Guest Editorial

UNEQUAL TREATMENT: THE INSTITUTE OF MEDICINE REPORT AND ITS PUBLIC HEALTH IMPLICATIONS

Over the course of its history, the United States has experienced dramatic improvements in overall health and life expectancy largely due to public health initiatives. Our ability to prevent some diseases and to detect and treat other diseases in their early stages has allowed us to target and reduce premature and costly morbidity and mortality. Despite interventions that have improved the overall health of the majority of Americans, members of racial/ethnic minority groups have benefited less than the U.S. population as a whole from these advances. For instance, research has shown that minority Americans suffer disproportionately from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, cancer, and HIV/AIDS, among others.[1]

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 their poorer health outcomes.[2–8] For example, three of the five largest landfills in the country are found in predominantly African American and Latino communities, manifesting in some of the highest rates of pediatric asthma in the country.[9] Lack of access to care also takes a significant toll, as uninsured individuals are less likely to have a regular source of care than those with insurance, more likely to report delays in seeking care, and more likely to report that they have not received needed care—all resulting in avoidable hospitalizations, unnecessary emergency department care, and adverse health outcomes.[10–12]

In 1998, as part of his "Initiative on Race," President Clinton set forth the goal of eliminating racial/ethnic disparities in health. This initiative focused the Department of Health and Human Services on an initial target of eliminating disparities in cardiovascular disease, diabetes, cancer screening and management, HIV/AIDS, infant mortality, and vaccination rates by the year 2010. Through research and programmatic grantmaking, the federal government has been actively engaged in fostering efforts to better understand the root causes of disparities, while also trying to develop interventions to eliminate them. Among the most notable of these efforts have been the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) projects—awarded for community-based programmatic efforts to eliminate racial/ethnic disparities in health.

Despite a significant amount of progress in addressing racial/ethnic disparities in *health*, the emerging evidence of racial/ethnic disparities in *quality of care* for those *with* access to the health care system has been of concern. Disparities have been shown to exist in the utilization of cardiac diagnostic and therapeutic procedures (African Americans are less likely than whites to be referred for cardiac catheterization and bypass grafting[13–17]), prescription of analgesia for pain control (African Americans and Latinos receive less pain medication than whites for long bone fractures and cancer[18–20]), and surgical treatment of lung cancer (African Americans are less likely to receive curative surgery than whites for non–small cell lung cancer[21]). Disparities have also been seen in referral to renal transplantation (African Americans with end-stage renal disease are less likely to be referred to the transplant list than whites[22]), treatment of pneumonia and congestive heart failure (African Americans receive less optimal care than whites while hospitalized for these conditions[23]), and utilization of specific services covered by Medicare (i.e., vaccinations and mammograms[24]). Perhaps the most important issue that should be noted about all of these studies is that disparities were found even when variations in such factors as insurance status, income, age, comorbid conditions, and symptom expression were taken into account.

As a result, in 1999, Congress commissioned the Institute of Medicine (IOM) to take on the issue of racial/ethnic disparities in the health care system. The IOM, part of the National Academy of Sciences and chartered by Congress to advise the federal government on issues of health policy, medical care, research, and education, was asked to:

- Assess the extent of racial/ethnic differences in health care that are not attributable to known factors such as access to care (e.g., ability to pay or insurance coverage);

- Evaluate potential sources of racial/ethnic disparities in health care, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health systems level;

- Provide recommendations regarding interventions to eliminate health care disparities.

IOM'S *UNEQUAL TREATMENT*

To study this issue, the IOM convened a committee of academicians, medical educators, health service researchers, health policy makers, public health practitioners, economists, social scientists, lawyers, and practicing physicians and nurses—some with experience and knowledge in the area of disparities and others with expertise and proven leadership in other aspects of health care delivery and research. This approach is consistent with the goal of the IOM to assemble an objective and open-minded group of committee members who can effectively evaluate evidence and come up with findings and recommendations. Given that the charge of the committee was limited to disparities in *health care* (versus the larger issue of health outcomes) once access is achieved, specific areas of exploration included health system factors (e.g., financial and institutional arrangements, structural processes of care), provider factors (e.g., communication in the medical encounter, the effect of race/ethnicity on clinical decision-making), and consumer factors (patient preferences). To carry out its responsibilities over the 18 months of the study, the committee reviewed a significant amount of evidence from five main streams, including a literature review (with strict inclusion and exclusion criteria), commissioned papers (on topics ranging from an exploration of health disparities to the economic, ethical, and legal ramifications of disparities in health), expert testimony, focus groups of patients and providers, and a public workshop. The final report, titled *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care,*[25] was released on March 20, 2002. The study found that:

- Racial/ethnic disparities in health care exist and, because they are associated with differences in health outcomes, are unacceptable.

- Racial/ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality and evidence of persistent racial/ethnic discrimination in many sectors of American life.

- Many sources—including health systems, health care providers, patients, and utilization managers—contribute to racial/ethnic disparities in health care.

- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers contribute to racial/ethnic disparities in health care.

- A small number of studies suggest that certain patients are more likely to refuse treatments, yet these refusal rates are generally small and do not fully explain health care disparities.

On the basis of these findings, a series of recommendations for addressing and eliminating racial/ethnic disparities in health care was developed:

First, awareness of the existence of racial/ethnic disparities in health care must be raised among health care providers, policy makers, and the public. Recent surveys have shown that both physicians[26] and the public aren't aware of the extent or severity of racial/ethnic disparities in health care in the U.S. Increasing awareness about this issue can occur through several venues—including the lay press, professional medical societies, and even educational institutions such as medical and nursing schools. The ultimate goal of increasing awareness about racial/ethnic disparities in health care would be to generate discourse and mobilize action to address them in multiple areas, including at the level of health policy, health systems, and the community.

Second, legal, regulatory, and policy interventions should be set into motion to address disparities. One such intervention would involve strengthening patient-provider relationships in publicly funded plans to assure that there is time for physicians and patients to communicate effectively. This can be achieved by restructuring health care financing and the mechanisms of compensation for providers. For instance, compensation might shift toward incentives for quality of care provided, as opposed to productivity or volume of patients seen. Another intervention in light of the recent "Patients' Bill of Rights" debates is assuring that the managed care protections that apply to private managed care enrollees are offered to publicly funded managed care enrollees. The committee also recommended redoubling efforts to improve our health care workforce diversity. For example, fewer than 10% of all physicians in this country are members of minority groups,[27] despite minorities making up close to 30% of the population.[28] The committee determined that the goal should be to have a health care workforce that more closely reflects this nation's population. Finally, greater resources should be provided to the Department of Health and Human Services Office of Civil Rights to enforce civil rights law and monitor these processes.

Third, health systems interventions were deemed critical to eliminating disparities. This includes the use of evidence-based guidelines in the treatment of patients. We now have excellent science to inform us how to best man-

age diabetes, for example, and therefore the goal is to remove, through the use of guidelines, any subjectivity in treatment of patients based on clinician discretion and ensure that all patients are getting the highest quality of care, regardless of their race/ethnicity, culture, or class. Promotion of guidelines and enhancement of patient-provider communication and trust can occur through financial incentives. Finally, interpreter services should be provided for patients with limited English proficiency, when needed, and the use of community health workers and multidisciplinary teams should be encouraged.

Fourth, strategies to educate patients on how to navigate the health care system, and how to be more active in the medical encounter, should be implemented. Difficulty navigating the health care system and obtaining access to care can be a hindrance to all populations, but to members of minority groups in particular.[29] Similarly, lack of empowerment in the medical encounter by minorities (which may stem from historical mistrust of the health care system, perhaps due to events such as the Tuskegee Syphilis Study)[30] can be a barrier to care. Programs should be developed to increase patients' knowledge of how to best access care and participate in treatment decisions.

Fifth, cross-cultural education should be integrated into the training of all current and future health care professionals. Education should focus on equipping providers with the tools and skills to better understand and care for patients from diverse backgrounds. This includes curricula on health care disparities, the clinical decision-making process (including strategies to avoid stereotyping), how to use an interpreter, and how to effectively communicate and negotiate across cultures. These can be incorporated into health professions training at medical and nursing schools and as part of continuing education.

Sixth, data collection capacity should be improved so that we can systematically collect information on patients' race/ethnicity, socioeconomic status, and primary language. This will allow us to more effectively identify disparities locally and then implement strategies to monitor and eliminate them as part of quality improvement and performance measurement.

Seventh, further research should be conducted to identify sources of racial/ethnic disparities and assess promising intervention strategies. Barriers to and strategies for eliminating disparities should also be explored.

IMPLICATIONS FOR PUBLIC HEALTH

The IOM report *Unequal Treatment* focused on racial/ethnic disparities that emerge from the process of receiving health care, and not those that derive from social determinants or access. The public health infrastructure is an integral part of our health delivery system (a key area of exploration for the Committee), and several of the IOM's recommendations have direct relevance to public health agencies, public health education, and public health practice:

Increasing awareness of racial/ethnic disparities in health care. Invariably, any effort to increase awareness of racial/ethnic disparities in health care must be accompanied by a broader discussion of *all* of the root causes for this crisis. A central theme must be that although there are disparities in health care that contribute to racial/ethnic disparities in health, they are only one piece of the puzzle. The federal effort to eliminate racial/ethnic disparities in health, as set forth by the Clinton administration and carried on by the Bush administration, must include support for the public health infrastructure that aims to tackle the significant social determinants that impact minority health in this country. Eliminating disparities in health care alone will just chip away at the problem, not solve it. Racial/ethnic disparities will only be eliminated when economic, educational, housing, criminal justice, and environmental policy makers come together to address all of the issues that impact health—and contribute to poorer outcomes for certain communities.

Diversity in the health care workforce. In addition to the shortage of minorities among the physician ranks, shortages exist among dentists, nurses, city and county public health officials, and public health school faculty. Research has documented that despite making up almost 30% of the population,[28] members of minority groups represent only 5% of dentists, 14% of nurses, 17% of city and county public health officials, and 16% of public health school faculty.[27] The underrepresentation of minorities in the health care workforce and in health care leadership has broad implications for the elimination of racial/ethnic disparities in health and health care, and should be given great attention. Diversity is necessary in *all* areas of the health care workforce, as many of the aforementioned professionals actively straddle the worlds of public health and what many would consider the "traditional" health system.

Support for the use of interpreter services. Limited English proficiency affects an individual's health much earlier than when he or she arrives at a hospital clinic

or emergency room. The report's recommendation for support of interpreter services has clear implications not only for mainstream health care settings but also for public health. Public health programs that target vulnerable populations with limited English proficiency must assure that their intervention is linguistically appropriate and that interpreters are built into the interventions when needed. Some situations require skilled interpreters that are well trained and experienced.

Support for the use of community health workers and multidisciplinary teams. The recommendation to support the use of community health workers and multidisciplinary teams is perhaps most in line with public health principles. Community health workers and multidisciplinary teams are central to many public health functions, including epidemiological assessment; neighborhood health promotion, disease prevention, and treatment; and more recently, linkage to primary, secondary, and tertiary care in the clinic or hospital setting. In fact, the bridge between public health and primary care has been heralded as a powerful strategy to address and eliminate racial/ethnic disparities in health.[31]

Patient education and empowerment. Classic public health education has taken on many forms, including increasing a community's awareness of health-promoting behaviors such as diet and exercise, stressing the importance of screening for certain preventable diseases such as breast cancer, and providing training to deal with certain conditions such as diabetes. To better address racial/ethnic disparities in health and health care, public health education should expand to train patients in how to effectively navigate the health care system and how to be more active and empowered in the medical encounter. This education might include strategies to empower patients to be better prepared to both answer and ask questions in the clinical encounter.

Cross-cultural education for health professionals. Cross-cultural education has emerged as a strategy to enhance health care providers' knowledge of the impact of sociocultural factors on patient's health beliefs and behaviors while also equipping providers with the tools and skills to negotiate these issues in the clinical encounter. The clinical encounter, however, is not the only context in which these issues are important. Public health professionals and students should also become intimately aware of the nexus between social factors, culture, and health—and how to both assess this relationship and plan accordingly when developing interventions to eliminate racial/ethnic disparities in health and health care.

Data collection and research. Epidemiological and community assessment are major pillars of public health practice. The IOM's recommendation to include the recording of race/ethnicity and language preference as part of data collection should also apply to the public health strategies of assessment and intervention. In this way, it becomes possible to monitor for the elimination of racial/ethnic disparities in health and health care and to foster research that focuses on at-risk populations.

CONCLUSION

The IOM report, *Unequal Treatment,* provides the first detailed, systematic examination of racial/ethnic disparities in health care. Its focus and scope shines light on the overwhelming evidence of disparities and provides a blueprint for how to address them within the health care system. The charge of the report, however, was artificially narrowed specifically to those issues that are prominent contributors to disparities when factors such as socioeconomic status and access to care are held constant. In reality, racial/ethnic disparities can only be eliminated with broad-based efforts that don't "control" for these critical factors but, instead, take them into account. In fact, the report's summary acknowledges as much, stating that, "Health care is a necessary but insufficient commodity in itself to address racial/ethnic disparities in health status."[25]

Public health policy makers and practitioners need to be willing and committed partners in all efforts to eliminate disparities in health and health care. Several of the lessons learned by the IOM committee that authored the report have direct implications for public health, such as the need to increase awareness of disparities; to foster health workforce diversity; to support interpreter services, community health workers, and multidisciplinary teams; to engage in patient and provider education; to support race/ethnicity and language-preference data collection; and to promote research. It is only through collaboration and partnership across disciplines that the ambitious goal of eliminating racial/ethnic disparities in health and health care can be achieved—and the road map set forth by *Unequal Treatment* is just one, long overdue step in the right direction.

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