Practitioner Forum

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Eliminating Ethnic and Racial Disparities in Health Care

The United States today is a multicultural nation with a rapidly growing racial and ethnic minority population. Minorities are expected to represent 40% of the population by 2035 and 47% by 2050.[1] And while the white labor force is projected to grow at a rate of only 3% between 2002 and 2012, the Asian labor force is projected to grow at a rate of 51% during the same period.[2]

Meanwhile, wide health-related disparities exist among the country's racial and ethnic populations. The rate of diabetes is about 70% higher in African Americans than in white Americans, the rate of cervical cancer is about five times higher in Vietnamese women than in white women, and the rate of stomach cancer is two to three times higher in Latinos than in whites.[3]

Furthermore, and perhaps even more concerning, racial and ethnic disparities also exist in the way health care services are provided and in health care outcomes. Minorities are less likely than whites to receive needed services involving cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness.[4] Infant mortality rates are 2.5 and 1.5 times higher for African Americans and American Indians, respectively, than for whites.[1] African Americans and American Indians/Alaska Natives have higher rates of influenza mortality than do whites.[1] African American women are more likely than white women to die from breast cancer, even though the disease is less common among African American women.[1] And African Americans are 3.6 times more likely than whites to lose lower limbs due to diabetes.[5]

In this column, we discuss the factors at work behind these disparities and the steps that we believe are necessary to eliminate them. While some work has been done to address these problems, much remains for individuals and organizations alike to undertake in order to ensure that all patients receive high quality, respectful, and effective health care.

REASONS FOR DISPARITIES

According to data from 2002 and 2003, 32.7% of Hispanics, 22.7% of American Indians/Alaska Natives, 19.6% of African Americans, and 18.8% of Asians and Pacific Islanders in the United States do not have any form of health insurance—compared with 11.1% of white, non-Hispanic Americans.[6] Yet the higher percentages of uninsured individuals and individuals with lower socioeconomic status among racial and ethnic minorities do not fully account for the health care disparities that exist.[1,6] In a 2002 report, the Institute of Medicine (IOM) concluded that minorities receive a poorer quality of health care even when they have the same insurance status and incomes as whites.[7] Similarly, there have been documented disparities within health systems, including the VHA, that provide the same financial benefits to all beneficiaries.[6] Instead, the IOM study cited cultural misunderstandings and linguistic differences as primary causes of racial and ethnic treatment disparities.[5]

Unfamiliarity with a patient's cultural background can lead to a number of problems. For example, a health care professional who is not familiar with the traditional Asian practice of coin rubbing—which involves rubbing the skin with a coin in order to induce ecchymosis and remove toxins—might assume that a patient's ecchymosis resulted from physical abuse.[8] In addition, patients from some religious traditions may accept care only from a provider of the same gender as themselves.[9] Providers also may fail to account for the possibility that a patient is taking a traditional home remedy that might affect his or her response to treatment. African American folk medicine, for example, uses such environmental resources as herbs and roots to treat illness.[10] And hospital visitation policies may not sufficiently accommodate the needs of patients whose culture encourages family and friends to visit in person rather than send flowers or cards to express their support and concern.[9]

Language differences are a problem for 21% of minority patients in the United States. Difficulties with language have been linked to fewer physician visits, reduced receipt of preventive services, and lower satisfaction with care. In addition, such factors as rapport, communication quality, and understanding of prescribed medications may be affected negatively when clinicians try to speak a language in which they are not fluent.[1]

The IOM also found evidence that health care providers' biases, prejudices, and uncertainty when treating

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minorities can contribute to differences in care. Health care professionals risk being influenced by their personal health beliefs about gender, race, and socioeconomic status when they treat people of different races and cultures.[4] Once a patient enters a health care system, the professional's opinion and attitude can influence continuation of care.

ELIMINATING THE DISPARITIES

Some government programs have been implemented to reduce ethnic and racial disparities in health care. In 1998, for example, President Bill Clinton allocated $400 million to reduce disparities in cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, immunizations, and infant mortality.[11] According to David Satcher, MD, PhD, the 16th surgeon general of the United States, these areas were highlighted because "they are known to affect multiple racial and ethnic minority groups at all life stages."[12]

Cultural competence is a key concept that can help guide efforts to eliminate health care disparities. Brach and Fraser describe cultural competence as a set of behaviors, attitudes, and policies that promote effective work in cross-cultural situations. They list nine major techniques for promoting cultural competency:

- interpreter services,
- recruitment and retention policies,
- training,
- coordination with traditional healers,
- use of community health workers,
- culturally competent health promotion,
- inclusion of family and community members,
- immersion into another culture, and
- administrative and organizational accommodations.[1]

These authors emphasize that health care professionals will "only become culturally competent with the support and or encouragement of the health system in which they participate."[1] A later study also concluded that developing a health care organizational mission and vision that encompass cultural and social diversity can help to support cultural competence.[13]

With regard to language difficulties, studies have suggested that providing patients with interpreter services can have a positive impact on their health care utilization, satisfaction, adherence to treatments, and outcomes.[1] Another strategy is for providers to enhance their familiarity with foreign languages in order to communicate better with patients. When the number of immigrant patients being treated in St. Louis area hospitals increased, for example, some providers in the area responded by taking language classes.[14]

Other types of education also can help to enhance cultural competence. Health care professionals should be made aware of racial and ethnic disparities in health care and be provided with cross-cultural education focusing on attitudes, knowledge, and skills.[4] They should have some understanding of what minority patients have faced in their lives when they provide health education to these patients.[15] Taking more time with minority patients and understanding their expectations may help to reduce disparities as well.

Also important is the recruitment and retention of minority health care staff. Such staff may be less likely to practice racial or ethnic discrimination and might provide a more "user friendly" experience for minority patients.[1] Increasing diversity in the nursing profession is one goal of the Workforce Diversity Grant Program, which helps disadvantaged students become nurses.[2]

CLAS standards

In 2000, the HHS's Office of Minority Health (OMH) released 14 standards—called the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards)—that are intended to promote cultural competence.[16] These standards are directed primarily at health care organizations, although the OMH encourages individual providers to "use the standards to make their practices more culturally and linguistically accessible."[16] Health care organizations that receive federal reimbursements (including Medicare and Medicaid) are expected to make a good faith effort to address all of the CLAS standards, and they are required to comply with the four standards that deal specifically with language services (standards 4 through 7).[5,16]

The language services standards, which are mandates under the Civil Rights Act of 1964, are intended to ensure that patients receive health

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care information in a language they can understand.[5] The standards require organizations to provide language assistance services at no extra cost to patients with limited English proficiency, ensure the competence of such assistance, and provide patient materials and signage in languages that are common in the service area. Organizations also are required to inform patients, in their preferred language, of their right to receive language assistance.[16]

The other 10 CLAS standards are general principles of cultural competence.[5] Standards 1 through 3 address the need to provide care that is compatible with a patient's cultural and health beliefs, recruit and maintain a culturally diverse staff, and provide ongoing education and training in culturally appropriate services. Standards 8 through 14 deal with organizational supports for cultural competence. They encourage organizations to formulate a plan for providing culturally appropriate services, implement a organizational self-assessment of CLAS-related activities, ensure that patients' records include ethnic information, maintain a demographic profile of the community, ensure that conflict resolution processes are culturally sensitive, and make information about the organization's implementation of CLAS standards public.[16]

A SHARED RESPONSIBILITY

The health care system, as it is structured, currently is not meeting the needs of minority patients, and this problem requires social, organizational, and individual changes. Minorities can contribute to the diversity of the health care workforce by choosing to pursue health care careers. Hospitals can enhance the cultural competence of their employees by actively building and maintaining a diverse staff and by providing language and cultural awareness classes. Individual providers can improve the care they provide to minority patients by striving for cultural competence and a better understanding of their patients' cultural backgrounds and beliefs. These improvements will not happen overnight—but acknowledging the existence of racial and ethnic disparities in health care is an important first step.

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this column.

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