physician prejudices and ignorance. Up to 75 percent of lesbians report having negative experiences with health-care providers because of their sexual orientation.¹⁵ According to a Gay and Lesbian Medical Association study, up to 45 percent of the gynecologists had given substandard care to their lesbian patients.¹⁶ Studies suggest that 5 to 8 percent of lesbians have never had a Papanicolaou smear because of the belief that cervical cancer is a lower risk for lesbian women.¹⁷ However, up to 80 percent of lesbians have had heterosexual intercourse, and about 33 percent had some type of STD, according to one study.¹⁷ In addition, one quarter of the lesbian women who have not had sex with a male for a year were diagnosed with bacterial vaginosis. It has also been hypothesized that lesbian women may be at an increased risk for breast cancer, ovarian cancer and endometrial cancer due to nulliparity and lower oral contraceptive use. However, due to poor patient-physician relationships and financial barriers, lesbian women may be less likely to seek mammography screening.¹⁵

Both substance abuse and mental health problems are seen more in homosexual patients than are seen in the general population. Thirty-five percent of the homosexual population report substance abuse compared to the 12 percent of the heterosexual population. According to one study, 32 percent of adolescent gay and bisexual males have attempted suicide; another study reports that 24 percent of lesbians between the ages of 17 and 24 have attempted suicide.¹⁶ Chemical



dependency and mental health problems can both be linked to perceived barriers to health care.

Disabilities and Chronic Conditions

In 1990, the American with Disabilities Act (ADA) became a law, and it restricted discrimination based on physical and/or mental disabilities and required accommodation for those with disabilities.¹⁸ Although disabled people make up 10 percent of the population,¹⁹ they still face barriers to health care. One study showed that even after the ADA law went into effect, 18 percent of the primary care doctors surveyed had at least once been unable to serve their disabled patients in the prior year due to reasons that could be considered noncompliant with the ADA law. These reasons include inappropriate referrals, inaccessible equipment, improper architectural elements and inadequate auxiliary aids.¹⁸ Access to primary care for chronic care and disabled patients is especially lacking in rural areas. It has been estimated that 20 percent of the rural people with a mental illness do not acquire services from a mental health professional.¹⁹

Health Insurance

Probably the biggest barrier to health care is lack of health insurance coverage. There are 44.3 million people in United States without health insurance. Low-income families who live at 200 percent of federal poverty level make up the highest number of the uninsured. Three-quarters of these families have at least one person working full-time and another one-tenth have at least one person working part-time.²⁰ The rising cost of premiums for health insurance is partly to blame for the increasing numbers of uninsured patients.^{20, 21} Without insurance, Americans are less likely to use preventive care such as immunizations, prenatal care, Pap smears, mammographies, and annual blood pressure checks.^{22, 23} Uninsured children are four times less likely to have received appropriate medical, dental and mental health care.²¹ Uninsured patients are also more likely to use emergency room care over primary care providers.^{23, 24}

A study of diabetic patients who sought care in urban walk-in clinics showed that uninsured people were less likely to have a regular source of care, worsening their health outcomes.²³ Another study showed that uninsured patients hospitalized with asthma fare worse than their insured counterparts. It has also been shown that insured HIV-positive patients are more likely to receive AZT treatment than uninsured HIV-positive patients.²³ Finally, uninsured patients have a 25 percent greater risk of mortality.²⁴ Among the 29 Organization of Economic Development and Cooperation nations, the United States has fallen from 12th in infant mortality to 23rd, as the number of uninsured has steadily increased.²⁵

Clearly, there are barriers to health care for many populations in the United States. Breaking down these barriers is a goal for all health care professionals. As a medical student, you can help also. Educating yourself and others on barriers to health care and solutions to the problem is an important first step.

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Giving the “Breaking Barriers” Presentation

Thank you for taking the initiative to educate your fellow students on health-care barriers. This section will show you how to use these modules to obtain the best results.

Technical Issues

How long is this presentation supposed to be?

There are two modules on this CD-ROM: Introduction to Barriers to Health Care and Ethnic Minorities. Each module is designed to be shown to a group of people over a one-hour time period. However, if you have less time, you may decide to leave less time for discussion. Or you can ask the participants to think about their questions, and the next time you convene as a group you will discuss them together.

How many people can I show this to at one time?

Ideally, you will have about 20 people in one group. This number is enough so that your discussion should be lively and interesting but not too many that some participants won't have the opportunity to participate. Of course, you may decide to show the presentation to a larger or smaller group.

How does it work?

To use the accompanying CD-ROM with the best results, be sure you have:

- A computer with a CD-ROM drive, Microsoft Internet Explorer and Windows Media Player
- An LCD projector
- A screen (or white wall)

If you are using a PC, insert the CD into your computer's CD drive. Click on *My Computer*. Then click on the CD drive of your computer. To watch the Breaking Barriers introductory module, click on *Breaking Barriers*, and then on *intro.html*. To watch the Racial and Ethnic Minorities module, click on *raciaethnic*, and then on *minorities.html*.

If you are using a Mac, insert the CD into your computer's CD drive. Click on the CD icon. To watch the Breaking Barriers introductory module, click on *Breaking Barriers*, and then on *intro.html*. To watch the Racial and Ethnic Minorities module, click on *raciaethnicmodule*, and then on *minorities.html*.

You will probably want to familiarize yourself with the CD completely before attempting to show it to a group of people.

Tips on Presenting

In some respects, "Breaking Barriers" looks similar to a Power Point presentation slide show, but it has bonus features. To make it more interesting, videos and audio clips are incorporated into the presentation. There is also a library with full-text articles relevant to health-care barriers. Finally, you can also access certain sites on the Internet through links on this presentation.



The video camera icon indicates a relevant multi-media clip, so click on the link and watch.



The book icon indicates a link to a full-text article on the CD-ROM in the electronic library. (AMSA has received permission for reproduction for educational purposes.) Click to read it or print it out for participants.



The globe icon indicates a link to an outside Web site, and, if you're connected to the Internet, click to go there.



Finally, when you see the stop sign, it is your cue to stop the slide show for a moment to lead a discussion with your participants.

Stimulating thought and discussion is your overall goal in presenting "Breaking Barriers" to your fellow medical students. Ideally, the presentation will be a catalyst for this thought and discussion; but participants will probably learn more from each other than from the module.

Each module has a few questions that should spark discussion, but do not hesitate to broaden the scope of the discussion as you see fit. If nobody seems willing to talk, try one of the following techniques to get the conversation started:

- Reframe or rephrase the question in a way you think will be more likely to elicit a response.
- Place the discussed subject in the context of a local problem or issue with which the group may be more familiar.
- Share a personal experience or personal view related to the discussion question, and then ask if anyone else will share something.

Good luck in your presentation!

Any questions or comments related to "Breaking Barriers" should be directed to Shadia Garrison at shadia_g@www.amsa.org or (703) 620-6600, ext. 214.





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great work you do!

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