

e3 Racial and Ethnic Disparities in Health Care

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Over the course of its history, the United States has experienced dramatic improvements in overall health and life expectancy due largely to initiatives in public health, health promotion, disease prevention, and chronic care management. Our ability to prevent, detect, and treat diseases in their early stages has allowed us to target and reduce morbidity and mortality. Despite interventions that have improved the overall health of the majority of Americans, racial and ethnic minorities (Blacks, Hispanics/Latinos, Native Americans/Alaska Natives, Asian/Pacific Islanders) have benefited less from these advances and suffer poorer health outcomes than whites from many major diseases (e.g., cardiovascular disease, cancer, diabetes) in the United States. Research has highlighted that minorities may receive lower quality of care than whites in the health care setting, even when confounders such as stage of presentation and comorbidities are controlled for and they have the same level of health insurance. These differences in quality are called *racial and ethnic disparities in health care*. This chapter will provide an overview of racial and ethnic disparities in health and health care, identify root causes, and provide key recommendations to address them at both the health system and clinical level.

NATURE AND EXTENT OF RACIAL AND ETHNIC DISPARITIES IN HEALTH AND HEALTH CARE

Minority Americans have poorer health outcomes (compared with whites) from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, cancer, and HIV/AIDS, among others (Fig. e3-1). Multiple factors contribute to these racial and ethnic disparities in health. First and foremost, there is little doubt that social determinants—such as lower levels of education, overall lower socioeconomic status, inadequate and unsafe housing, racism, and living in close proximity to environmental hazards—disproportionately impact minority populations and thus contribute to poorer health outcomes. For example, three of the five largest landfills in the country are found in African-American and Latino communities; these environmental hazards have contributed to some of the highest rates of pediatric asthma among these populations. Second, lack of access to care also takes a significant toll, as uninsured individuals are less likely to have a regular source of care, are more likely to report delaying seeking care, and are more likely to report that they have not received needed care—

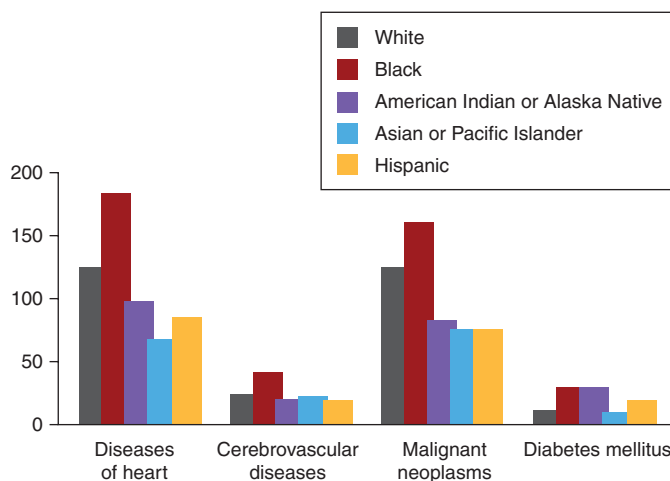


FIGURE e3-1 Age-adjusted death rates for selected causes by race and Hispanic origin, 2000. (From Institute of Medicine: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC, National Academy Press, 2002.)

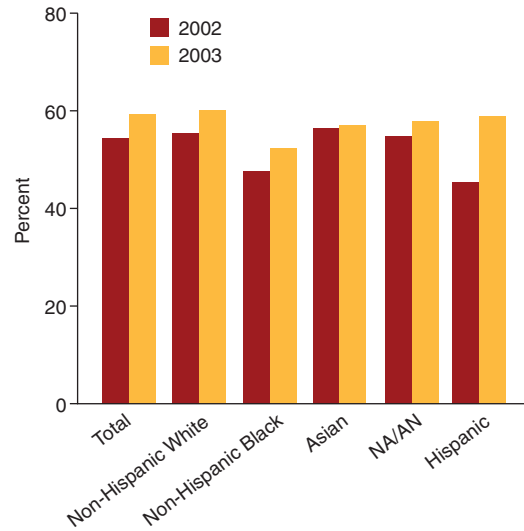


FIGURE e3-2 Recommended hospital care received by Medicare patients with pneumonia, by race/ethnicity, 2002–2003. Reference population is Medicare beneficiaries with pneumonia who are hospitalized. Composite is calculated by averaging the percentage of the population that received each of the five incorporated components of care. NA/AN, Native American or Alaska Native. (Adapted from Agency for Health Care Research and Quality: *The 2005 National Health Care Disparities Report*.)

all resulting in avoidable hospitalizations, emergency hospital care, and adverse health outcomes.

In addition to the existence of racial and ethnic disparities in *health*, there are racial/ethnic disparities in the *quality of care* for those with access to the health care system. For instance, disparities have been found in the treatment of pneumonia (Fig. e3-2) and congestive heart failure (African Americans receiving less optimal care than whites when hospitalized for these conditions) and referral to renal transplantation (African Americans with end-stage renal disease being referred less often to the transplant list than whites) (Fig. e3-3). Disparities have also been found in the utilization of cardiac diagnostic and therapeutic procedures (African Americans being referred less than whites for cardiac catheterization and bypass grafting), prescription of analgesia for pain control (African Americans and Latinos receiving less pain medication than whites for long bone fractures and cancer), and surgical treatment of lung cancer (African Americans re-

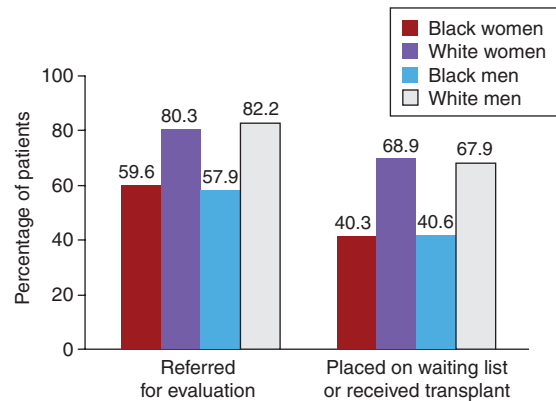


FIGURE e3-3 Referral for evaluation at a transplantation center or placement on a waiting list or receipt of a renal transplantation within 18 months after the start of dialysis among patients who wanted a transplant, according to race and sex. Reference population is 239 black women, 280 white women, 271 black men, and 271 white men. Racial differences were statistically significant among the women and the men ($p < .0001$ for each comparison). (From JZ Ayanian et al: *N Engl J Med* 341:1661, 1999.)

ceiving less curative surgery than whites for non-small cell lung cancer), among others. Again, many of these disparities occurred even when variations in factors such as insurance status, income, age, comorbid conditions, and symptom expression are taken into account.

Little progress has been made in addressing racial/ethnic disparities in cardiovascular procedures and other advanced surgical procedures, while some progress has been made in eliminating disparities in primary care process measures. Data from the National Registry of Myocardial Infarction found no evidence that the racial differences in rates of reperfusion therapy, coronary angiography, and in-hospital death after myocardial infarction have narrowed between 1994 and 2002 (Fig. e3-4). Black women fared worst of all groups, while white men were significantly more likely to receive more aggressive interventions. Using Medicare data from 1992–2001 on annual rates of receipt of nine surgical procedures (such as coronary artery bypass surgery and total hip replacement) previously shown to have disparities, the difference between the rates among whites and blacks increased significantly for five of the nine procedures, remained unchanged for three procedures, and narrowed significantly for only one procedure (Fig. e3-5). Overall, there were no meaningful or consistent reductions in the gaps in care between black and white Medicare enrollees. Using data from enrollees in Medicare managed care plans, there is evidence for a narrowing in racial disparities between 1997 and 2003 in several “report card” preventive care measures such as mammography and glucose and cholesterol testing. However, racial disparities in more complex items such as glucose control in diabetics and cholesterol levels in patients after a heart attack had actually worsened.

The second National Healthcare Disparities Report (NHDR), released by the Agency for Healthcare Research and Quality in January 2006, found that in comparison to the previous year, disparities for blacks are improving in some areas, but disparities for Hispanic/Latino populations appear to be widening. For example, for disparities

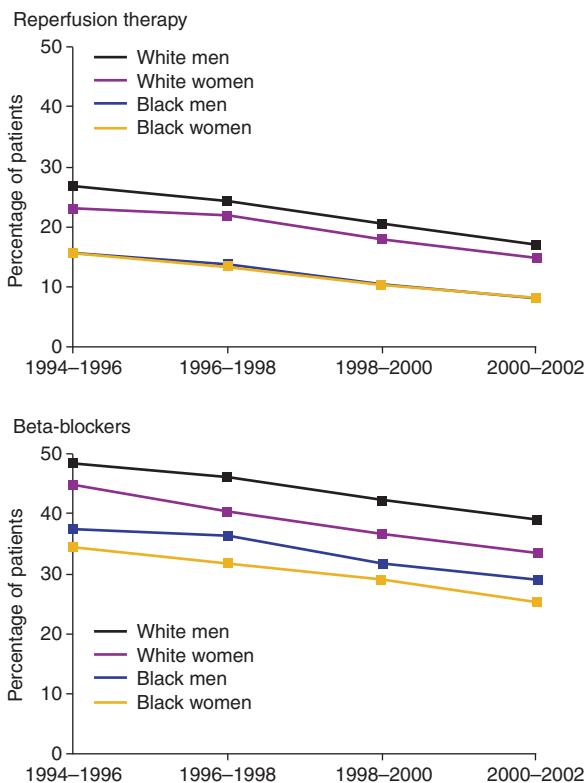


FIGURE e3-4 Sex and racial differences in the management of acute myocardial infarction, 1994–2002. Reference population is 598,911 patients hospitalized with myocardial infarction between 1994 and 2002 who were ideal candidates for particular treatments; data from the National Registry of Myocardial Infarction. (From V Vaccaro et al: *N Engl J Med* 353:671, 2005.)

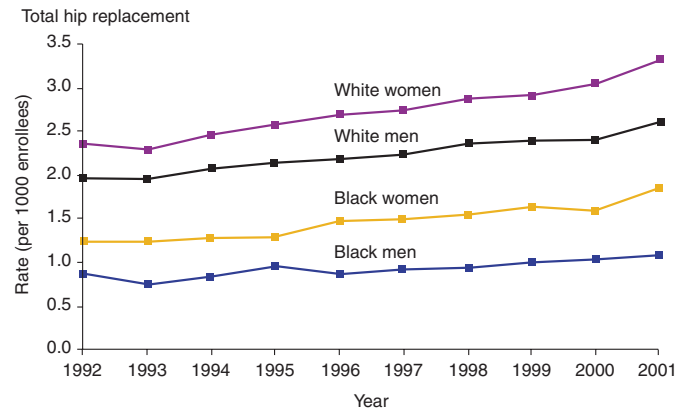


FIGURE e3-5 Racial trends in the use of total hip replacement, 1992–2001. Reference population is men and women enrolled in Medicare from 1992 through 2001. (From AK Jha et al: *N Engl J Med* 353:683, 2005.)

measured between blacks and whites, 58% are narrowing, while 42% are widening. For disparities measures between Hispanics/Latinos and whites, 41% are narrowing while 59% are widening. For both populations, significant disparities persist, yet for Hispanics/Latinos, the situation seems to be getting worse, not better. Ultimately, in none of the measured areas have disparities been eliminated.

ROOT CAUSES FOR RACIAL/ETHNIC DISPARITIES IN HEALTH CARE

The Institute of Medicine (IOM) report *Unequal Treatment*, released in March 2002, remains the preeminent study of the issue of racial and ethnic disparities in health care in the United States. The IOM was charged to assess the extent of racial/ethnic differences in health care that are not otherwise attributable to known factors such as access to care. To provide recommendations regarding interventions to eliminate health care disparities, the IOM studied health system, provider, and patient factors. The report found the following:

- Racial and ethnic disparities in health care exist and, because they are associated with worse health outcomes, are unacceptable.
- Racial and ethnic disparities in health care occur in the context of (1) broader historic and contemporary social and economic inequality and (2) evidence of persistent racial and ethnic discrimination in many sectors of American life.
- Many sources—including health systems, health care providers, patients, and utilization managers—may contribute to racial and ethnic disparities in health care.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care.
- A small number of studies suggest that certain patients may be more likely to refuse treatments, yet these refusal rates are generally small and do not fully explain health care disparities.

Unequal Treatment went on to identify a set of root causes that included the following, among others:

- Health system factors: These include issues related to the complexity of the health care system, the difficulty that minority patients may have in navigating this complex health system, and the lack of availability of interpreter services to assist patients with limited English proficiency.
- Provider-level factors: These include issues related to the health care provider, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication.
- Patient-level factors: These include patient’s refusal of services, poor adherence to treatment, and delay in seeking care.

A more detailed analysis of these root causes is presented here.

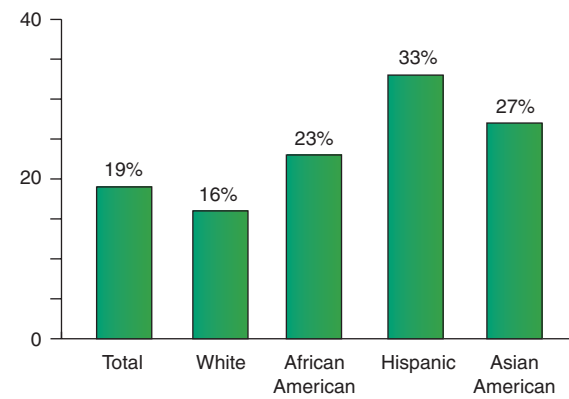
Health System Factors • **HEALTH SYSTEM COMPLEXITY** Even among those who are insured and educated, and who have a high degree of health literacy, navigating the health care system can be complicated and confusing. Some individuals, however, may be at higher risk for receiving substandard care because of their difficulty navigating the complexities of the U.S. health care system. These individuals may include those from cultures unfamiliar with the Western model of health care delivery, those with limited English proficiency, those with low health literacy, and those who are mistrustful of the health care system. People from these backgrounds may have difficulty knowing how and where to go for a referral to a specialist; how to prepare for a procedure, such as a colonoscopy; or how to follow up on an abnormal test, such as a mammogram, for example. Since people of color in the United States tend to be overrepresented among the groups listed above, the inherent complexity of navigating our health care system has been seen as a root cause for racial/ethnic disparities in health care.

Provider-Level Factors • **PROVIDER-PATIENT COMMUNICATION** Significant evidence highlights the impact of sociocultural factors, race, ethnicity, and limited English proficiency on health and clinical care. Health care professionals frequently care for diverse patient populations who present varied perspectives, values, beliefs, and behaviors regarding health and well-being. These include variations in recognition of symptoms, thresholds for seeking care, comprehension of management strategies, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to preventive measures and medications. In addition, sociocultural differences between patient and provider influence communication and clinical decision-making and are especially pertinent given evidence that clearly links provider-patient communication to improved patient satisfaction, adherence, and, subsequently, better health outcomes (Fig. e3-6). Thus, when sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated effectively in the medical encounter, patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care may result.

A survey of 6722 Americans age 18 and older is particularly relevant given the important link between provider-patient communication and health outcomes. Whites, African Americans, Hispanics/Latinos, and Asian Americans who had a medical visit in the last 2 years were asked whether they had trouble understanding their doctor; whether they felt the doctor did not listen; and whether they had medical questions they were afraid to ask. The survey found that 19% of all patients experienced one or more of these problems, yet whites experienced them 16% of the time, compared with 23% of the time for African Americans, 33% for Hispanics/Latinos, and 27% for Asian Americans (Fig. e3-7).

In addition, provider-patient communication without an interpreter, in the setting of even a minimal language barrier, is recognized as a major challenge to effective health care delivery. Spanish-speaking patients discharged from the emergency room are less likely than their English-speaking counterparts to understand their diagnosis, pre-

Percent of adults with one or more communication problems*



Base: Adults with health care visit in past two years
*Problems include understanding doctor, feeling doctor listened, had questions but did not ask.

FIGURE e3-7 Communication difficulties with physicians, by race/ethnicity. Reference population is 6722 Americans age 18 and older who had had a medical visit in the last 2 years and were asked whether they had trouble understanding their doctor, whether they felt the doctor did not listen, and whether they had medical questions they were afraid to ask. (From Commonwealth Fund Health Care Quality Survey, 2001.)

scribed medications, special instructions, and plans for follow-up care; less likely to be satisfied with their care or willing to return if they have a problem; more likely to report problems with their care; and less satisfied with the patient-provider relationship. In addition, physicians who have access to trained interpreters report a significantly higher quality of patient-physician communication than physicians who used other methods. Hispanic patients with language-discordant physicians are more likely to omit medication, miss office appointments, and visit the emergency department for care. Communication issues related to discordant language disproportionately affect minorities and others with limited English proficiency and likely contribute to racial/ethnic disparities in health care.

CLINICAL DECISION-MAKING Theory and research on clinical decision-making suggest that physicians' understanding and interpretations of information obtained from patients, as well as assumptions about patients themselves, may contribute to racial and ethnic disparities in health care. Two factors are central to this process: clinical uncertainty and stereotyping. A doctor's decision-making process is nested in clinical uncertainty—in sum, doctors must depend on inferences about severity based on what they understand about illness, and the information they obtain from the patient. If the doctor is caring for a patient for whom they have difficulty understanding the symptoms and are less sure of the "signal"—the set of clues and indications that physicians rely on to make clinical decisions—their decisions may not be the same for two patients who present with the exact same condition. Given that the expression of symptoms may differ among and between cultural and racial groups, doctors—the overwhelming majority of whom are white—may understand symptoms best from patients of their own racial group. The consequence is that white patients may be treated differently from minority patients. Differences in clinical decisions from this mechanism can arise when the doctor has the same regard for each patient (i.e., no prejudice).

Stereotyping can be defined as the process by which people use social categories (e.g., race, gender) in acquiring, processing, and recalling information about others. The literature on social cognitive theory highlights the ways in which natural tendencies to stereotype may influence clinical decision-making. Faced with enormous information loads and the need to make many decisions, people subconsciously simplify the decision-making process and lessen cognitive effort by us-

How do we link communication to outcomes?



FIGURE e3-6 The link between effective communication, patient satisfaction, adherence, and health outcomes. (From Institute of Medicine: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC, National Academy Press, 2002.)

ing “categories” or “stereotypes” that group information and decisions into groups or types that can be more quickly processed and executed. Sometimes, those stereotypes are applied to individuals who are lumped together into groups to which certain beliefs and expectations are attached. Interestingly, people may not be aware of their attitudes or they may consciously endorse stereotyping. Nevertheless, when people assign someone to a particular class or group, they tend to make a “snap judgment” in which they subconsciously and automatically assign the group’s characteristics to that individual. Although functional, stereotyping can be systematically biased as people are automatically classified into social categories relating to dimensions such as *race*, *gender*, and *age*. These biases may exist in overt forms, as represented by outward racism or bigotry. However, because of their origins in virtually universal social categorization processes, they may also exist, often subconsciously, among people who strongly endorse egalitarian principles and truly believe they are not prejudiced. Moreover, this social categorization enhances perceptions of similarities within groups and differences between groups (particularly with respect to one’s own group), which emphasizes social difference and group distinctiveness. In the process of categorizing people into two different groups, people typically classify themselves into one of the social categories and out of the other. Upon categorization of individuals into in-groups and out-groups, people experience more positive feelings toward the in-group, as well as favor them in terms of evaluation and resource allocation. Although stereotyping may be a normal cognitive process, the cues that lead to particular stereotypes are also strongly influenced by the messages presented consciously and subconsciously in society. For instance, if the media constantly present images of minorities as being less educated, violent, and nonadherent to health care recommendations, these impressions may generate stereotypes that unnaturally and unjustly impact clinical decision-making. Thus, as signs of racism, classism, gender bias, and ageism are experienced—consciously or unconsciously in our society—stereotypes may be created that impact the way doctors manage patients from these groups. In addition, based on training or practice location, doctors may develop certain perceptions about race/ethnicity, culture, and class that may evolve into stereotypes. For example, many medical students and residents are often trained—and minorities cared for—in academic health centers or public hospitals located in socioeconomically disadvantaged areas. As a result, doctors may begin to equate certain races and ethnicities with specific health beliefs and behaviors (e.g., “these patients” engage in risky behaviors, or “those patients” tend to be noncompliant) that are more associated with the social environment (e.g., poverty) than a patient’s racial/ethnic background or cultural traditions. This “conditioning” phenomenon may also occur if doctors are faced with certain racial/ethnic patient groups who don’t frequently choose aggressive forms of diagnostic or therapeutic interventions. The result over time may be that doctors begin to believe that “these patients” don’t like invasive procedures, and thus they may not offer them as options very ardently, if at all.

In addition, doctors are commonly taught that their own personal characteristics (race, ethnicity, socioeconomic status), as well as personal characteristics of the patient and the clinical setting, should be excluded from consideration in the formulation of clinical decisions. Many nonmedical factors, however, ranging from the patient’s physical appearance to the organizational setting in which medical care is delivered, may have as much influence on clinical decisions as the actual signs and symptoms of disease. These nonmedical factors include characteristics of the patient (including patient age, gender, socioeconomic status, race/ethnicity, language proficiency, and insurance status), characteristics of the doctor (including the specialty, level of training, clinical experience, age, gender, and race/ethnicity), and features of the practice setting (including location, organization of practice, form of compensation, performance expectations, and incentives). This may furthermore contribute to unconscious stereotyping.

It is important to differentiate stereotyping from prejudice and discrimination, both conscious processes. Prejudice is a conscious, knowledgeable prejudgment of individuals that may lead to disparate

treatment, and discrimination is conscious and intentional disparate treatment. All individuals stereotype subconsciously, despite the best intentions to treat every patient equitably. The challenge is that if left unchecked, stereotyping (especially based on stereotypes derived abnormally from conscious and subconscious societal cues, such as those related to race) may lead to lower quality of care for certain groups—such as minorities—who may be deemed less worthy of diagnostic or therapeutic procedures or resources. What is particularly salient is that stereotypes tend to be activated most in environments where the individual is stressed, multitasking, and under the time pressure—the hallmarks of the clinical encounter.

Patient-Level Factors • MISTRUST Lack of trust has become a major concern for many health care institutions today. For example, an Institute of Medicine Report, *To Err Is Human: Building a Safer Health System*, documented alarming rates of medical errors and made patients feel vulnerable and less trustful of the U.S. health care system. The increased media and academic attention to problems of quality of care (and even disparities themselves) have clearly diminished trust in doctors and nurses.

Trust is a crucial element in the therapeutic alliance between patient and health care provider. It facilitates open communication and is directly correlated with adherence to physician recommendations and patient satisfaction. Patients who mistrust their health care providers are less satisfied with the care they receive, and mistrust of the health care system greatly affects patients’ use of services. This lack of confidence in physicians also results in inconsistent care, doctor-shopping, self-medicating, and an increased demand for referrals and diagnostic tests by patients.

Based on historic factors of discrimination, segregation, and medical experimentation, African Americans may be especially mistrustful of providers. The exploitation of African Americans by the U.S. Public Health Service during the Tuskegee study left a legacy of mistrust that persists even today among this population. A national survey by the Kaiser Family Foundation found that there is significant mistrust of the health care system among minority populations. Of the 3884 individuals surveyed, 36% of Hispanics and 35% of African Americans (compared with 15% of whites) felt they were treated unfairly in the health care system in the past based on their race and ethnicity. Perhaps even more alarming, 65% of African Americans and 58% of Hispanics (compared with 22% of whites) were afraid of being treated unfairly in the future based on their race/ethnicity (Fig. e3-8).

This mistrust may contribute to wariness in accepting or following recommendations, undergoing invasive procedures, or participating in clinical research. This in turn may lead doctors to misunderstand

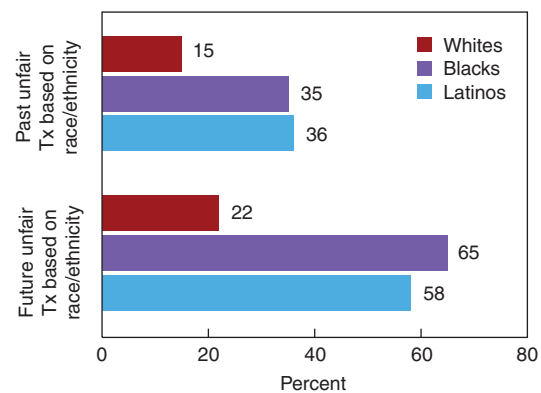


FIGURE e3-8 Patient perspectives regarding how fairly they have been treated in the health care system, by race/ethnicity. Reference population is 3884 individuals surveyed about how fairly they have been treated in the health care system in the past, and how fairly they feel they will be treated in the future based on their race/ethnicity. (From *Race, Ethnicity & Medical Care: A Survey of Public Perceptions and Experiences*. Kaiser Family Foundation, 2005.)

why African-American populations seem less adherent to or less interested in aggressive treatments.

KEY RECOMMENDATIONS TO ADDRESS RACIAL/ETHNIC DISPARITIES IN HEALTH CARE

The publication *Unequal Treatment* provides a series of recommendations to address racial and ethnic disparities in health care, focusing on a broad set of stakeholders. These include *health systems interventions*, *provider interventions*, and *patient interventions*, as well as *general recommendations*. These recommendations are described in more detail below.

Health System Interventions

1. *Collect and report health care access and utilization data by patient's race/ethnicity*

Unequal Treatment found that the appropriate systems to track and monitor racial and ethnic disparities in health care are lacking, and there is less known about the disparities for minority groups (Hispanics, Asian Americans, Pacific Islanders, Native Americans, and Alaska Natives) other than African Americans. For instance, only in the mid-1980s did the Medicare database begin to collect data on patient groups outside the standard categories of “white,” “black,” and “other.” Federal, private, and state-supported data collection efforts are scattered and unsystematic, and many health care systems and hospitals, with a few notable exceptions, do not collect data on the race, ethnicity, or primary language of patients or enrollees. A Robert Wood Johnson Foundation survey found that 51% of health plans either ask members to provide their race voluntarily on enrollment and other forms, or use indirect methods to obtain aggregate data on race. Any effort to identify and address disparities must begin with the collection of race/ethnicity data and the stratification of quality measures by these groupings.

2. *Encourage the use of evidence-based guidelines and quality improvement*
Unequal Treatment highlights the subjectivity of clinical decision-making as a potential cause of racial and ethnic disparities in health care by describing how clinicians may offer different diagnostic and treatment options to different patients (consciously and unconsciously) based on their race or ethnicity, even in the presence of well-delineated practice guidelines. Therefore, the adoption and implementation of evidence-based guidelines broadly is a major recommendation to eliminate disparities. For instance, there now exist evidence-based guidelines for the management of diabetes, HIV/AIDS, cardiovascular diseases, cancer screening and management, and asthma—all areas where significant disparities exist. As part of ongoing quality improvement efforts, particular attention should be paid to the implementation of evidence-based guidelines for all patients, regardless of their race and ethnicity.

3. *Support the use of language interpretation services in the clinical setting*
As described previously, health care systems that lack interpreter services can lead to patient dissatisfaction, poor comprehension and compliance, and ineffective/lower-quality care for patients with limited English proficiency. *Unequal Treatment's* recommendation to support the use of interpretation services has clear implications for delivery of quality health care by improving doctors' ability to communicate effectively with patients with limited English proficiency.

4. *Increase the proportion of underrepresented minorities in the health care workforce*

Recent data from the American Medical Association indicate that of the 70.5% of U.S. physicians whose race and ethnicity is known, Hispanics make up 3.5%, African Americans 2.6%, and American Indian and Alaska Natives less than 0.5% percent. Data regarding the racial/ethnic composition of medical school faculty are no different, with minorities composing only 4.2% nationally. It should further be noted that approximately 20% of these faculty teach at the four historically black medical schools and the three Liaison Committee on Medical Education (LCME)-accredited medical schools in Puerto Rico. Despite composing 30% of the population, minority students accounted for approximately 10% of medical school graduates in 2001. It will be difficult to develop a diverse health care workforce that can meet the needs of an increasingly diverse population without dramatic change in the racial and ethnic composition of medical student bodies.

Provider Interventions

Integrate Cross-Cultural Education into the Training of All Health Care Professionals

The goal of cross-cultural education is to improve providers' ability to understand, communicate with, and care for patients from diverse backgrounds; such education focuses on enhancing awareness of sociocultural influences on health beliefs and behaviors, and on providing skills to understand and manage these factors in the medical encounter. Cross-cultural education includes curricula on health care disparities, how to use an interpreter, and how to effectively communicate and negotiate across cultures. These curricula can be incorporated into health professions training in medical schools and nursing schools, and as part of continuing education. Despite the importance of this area of education, as well as the attention it has attracted from medical education accreditation bodies, a national survey of resident physicians by Weissman and colleagues found that more than one in five felt unprepared to deal with cross-cultural issues, including caring for patients who have religious beliefs that may affect treatment, patients who use complementary medicine, patients with health beliefs at odds with Western medicine, patients with mistrust of the health care system, and new immigrants. Efforts to incorporate cross-cultural education into undergraduate and graduate medical education will contribute to improving doctor-patient communication and to better quality of care.

Incorporate Teaching on the Impact of Race, Ethnicity, and Culture on Clinical Decision-Making

Unequal Treatment found that stereotyping by health care providers might lead to disparate treatment based on a patient's race or ethnicity. The LCME—the body that accredits medical schools—now has a directive that medical education should teach how a patient's race, ethnicity, and culture might subconsciously impact on communication and clinical decision-making.

Patient Interventions

Educate Patients on How to Navigate the Health Care System and How to Be More Active in the Medical Encounter

Difficulty navigating the health care system and obtaining access to care can be a hindrance to all populations, particularly to minorities. Similarly, lack of empowerment or involvement in the medical encounter by minorities can be a barrier to care as well. Interventions should be used to increase patients' knowledge of how to best access care and participate in treatment decisions.

General Recommendations

Increase Awareness of Racial/Ethnic Disparities in Health Care

Recent surveys have shown that both physicians and the public tend to be unaware of the extent and severity of racial and ethnic disparities in health care in the United States. For example, a Kaiser Family Foundation survey of 2608 physicians whose primary activity is patient care found that the majority of respondents (mainly white) said that the health care system “never” (14%) or “rarely” (55%) treats people differently based on race/ethnicity. In 2003, shortly after the release of *Unequal Treatment*, a national survey was conducted in which individuals were asked “Do all Americans receive the same quality of health care?” Most thought so, and the majority of physicians felt patients were treated equally regardless of their race or ethnicity. These beliefs were held despite a large body of published research to the contrary. A poll in 2005 showed that the majority of Americans were actually unaware that racial and ethnic minorities receive poorer care than whites, with the lack of awareness being greatest among whites. Despite this lack of awareness, most believed that all Americans deserve quality care, regardless of their background. Increasing awareness of racial and ethnic disparities among health care professionals and the public is an important first step in addressing disparities in health care. The ultimate goal is to generate discourse and mobilize action to address disparities in multiple areas, including at the level of health policy, health systems, and the community.

Conduct Further Research to Identify Sources of Disparities and Promising Interventions

While the literature that formed the basis of the findings and recommendations of *Unequal Treatment* provided significant evidence for racial and ethnic disparities, additional research is needed

in several areas. First, most of the literature on disparities focuses on black-versus-white differences; much less is known about the experiences of other minority groups. Improving the ability to collect racial and ethnic patient data should facilitate this process, but in instances where those systems are not yet in place, racial and ethnic patient data may be collected prospectively in the setting of clinical or health services research to better understand disparities for other populations. Second, much of the literature on disparities to date has focused on defining areas where they exist, but much less has been done to identify the multiple factors that contribute to disparities, and very little has been done to test interventions to address them. There is clearly a need for a research agenda that identifies promising practices and solutions to disparities.

IMPLICATIONS FOR CLINICAL PRACTICE

Individual health care providers can do several things in the clinical encounter to address racial and ethnic disparities in health care. These approaches are discussed here.

Be Aware That Disparities Exist Increasing awareness of racial and ethnic disparities among health care professionals is an important first step in addressing disparities in health care. Only then can they be attuned to monitoring their behavior and clinical practice so as to ensure that all patients receive the highest quality of care, regardless of their race, ethnicity, or culture.

Practice Culturally Competent Care Many have thought of “cultural competence” as simply the skills necessary for addressing language barriers in the clinical encounter, or learning as much as you can about patients from specific cultures. While the former is important and remains a key component of cultural competence, the latter is an area in evolution. Previous efforts in cultural competence have aimed to teach clinicians about the attitudes, values, beliefs, and behaviors of certain cultural groups—the key practice “do’s and don’ts” for caring for “the Hispanic patient,” for example. In certain situations, learning about a particular local community or cultural group can be helpful (following the principles of community-oriented primary care), but, when broadly and uncritically applied, this approach can also lead to stereotyping and oversimplification of culture without respect for its complexity.

Cultural competence has thus evolved from learning information and making assumptions about patients based on their background to focusing on the development of skills that follow the principles of patient-centered care. Patient-centeredness encompasses the qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient. Cultural competence aims to take this a step further, by expanding the repertoire of knowledge and skills classically defined as patient-centered to include those that are especially useful in cross-cultural interactions (but remain vital to all clinical encounters). This includes eliciting the patient’s understanding of his or her condition, identifying and negotiating different styles of communication, assessing decision-making preferences and the role of family, determining the patient’s perception of biomedicine and complementary and alternative medicine, recognizing sexual and gender issues, and being aware of mistrust, prejudice, and racism, among others. For example, while it is important to understand all patients’ health beliefs, it may be particularly crucial to understand the health beliefs of those who come from a different culture or have a different health care experience. With the individual patient as teacher, one can adjust their practice style accordingly to meet their specific needs.

Avoid Stereotyping Several strategies can allow us to counteract, both systemically and individually, our normal tendency to stereotype. For example, when racially/ethnically/culturally/socially diverse teams are assembled (in which each member is given equal power) and are tasked to achieve a common goal, a sense of camaraderie develops and prevents the future development of stereotypes based on

race/ethnicity, gender, culture, or class. Thus, we should aim to gain experiences working with, and learning from, a diverse set of colleagues. In addition, simply being aware of the operation of social cognitive factors allows one to actively “check” or “monitor” behavior. For instance, physicians can constantly ensure that they are offering the same things, in the same ways, to all patients. Understanding how we are susceptible to stereotyping—and how this may lead to disparities—is essential if we are to provide equitable, high-quality care to all patients.

Work to Build Trust Patient mistrust of the health care system and health care providers impacts multiple facets of the medical encounter, from decreased patient satisfaction to the delay of care. Although the historic legacy of discrimination can never be erased, several steps can be taken to build trust with patients and address disparities. First, providers must be aware that mistrust exists and may be more prevalent among minority populations given this nation’s history. Second, providers must reassure patients that they come first, and that we will do everything in our power to ensure that they always get the best care possible, and that we will serve as their advocates. Third, interpersonal skills and communication techniques that demonstrate honesty, openness, compassion, and respect on the part of the health care provider are essential tools in dismantling mistrust. Finally, patients indicate that trust is built when there is shared, participatory decision-making and the provider makes a concerted effort to understand the patient’s background. By reframing the doctor-patient relationship as one of solidarity, the patient’s sense of vulnerability can be transformed into one of trust. For the process of eliminating disparities to be successful, we must utilize trust-building interventions and strengthen the doctor-patient relationship.

New Areas for Exploration • **DISPARITIES AND QUALITY IMPROVEMENT** A major advance is that key health care stakeholders have begun to understand that disparities are an inequality in quality. Health plans and hospitals, for example, have begun to consider the importance of stratifying their quality data by race/ethnicity so as to identify disparities and develop interventions to address them. The emergence of targeting disparities through quality improvement has gained significant traction nationally, especially given the fact that the IOM report *Crossing the Quality Chasm* highlighted among its six pillars of quality the concept of equity—the principle that health outcomes should not vary based on personal characteristics such as race, ethnicity, and gender. There is no doubt that the quality approach to address disparities has great promise.

GEOGRAPHIC VARIATIONS IN CARE Where a patient lives can itself have a large impact on the level and quality of health care. Since black or Hispanic populations tend to live in different areas from non-Hispanic white populations, location likely matters in the measurement and interpretation of health (and health care) disparities. There is preliminary evidence to suggest wide variation in racial disparities across geographic lines: some areas have substantial disparities, while others have equal treatment. The problem of differences in quality of care across regions remains an important area of study and should remain a target of policy makers, as reducing quality disparities would play a major role in improving the health care received by all Americans and by minority Americans in particular.

CONCLUSION

The issue of racial and ethnic disparities in health care has gained national prominence, both with the release of the IOM report *Unequal Treatment* and with the many recent articles that have confirmed their persistence. Furthermore, another influential IOM report, *Crossing the Quality Chasm*, highlights the importance of equity—that there be no variations in quality of care by personal characteristics including race and ethnicity—as a central principle of quality. There are many obvious opportunities for interventions to eliminate racial and ethnic disparities in health care. Greater attention to addressing the root causes

of disparities will improve the care provided to all patients, not just those who are racial and ethnic minorities.

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