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Culture, race, and disparities in health care

CULTURAL COMPETENCE in health care isn't about "political correctness." It's about people's health.

In this issue of the *Journal*, Dr. Misra-Hebert[1] defines cultural competence—basically, the ability to communicate effectively with people different from oneself—and why it is important for physicians.

The concept is germane for two reasons. First, despite talk about "united we stand," we remain a country divided by race and culture, and the percentage of "minority" (read non-white, non-English-speaking) people is on the rise.

Second and more important, to be a member of a minority in America is to be at risk of a host of adverse outcomes, at least some of which are due to suboptimal care. And at least some of the suboptimal care may be due to poor communication.

MINORITIES INCREASING IN NUMBER

In 1970, all minorities (African American, Hispanic, Asian, and Native American) comprised 12.3% of the US population; now they account for 25%. These demographic changes are predicted to continue. By 2050, one in every two Americans will be African American, Hispanic, Asian American, Pacific Islander, or Native American.

DISPARITIES IN HEALTH

Despite advances in medicine, minority Americans face pervasive disparities in health—measurable differences in disease incidence, morbidity and mortality—and in the care they receive.

I could cite examples of disparities for many American minorities. Consider these for African Americans:

- **Infant mortality** is higher in black people than in white people. The disparity has been attributed to differences in birth weight, age of mothers, income, and education.
- **Strokes.** Black people have a higher incidence of stroke, but are less likely than white people to receive the invasive procedures that are used to diagnose and treat cerebrovascular disease.[2]
- **Acute coronary syndromes.** African Americans wait longer before seeking care for acute coronary syndromes than do whites. They are also significantly less likely to receive a revascularization procedure after coronary angiography, with an adjusted odds ratio 78% higher for whites than for blacks,[3] raising the suspicion of hospital or physician bias.
- **Mental health.** African Americans with a diagnosis of schizophrenia are significantly less likely than white patients to report having past or current treatment for depression, manic depression, or anxiety disorder,[4] suggesting that the US mental health system unequally serves the minority population.
- **Renal transplantation.** Among appropriate candidates for transplantation, blacks are less likely to be referred for evaluation, to be placed on a waiting list, or to receive a transplant.[5] And they wait two to four times longer on the transplant waiting list.

Many feel that the current system for organ allocation is unfair to African Americans in that it is weighted according to HLA (human lymphocyte antigen) matching, which favors white patients, who have more HLA antigen matches with prospective cadaver donors. Confounding the problem,

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there are fewer black cadaver and living donors.

Clearly, there needs to be more organ donation within the black community, but also the system by which organs are allocated should seriously be reexamined to eliminate racial disparity in the distribution of organs.

In addition, after transplantation African Americans suffer higher rates of rejection and diminished allograft survival, suggesting that African Americans should have tailored immunosuppressive regimens, reflecting the higher risk for acute rejection.[6]

- **Prostate cancer.** Black men have a higher incidence of prostate cancer and a higher mortality rate from it than do white men, stage for stage. This underscores the need for both earlier prostate cancer screening in African American men and more research into the epidemiology of this disease.
- **Cervical cancer.** A recent study of African American women with cervical carcinoma demonstrated that equal care ensures equal survival for African American women compared with their nonminority counterparts.[7] However, racial differences in cervical screening persist. Disconcerting are reports that even with a diagnosis of a high-grade abnormality on a Papanicolaou smear, black women are less likely to receive a workup.[8]

REASONS FOR THE DISPARITIES

Reasons for these disparities are multifactorial and include economics and lack of health insurance for minorities, but undoubtedly also relate to a lack of understanding by health care providers of the importance of cultural competency.

Suffice it to say that ethnic and minority populations demonstrate patterns of disease occurrence, health care utilization, and mortality that differ from the majority population. Social and cultural influences due to historical, political, environmental, hereditary, and economic factors shape these differences.

CORRECTING THE DISPARITIES

The first step to correcting these disparities is to recognize that they exist.

Several national agencies are aware of the crisis that health disparities pose to our national health and have launched initiatives to eliminate them. An example is the Healthy People 2010 Initiative.

The National Institutes of Health (NIH) in 1994 mandated that all biomedical and behavioral research that it funds include plans to recruit and retain minorities as subjects. Further, NIH-funded clinical trials must be designed to measure differences in intervention effects in subpopulations when warranted.

The NIH also recently created the National Center for Minority Health and Health Disparities, with the expressed purpose of promoting and supporting research in eliminating health disparities.

Training in cultural competency

To break down barriers in communication between health care providers and patients of different cultures, all health care workers need to become sensitive to the traditions, values, and attitudes of all ethnic groups. To this end, cultural competency training should become mandatory for all health care providers.

Health care providers must also be sensitive to the fact that historically an important barrier to health care for minorities has been a distrust and skepticism of white health care providers and researchers. Researchers and health care providers must make a concerted effort to gain knowledge of and respect for communities whose culture, values, and beliefs may differ from their own.

Dr. Misra-Hebert has researched and outlined a variety of methods, mechanisms, and models in which cultural competency may be achieved.[1]

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Reaching out to minorities

We must begin to "think outside the box" and devise innovative strategies to overcome barriers to health in minority communities. For example:

- We at tertiary care centers should link up with primary care providers in the communities where minorities live and work, to help provide state-of-the art health care to minorities.
- We must encourage corporate America to help solve this problem by providing employ-

ees with opportunities for health education and health screening.

- Health promotion strategies must be designed and implemented in a variety of settings, starting with elementary schools, to address the priority health needs of minorities.
- Health care institutions could have a considerable impact on solving this crisis by developing dedicated minority health initiatives to focus their financial and academic resources (research initiatives) on this health disparity crisis.
- Researchers should be encouraged to look into the epidemiology of diseases that disproportionately afflict minorities to gain insight into more effective treatments and prevention.

The Council on Ethical and Judicial Affairs of the American Medical Association has emphasized the need for greater access to necessary health care for black Americans, greater awareness among physicians of existing and potential disparities in treatment, and the continued development of practice parameters, including criteria that would preclude or diminish racial disparities in health care decisions.[9]

More minority health care workers

More African Americans and members of other minorities should be trained and incorporated into health care professions as primary health care providers, specialists, and leaders. This would go a long way toward facilitating the elimination of disparities in care because minority physicians, nurses, and social workers have historically been the health providers treating minority patients in minority communities.

I applaud Dr. Misra-Hebert for bringing the issue of cultural competence to the forefront of discussion.

The first step to correcting disparities is to recognize they exist

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