CHAPTER e4

Racial and Ethnic Disparities in Health Care

Joseph R. Betancourt
Alexander R. Green

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/Alaskan 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 less care and lower quality care than whites, even when confounders such as stage of presentation, comorbidities, and health insurance are controlled. 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 clinical and health system levels.

■ 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. e4-1). 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, 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 black 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, and are more likely to delay seeking care and go without needed care—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. e4-2) and congestive heart failure (blacks receiving less optimal care than whites when hospitalized for these conditions) and referral to renal transplantation (blacks with end-stage renal disease being referred less often to the transplant list than whites) (Fig. e4-3). Disparities have also been found in the utilization of cardiac diagnostic and therapeutic procedures (blacks being referred less often than whites for cardiac catheterization and bypass grafting), prescription of analgesia for pain control (blacks and Latinos receiving less pain medication than whites for long bone fractures and cancer), and surgical treatment of lung cancer (blacks receiving 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 evidence of continued disparities
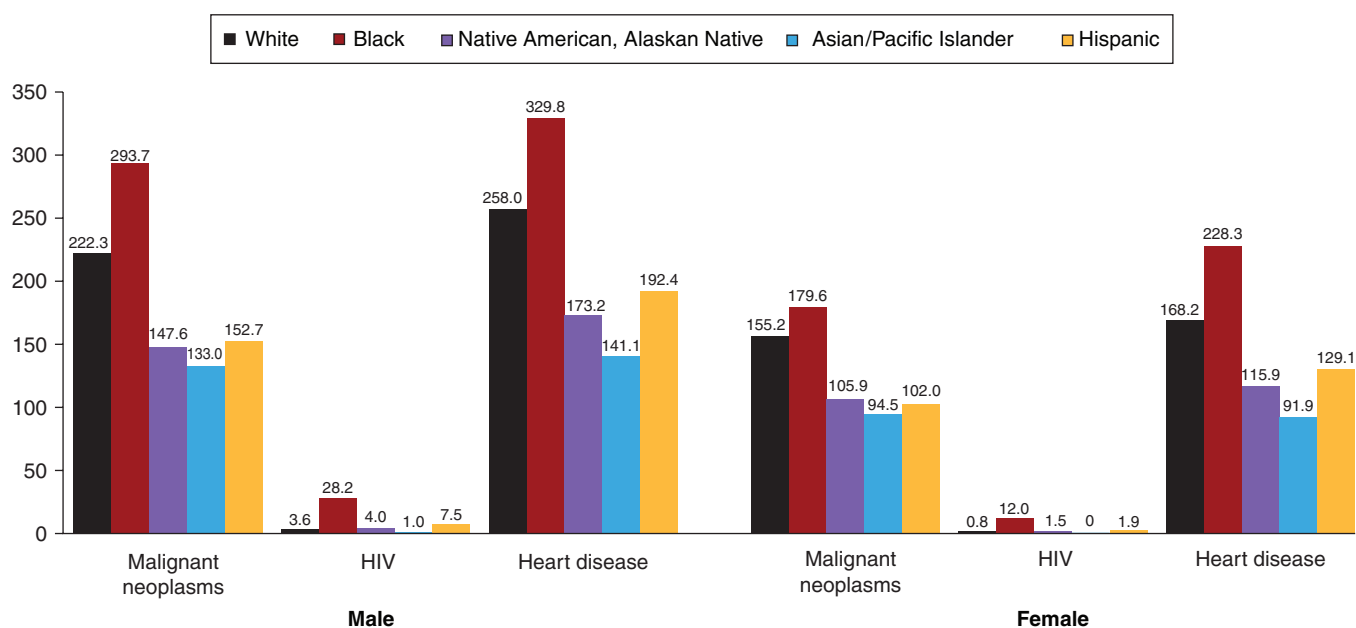

Figure e4-1 Age-adjusted death rates for selected causes by race and Hispanic origin, 2005. *(From U.S. Census Bureau, 2009.)*
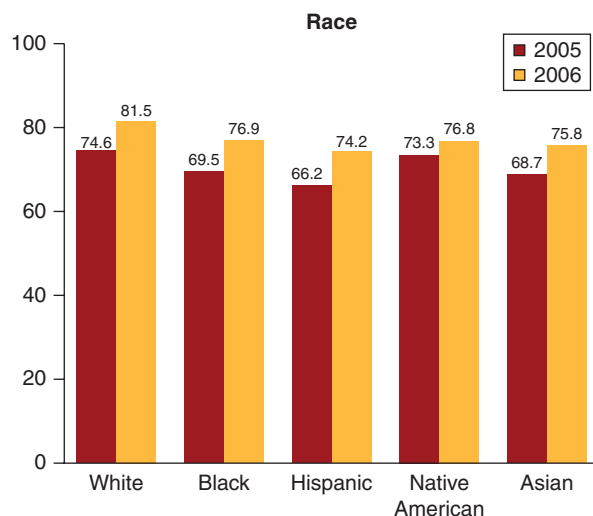
Figure e4-2 **Recommended hospital care received by Medicare patients with pneumonia, by race/ethnicity, 2006.** Reference population is Medicare beneficiaries with pneumonia who are hospitalized. Composite is calculated by averaging the percentage of the population that received each of the five incorporated components of care. *(Adapted from Agency for Health Care Research and Quality: The 2008 National Health Care Disparities Report.)*

in guideline-based admission, procedural, and discharge therapy use from 1994 to 2006. Compared to whites, black patients were less likely to receive percutaneous coronary intervention/coronary artery bypass grafting (PCI/CABG), a disparity that has shown little improvement since 1994. Further, compared to whites, black patients were less likely to receive lipid-lowering medications at discharge, with a gap that has widened since 1998 (Fig. e4-4). The Centers for Disease Control and Prevention (CDC) analyzed national and state rates of total knee replacement (TKR) for Medicare enrollees for the period 2000 to 2006, stratified by sex, age group, and black or white race. TKR rates overall in the United States increased 58%, with similar increases among whites (61%) and blacks (56%). However, the TKR rate for blacks was 37% lower than the rate for whites in 2000 and 39% lower in 2006—no improvement and even a slight worsening of the disparity (Fig. e4-5). Using data from enrollees
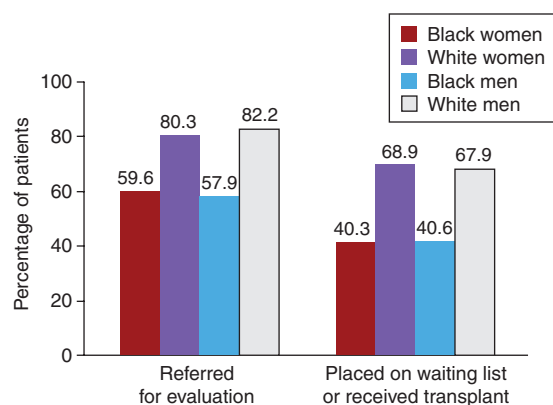

Figure e4-3 **Referral for evaluation at a transplantation center or placement** on a waiting list or receipt of a renal transplantation within 18 months after the start of dialysis among patients who wanted a transplant, according to race and sex. Reference population is 239 black women, 280 white women, 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.)*

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 sixth National Healthcare Disparities Report (NHDR), released by the Agency for Healthcare Research and Quality in January 2008, found that disparities in core measures of quality have improved little between 2001 and 2006. The report shows that for blacks, Asians, Native Americans/Alaskan Natives, Hispanics, and poor people, 60–80% of core quality measures, including measures of effectiveness, patient safety, and timeliness of care either stayed the same or worsened. While a smaller number of these measures have improved, 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. In addition, health care systems are generally ill-prepared to identify and address disparities.
- 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

Beta blocker within 24 hours

1994–1996
0.92 (0.90, 0.95)

1997–1999
0.98 (0.96, 1.0)

2000–2002
1.0 (0.9, 1.0)

2003–2006
1.1 (1.0, 1.1)

Whites more
likely to receive

Blacks more
likely to receive

0.75   1   1.25

PCI/CABG

1994–1996
0.53 (0.51, 0.54)

1997–1999
0.52 (0.50, 0.53)

2000–2002
0.55 (0.53, 0.56)

2003–2006
0.54 (0.52, 0.56)

Whites more
likely to receive

Blacks more
likely
to receive

0.25   0.5   0.75   1   1.25

Discharge lipid-lowering egent

1998–1999
0.92 (0.89, 0.96)

2000–2002
0.84 (0.82, 0.86)

2003–2006
0.76 (0.75, 0.81)

Whites more
likely to receive

Blacks more
likely
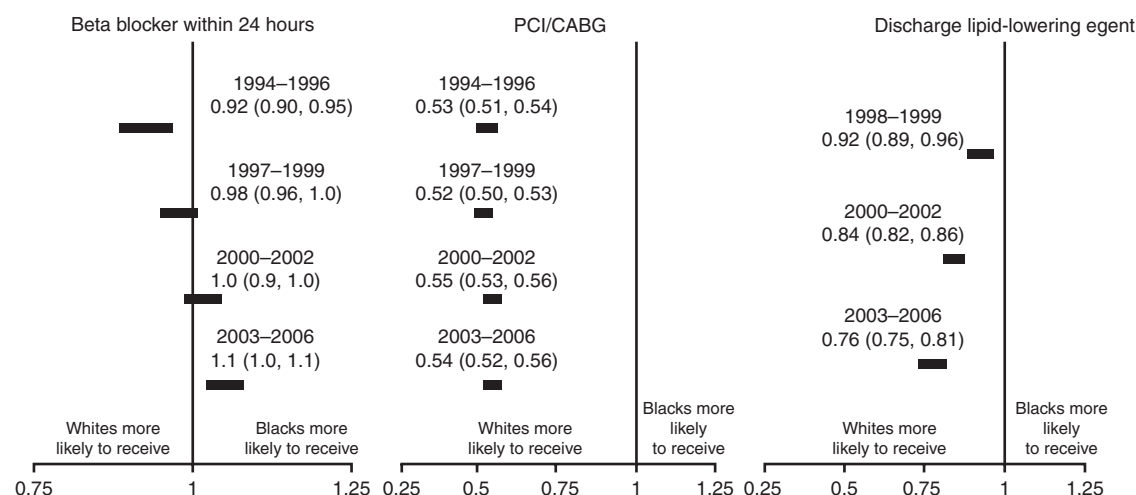to receive

0.25   0.5   0.75   1   1.25

Figure e4-4   Racial differences in guideline-based treatments for acute myocardial infarction (AMI). Reference population is 2,515,106 patients with AMI admitted to U.S. hospitals between July 1990 and December 2006. CABG, coronary artery bypass grafting; PCI, percutaneous coronary intervention. *(From ED Peterson et al: Am Heart J 156:1045, 2008.)*

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. These individuals 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 result 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.

Other health system factors   Racial/ethnic disparities are due not only to differences in care provided within hospitals, but also result from where and from whom minorities receive their care (i.e., specific providers, geographic regions, or hospitals that are lower-performing on certain aspects of quality).

For example, one study showed that 25% of hospitals cared for 90% of black Medicare patients in the United States and these hospitals tended to have lower performance scores on certain quality measures than other hospitals. This being said, health systems are generally not well prepared to measure, report, and intervene to reduce disparities in care. Few hospitals or health plans stratify their quality data by race/ethnicity or language to measure disparities, and even fewer use data of this type to develop disparities-targeted interventions.

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. e4-6). Thus, when sociocultural differences between patient and provider are not appreciated, explored, understood, or communicated effectively in the medical encounter, patient dissatisfaction,
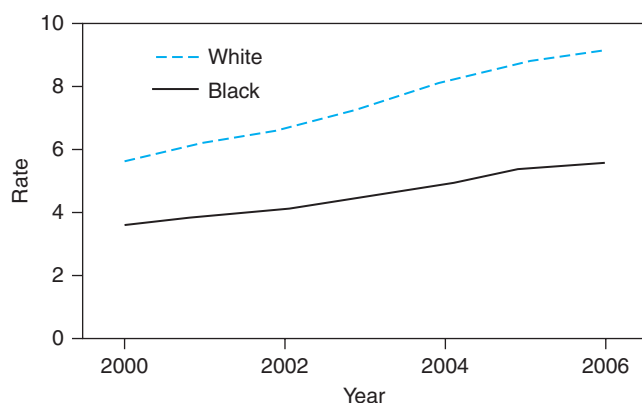
Rate

10

8

6

4

2

0

White
Black

2000   2002   2004   2006

Year

Figure e4-5   Racial trends in age-adjusted total knee replacement in Medicaid enrollees from 2000 to 2006. Reference population are Medicaid part A enrollees who are aged 65 or older and are not members of a managed care plan. *(From Centers for Disease Control and Prevention, 2009.)*
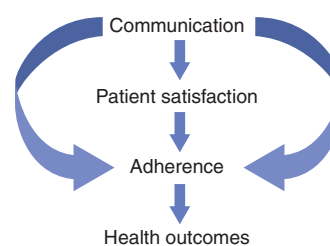
How do we link communication to outcomes?

Communication

Patient satisfaction

Adherence

Health outcomes

Figure e4-6   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.)*

Percent of adults with one or more communication problems*
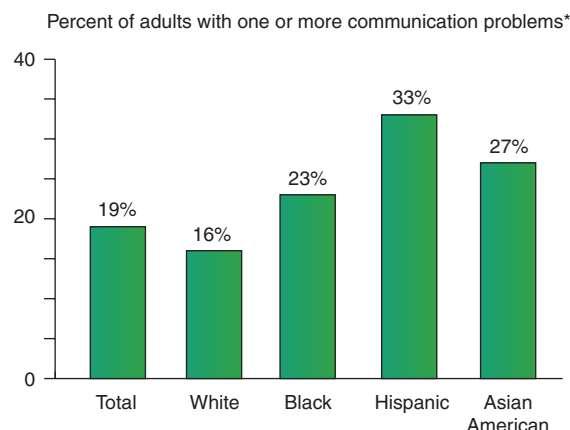
Base: Adults with health care visit in past 2 years
*Problems include understanding doctor, feeling doctor listened,
had questions but did not ask.

Figure e4-7 Communication difficulties with physicians, by race/ethnicity. Reference population is 6722 Americans age 18 and older who had a medical visit in the last 2 years and were asked whether they had trouble understanding their doctors, whether they felt the doctors did not listen, and whether they had medical questions they were afraid to ask. *(From Commonwealth Fund Health Care Quality Survey, 2001.)*

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, blacks, Hispanics/Latinos, and Asian Americans who had a medical visit in the past 2 years were asked whether they had trouble understanding their doctors; whether they felt the doctors 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 blacks, 33% for Hispanics/Latinos, and 27% for Asian Americans (Fig. e4-7).

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, prescribed 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 suggest that variations in clinical decision making may contribute to racial and ethnic disparities in health care. Two factors are central to this process: clinical uncertainty and stereotyping.

First, a doctor's decision-making process is nested in *clinical uncertainty*. Doctors depend on inferences about severity based on what they understand about illness and the information obtained from the patient. If the doctor is caring for a patient for whom he or she has difficulty understanding the symptoms and is less sure of the "signal"—the set of clues and indications that physicians rely on to make clinical decisions—the decision may be different than for another patient who presents with the exact same clinical 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/ethnic groups. The consequence is that white patients may be treated differently from minority patients. Differences in clinical decisions from this mechanism can arise even when the doctor has the same regard for each patient (i.e., no prejudice).

Second, the literature on social cognitive theory highlights how natural tendencies to stereotype may influence clinical decision making. *Stereotyping* can be defined as the process by which people use social categories (e.g., race, gender, age) in acquiring, processing, and recalling information about others. Faced with enormous information loads and the need to make many decisions, people frequently subconsciously simplify the decision-making process and lessen cognitive effort by using "categories" or "stereotypes" that bundle information into groups or types that can be more quickly processed. Although functional, stereotyping can be systematically biased as people are automatically classified into social categories relating to dimensions such as *race*, *gender*, and *age*. Interestingly, people may not be aware of their attitudes, may not consciously endorse specific stereotypes, and paradoxically may consider themselves egalitarian and not prejudiced.

Stereotypes may be strongly influenced by the messages presented consciously and subconsciously in society. For instance, if the media and our social/professional contacts tend to present images of minorities as being less educated, violent, and non-adherent 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. 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. A wide range of studies have documented the potential for provider biases to contribute to racial/ethnic disparities in health care. For example, one study measured physicians' unconscious (or implicit) biases and showed that these were related to differences in decisions to provide thrombolysis for a hypothetical black or white patient with a myocardial infarction. (See Green in "Further Readings.")

To further compound this issue, doctors are commonly taught that their own personal characteristics (race, ethnicity, socioeconomic status), the personal characteristics of the patient, and the clinical setting, should be excluded in the formulation of clinical decisions. Many nonmedical factors, however, ranging from

the patient's physical appearance and background (race/ethnicity, gender, age, socioeconomic status, insurance status) to the doctor's background (specialty, level of training, clinical experience, age, gender, race/ethnicity) to the organizational setting in which medical care is delivered (location, form of compensation, performance expectations, incentives), may have as much influence on clinical decisions as the actual signs and symptoms of disease.

It is important to differentiate stereotyping from prejudice and discrimination. Prejudice is a conscious prejudgment of individuals that may lead to disparate treatment, and discrimination is conscious and intentional disparate treatment. All individuals stereotype subconsciously, yet if left unchecked, this 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. It can also result 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, Black may be especially mistrustful of providers. The exploitation of blacks by the U.S. Public Health Service during the Tuskegee syphilis study from 1932 to 1972 left a legacy of mistrust that persists even today among this population. Other populations including Native Americans/Alaskan Natives, Hispanics/Latinos, and Asian Americans also harbor significant mistrust of the health care system. A national Kaiser Family Foundation survey of 3884 individuals found that 36% of Hispanics and 35% of black (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 blacks and 58% of Hispanics (compared with 22% of whites) were afraid of being treated unfairly in the future based on their race/ethnicity (Fig. e4-8).

This mistrust may contribute to wariness in accepting or following recommendations, undergoing invasive procedures, or participating in clinical research, which may lead to misunderstanding and stereotypes by health professionals.

■ 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*, *patient interventions*, and *general recommendations*, described in more detail below.
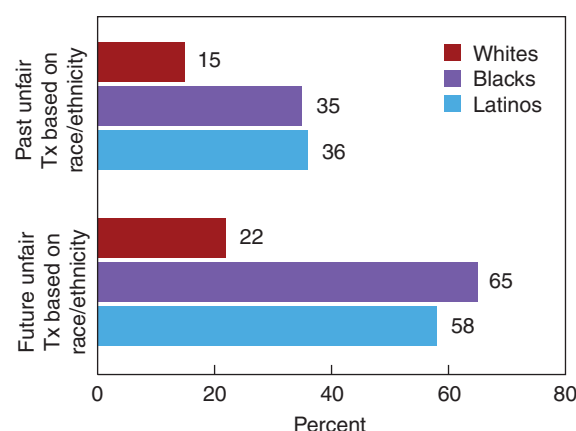

Figure e4-8 **Patient perspectives regarding unfair treatment, based on race/ethnicity.** Reference population is 3884 individuals surveyed about how fairly they have been treated in the health care system in the past, and how fairly they feel they will be treated in the future based on their race/ethnicity. *(From Race, Ethnicity & Medical Care: A Survey of Public Perceptions and Experiences. Kaiser Family Foundation, 2005.)*

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 Alaskan 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 still do not collect data on the race, ethnicity, or primary language of patients or enrollees. A survey of 501 U.S. hospitals by Regenstein and Sickler in 2006 found that 78% collected race information, 50% collected data on patient ethnicity, and 50% collected data on primary language. However, the information was not collected using standard categories or collection methods, so it is difficult to assess the accuracy of the data. Surveys by America's Health Insurance Plans (AHIP) in 2003 and 2006 showed the number of enrollees who were in plans that collected race/ethnicity data of some type increased from 54 to 67%.

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, despite the existence 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 efficient and effective interpreter services can lead to patient dissatisfaction, poor comprehension and adherence, 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*

Data from the Association of American Medical Colleges (AAMC) indicate that in 2004, of the 72.4% of U.S. physicians whose race and ethnicity is known, Hispanics make up 2.8%, blacks 3.3%, and Native American and Alaskan Natives 0.3%. Data regarding the racial/ethnic composition of medical school faculty are no different, with minorities, excluding Asians, composing 7.5% nationally. Additionally, minority faculty in 2007 were more likely to be at or below the rank of assistant professor, while whites composed the highest proportion of full professors. Despite representing about 26% of the U.S. population (a number projected to almost double by 2050), minority students are still underrepresented in medical schools. In 2007, matriculants to U.S. medical school were 7.2% Latino, 6.4% African American, 0.2% Native Hawaiian or Other Pacific Islander, and 0.3% Native American or Alaskann Native. These numbers have decreased or maintained the same since 2006. 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 building 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, residency programs, 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 senior resident physicians by Weissman and colleagues found that up to 28% 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 medical education will contribute to improving communication and to better quality of care for all patients.

Incorporate Teaching on the Impact of Race, Ethnicity, and Culture on Clinical Decision-Making   *Unequal Treatment* and more recent studies found that stereotyping by health care providers can lead to disparate treatment based on a patient's race or ethnicity. The Liaison Committee on Medical Education (LCME), which accredits medical schools, now has a directive that medical education should teach how a patient's race, ethnicity, and culture might unconsciously impact 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   Efforts to raise awareness of racial/ethnic health care disparities have done little for the general public but have been fairly successful among physicians according to a Kaiser Family Foundation report. In 2006, nearly 6 in 10 people surveyed believed blacks received the same quality of care as whites, and 5 in 10 believed Latinos received the same quality care as whites. These estimates are similar to findings in a 1999 survey. Despite this lack of awareness, most believed that all Americans deserve quality care, regardless of their background. In contrast, the level of awareness among physicians has risen sharply. In 2002, the majority (69%) of physicians said that the health care system "rarely or never" treated people unfairly based on an individual's racial/ethnic background. In 2005, less than a quarter (24%) of physicians disagreed with the statement "minority patients generally receive lower quality care than white patients." 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 less has been done to identify the multiple factors that contribute to disparities, or to test interventions to address them. There is clearly a need for research 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

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," or the "Asian 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 effectively using interpreter services, eliciting the patient's understanding of his or her condition, assessing decision-making preferences and the role of family, determining the patient's views about biomedicine versus complementary and alternative medicine, recognizing sexual and gender issues, and building trust. 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 his or her practice style accordingly to meet the patient's 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 is more prevalent among minority populations given the history of discrimination in the United States and other countries. Second, providers must reassure patients that they come first, 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.

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 more recent articles that have confirmed their persistence and explored their root causes. 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.

FURTHER READINGS

Agency for Health Care Research and Quality: *The 2008 National Health Care Disparities Report*. Rockville, MD, Agency for Health Care Research and Quality, 2009

America's Health Insurance Plans (AHIP): Collection and Use of Race and Ethnicity Data for Quality Improvement. AHIP-RWJF Survey of Health Insurance Plans, 2006

Andrulis DP: Access to care is the centerpiece in the elimination of socioeconomic disparities in health. Ann Intern Med 129:412, 1998

Association of American Medical Colleges (AAMC): Diversity in the Physician Workforce: Facts & Figures 2006, 2006

———: Diversity in Medical Education: Facts and Figures 2008, 2008

Ayanian JZ et al: Quality of care by race and gender for congestive heart failure and pneumonia. Med Care 37:1260, 1999

———: The effect of patients' preferences on racial differences in access to renal transplantation. N Engl J Med 341:1661, 1999

Baicker K et al: Who you are and where you live: How race and geography affect the treatment of medicare beneficiaries. Health Aff (Millwood) Suppl Web Exclusive: VAR 33, 2004

Berger JT: Culture and ethnicity in clinical care. Arch Intern Med 158:2085, 1998

Betancourt JR: Cultural competence—Marginal or mainstream movement? N Engl J Med 351:953, 2004

——— et al: Hypertension in multicultural and minority populations: Linking communication to compliance. Curr Hypertens Rep 1:482, 1999

Carrasquillo O et al: Impact of language barriers on patient satisfaction in an emergency department. J Gen Intern Med 14:82, 1999

Carrillo JE et al: Cross-cultural primary care: A patient-based approach. Ann Intern Med 130:829, 1999

Centers for Disease Control and Prevention (CDC): Racial disparities in total knee replacement among Medicare enrollees—United States, 2000–2006. MMWR Morb Mortal Wkly Rep 20:133, 2009

Flores G et al: The health of Latino children: Urgent priorities, unanswered questions, and a research agenda. J Am Med Assoc 288:82, 2002

Gamble V: Under the shadow of Tuskegee: African Americans and health care. Am J Public Health 87:1773, 1997

Green AR et al: Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med 22:1231, 2007

Institute of Medicine: *Health Literacy: A Prescription to End Confusion*. Washington, DC, National Academy Press, 2004

———: *To Err Is Human: Building a Safer Health System*. Washington, DC, National Academy Press, 2000

———: *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC, National Academy Press, 2001

———: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC, National Academy Press, 2002

———: *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. Washington, DC, National Academy Press, 2004

Jha AK et al: Concentration and quality of hospitals that care for elderly black patients. Arch Intern Med 167:1177, 2007

Kaiser Family Foundation: Race Ethnicity & Medical Care: Survey of Public Perceptions and Expectations, 1999

———: National Survey of Physicians, Part 1: Doctors on Disparities in Medical Care, 2002

Perez-Stable EJ et al: The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. Med Care 35:1212, 1997

Peterson ED et al: Trends in quality of care for patients with acute myocardial infarction in the National Registry of Myocardial Infarction from 1990 to 2006. Am Heart J 156:1045, 2008

Rathore SS et al: The effects of patient sex and race on medical students' ratings of quality of life. Am J Med 108:561, 2000

Regenstein M, Sickler D: *Race, Ethnicity and Language of Patients: Hospital Practices Regarding Collection of Information to Address Disparities in Health Care*. Washington, DC: National Public Health and Hospital Institute, 2006

Schulman KA et al: The effect of race and sex on physicians' recommendations for cardiac catheterization. N Engl J Med 340:618, 1999

Skinner J et al: Mortality after acute myocardial infarction in hospitals that disproportionately treat black patients. Circulation 12:2634, 2005

Todd KH et al: Ethnicity as a risk factor for inadequate emergency department analgesia. J Am Med Assoc 269:1537, 1993

Trivedi AN et al: Trends in the quality of care and racial disparities in Medicare managed care. N Engl J Med 353:692, 2005

U.S. Census Bureau: *Statistical Abstract of the United States: 2010*, 129th ed. Washington, DC, 2009; Available at *http://www.census.gov/statab*

Vaccarino V et al: Sex and race differences in the management of acute myocardial infarction, 1994–2002. N Engl J Med 353:671, 2005

van Ryn M, Burke J: The effect of patient race and socio-economic status on physician's perceptions of patients. Soc Sci Med 50:813, 2000

———, Fu SS: Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? Am J Public Health 93:248, 2003

Weissman JS et al: Resident physicians' preparedness to provide cross-cultural care. J Am Med Assoc 294:1058, 2005