

# **Racial and Ethnic Disparities in Health Care**

**American College of Physicians**  
A Position Paper  
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**A Position Paper of the  
American College of Physicians**

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## EXECUTIVE SUMMARY

The American College of Physicians (ACP) is the world's largest medical specialty society and the second-largest physician group in the United States. Membership includes more than 115,000 internal medicine physicians and medical students. As a medical professional society, the College is particularly concerned about eliminating racial and ethnic disparities in health care.

The ACP has a long-standing commitment to improving the health of all Americans. The fact that disparities exist in health care among racial and ethnic minorities has been well documented. This position paper articulates the College's opposition to any form of discrimination in the delivery of health care services and its commitment to eliminating disparities in the quality of or access to health care for racial and ethnic minorities. The paper includes statements of principle and proposes actions that can be taken by health policy decision-makers, the medical profession, educators, and researchers to eliminate disparities in health care.

The ACP identified six issue areas where racial and ethnic disparities in health care need to be addressed: health insurance coverage, patient care, provider issues, systems that deliver health care, societal concerns, and research. Within each area, ACP has developed positions indicating specific actions that should be taken.

The ACP's position statements on the issue of eliminating disparities in health care among racial and ethnic minorities are as follows:

**Position 1:** *All patients, regardless of race, ethnic origin, nationality, primary language, or religion, deserve high quality health care.*

**Position 2:** *Providing all Americans with affordable health insurance is an essential part of eliminating racial and ethnic disparities in health care.*

**Position 3:** *Clear communication between patients and providers is an essential part of the provider/patient relationship and affects the quality of clinical encounters.*

**A:** *Health care providers should understand and practice culturally competent care in all of their clinical encounters.*

**B:** *Clear communication between patients and providers is an essential part of the provider/patient relationship and affects the quality of clinical encounters. The ACP encourages increased use of interpreter services for patients who are in need of them. The ACP suggests that these services often can be obtained by using volunteer services and that physicians should not be responsible for arranging or paying for such services. Public and private health insurance should provide reimbursement for interpreters when volunteer services are unavailable. Coverage under Medicaid, Medicare, and State Child Health Insurance Program (SCHIP) is particularly warranted in light of the federal guidelines requiring interpreter services for limited-English proficiency patients who are covered by these programs.*

**Position 4:** *Physicians and other health care providers must be sensitive to cultural diversity among patients and recognize that inherent biases can lead to disparities in health care among racial and ethnic minorities.*

**A:** *Cultural competency training should be incorporated in the training and professional development of all health care providers, at all levels.*

**Position 5:** *Action is needed throughout the entire continuum of the health care delivery system to address disparities in health care among racial and ethnic minorities.*

**A:** *Health care organizations should reach out to surrounding community members and involve community representatives in planning and quality improvement initiatives.*

**B:** *Managed care organizations and other large providers need to take effective steps in reducing disparities in health care.*

**C:** *Quality improvement projects should incorporate race, ethnicity, and primary language measures.*

**Position 6:** *A diverse workforce of health professionals is an important part of eliminating disparities among racial and ethnic minorities.*

**A:** *Education of minority students at all educational levels, especially in the fields of math and science, needs to be strengthened and enhanced to create a larger pool of qualified minority applicants for medical school.*

**B:** *Medical and other health professional schools should revitalize efforts to improve matriculation and graduation rates of minority students. ACP supports the consideration of race and ethnicity in determining admissions to institutions of higher education. Programs that provide outreach to encourage minority enrollment in medical and health professional schools should be maintained, reinstated, and expanded.*

**C:** *Medical schools need to increase efforts to recruit and retain minority faculty.*

**D:** *Efforts should be made to hire and promote minorities in leadership positions in all arenas of the health care workforce.*

**E:** *Funding should be continued and increased for programs and initiatives that work to increase the number of health care providers in minority communities.*

**Position 7:** *Many socioeconomic issues contribute to disparities in health care among racial and ethnic minorities. While all need to be addressed, ACP has specific recommendations concerning public education, targeting the sale of products that negatively impact the health of racial and ethnic minorities, and reducing deaths and injuries from firearms.*

**A:** *The ACP advocates public education programs, targeted to minority communities, on primary and secondary prevention of chronic diseases.*

**B:** *The ACP supports public policies designed to reduce the targeting of minority populations for sales of tobacco, alcohol, foods lacking nutritive quality, and other products that negatively impact the health of racial and ethnic minorities.*

**C:** *The ACP reaffirms its support for public policies to reduce injuries and deaths from firearms.*

**Position 8:** *Research is a vital part of identifying, monitoring, and addressing disparities in health care among racial and ethnic minorities.*

**A:** *Research to identify sources of disparities, as well as effectiveness of initiatives targeted to eliminate disparities, will necessitate the collection of better data on race, ethnicity, and primary language using reliable and standardized measurement tools.*

## Overview

Minority Americans do not fare as well as whites in our health care system. Even when controlling for insurance status and income, racial and ethnic minorities tend to have less access to health care and have a lower quality of health care than nonminorities. The proportion of minority groups within the U.S. population is growing rapidly, increasing the need to respond to their public health and health care needs.

Death rates for whites, African Americans, and Latinos from many common diseases have declined during the last decade (1). The Centers for Disease Control (CDC) reports, however, that “relatively little progress has been made toward the goal of eliminating racial/ethnic disparities” among a wide range of health indicators (1). Therefore, while all Americans are healthier, the gaps between minority groups and whites remain nearly the same as a decade ago. African Americans have the highest rates of morbidity and mortality of any U.S. racial and ethnic group (2). The mortality rate for African Americans is approximately 1.6 times higher than that for whites—a ratio that is identical to the black/white mortality ratio in 1950 (3).

Infant mortality rates are one of the best indicators of the health of a population. In 1997, the United States ranked 27th among industrialized countries for infant mortalities (4). In looking at why the United States ranks so high for infant mortality rates, it becomes evident that much of the problem is due to high rates in the African-American population. African Americans have a rate of infant mortality that is 2.5 times that of whites (14.6 versus 5.8, respectively) (4). The infant mortality rate for Native Americans and Alaska Natives is 9.3;

for Latinos, it is 5.8, a rate similar to that of whites; and for Asian Americans and Pacific Islanders, it is just slightly lower than whites and Latinos (4). Compared to developing countries, Croatia, Kuwait, and Malaysia have lower infant mortality rates and Bosnia, Libya, Sri Lanka, and Uruguay have approximately the same infant mortality rates as African Americans in this country. Those who live in these developing countries are, in some respects, healthier or as healthy as African Americans in this country (5).

African Americans, Asian Americans, and Latinos are also more likely than whites to experience difficulty communicating with physicians, to feel that they are treated with disrespect when receiving health care services, and to experience barriers to care, including lack of insurance or a regular doctor. Moreover, a substantial proportion of minorities feel they would receive better care if they were of a different race or ethnicity (6).

The ACP has a long-standing commitment to improving public health. The mission of ACP is, "To enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine." Eliminating health disparities among racial and ethnic minorities will take the efforts of all involved in the practice of health care delivery. The ACP sees the need to address these disparities on six fronts: increasing access to quality health care, patient care, provider issues, systems that deliver health care, societal concerns, and continued research.

The ACP has been involved in activities aimed at eliminating disparities in health care among racial and ethnic minorities. A few of these include the following:

- The ACP has endorsed Healthy People 2010, a set of health objectives for the nation to achieve by 2010. The two goals of Healthy People 2010 are to: 1) increase quality and years of healthy life and 2) eliminate health disparities (7).
- The ACP has included the elimination of racial and ethnic minority disparities in health care as a core principle in providing access to care for all Americans (8).
- The ACP is a cosponsor of a \$1 million initiative to reduce racial and ethnic disparities in health care. The effort, called the Initiative To Engage Physicians in Dialogue about Racial/Ethnic Disparities in Medical Care, is cosponsored by the Henry J. Kaiser and Robert Wood Johnson foundations, the Association of American Medical Colleges (AAMC), and eight other health care associations (9). The initiative includes an outreach effort to engage physicians in dialogue, an advertising campaign in major medical publications, and a review of the evidence on racial/ethnic disparities in health care. The campaign begins with a focus on disparities within cardiac care.
- The ACP's Foundation is also involved in a project on improving communication as a way of improving health. As part of this effort, the Foundation, along with the Institute of Medicine (IOM), held a conference in October 2002 that included discussion of communication as a way of breaking down racial and ethnic disparities.

## Health Insurance Coverage

**Position 1:** *All patients, regardless of race, ethnic origin, nationality, primary language, or religion, deserve high quality health care.*

There is no justification for disparities in the quality of health care based on characteristics such as race, ethnicity, nationality, primary language, or religion. Yet people who are from racial and ethnic minority groups typically do not receive the same quality of health care as nonminorities. In 2002, the IOM released a breakthrough report clearly documenting that minorities do not receive the same quality of care as nonminorities, regardless of insurance or socioeconomic status. The IOM also found that adjusting for socioeconomic status almost always reduces, though seldom eliminates, the effects of race and ethnicity on the health care a patient receives (3).

Some evidence that racial and ethnic minorities do not enjoy the same quality of health care as nonminorities includes the following facts:

- At each age of the life span, until age 44 years, African Americans, Latinos, and Native Americans have, on average, higher mortality rates than whites. Only Asian Americans have, on average, lower mortality rates than whites. However, particular Asian subpopulations, such as Vietnamese, have much higher mortality rates (10).
- African Americans continue to have the highest mortality rates for heart disease—about 50% higher than that of whites. While the gap between African Americans and whites for cardiac catheterizations has narrowed over time, large racial disparities in the treatment of heart disease with angioplasty and coronary bypass surgery persist, with the chances of African Americans undergoing these procedures about half of those for whites (10).
- Although African Americans suffer strokes at a rate as much as 35% higher than whites do, several studies have found that they are less likely to receive major diagnostic and therapeutic interventions (2).
- Mortality rates for African Americans are much higher than any other group's for breast, colon, prostate, and lung cancer (10).
- Among patients with diabetes, high blood pressure, or heart disease, Latino and Asian Americans are least likely to receive clinical services important to monitoring and controlling these chronic conditions (6).
- Latinos are less likely than whites or African Americans to receive important preventive services and, in particular, are less likely to be screened for cancers (6).

In 1990, the IOM defined quality of health care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (11). ACP agrees with this definition and believes actions are needed at all levels of the health care delivery system to ensure that every individual receives quality health care.

Minorities face many barriers in obtaining quality health care. Perhaps the biggest obstacle minorities must overcome is the lack of affordable insurance. However, access to health care is also affected by factors that prevent patients from actually obtaining care. Lack of transportation, the location of health care facilities, the unequal distribution of providers in low-income and underserved areas, inability to afford copayments, and referral patterns all contribute to the difficulty that racial and ethnic minorities have in accessing health care services.

**Position 2: *Providing all Americans with affordable health insurance is an essential part of eliminating racial and ethnic disparities in health care.***

Increasing health insurance coverage is one way to improve access to medical care for all racial and ethnic groups, as individuals without coverage receive fewer preventive health services, rely heavily on hospital emergency rooms for care, and have poorer-quality interactions with physicians (12). The rising number of uninsured is a problem plaguing our nation’s health. The number of uninsured Americans in 2001 rose to 41.2 million, up from 39.8 million in 2000 (13). A report published by ACP in 2000 found what was long thought to be true: Uninsured Americans experienced reduced access to care and poorer medical outcomes and tend to live sicker and die earlier than privately insured Americans (12).

Although many barriers, including race, ethnicity, and primary language, impede access to quality health care, insurance coverage appears to be a key to access. The IOM found that insurance status, more than any other demographic or economic factor, determines the timeliness and quality of health care, if it is received at all (14). Keeping this in mind, eliminating disparities in minority health care will be difficult without first eliminating gaps in the rate in which minorities have health insurance.

Minorities are disproportionately represented in the uninsured population. Latinos are the least likely of all racial and ethnic groups to be insured. Nearly half of all nonelderly Latinos have been without health insurance in the past year (6). Representing only 12.5% of the U.S. population, Latinos account for 25.8% of the uninsured population. The table below shows, using the latest census figures, the breakdown of the uninsured population by race, compared to the racial breakdown of the U.S. population.

	<b>U.S. Population, by Race</b>	<b>Uninsured Population, by Race</b>
Non-Latino White	69.1%	50.2%
Latino	12.5%	25.8%
African American	12.3%	17.1%
Asian or Pacific Islander	3.3%	5.2%
American Indian or Alaska Native	0.9%	1.8%

Source: U.S. Census Bureau

There are many reasons why minorities are disproportionately uninsured, as compared to nonminorities. One significant reason is that, since the late 1970s, members of racial and ethnic minority groups have experienced a disproportionate decline in employment-based coverage (14). Employer-based insurance coverage has declined among all racial and ethnic groups since the 1970s, but the disproportionate decline for minorities is due in part to higher unemployment rates, lower-paying jobs, and immigration status among minority populations (14).

Ethnic and racial disparities in access to health care exist even within the uninsured population. Minorities without insurance have much more difficulty getting care than uninsured whites (15). Uninsured minorities are also consistently less likely than uninsured whites to have a regular health care provider (15).

Even when insurance is not a factor, African Americans and Latinos continue to have less access to a regular health care provider, and see a doctor and specialists less often, than whites (15). The problem transcends age groups, as

well. Despite significant strides in increasing the number of insured children through SCHIP, white children, regardless of insurance status, see physicians at twice the rate of minority children (3).

Access to health insurance is also hindered by problems with enrollment procedures for SCHIP, Medicaid, and other public insurance programs. Studies have shown that lengthy and complex applications, lack of applications in other languages, lack of translators to assist in the application process, fear that enrollment would threaten immigration status, difficulty in verifying eligibility, difficulty in continuing coverage, and overall lack of knowledge of available programs are all substantial barriers to increasing enrollment in Medicaid and SCHIP programs (16).

In order to effectively expand health insurance coverage, outreach efforts need to be increased to inform the public about available programs. Additional steps that can help eligible participants enroll in Medicaid and SCHIP include the following:

- Simplifying applications and income eligibility verification.
- Allowing enrollment by mail, over the phone, or through the Internet.
- Simplifying eligibility reviews for individuals and families already enrolled.
- Offering culturally sensitive applications and language assistance to limited-English applicants.

Disparities in health care attributable to race and income have also been found among Medicare beneficiaries. Minority Medicare beneficiaries have higher mortality rates and lower utilization rates than nonminority beneficiaries. Medicare coverage alone has not been sufficient to promote effective patterns of use (17).

The ACP has developed a plan to help ensure that all Americans have access to affordable health insurance. The plan, entitled “Achieving Affordable Health Insurance Coverage for All within Seven Years: A Proposal from America’s Internists,” offers a framework for policies that would enable all Americans to obtain affordable health insurance within 7 years (18). The paper recommends that coverage be expanded in steps, starting with the poor and near-poor. A total of 65% of the uninsured are in families with incomes up to 200% of the federal poverty level; racial and ethnic minorities are disproportionately represented in this group. By requiring that states enroll all individuals with incomes up to 100% of the federal poverty level in Medicaid (with an appropriate increase in federal funds to support expanded enrollment), converting the SCHIP program to a federal–state entitlement program, and providing income-related premium subsidies to obtain private insurance coverage, ACP’s proposal will eliminate the principal barriers that minorities experience in obtaining health insurance coverage. Eliminating the health insurance gap will be a vital step in eliminating health disparities among ethnic and racial minorities.

## Patient Issues

**Position 3:** *As our society increasingly becomes racially and ethnically diverse, health care providers need to acknowledge the culture of their patients.*

**A:** *Health care providers should understand and practice culturally competent care in all of their clinical encounters.*

**B:** *Clear communication between patients and providers is an essential part of the provider/patient relationship and affects the quality of clinical encounters. ACP encourages increased use of interpreter services for patients who are in need of them. ACP suggests that these services often can be obtained by using volunteer services and that physicians should not be responsible for arranging or paying for such services. Public and private health insurance should provide reimbursement for interpreters when volunteer services are unavailable. Coverage under Medicaid, Medicare, and SCHIP is particularly warranted in light of the federal guidelines requiring interpreter services for limited-English proficiency patients who are covered by these programs.*

Physicians and other health care providers must realize the role that an individual's culture plays in his or her health status. There are many negative health consequences that could result from ignoring culture, including missed opportunities for screening because of a lack of familiarity with the prevalence of conditions among certain minority groups; failure to take into account differing cultural responses to prescription medication; lack of knowledge about traditional remedies, leading to harmful drug interactions; and diagnostic errors resulting from miscommunication (19). Research has shown that quality health care requires attention to differences in culture—the “integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group” (20).

### *Culturally Competent Care*

Practicing culturally competent health care can help reduce disparities among racial and ethnic minorities. A 2002 report published by The Commonwealth Fund defined cultural competence as the following:

Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs. Cultural competence is both a vehicle to increase access to quality care for all patient populations and a business strategy to attract new patients and market share (21).

Cultural competence techniques include such interventions as the use of interpreter services, racially or linguistically concordant clinicians and staff, culturally competent education and training, and culturally competent health education (20). Cultural competence techniques have been shown to effectively change provider and patient behavior by improving communication, increasing trust, improving racially or ethnically specific knowledge of epidemiology and treatment efficacy, and expanding understanding of patients' cultural behaviors and environment (20).

*Clear Communication*

Communication in clinical encounters is key to healthy patient outcomes. Clear communication between patients and providers leads to better health status and functioning, greater patient satisfaction, and increased quality of care, which have been shown to increase health care-seeking behavior (19). Providers need to be aware that communication problems occur even when the provider and patient speak the same language. Different populations and communities may use phrases or slang, such as Ebonics, that may present barriers to clear communication. Different dialects, even within the English language, can cause difficulty in communication, and providers need to be mindful of alternative ways of communication within these circumstances.

Over 300 different languages are spoken in the United States (22). According to the U.S. Census Bureau, 28 million Americans (11.1% of the U.S. population) are foreign born (23). Many of these residents and others with limited-English proficiency (LEP) experience difficulty communicating with physicians, an important factor in the physician-patient relationship. According to a 2002 report by the Office of Management and Budget, there are an estimated 66 million patient/provider encounters that take place across language barriers each year (24). Patient surveys have gone further to show that approximately one third of Latinos in this country and one fourth of Asian Americans have problems communicating with doctors (6).

Studies have linked language barriers with fewer physician visits and reduced receipt of preventive services, even after controlling for such factors as literacy, health status, health insurance, regular source of care, and economic indicators (19). Studies also have shown that, without interpreter services, patients with LEP have a more difficult time obtaining medical services, have less quality health care, and have a greater chance for experiencing negative health outcomes. Language barriers directly affect access to care: as many as one in five Spanish-speaking Latinos reports not seeking medical care due to language barriers (3).

The Department of Health and Human Services Office of Minority Health issued guidelines in August 2000 clarifying requirements of the Civil Rights Act of 1964 that federal services (including services provided through Medicare and Medicaid) cannot be denied based on national origin or other factors, including language. These guidelines state that medical facilities receiving federal funds must provide interpreters for patients with LEP. The guidelines permit a range of options that include hiring interpreters and using telephone interpreting services.

The ACP recognizes the important role of interpreter services during medical encounters for increasing access to care for ethnic and racial minorities. However, the cost of providing these services could be exorbitant, and staffing would be impractical for a physician practice serving multiple ethnic and minority populations speaking many different languages.

The ACP also cautions that, although young children may be the only family members who speak English, they should not be used as interpreters, as this may place them in situations that are beyond their maturity to handle. Health care professionals should also use caution when using friends or family members as interpreters in confidentiality cases, such as where domestic violence, sexual assault, or HIV/AIDS is suspected.

## Provider Issues

**Position 4:** *Physicians and other health care providers must be sensitive to cultural diversity among patients and recognize that inherent biases can lead to disparities in health care among racial and ethnic minorities.*

**A:** *Cultural competency training should be incorporated in the training and professional development of all health care providers, at all levels.*

Bias, prejudice, and stereotyping occur in many facets of American life, and the health care delivery system is not exempt from such behavior. The IOM found that bias, prejudice, and stereotyping on the part of health care providers might contribute to differences in care (3). Even though most health care providers probably are disturbed by the idea that prejudice, bias, and stereotyping could play a role in their interactions with patients, studies show that even providers who are not overtly biased or prejudiced typically demonstrate unconscious negative racial attitudes and stereotypes (3). Despite being well educated and well meaning and subscribing to a professional ethic that should mitigate against discrimination on the basis of race or ethnicity, health care providers do exhibit stereotyping within their clinical encounters (3).

Currently, there is no direct evidence suggesting that provider biases affect the quality of care of minority patients. However, research does suggest that health care providers' diagnostic decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity. One study found that doctors rated African-American patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients' income, educational level, and personality characteristics were taken into account (3). These findings help illustrate how providers' perceptions and attitudes toward patients are influenced by patient race or ethnicity, often in subtle ways. Providers must be aware of their biases and stereotypes and attempt to understand how they influence their actions and decisions during clinical encounters.

### *Cultural Competency Training*

Health care providers need training in communicating and interacting effectively with patients from different cultures. Cultural competency and self-awareness training should be incorporated in the training and professional development of all health care providers, at all levels, including medical schools and residency programs, to ensure that their graduates are able to provide high quality care in an increasingly diverse society. Numerous studies have shown that racial concordance (when a provider and patient are of the same racial or ethnic background) is significantly and positively related to patient satisfaction (25). This is not to say that racial concordance is necessary for patient satisfaction or that any health professional should restrict his or her practice only to patients of his or her own race.

The ACP advocates that all physicians be trained to provide efficient, quality healthcare to all racial and ethnic groups, because it is unlikely that the racial makeup of physicians will emulate the racial makeup of the country at any time soon and because all physicians should be sensitive to the health care needs of all of their patients. The ACP also realizes the importance for all health care workers that have interaction with patients, including receptionists, intake coordinators, and health care administrators, to have training in cultural competency.

Minority patients often describe physician visits negatively. For example:

- Asian Americans are least likely of all ethnic and racial minority groups to feel that their doctor understands their background, to have confidence in their doctor, and to be as involved in decision making as they would have liked (6).
- African Americans and Latinos are most likely to feel that they have been treated with disrespect during a health care visit. Reasons for feeling this way often are related to aspects of communication—the patient thought he or she was spoken to rudely, talked down to, or ignored (6).

The Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education should develop competencies of cultural knowledge for medical schools and residency programs and provide these competencies, as well as guidance on how to accomplish them, to all medical schools and residency programs. Similar steps should be taken for continuing medical education and for certification and recertification by specialty boards.

Continuing education for health care providers is one way to identify and change unconscious negative racial attitudes and stereotypes. By allowing cultural competency courses to be used for continuing medical education credits, providers can improve the quality of care they deliver to racial and ethnic minorities.

Offering medical language courses in medical school can also help medical students, even bilingual medical students, become familiar with medical terminology in languages frequently spoken in the communities they serve.

### **Health Care Delivery Issues**

**Position 5:** *Action is needed throughout the entire continuum of the health care delivery system to address disparities in health care among racial and ethnic minorities.*

**A:** *Health care organizations should reach out to surrounding community members and involve community representatives in planning and quality improvement initiatives.*

**B:** *Managed care organizations and other large providers need to take effective steps in reducing disparities in health care.*

**C:** *Quality improvement projects should incorporate race, ethnicity, and primary language measures.*

To effectively eliminate disparities among racial and ethnic minorities, steps need to be taken across all levels of health care delivery, within all systems of delivery. Administrators, providers, public health officers, and others within the health care delivery system should all be aware of the disparities that occur in health care among minorities and work to eliminate these disparities within their organizations.

### *Involving the Community*

Only by understanding the populations that a health care organization is serving can culturally competent care be effectively applied. By interacting with community representatives, a health care organization can assess the community's health care needs and the organization and community members can work to better address these needs. An ongoing dialogue with surrounding communities can also increase the organization's cultural awareness and help to improve the integration of cultural beliefs and perspectives into health care practices and health promotion activities.

### *Large Providers and HMOs*

Health maintenance organizations (HMOs) were originally established with the mission of improving health care by managing care. Effectively managing the health care of minority patients, using culturally appropriate care, improves the health of communities and, as such, should be a tenet of the mission of HMOs. There are many opportunities within a managed care plan and HMO to address disparities. For example, managed care plans are both agents for quality improvement and potential sources of data for examining disparities in health care. An organization can focus on the opportunity to improve business and health services by improving patient satisfaction and by improving culturally competent health care. The fact that minorities are a growing part of the health care market should also serve as an incentive for managed care organizations to increase their appeal to minority consumers, thereby enlarging their market share (20).

Many managed care plans and HMOs are already working to address disparities in health care and can serve as models as to what large providers can do to improve the health of the racial and ethnic minority patients they serve. Kaiser Permanente, for example, has established an Institute for Culturally Competent Care, which has, in turn, established "Centers of Excellence," which are models across Kaiser Permanente that demonstrate how to respond to the health needs of specific populations. Kaiser has made it a mission to improve the health quality of minorities and sees culturally competent care as "better care delivery from a service and quality perspective, and it has the potential to reduce errors and enhance effectiveness" (26).

Large-scale providers that have communities with a density of LEP patients should also offer services in other languages and advertise these services to the surrounding communities. In California, the state advocate's office now publishes report cards on the HMOs in the state, with one grade representing patient satisfaction and communication skills of providers. In 2002, the state released an addendum to the report card focused on interpreter services. Patients can find out which HMOs offer interpreter services in specific languages, how the interpreter services are offered (call center, in-person translators), and if written materials are available in other languages.

*Quality Improvement*

There has been much attention paid to the issue of the quality of health care in the media, in academic journals, by the medical profession, and by public policymakers. In 1999 and 2001, the IOM released two reports indicating that the quality of health care in this country was inconsistent, harms patients, and routinely fails to deliver its potential benefits (27). As a result, many hospitals and health plans are currently undergoing quality improvement measures. In order to improve the quality of care delivered to all patients, eliminating racial and ethnic disparities should be an integral part of these efforts.

A Commonwealth Fund–U.S. Health Resources Services Administration (HRSA) pilot study shows that if a health plan improves its quality of care in general, the care of minority patients may improve, also. However, a set of performance measures applied to all patients may mask or miss key disparities in quality of care for minorities (28). By including specific measurements of the quality of care that minorities receive within quality improvement efforts, researchers can develop benchmarks, performance targets, and specific goals for health plans and providers to focus on for improvement.

Possible ways to address disparities within quality improvement include the following:

- Accreditation organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA), should incorporate standards for measuring cultural competence into their quality measurements. Both NCQA and JCAHO are already working to address disparities within their accreditation work. In 2002, NCQA solicited comments for a new accreditation standard requiring organizations to collect and analyze data that could also be used to address disparities in health care (29). The JCAHO currently has standards that pertain to culturally and linguistically appropriate patient care and is working to further address disparities within its accreditation process.
- Greater opportunities must be created for health care facilities that serve large minority populations to participate in the latest quality improvement innovations.

## Societal Concerns

**Position 6:** *A diverse workforce of health professionals is an important part of eliminating disparities among racial and ethnic minorities.*

- A:** *Education of minority students at all educational levels, especially in the fields of math and science, needs to be strengthened and enhanced to create a larger pool of qualified minority applicants for medical school.*
- B:** *Medical and other health professional schools should revitalize efforts to improve matriculation and graduation rates of minority students. The ACP supports the consideration of race and ethnicity in determining admissions to institutions of higher education. Programs that provide outreach to encourage minority enrollment in medical and health professional schools should be maintained, reinstated, and expanded.*
- C:** *Medical schools need to increase efforts to recruit and retain minority faculty.*
- D:** *Efforts should be made to hire and promote minorities in leadership positions, in all arenas of the health care workforce.*
- E:** *Funding should be continued and increased for programs and initiatives that work to increase the number of health care providers in minority communities.*

Currently, many minority groups are poorly represented in the health professions, relative to their proportion in the overall U.S. population. Whereas minorities make up 28% of the U.S. population, they account for only 7% of physicians (30). During the 2001–2002 academic year, only 12.6% of students enrolled in medical school were members of underrepresented minority groups, down from 13.3% during the academic year 1999–2000 (31). Other health professions have similar statistics: minorities comprise only 5% of dentists, 3% of pharmacists, 4% of optometrists, and 3% of nurses (21).

Increasing the diversity of the health care workforce is a key to increasing access to care and improving the quality of care for minorities. Minority staff, because of shared cultural beliefs and common language, may improve communication, create a more welcoming environment, and structure health systems to better reflect the needs of minority communities (19). While there is no strong evidence that minority providers eliminate health disparities in minority populations, there is evidence that minority providers are more likely to serve in a minority community. According to one study, minority physicians see significantly more minority patients than other physicians (63% versus 42%) and more uninsured or Medicaid patients (53% versus 40%) (32).

*Education of Minority Students at All Levels*

During the 1990s, minority enrollment in medical schools increased substantially. In 1994, for the first time in history, more than 2,000 underrepresented minority students entered medical school, up from fewer than 1,500 in 1990 (33). However, as the number of minority students in medical schools increased, unequal access to educational opportunities in primary and secondary schools for minority students was still apparent (33).

Many scholars and experts have called attention to problems within the educational pipeline that produces the pool of qualified candidates for medical school. Beginning with early childhood education, minorities are often disadvantaged throughout the educational systems. Minorities, at times, are enrolled in schools with inadequate resources, poorly trained educators, and a lack of courses in math and science that prepare students for prehealth degrees at colleges and universities.

Strategies are needed to improve the matriculation and graduation rates of minorities throughout elementary, middle, and high school. Math and science curricula at elementary, middle, and high schools with high percentages of minority students also need to be strengthened to ensure a strong pool of eligible, qualified minority students for prehealth degrees at colleges and universities. Magnet health science schools, partnerships between local hospitals and medical schools, science education partnerships, mentoring relationships, and strong counseling are all ways in which elementary, middle, and high schools can work to strengthen the educational pipeline that will lead to undergraduate and post-graduate health programs.

Undergraduate institutions also need to work to ensure that minority students are recruited and retained, with emphasis on students who seek careers in health care. Undergraduate institutions experience losses of minority students, especially students who enter colleges and universities expressing an interest in the health professions, regardless of their intellectual abilities (34). Educators and advisors need to pay particular attention to the academic preparation and personal growth of minority students interested in health professions. Outreach, tutoring, and mentoring programs directed towards minority students are vital to improving the graduation rates of minority students from colleges and universities. Without strong efforts throughout the entire educational pipeline, the number of minority applicants to health professional schools and, subsequently, the number of minorities in the health professions, will only decrease.

*Minorities in Medical School*

ACP believes that admission policies that consider race and ethnicity, as one factor among many, are effective and necessary to improve the number of minorities enrolled in medical schools. According to a study by the AAMC, 80% fewer minorities would have been accepted into U.S. medical schools without such efforts. This rate, according to the study, would have been approximately the same rate of minorities entering medical school as in the 1960s (35).

Diverse medical schools enhance the cultural competency of medical students. Educators have long established the educational benefits of diversity within higher education. One such expert has asserted that racial and ethnic diversity in the educational setting is paramount to a student's ability to effectively live and work in a diverse society (33). Analyses of the benefit of diversity on a student's learning further confirms that racial diversity and student involvement in activities related to diversity had a direct and strong effect on learning and the way students conduct themselves in later life, including disrupting prevailing patterns of racial separation (33).

Cultural competency is not something that can be taught solely through books and presentations. Through interaction with people from different cultures, students can begin to practice cultural competency by challenging their own viewpoints and stereotypes. In medical school, minority students can also help shape the curriculum and create more of a focus on the health care needs of racial and ethnic minorities.

The effectiveness of admission policies that take into consideration race and ethnicity in increasing the enrollment of underrepresented minority students can now be clearly identified, after the prohibition of such policies at public schools in four states. In 1995, the regents of the University of California prohibited the use of race and ethnicity as a factor in the admission process. This policy went into effect in 1999. However, effective in 1996, race-conscious admission policies were prohibited at all public universities in California after the passage of Proposition 209. In 1996, the Fifth Circuit Court of Appeals ruled in *Hopwood v State of Texas* that race cannot be considered a factor in the admission process, which effectively stopped such practices at public universities in Texas, Louisiana, and Mississippi.

The following chart illustrates the changes in enrollment of underrepresented minority students at all U.S. medical schools and at medical schools in California and Texas before, and after, the end of considering race and ethnicity in admission processes in those states.

**Percentages of Underrepresented Minority Students Enrolled in Entering Classes of U.S., California, and Texas Medical Schools from 1995 to 1999 (36)**

<b>Year</b>	<b>U.S. Medical Schools</b>	<b>California</b>	<b>Texas</b>
1995	12.66	17.5	20
1996	12.02	14.1	18
1997	10.91	11.6	13
1998	11.5	12.9	15
1999	10.65	12.3	14

Because California and Texas are the two states that produce the largest number of underrepresented minority students in medical schools, the elimination of the consideration of race and ethnicity in admissions decisions had a detrimental effect for not only those two states but also on the percentage of underrepresented minority students enrolled in all U.S. medical schools (36). Following Proposition 209 and the Hopwood decision, there was a decrease in underrepresented minority student enrollment at all U.S. medical schools. Nationally, the decline was 9.1% in matriculation at public medical schools and 1.8% at private medical schools. However, the four states where admission policies considering race and ethnicity were challenged accounted for 18% of underrepresented minority students nationally and for 44% of the national decline in underrepresented matriculation (37).

Alternatives to policies that consider race and ethnicity for admission include percent plans, where states admit a certain percent of the highest performing graduates of each high school to public universities in a state. A recent Harvard University study concluded that there is “insufficient evidence to suggest that percent plans, even with other race-conscious processes, are effective alternatives to using race/ethnicity as a factor in admissions” (38). The study found that diversity at schools that currently use percent policies has suffered. The University of California system now offers admission to those that rank in the top 4% of their graduating class. At University of California, Berkeley, one of the most elite public institutions in the state and in the country, the percentage of African-American freshmen declined from 6.7% in 1995, under admissions policies that consider race/ethnicity, to 3.9% in 2001, under the percent plan. The percentage of Latino freshmen also declined from 16.9% in 1995 to 10.8% in 2001 (38). Percent plans only affect public, undergraduate institutions and do not apply to graduate or professional programs. Percent programs also do not apply to candidates applying from out of state. As a result, ACP does not support percent plans in university admissions, as they do not seem to be a viable means of increasing diversity at both undergraduate institutions and medical schools.

The ACP has filed an amicus brief in support of the University of Michigan in the two U.S. Supreme Court cases examining the constitutionality of race-conscious university admission policies: *Grutter v Bollinger, et al.* and *Gratz and Hamacher v. Bollinger, et al.* These two cases challenge the University of Michigan’s diversity programs, in which extra points are granted to minority students in an admissions process that considers a variety of criteria for admission to both the university’s undergraduate program and law school. These cases threaten to eliminate, nationwide, the consideration of race and ethnicity as one factor in admissions decisions, and ACP believes that diversity at undergraduate institutions, medical and other health professional schools, and, ultimately, our health profession workforce will suffer as a result.

### *Minority Faculty at Medical Schools*

Minorities make up 28% of the U.S. population but only 3% of medical school faculty (39). However, 16% of all African-American faculty in U.S. medical schools are at three historically black universities, Howard, Morehouse, and Meharry, and 53% of the Puerto Rican faculty are at the three medical schools in Puerto Rico (35).

Studies have shown that, often, minority faculty spend more time with students and patients than nonminority faculty. One study in particular showed that African-American and Asian-American faculty members spend more time on patient care and less time on research (39). However, minority faculty members are less likely to be promoted than nonminority faculty. Data from the AAMC faculty roster system indicate that underrepresented minority faculty members are significantly less likely to achieve faculty promotion than whites (40).

By improving the diversity of medical school faculty, and the rate at which minority faculty are promoted, minority medical students may have more role models and mentors, which may also serve to improve minority application and graduation rates in medical schools. Minority faculty members may also work to change curricula at medical schools, adding an emphasis on cultural competency and the health care needs of minority populations.

### *Minorities in Leadership Positions in Health Care*

Journal articles often cite the lack of diversity in health care leadership as a potential barrier to health care (21). Minorities make up 28% of the U.S. population but only 3% of medical school faculty, 16% of public health school faculty, and 17% of all city and county health officers. In addition, 98% of senior leaders in health care management are white (21). Minority health care professionals, in general, may be more likely to take into account the needs of minority populations when organizing health care delivery systems (21). Concerted efforts to recruit, prepare, and promote minorities to leadership positions in health care are necessary to overcome current underrepresentation.

### *Providers in Underserved Areas*

A 1997 study of physician practice found that the physician-to-population ratio in impoverished neighborhoods ranged from one physician for every 10,000 residents to one per 15,000 residents. In wealthier areas, the ratio was about one per 300 residents. Therefore, wealthier areas had 33 to 50 times more physicians than poorer areas (41). According to the IOM, one of the reasons that minority patients lack a consistent relationship with a health care provider is the lack of doctors in minority communities (3).

The ACP believes that continuing and increasing funding of programs and initiatives that help to increase the diversity of the health care workforce, as well as increase the number of providers, in minority communities is a necessary step in eliminating disparities in care. Members of ethnic and racial minority groups should also be encouraged to apply to these programs.

Examples of such programs and initiatives include:

- Title VII and Title VIII of the Public Health Services Act, which places physicians and other health professionals in underserved communities. These programs increase the number of providers and enhance the diversity of the health care workforce by recruiting and training more underrepresented minorities. Graduates of these programs are 3 to 10 times more likely to practice in medically underserved areas than graduates of nonfunded programs. Often, they serve as the only source of health care in many disadvantaged communities (42).
- Other federal programs aimed at increasing diversity within the health fields, such as the Health Careers Opportunity Program, Centers of Excellence, and Minority Faculty Fellowship Program.
- Programs such as the National Health Service Corps (NHSC) and the Indian Health Service (IHS) that not only provide health care services to underserved populations but also provide scholarship and loan repayment programs to encourage opportunities for students from diverse backgrounds.
- Area Health Education Centers (AHECs) and Health Education Training Centers (HETCs) are supported by a combination of local and federal funds and work to recruit minority students into health professions, provide continuing education to providers in underserved communities, increase the number of community health centers, and improve the quality of life for ethnic and racial minorities.

Community health centers are a particularly important source of care for minorities, especially for Latinos. One in five Latinos regularly depends on a community health center for medical care (6). By increasing, and improving, the number of community health centers in underserved rural and urban areas, minorities can have greater access to health services, in particular primary care services.

**Position 7:** *Many socioeconomic issues contribute to disparities in health care among racial and ethnic minorities. While all need to be addressed, ACP has specific recommendations concerning public education, targeting the sale of products that negatively impact the health of racial and ethnic minorities, and reducing deaths and injuries from firearms.*

**A:** *The ACP advocates public education programs, targeted to minority communities, on primary and secondary prevention of chronic diseases.*

**B:** *The ACP supports public policies designed to reduce the targeting of minority populations for sales of tobacco, alcohol, foods lacking nutritive quality, and other products that negatively impact the health of racial and ethnic minorities.*

**C:** *The ACP reaffirms its support for public policies to reduce injuries and deaths from firearms.*

There are many factors that need to be addressed in working to eliminate disparities in health care among racial and ethnic minorities. Many of these issues are inextricably tied to income, as a higher percentage of minorities are considered among the poor or near poor (43). Minorities often live in low-income neighborhoods, where there are few health resources to utilize. Diet, nutrition, and the usage of addictive and harmful substances are other health factors that affect minority communities. Understanding the role that social environment plays in the health status of minorities will help to target interventions aimed at improving the health of minorities.

#### *Public Education Programs*

For all adults, preventive care rates are significantly below recommended levels for many key services (6). Primary care physicians should educate all patients about the benefits of regular preventive care visits. However, increasing preventive care is particularly important for improving the health of minorities, because ethnic and racial minorities have much higher mortality rates for treatable, preventable conditions. Some progress has been made in the health care of African Americans, whose receipt of preventive care and reported levels of patient satisfaction are similar to whites (6). However, despite these gains, the health outcomes of African Americans remain worse than those of whites (6). Identifying the causes for this disparity will require analysis of other factors within health care delivery where problems may be occurring.

The ACP also advocates educational programs for health care providers to improve their ability to change health care-seeking behaviors and health risk behaviors in minority communities. Health education and promotion efforts are often not effectively targeted to minority populations. Culturally appropriate health services, such as tailored preventive care, timely health screenings, indicated diagnostic tests, and early intervention and treatment, could result in improved health outcomes and status (19). ACP advocates for increased resources for identifying and implementing educational approaches and behavior change strategies designed for minority audiences and the providers who treat them.

#### *Marketing of Harmful Products*

Marketing of tobacco, alcohol, high-fat foods, and other unhealthful products to minority populations is a major contributor to higher morbidity and mortality among racial and ethnic minorities. To improve the health of racial and ethnic minorities, public policies should be designed to reduce the targeting of minority populations for these unhealthful products.

According to the CDC, in 1996, smoking rates among African-American males had doubled within 4 years (44). In 1998, the Surgeon General released a report documenting how tobacco companies market cigarettes more heavily toward minorities and especially how menthol cigarettes, a more harmful type of cigarette, are overwhelmingly marketed towards minorities (45). One study found that 12% more advertisements appear in African-American magazines than in magazines directed at the general population. In addition, 65.9% of the cigarette advertisements in African-American magazines were for menthol cigarettes, compared with 15.4% of those in the general population magazines (45). Other studies have found that the density of cigarette advertisements on billboards is much higher in African-American, Asian-American, and Latino neighborhoods than in white neighborhoods (45).

According to the National Institutes of Health (NIH), members of many minority groups report higher rates of heavy drinking and alcohol-related problems than whites (46). Similar to tobacco, alcohol—especially more harmful alcohol—is heavily marketed towards racial and ethnic minorities. Advertising for malt liquor, targeted primarily at urban African Americans, Latinos, and Native Americans, often promotes heavier alcohol consumption. Malt liquors are usually sold in 40-ounce glass containers, contain nearly twice as much alcohol as regular beer, and, with an annual growth rate between 25% and 30%, have become the fastest growing type of beer (47).

### *Firearm Injury Prevention*

Firearm injuries are also a major contributor to higher rates of injuries and premature deaths in certain racial and ethnic minority populations. Racial and ethnic minorities suffer from firearms violence at higher rates than whites, as the following statistics demonstrate:

- In 1998, 74% of African-American homicide victims were killed with a firearm, compared to 72% of Latino victims and 56% of white victims (48).
- Firearms homicide is the second-leading cause of death for African-American males age 10 to 17 years (49).
- The total firearm injury (fatal and nonfatal) rate for Latinos is almost three times higher than the rate for whites (48).
- The suicide rate for all U.S. youth aged 10 to 19 years increased from 1980 to 1995. Suicide rates for African-American youth, which had been below those for white youth, showed the sharpest increase. Firearm-related suicides accounted for 96% of the increase in the suicide rate for African-Americans aged 10 to 19 years (50).
- African-American men and women are more likely to be victims of firearm homicide than white men and women. African-American men experience a firearm homicide rate that is more than eight times that of white men (51).

The ACP recognizes the public health impact that firearms have on racial and ethnic minorities and reaffirms its support for public policies to reduce injuries and deaths from firearms (52).

### **More Research Needed**

**Position 8:** *Research is a vital part of identifying, monitoring, and addressing disparities in health care among racial and ethnic minorities.*

**A:** *Research to identify sources of disparities, as well as effectiveness of initiatives targeted to eliminate disparities, will necessitate the collection of better data on race, ethnicity, and primary language, using reliable and standardized measurement tools.*

Understanding the origins of disparities in health care among racial and ethnic minorities is not an exact science. Because of the many environmental factors that contribute to the health status of an individual, and because of the difficulty in measuring stereotypes and bias, it is difficult to grasp the nature of disparities in minority health. More research is therefore needed to better comprehend disparities, to understand what creates disparities, and to identify effective ways for eliminating disparities.

### *Sources of Disparities*

Biological factors that contribute to minority health need to be understood. Clinical research focused on minority populations is essential for comprehending how much biological versus environmental factors play into the high rates of diabetes, heart disease, colon cancer, and other diseases that are commonly found in minority communities.

Currently, health insurers and health care plans are not required to collect or report data on a patient's race, ethnicity, or primary language. Without any reporting of summary standardized data, it is difficult to ascertain the exact nature and scope of disparities. Government programs, recipients of federal funding, and private organizations should collect data on race, ethnicity, and language preference for all beneficiaries, members, and clinical encounters to measure and monitor disparities and to help implement and measure initiatives to improve quality of care.

Measurements should include specific measures of utilization of health care services by minorities indicating poor health care quality due to either over- or under-utilization of services. Privacy rights of patients should be respected in collecting and reporting this data so that individuals are not identifiable. Measurements should also include data on racial and ethnic subpopulations, because there is great diversity within minority populations in this country. Many studies have shown that Asian Americans, as a minority group, tend to be healthier than Latinos and Vietnamese and Korean Americans (6).

A common misperception among health plans is that federal law prohibits the routine collection of data on their enrollees' race and ethnicity. According to the Health and Human Services Office for Civil Rights, there is no such federal prohibition (53). Four states do currently place restrictions on data collection by health insurers, but there are differences among the states' regulations regarding whether the restrictions apply before, during, or after enrollment.

Some race/ethnicity and primary language data collection efforts already underway include the following:

- Plans participating in Medicare+Choice will be required in 2003 to participate in a special project on either racial/ethnic disparities in care or culturally and linguistically appropriate services.
- The SCHIP program requires states to collect and report data on the race, ethnicity, and primary language of enrolled children (54).
- Two states (South Carolina and Texas) have laws recommending or requiring health plans to collect data on race and ethnicity (55).

If state Medicaid programs, accrediting bodies such as the NCQA or JCAHO, and private purchasers make requirements to collect such data, plans will have a strong incentive to learn how to gather information on members' race/ethnicity and use that information to reduce disparities and improve quality.

Cultural competency also needs to be measured to ensure its efficacy in improving patient and provider relations. A 2002 Commonwealth Fund study states that health care experts "saw a need to translate cultural competence into quality indicators or outcomes that can be measured. They saw this, in and of itself, as a tool with which to eliminate barriers and disparities" (21).

The Agency for Healthcare Research and Quality and the IOM are collaborating on an annual national report on health care disparities. This report is intended to track changes in disparities over time; assess the effects of policy and research initiatives; identify the most important areas in which to focus; and guide future research, education, quality improvement, and health policy initiatives. ACP feels this initiative is a vital research endeavor that will help all involved in health care delivery have a better understanding of disparities, as well as help develop effective initiatives that will lead to the elimination of disparities.

## **Summary**

Disparities clearly exist in the health care of racial and ethnic minorities. This position paper provides ample evidence illustrating that minorities do not always receive the same quality of health care, do not have the same access to health care, are less represented in the health professions, and have poorer overall health status than nonminorities. The ACP finds this to be a major problem in our nation's health system, which must be addressed. The ACP is dedicated to working towards the elimination of all disparities in health care. This position paper has set forth specific positions for reducing these disparities and will be the foundation for public policy advocacy by ACP for eliminating racial and ethnic disparities in health care.

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