Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care

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Editor's note: National Medical Association President Lucille Norville-Perez invited American Medical Association Past President Alan Nelson, MD to contribute his opening speech from the March 22, 2002 briefing of the Institute of Medicine in Washington, DC as the guest editorial in this issue of JNMA.

On behalf on the Institute of Medicine and my colleagues on the committee, I would like to outline the major findings and recommendations of our report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* First a little background information. This study was done at the request of Congress, which asked the Institute of Medicine to assess the extent of racial and ethnic differences in the quality of health care received by patients, not attributable to known factors such as access to care, ability to pay, or insurance coverage; evaluate potential sources of these disparities, including the role of bias, discrimination, and stereotyping at the provider, patient, institutional, and health system levels; and lastly, to provide recommendations regarding interventions to eliminate health care differences.

Our 15-member committee met five times during the course of a year, reviewed all the relevant literature, gained further insights from commissioned papers, and convened four workshops to gain additional information from the public. Information also was gathered from a series of focus groups, roundtable discussions, and technical liaison panels.

As the committee dug deeper into its work, it became clear that there are many complex sources of racial and ethnic disparities in health care. This is reflected in the committee's findings and recommendations. Our key findings include the following:

- Racial and ethnic disparities in health care exist even when insurance status, income, age, and severity of conditions are comparable, And because death rates from cancer, heart disease, and diabetes are significantly higher in racial and ethnic minorities than in whites, these disparities are unacceptable.
- These differences in health care occur in the context of broader historic and contemporary social and economic inequality and persis-

tent racial and ethnic discrimination in many sectors of American life.

- Many sources—including health systems as a whole, health care providers, patients, and health care plan managers—contribute to racial and ethnic disparities.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care. While indirect evidence from several lines of research support this statement, a greater understanding of the prevalence and influence of the processes is needed and should be sought through research.
- Finally, racial and ethnic minority patients are more likely than white patients to refuse treatment, but differences in refusal rates are generally small. Minority patient refusal does note fully explain health care disparities.

The committee devoted a great deal of attention to making recommendations that might be expected to reduce and eventually eliminate disparities in the United States. It finished its work convinced that the real challenge lies not in debating whether disparities exist, because the evidence is overwhelming, but in the developing and implementing of strategies to reduce and eliminate them.

The existence of disparities in health care is still largely unrecognized. Public and professional awareness is an essential starting point for efforts at reduction. The committee therefore, recommends that steps be taken to increase awareness of racial and ethnic disparities in health care providers, the general public, and key stakeholders.

The committee was persuaded by the evidence it gathered that disparities can be partly attributed to a complex, often fragmented, and economically driven health care environment. A number of legal, regulatory and policy interventions are indicated:

- Because a disproportionate number of minorities are in the "lower-end" health care plans, the committee recommends avoiding the fragmentation of health plans along socioeconomic lines and strengthening the stability of relationships between patients and providers in publicly-funded health plans. The same managed care protections that private HMO enrollees have, or would get under a "patients' bill of rights," should be accorded to publicly funded HMO enrollees, as well.
- In addition, racial and ethnic minorities among US health professionals are underrepresented and need to be increased. This echoes recommendations made in previous IOM reports.
- More resources should be given to the Office of Civil Rights within the Department of Health and Human Services to investigate and enforce civil rights violations.

The committee recognizes that disparities can be reduced by ensuring that clinical practices are uniform and based on the best available science; by providing incentives to doctors to encourage the use of preventative services such as flu shots, cancer screening, and immunizations; and by enhancing the quality of communications within the health care delivery system. A number of recommendations are directed toward such strategies:

- The consistency and equity of care should be promoted through the use of evidence-based guidelines.
- Payment systems should be structured to ensure an adequate supply of services to minority patients, and to limit provider incentives that may promote disparities.
- Communication and trust between patients and providers should be enhanced through financial incentives for practices that reduce barriers and encourage evidence-based decision-making.
- The use of language interpretation services should be promoted where community need exists.
- Finally, the use of community health workers—such as non-medical personnel who help patients navigate the health care system—as

well as multidisciplinary treatment and preventative care teams, should be supported.

The committee agrees that disparities also may be reduced through better patient education and empowerment, and recommends that education programs should be implemented to increase patients' knowledge of how to best access care and participate in treatment decisions. Also, education programs aimed at current and future health professionals should integrate cross-cultural education into the training.

In addition, better data collection is necessary in order to track the nation's progress in understanding the causes of disparities and reducing them. The committee was very aware of concerns about patient privacy and confidentiality. Nonetheless, better data are necessary to know where we are going. The committee developed three recommendations with respect to data collection and monitoring:

- First, collect and report data on health care access and utilization by patient's race, ethnicity, socio-economic status, and where possible, language.
- Second, include measures of racial and ethnic disparities in assessing provider performance.
- And third, monitor progress toward the elimination of health care disparities.

Confronting unequal treatment and reducing racial and ethnic disparities in health care will require a broad and sustained commitment from those who provide and finance care, as well as those who receive it. We hope that our recommendations to understand and eliminate disparities are embraced. As one of our workshop participants observed, "we are all in this together."

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Alan Nelson is a retired physician, former president of the American Medical Association, and current special adviser to the chief executive officer, American College of Physicians-American Society of Internal Medicine, Washington, DC, and chair of the committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.