UNEQUAL TREATMENT

CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors

Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care

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COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

ALAN R. NELSON, M.D., (Chair), retired physician and current Special Advisor to the Chief Executive Officer, American College of Physicians–American Society of Internal Medicine, Washington, DC

MARTHA N. HILL, Ph.D., R.N., (Co-Vice Chair), Interim Dean, Professor and Director, Center for Nursing Research, Johns Hopkins University School of Nursing, Baltimore, MD

RISA LAVIZZO-MOUREY, M.D., M.B.A., (Co-Vice Chair), Senior Vice President, Health Care Group, Robert Wood Johnson Foundation, Princeton, NJ

JOSEPH R. BETANCOURT, M.D., M.P.H., Senior Scientist, Institute for Health Policy, Director for Multicultural Education, Multicultural Affairs Office, Massachusetts General Hospital, Partners HealthCare System, Boston, MA

M. GREGG BLOCHE, J.D., M.D., Professor of Law, Georgetown University and Co-Director, Georgetown-Johns Hopkins Joint Program in Law and Public Health, Washington, DC

W. MICHAEL BYRD, M.D., M.P.H., Instructor and Senior Research Scientist, Harvard School of Public Health, and Instructor/Staff Physician, Beth Israel Deaconess Hospital, Boston, MA

JOHN F. DOVIDIO, Ph.D., Charles A. Dana Professor of Psychology and Interim Provost and Dean of Faculty, Colgate University, Hamilton, NY

JOSE ESCARCE, M.D., Ph.D., Senior Natural Scientist, RAND and Adjunct Professor, UCLA School of Public Health, Los Angeles, CA

SANDRA ADAMSON FRYHOFER, M.D., M.A.C.P., practicing internist and Clinical Associate Professor of Medicine, Emory University School of Medicine, Atlanta, GA

THOMAS INUI, Sc.M., M.D., Senior Scholar, Fetzer Institute, Kalamazoo and Petersdorf Scholar-in-Residence, Association of American Medical Colleges, Washington, DC

JENNIE R. JOE, Ph.D., M.P.H., Professor of Family and Community Medicine, and Director of the Native American Research and Training Center, University of Arizona, Tucson, AZ

THOMAS McGUIRE, Ph.D., Professor of Health Economics, Department of Health Care Policy, Harvard Medical School, Boston, MA
REVIEWERS

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the NRC’s Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process. We wish to thank the following individuals for their review of this report:

LU ANN ADAY, Professor of Behavioral Sciences, University of Texas-Houston Science Center, TX
JOHN F. ALDERETE, Professor of Microbiology, University of Texas Health Science Center at San Antonio, TX
NAIHUA DUAN, Professor-in-Residence, Center for Community Health, UCLA Wilshire Center, Los Angeles, CA
DEAN M. HASHIMOTO, Associate Professor, Boston College Law School, Newton, MA
SHERMAN A. JAMES, Director, Center for Research on Ethnicity Culture & Health, School of Public Health, University of Michigan, Ann Arbor, MI
JEROME P. KASSIRER, Yale University School of Medicine, New Haven, CT
WOODROW A. MYERS, Executive Vice President, Wellpoint Health Networks, Thousand Oaks, CA
FRANK A. SLOAN, Director, Center for Health Policy, Law & Management, Duke University, Durham, NC
KNOX H. TODD, Adjunct Associate Professor, The Rollins School of Public Health, Emory University School of Medicine, Atlanta, GA
WILLIAM A. VEGA, Director, Behavioral and Research Training Institute, Universit of Medicine and Dentistry of New Jersey, New Brunswick, NJ
EUGENE WASHINGTON, Professor and Chair, Department of Ob/Gyn & Reproductive Sciences, University of California, San Francisco, CA

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Summary

ABSTRACT

Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled. The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and patients. Consistent with the charge, the study committee focused part of its analysis on the clinical encounter itself, and found evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment. The conditions in which many clinical encounters take place—characterized by high time pressure, cognitive complexity, and pressures for cost-containment—may enhance the likelihood that these processes will result in care poorly matched to minority patients’ needs. Minorities may experience a range of other barriers to accessing care, even when insured at the same level as whites, including barriers of language, geography, and cultural familiarity. Further, financial and institutional arrangements of health systems, as well as the legal, regulatory, and policy environment in which they operate, may have disparate and negative effects on minorities’ ability to attain quality care.

A comprehensive, multi-level strategy is needed to eliminate these disparities. Broad sectors—including healthcare providers, their patients, payors, health plan purchasers, and society at large—should be made aware of the healthcare gap between racial and ethnic groups in the United States. Health systems should
base decisions about resource allocation on published clinical guidelines, insure that physician financial incentives do not disproportionately burden or restrict minority patients’ access to care, and take other steps to improve access—including the provision of interpretation services, where community need exists. Economic incentives should be considered for practices that improve provider-patient communication and trust, and reward appropriate screening, preventive, and evidence-based clinical care. In addition, payment systems should avoid fragmentation of health plans along socioeconomic lines.

The healthcare workforce and its ability to deliver quality care for racial and ethnic minorities can be improved substantially by increasing the proportion of underrepresented U.S. racial and ethnic minorities among health professionals. In addition, both patients and providers can benefit from education. Patients can benefit from culturally appropriate education programs to improve their knowledge of how to access care and their ability to participate in clinical-decision making. The greater burden of education, however, lies with providers. Cross-cultural curricula should be integrated early into the training of future healthcare providers, and practical, case-based, rigorously evaluated training should persist through practitioner continuing education programs. Finally, collection, reporting, and monitoring of patient care data by health plans and federal and state payors should be encouraged as a means to assess progress in eliminating disparities, to evaluate intervention efforts, and to assess potential civil rights violations.

Looking gaunt but determined, 59-year-old Robert Tools was introduced on August 21, 2001, as a medical miracle—the first surviving recipient of a fully implantable artificial heart. At a news conference, Tools spoke with emotion about his second chance at life and the quality of his care. His physicians looked on with obvious affection, grateful and honored to have extended Tools’ life. Mr. Tools has since lost his battle for life, but will be remembered as a hero for undergoing an experimental technology and paving the way for other patients to undergo the procedure. Moreover, the fact that Tools was African American and his doctors were white seemed, for most Americans, to symbolize the irrelevance of race in 2001. According to two recent polls, a significant majority of Americans believe that blacks like Tools receive the same quality of healthcare as whites (Lillie-Blanton et al., 2000; Morin, 2001).

Behind these perceptions, however, lies a sharply contrasting reality. A large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are white Americans. Relative to whites, African Americans—and in some cases, Hispanics—are less likely to receive appropriate cardiac medication (e.g., Herholz et al., 1996)
or to undergo coronary artery bypass surgery (e.g., Ayanian et al., 1993; Hannan et al., 1999; Johnson et al., 1993; Petersen et al., 2002), are less likely to receive peritoneal dialysis and kidney transplantation (e.g., Epstein et al., 2000; Barker-Cummings et al., 1995; Gaylin et al., 1993), and are likely to receive a lower quality of basic clinical services (Ayanian et al., 1999) such as intensive care (Williams et al., 1995), even when variations in such factors as insurance status, income, age, co-morbid conditions, and symptom expression are taken into account. Significantly, these differences are associated with greater mortality among African-American patients (Peterson et al., 1997; Bach et al., 1999).

STUDY CHARGE AND COMMITTEE ASSUMPTIONS

These disparities prompted Congress to request an Institute of Medicine (IOM) study to assess differences in the kinds and quality of health-care received by U.S. racial and ethnic minorities and non-minorities. Specifically, Congress requested that the IOM:

- Assess the extent of racial and ethnic differences in health-care that are not otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage);
- Evaluate potential sources of racial and ethnic disparities in health-care, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels; and,
- Provide recommendations regarding interventions to eliminate health-care disparities.

This Executive Summary presents only abbreviated versions of the study committee’s findings and recommendations. For the full findings and recommendations, and a more extensive justification of each, the reader is referred to the committee report. Below, findings and recommendations are preceded by text summarizing the evidence base from which they are drawn. For purposes of clarity, some findings and recommendations are presented in a different sequence than they appear in the full report; however, their numeric designation remains the same.

Defining Racial and Ethnic Healthcare Disparities

The study committee defines disparities in health-care as racial or ethnic differences in the quality of health-care that are not due to access-