

# INSTITUTE OF MEDICINE

*Shaping the Future for Health*

## **UNEQUAL TREATMENT: WHAT HEALTHCARE PROVIDERS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTH- CARE**

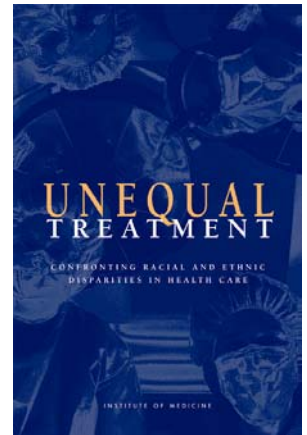
**N**ews accounts of the state of healthcare delivery seem to be full of bad news, including concerns about rising healthcare costs, patient safety and medical errors, and the growing numbers of uninsured Americans. To add to these problems, many recent news reports indicate that racial and ethnic minorities receive lower quality healthcare than whites, even when they are insured to the same degree and when other healthcare access-related factors, such as the ability to pay for care, are the same.

The Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, added to the media fray when the IOM concluded that “(al)though myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care.”

This finding was alarming to many healthcare professionals, the vast majority of whom work hard under very challenging conditions to ensure that patients receive the best possible healthcare to meet their needs. How could bias, prejudice, and stereotyping contribute to unequal treatment, particularly given that healthcare providers are sworn to beneficence and cannot, by law, discriminate against any patient on the basis of race, ethnicity, color, or national origin? This brief summary of the IOM *Unequal Treatment* report addresses this question, and summarizes other relevant findings to help healthcare professionals meet the objective of providing high-quality care for all patients.

### **DO RACIAL AND ETHNIC MINORITIES RECEIVE A LOWER QUALITY OF HEALTHCARE?**

In 1999, Congress requested that the IOM assess the extent of racial and ethnic disparities in healthcare, assuming that access-related factors – such as insurance status and the ability to pay for care are the same; identify potential sources of these



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disparities, including the possibility that overt or subtle biases or prejudice on the part of healthcare providers might affect the quality of care for minorities; and suggest intervention strategies.

To fulfill this request, an IOM study committee reviewed well over 100 studies that assessed the quality of healthcare for various racial and ethnic minority groups, while holding constant variations in insurance status, patient income, and other access-related factors. Many of these studies also controlled for other potential confounding factors, such as racial differences in the severity or stage of disease progression, the presence of co-morbid illnesses, where care is received (e.g., public or private hospitals and health systems) and other patient demographic variables, such as age and gender. Some studies that employed more rigorous research designs followed patients prospectively, using clinical data abstracted from patients' charts, rather than administrative data used for insurance claims. The study committee was struck by the consistency of research findings: even among the better-controlled studies, the vast majority indicated that minorities are less likely than whites to receive needed services, including clinically necessary procedures. These disparities exist in a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, and are found across a range of procedures, including routine treatments for common health problems.

## **WHAT ARE THE SOURCES OF HEALTH CARE DISPARITIES?**

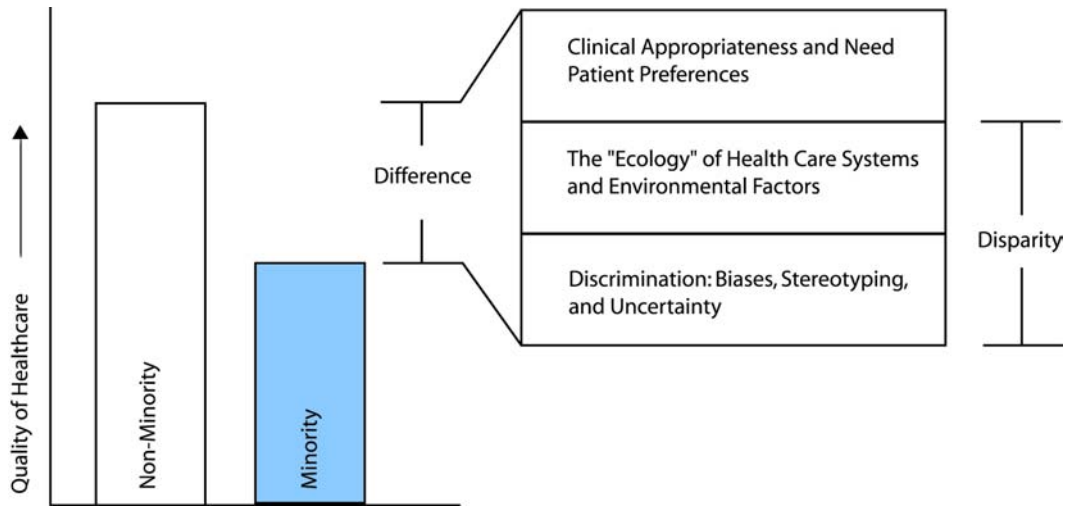
Many factors may contribute to the health care disparities observed in these studies. Some researchers suggest that there may be subtle differences in the way that members of different racial and ethnic groups respond to treatment, particularly with regard to some pharmaceutical interventions, suggesting that variations in some forms of treatment may be justified on the basis of patient race or ethnicity. In addition, patients vary in help-seeking behavior, and some racial and ethnic minorities may be more likely than whites to avoid or delay seeking care. However, the majority of studies find disparities in clinical services that are equally effective for all racial and ethnic groups. Further, the studies that the IOM reviewed suggest that racial differences in patients' attitudes, such as their preferences for treatment, do not vary greatly and cannot fully explain racial and ethnic disparities in healthcare. A small number of studies, for example, find that African Americans are slightly more likely to reject medical recommendations for some treatments, but these differences in refusal rates are generally small (African Americans are only 3-6% more likely to reject recommended treatments, according to these studies). It remains unclear why African-American patients are more likely to reject treatment recommendations. Are they refusing treatment because of a general mistrust of health care providers? Or do some decline treatment because of negative experiences in the clinical encounter or a perception that their doctor is not invested in their care? More research is needed to fully understand treatment refusal because the reasons for refusal may lead to different strategies to help patients make informed treatment decisions.

If minority patients' attitudes toward healthcare and preferences for treatment are not likely to be a major source of health care disparities, what other factors may contribute to these disparities? As shown in the figure below, the IOM study committee considered two other sets of factors that may be associated with disparities in healthcare, assuming that all populations have equal access to care. The first set of factors are those related to the operation of healthcare systems and the legal and regulatory climate in which they operate. These include factors such as cultural or linguistic barriers (e.g., the lack of interpretation services for patients with limited English proficiency), fragmentation of

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healthcare systems (as noted earlier, these include the possibility that minorities are disproportionately enrolled in lower-cost health plans that place greater per-patient limits on healthcare expenditures and available services), the types of incentives in place to contain costs (e.g., incentives to physicians to limit services), and where minorities tend to receive care (e.g., minorities are less likely to access care in a private physician's office, even when insured at the same level as whites).



Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare.  
SOURCE: Gomes and McGuire, 2001

The second set of factors emerges from the clinical encounter. Three mechanisms might be operative in healthcare disparities from the provider's side of the exchange: bias (or prejudice) against minorities; greater clinical uncertainty when interacting with minority patients; and beliefs (or stereotypes) held by the provider about the behavior or health of minorities. Patients might also react to providers' behavior associated with these practices in a way that also contributes to disparities. Research on how patient race or ethnicity may influence physician decision-making and the quality of care for minorities is still developing, and as yet there is no direct evidence to illustrate how prejudice, stereotypes, or bias may influence care. In the absence of such research, the study committee drew upon a mix of theory and relevant research to understand how these processes might operate in the clinical encounter.

### *Clinical Uncertainty*

Any degree of uncertainty a physician may have relative to the condition of a patient can contribute to disparities in treatment. Doctors must depend on inferences about severity based on what they can see about the illness and on what else they observe about the patient (e.g., race). The doctor can therefore be viewed as operating with prior beliefs about the likelihood of patients' conditions, "priors" that will be different according to age, gender, socioeconomic status, and race or ethnicity. When these priors are considered alongside information gathered in a clinical encounter, both influence medical decisions.

Doctors must balance new information gained from the patient (sometimes with varying levels of accuracy) and their prior expectations about the patient to make a diagnosis and determine a course of treatment. If the physician has difficulty accurately understanding the symptoms or is less sure of the "signal" – the set of clues and indications that

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physicians rely upon to make diagnostic decisions – then he or she is likely to place greater weight on “priors.” The consequence is that treatment decisions and patients’ needs are potentially less well matched.

### *The Implicit Nature of Stereotypes*

A large body of research in psychology has explored how stereotypes evolve, persist, shape expectations, and affect interpersonal interactions. Stereotyping can be defined as the process by which people use social categories (e.g., race, sex) in acquiring, processing, and recalling information about others. The beliefs (stereotypes) and general orientations (attitudes) that people bring to their interactions help organize and simplify complex or uncertain situations and give perceivers greater confidence in their ability to understand a situation and respond in efficient and effective ways.

Although functional, social stereotypes and attitudes also tend to be systematically biased. These biases may exist in overt, explicit forms, as represented by traditional bigotry. However, because their origins arise from virtually universal social categorization processes, they may also exist, often unconsciously, among people who strongly endorse egalitarian principles and truly believe that they are not prejudiced. In the United States, because of shared socialization influences, there is considerable empirical evidence that even well-intentioned whites who are not overtly biased and who do not believe that they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes. Both implicit and explicit stereotypes significantly shape interpersonal interactions, influencing how information is recalled and guiding expectations and inferences in systematic ways. They can also produce self-fulfilling prophecies in social interaction, in that the stereotypes of the perceiver influence the interaction with others in ways that conform to stereotypical expectations.

### *Healthcare Provider Prejudice or Bias*

Prejudice is defined in psychology as an unjustified negative attitude based on a person’s group membership. Survey research suggests that among white Americans, prejudicial attitudes toward minorities remain more common than not, as over half to three-quarters believe that relative to whites, minorities – particularly African Americans – are less intelligent, more prone to violence, and prefer to live off of welfare. It is reasonable to assume, however, that the vast majority of healthcare providers find prejudice morally abhorrent and at odds with their professional values. But healthcare providers, like other members of society, may not recognize manifestations of prejudice in their own behavior.

While there is no direct evidence that provider biases affect the quality of care for minority patients, research suggests that healthcare providers’ diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients’ race or ethnicity. Schulman et al. (1999), for example, found that physicians referred white male, black male, and white female hypothetical “patients” (actually videotaped actors who displayed the same symptoms of cardiac disease) for cardiac catheterization at the same rates (approximately 90% for each group), but were significantly less likely to recommend catheterization procedures for black female patients exhibiting the same symptoms. In another experimental design, Abreu (1999) found that mental health professionals subliminally “primed” with African American stereotype-laden words were more likely to evaluate the same hypothetical patient (whose race was not identified) more negatively than when primed with neutral words. Further, in a study based on actual clinical encounters, van Ryn and Burke (2000) found that doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with

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medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients' income, education, and personality characteristics were taken into account. These findings suggest that while the relationship between race or ethnicity and treatment decisions is complex and may also be influenced by gender, providers' perceptions and attitudes toward patients are influenced by patient race or ethnicity, often in subtle ways.

#### *Medical Decisions Under Time Pressure with Limited Information*

Indeed, studies suggest that several characteristics of the clinical encounter increase the likelihood that stereotypes, prejudice, or uncertainty may influence the quality of care for minorities. In the process of care, health professionals must come to judgments about patients' conditions and make decisions about treatment, often without complete and accurate information. In most cases, they must do so under severe time pressure and resource constraints. The assembly and use of these data are affected by many influences, including various "gestalts" or cognitive shortcuts. In fact, physicians are commonly trained to rely on clusters of information that functionally resemble the application of "prototypic" or stereotypic constellations. These conditions of time pressure, resource constraints, and the need to rely on gestalts map closely onto those factors identified by social psychologists as likely to produce negative outcomes due to lack of information, to stereotypes, and to biases (van Ryn, 2002).

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#### *Patient Response: Mistrust and Refusal*

As noted above, the responses of racial and ethnic minority patients to healthcare providers are also a potential source of disparities. Little research has been conducted as to how patients may influence the clinical encounter. It is reasonable to speculate, however, that if patients convey mistrust, refuse treatment, or comply poorly with treatment, providers may become less engaged in the treatment process, and patients are less likely to be provided with more vigorous treatments and services. But these kinds of reactions from minority patients may be understandable as a response to negative racial experiences in other contexts, or to real or perceived mistreatment by providers. Survey research, for example, indicates that minority patients perceive higher levels of racial discrimination in healthcare than non-minorities. Patients' and providers' behavior and attitudes may therefore influence each other reciprocally, but reflect the attitudes, expectations, and perceptions that each has developed in a context where race and ethnicity are often more salient than these participants are even aware of.

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### **WHAT CAN HEALTHCARE PROVIDERS DO TO HELP ELIMINATE DISPARITIES IN CARE?**

Given that stereotypes, bias, and clinical uncertainty may influence clinicians' diagnostic and treatment decisions, education may be one of the most important tools as part of an overall strategy to eliminate healthcare disparities. Healthcare providers should be made aware of racial and ethnic disparities in healthcare, and the fact that these disparities exist, often despite providers' best intentions. In addition, all current and future healthcare providers can benefit from cross-cultural education. Cross-cultural education programs have been developed to enhance health professionals' awareness of how cultural and social factors influence healthcare, while providing methods to obtain, negotiate and manage this information clinically once it is obtained. Cross-cultural education can be divided into three conceptual approaches focusing on *attitudes* (cultural sensitivity/awareness approach), *knowledge* (multicultural/categorical approach), and *skills* (cross-cultural approach), and has been taught using a variety of interactive and experien-



tial methodologies. Research to date demonstrates that training is effective in improving provider knowledge of cultural and behavioral aspects of healthcare and building effective communication strategies.

Standardized data collection is also critically important in efforts to understand and eliminate racial and ethnic disparities in healthcare. Data on patient and provider race and ethnicity would allow researchers to better disentangle factors that are associated with healthcare disparities, help health plans to monitor performance, ensure accountability to enrolled members and payors, improve patient choice, allow for evaluation of intervention programs, and help identify discriminatory practices. Unfortunately, standardized data on racial and ethnic differences in care are generally unavailable, and a number of ethical, logistical, and fiscal concerns present challenges to data collection and monitoring, including the need to protect patient privacy, the costs of data collection, and resistance from healthcare providers, institutions, plans and patients. In addition, health plans have raised significant concerns about how such data will be analyzed and reported. The challenges to data collection should be addressed, as the costs of failing to assess racial and ethnic disparities in care may outweigh new burdens imposed by data collection and analysis efforts.

Many other strategies must be undertaken, in conjunction with the training and educational strategies described here, to eliminate racial and ethnic disparities in healthcare. As noted in the report, these include, for example, policy and regulatory strategies that address fragmentation of health plans along socioeconomic lines, and health systems interventions to promote the use of clinical practice guidelines and promote the use of interpretation services where community need exists. In short, a comprehensive, multi-level strategy is needed to eliminate these disparities. Broad sectors – including healthcare providers, their patients, payors, health plan purchasers, and society at large – must work together to ensure all patients receive a high quality of healthcare.

## GUIDE TO INFORMATION SOURCES

An increasing number of resources are available to healthcare providers and their patients to increase awareness of racial and ethnic healthcare disparities and means to improve the quality of care for racial and ethnic minorities. The following is only a partial list of some of these resources, and is not intended as an endorsement of the products or individuals and groups that produced them:

American Board of Internal Medicine. (1998). *Cultural Competence: Addressing a Multicultural Society: The ABIM Report 1997-1998*. Philadelphia: American Board of Internal Medicine.

American Medical Association. (1999). *Cultural Competence Compendium*. Chicago, IL: American Medical Association. Product Number OP209199/ Phone # 1-800-621-8335.

Betancourt JR, Like RC, and Gottlieb BR, eds. (2000). Caring for diverse populations: Breaking down barriers. *Patient Care*, Special Issue, May 15, 2000.

Lavizzo-Mourey R, and Mackenzie ER. (1996). Cultural Competence: Essential Measurements of Quality for Managed Care Organizations. *Annals of Internal Medicine* 124, pp. 919-21.

National Alliance for Hispanic Health. *Quality Services for Hispanics: the Cultural Competency Component*, Rockville, MD: U.S. Department of Health and Human Services, 2000.

In addition to these sources, the Henry J. Kaiser Family Foundation and the Robert Wood Johnson Foundation have recently joined forces to sponsor an initiative to increase dialogue among physicians regarding healthcare disparities. To learn more about this initiative, please visit the “Why the Difference?” website at [www.kff.org/whythedifference](http://www.kff.org/whythedifference).

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Schulman, K.A., Berlin, J.A., Harless, W., Kerner, J.F., Sistrunk, S., Gersh, B.J., Dube, R., Taleghani, C.K., Burke, J.E., Williams, S., Eisenberg, J., Escarce, J.J., Ayers, W. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *New England Journal of Medicine* 340:618-626.

van Ryn M, Burke J. 2000. The effect of patient race and socio-economic status on physician's perceptions of patients. *Social Science and Medicine* 50:813-828.



## For More Information...

Copies of *Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care* are available for sale from the National Academy Press; call (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area), or visit the NAP home page at [www.nap.edu](http://www.nap.edu). The full text of this report is available at <http://www.nap.edu/catalog/10260.html>

Support for this project was provided by the U.S. DHHS Office of Minority Health, with additional support for report dissemination provided by the California Endowment and The National Academies. The views presented in this report are those of the Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care and are not necessarily those of the funding agencies.

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