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Caution Urged in Concluding Disparities Mitigated by Increase in AA Docs

To the Editor,

Drs. LaVeist and Carroll report that among African Americans, race concordance between patient and health care provider was associated with higher patient satisfaction.[1] (*J Natl Med Assoc.* Nov 2002; 94 (11): 937-943). Though their findings corroborate other work,[2-4] we suggest some caution in concluding that racial and ethnic disparities in health can be substantially mitigated solely by increasing the production of African American providers.

We believe that the principle of equity is sufficient reason to increase the number of providers of under-represented racial and ethnic groups. However, without concomitant evidence linking patient-provider race concordance with more objective measures of the content or quality of care, meaningful reductions in disparities may not be fully realized. Moreover, understanding the mechanisms of the influence of racial and ethnic concordance in health care experiences is the most critical step in improving cultural competency, strengthening the patient-provider relationship, and ultimately reducing disparities.

Research on racial and ethnic concordance offers a unique opportunity to examine the potential mechanisms of racial and ethnic disparities in care. While satisfaction is an important outcome measure for race concordance, it provides somewhat subjective information about the behaviors of providers that may be sensitive to differences in patient expectations or preferences.

The use of satisfaction, however, in combination with more objective measures of health care content or quality can help to refine our understanding of the contributions of the patient-provider relationship to disparities in care. In particular, this combined use would allow for the simultaneous testing of contributions from both patients (expectations) and providers (behaviors) to disparities in health care experiences.

For example, our own preliminary analysis of a national sample of young children and their parents confirms a benefit of racial/ethnic concordance to parent satisfaction with care. However, we have found no association of concordance with more objective content and quality-of-care measures (e.g., provision of health supervision, developmental assessments, psychosocial counseling, and family-centered care).

Thus, while increasing the number of race-concordant relationships could be expected to improve satisfaction, it may not influence, as least for children, the content or quality of care. To

make the most effective and substantial reductions in racial/ethnic disparities in health and health care, we need to understand the influence of race concordance on experiences in care, and improve our ability to detect the mechanisms of racial/ethnic disparities more broadly.

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Authors Reply to Caution

To the Editor,

I appreciate Drs. Stevens, Mistry and Halfon's cautionary reminder that merely increasing the numbers of African American health care providers will not substantially reduce racial disparities in health. I agree. In fact, our article[1] made no such assertion. We found that African American patients reported greater satisfaction with care when they were matched with African American health care providers. I believe, as does the Institute of Medicine,[2,3] that patient satisfaction is an important endpoint in its own right.

However, while we are in agreement on the general point regarding increasing the number of African American providers, there are other points made in their letter that I cannot agree with. For example, they state, "without concomitant evidence linking patient-provider race concordance with more objective measures of the content or quality of care, meaningful reductions in disparities may not be fully realized." On first reading, this statement seems to be true, but upon closer examination it is one of the most common fallacies in health disparities research and policy. I would argue that even if there were no racial disparities in health care quality (as has been thoroughly documented in the Institute of Medicine's report, Unequal Treatment[4]), and even if efforts to substantially increase the ranks of African American health care providers were successful, disparities in health status still would exist.

There is substantial evidence that environmental, economic and social factors, such as lower socioeconomic status, poor housing, greater exposure to environmental toxins, targeting of African Americans for consumption of tobacco and alcohol, and so on, serves to degrade the health of the African American community before they ever encounter health care providers.

Let's set aside the fact that there are disparities in access to health care, and that this also plays an important role in producing health disparities. Even if equity in access to high-quality care were to be achieved, there is little in the physician's arsenal (regardless of his or her race) that can address the social ills that underlie racial disparities in health status.

I certainly agree that increasing the numbers of African American patients who are racially concordant with their health care providers will not solve the problem of health disparities, but I would go further. Progress in the elimination of health disparities cannot be made without the efforts of many facets of society. Certainly, medicine has an important role to play. My reading of the evidence leads me to conclude that medical interventions alone will have little more than a negligible impact on realizing the goal of health equality.

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