Racial and Ethnic Disparities in Health Care
A Position Paper of the American College of Physicians

Disparities clearly exist in the health care of racial and ethnic minorities. This position paper of the American College of Physicians (ACP) 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 that must be addressed. The ACP is dedicated to working toward eliminating all disparities in health care. This position paper sets 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.

Editor’s Note: From time to time, Annals publishes position papers of the American College of Physicians. Racial and ethnic disparities in health care is a timely, in fact urgent, topic for a position paper. The ACP staff researched and wrote the paper in collaboration with the ACP Health and Public Policy Committee. The ACP Board of Regents approved the recommendations on 31 March 2003. The Appendix describes the research, writing, and approval of this position paper. To provide in-depth perspective on some aspects of disparities in health care, we have commissioned 4 brief commentaries (see pages 221–225).

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

The Centers for Disease Control and Prevention (CDC) reports that “relatively little progress has been made toward the goal of eliminating racial/ethnic disparities” among a wide range of health indicators (1). Although all Americans are healthier today, the gaps between minority and white groups remain nearly the same as they did a decade ago. For example, the mortality rate for African Americans is approximately 1.6 times higher than that of white people—a ratio that is identical to the black–white mortality ratio in 1950 (2).

The American College of Physicians (ACP), whose mission is “to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine,” has a long-standing commitment to improving public health. Accordingly, ACP finds the disparities in the health care of racial and ethnic minorities to be a major problem in the U.S. health system and is dedicated to working toward eliminating all disparities in health care by addressing the issue on 6 fronts: increasing access to quality health care, patient care, provider issues, systems that deliver health care, societal concerns, and continued research.

**HEALTH INSURANCE COVERAGE**

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

The College believes that actions are needed at all levels of the health care delivery system to ensure that every individual receives high-quality health care. As documented by the Institute of Medicine (IOM) and studies by other researchers, minorities do not receive the same quality of care as nonminorities, regardless of insurance or socioeconomic status. For instance, although the mortality rate for heart disease among African Americans is about 50% higher than that of white people, the chance of African Americans undergoing angioplasty and coronary bypass surgery is about half of that for whites (3). Among patients with diabetes, high blood pressure, or heart disease, Latinos and Asian Americans are least likely to receive clinical services that are important for monitoring and controlling these chronic conditions. In addition, Latinos are less likely than white people or African Americans to receive important preventive services, including cancer screenings (4).

**Position 2: Providing all Americans with affordable health insurance is an essential part of eliminating racial and ethnic disparities in health care.**
More than 43 million Americans do not have health insurance (5). Our review of the literature published from 1990 to 2000 found that uninsured Americans had reduced access to care and poorer medical outcomes and tend to live sicker and die earlier than privately insured Americans (6). Increasing health insurance coverage is one way to improve access to medical care for all racial and ethnic groups. 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 (7).

Minorities are disproportionately represented in the uninsured population. Latinos are the least likely racial or ethnic group to be insured. Nearly half of all nonelderly Latinos were uninsured in the past year (4). Representing only 12.5% of the U.S. population, Latinos account for 25.8% of the uninsured population (Table).

One reason minorities are disproportionately uninsured is that since the late 1970s, they have experienced a disproportionate decrease in employment-based coverage; this decrease is partly due to higher unemployment rates, lower-paying jobs, and immigration status (7). Access to health insurance is also hindered by problems with enrollment procedures for public insurance programs, including lengthy and complex applications, lack of applications in other languages, fear that enrollment would threaten immigration status, and overall lack of knowledge of available programs (8).

The ACP position paper “Achieving Affordable Health Insurance Coverage for All within Seven Years: A Proposal from America’s Internists” (9) offers a framework for policies that would enable all Americans to obtain affordable health insurance within 7 years. The paper recommends that coverage be expanded in steps, starting with the poor and near-poor. Fifty-five percent 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. The ACP’s proposal will eliminate the principal barriers that minorities experience in obtaining health insurance coverage 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), converting State Children’s Health Insurance Program (SCHIP) to a federal-state entitlement program, and providing income-related premium subsidies to obtain private insurance coverage.

**Table. Racial Breakdown of the U.S. Population and Uninsured Population**

<table>
<thead>
<tr>
<th>Race</th>
<th>U.S. Population, %</th>
<th>Uninsured Population, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Latino white</td>
<td>69.1</td>
<td>50.2</td>
</tr>
<tr>
<td>Latino</td>
<td>12.5</td>
<td>25.8</td>
</tr>
<tr>
<td>African American</td>
<td>12.3</td>
<td>17.1</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>3.3</td>
<td>5.2</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>0.9</td>
<td>1.8</td>
</tr>
</tbody>
</table>

* Source: U.S. Census Bureau.

Ignoring culture can have many negative health consequences, including missed opportunities for screening because of a lack of familiarity with the prevalence of conditions among certain minority groups; failure to consider differing cultural responses to prescription medication; and lack of knowledge about traditional remedies, leading to harmful drug interactions (10).

**Culturally Competent Care**

Cultural competence techniques include the use of interpreter services, racially or linguistically concordant clinicians and staff, culturally competent education and training, and culturally competent health education (11). These techniques 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 (11).

Clear Communication

Clear communication in clinical encounters is key to healthy patient outcomes, leading to better health status and functioning, greater patient satisfaction, and increased quality of care, which increases health care-seeking behavior (10). Providers must be aware that communication problems occur even when the provider and patient speak the same language.

According to a 2002 report by the Office of Management and Budget, an estimated 66 million patient–provider encounters occur across language barriers each year (12). Without interpreter services, patients with limited English proficiency have a more difficult time obtaining medical services, receive lower-quality health care, and have a greater chance for experiencing negative health out-
comes. As many as 1 in 5 Spanish-speaking Latinos report not seeking medical care because of language barriers (2).

The U.S. 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 Medicare and Medicaid) cannot be denied on the basis of national origin or other factors, including language, and that medical facilities receiving federal funds must provide interpreters for patients with limited English proficiency.

The College recognizes the important role of interpreter services during medical encounters. However, the cost of providing these services could be exorbitant, and staffing would be impractical for a physician practice serving several ethnic and minority populations that speak many different languages.

The College also cautions that young children, although they may be the only family members who speak English, should not be used as interpreters, because 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 situations in which domestic violence, sexual assault, or HIV or 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. Cultural competency training should be incorporated in the training and professional development of all health care providers, at all levels.

Although no direct evidence suggests that provider biases affect the quality of care of minority patients, research indicates that health care providers’ diagnostic decisions, as well as their feelings about patients, are influenced by patients’ race or ethnicity. Providers must be aware of their biases and stereotypes and attempt to understand how they influence actions and decisions during clinical encounters.

Several studies have also shown that racial concordance (when a provider and patient share a racial or ethnic background) is substantially and positively related to patient satisfaction (13). This is not to say that racial concordance is necessary for patient satisfaction.

It is important that all health care workers interacting with patients, as well as receptionists, intake coordinators, and health care administrators, have training in cultural competency.

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

Offering medical language courses in medical school can also help medical students, even bilingual medical students, become familiar with medical terminology in languages that are 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 or ethnicity and primary language measures.

Involving the Community

Administrators, providers, public health officials, and others in the health care delivery system should be aware of and work to eliminate disparities in health care. An ongoing dialogue with surrounding communities can help a health care organization integrate cultural beliefs and perspectives into health care practices and health promotion activities.

Large Providers and Health Maintenance Organizations

Effectively managing the health care of minority patients, and using culturally appropriate care, improves the health of communities and, as such, should be a tenet of the mission of health maintenance organizations (HMOs). Many managed care plans and HMOs are already working to address disparities in health care and can be models for large care providers. Kaiser Permanente, which established an Institute for Culturally Competent Care, aims to improve the health quality of minorities. Kaiser Permanente 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” (14). In California, the state advocate’s office now publishes report cards on the HMOs in the state. Patients can find out which HMOs offer interpreter services in specific languages, how the interpreter services are offered, and whether written materials are available in other languages.

Quality Improvement

In 1999 and 2001, the IOM released 2 reports indicating that the quality of health care in this country was inconsistent, harms patients, and routinely fails to deliver its potential benefits (15, 16). Eliminating racial and ethnic disparities should be an integral part of quality improvement efforts. Accreditation organizations should consider incorporating standards for measuring cultural competence.
into their quality measurements. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) currently has standards that pertain to culturally and linguistically appropriate patient care and is working to further address disparities in its accreditation process.

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.

Many minority groups are poorly represented in the health professions relative to their proportion in the overall U.S. population. Although minorities make up 25% of the U.S. population, they account for only 6% of physicians (17). 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 1999–2000 academic year (18).

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 providers are more likely to serve in a minority community. According to one study, minority physicians see substantially more minority patients than other physicians (63% versus 42%) and more uninsured or Medicaid patients (53% versus 40%) (19).

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 2000 underrepresented minority students entered medical school, up from fewer than 1500 student in 1990 (20). However, unequal access to educational opportunities for minority students remains, and strategies are needed to improve the matriculation and graduation rates of minorities throughout the educational pipeline (20). These include magnet health science schools, partnerships between local hospitals and medical schools, science education partnerships, mentoring relationships, and strong counseling.

Minorities in Medical School

The ACP believes that admission policies that consider race and ethnicity among many factors are effective and necessary to improve the number of minorities enrolled in medical schools. According to a study by the Association of American Medical Colleges (AAMC), 80% fewer minorities would have been accepted into U.S. medical schools without such efforts—a rate similar to that of minorities entering medical school in the 1960s (21).

Analyses of the benefit of diversity on a student’s learning confirms that racial diversity and student involvement in activities related to diversity directly and strongly affected learning and the way students conduct themselves in later life, including disrupting prevailing patterns of racial separation (20).

The ACP filed an amicus brief in support of the University of Michigan in the 2 U.S. Supreme Court cases that examined the constitutionality of race-conscious university admission policies. Both cases threatened to eliminate, nationwide, the consideration of race and ethnicity as a factor in admissions decisions. The ACP believes the diversity of our health profession workforce would suffer as a result and is pleased that the U.S. Supreme Court ruled in favor of affirmative action in Grutter v Bollinger, et al. (02-241 288 F3d 732 [2003]).

Minority Faculty at Medical Schools

Minorities make up 28% of the U.S. population but only 3% of medical school faculty (22). However, 16% of all African-American faculty in U.S. medical schools are at 3 historically black universities (23).

Studies have shown that minority faculty tend to spend more time with students and patients than nonminority faculty. One study showed that African-American and Asian-American faculty members spend more time on patient care and less time on research (22). However, data from the AAMC faculty roster system indicate that underrepresented minority faculty members are substantially less likely to achieve faculty promotion than white faculty (24).

By improving the diversity of medical school faculty and the rate at which minority faculty are promoted, medical schools may have more role models and mentors for their minority medical students, which may also improve minority application and graduation rates. Minority faculty members may also work to change curricula at medical schools, emphasizing the health care needs of minority populations.

Minorities in Leadership Positions in Health Care

Minorities make up only 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 (25). Concerted efforts to recruit, prepare, and promote minorities to leadership positions in health care
Providers in Underserved Areas

According to the IOM, minority patients lack a consistent relationship with a health care provider because of the lack of doctors in minority communities (2). A 1997 study of physician practice found that the physician-to-population ratio in impoverished neighborhoods ranged from 1 physician for every 10,000 residents to 1 physician per 15,000 residents. Yet, in wealthier areas, the ratio was about 1 physician per 300 residents or 33 to 50 times more physicians than that of poorer areas (26).

The ACP believes that continuing and increasing funding of initiatives, such as the Minority Faculty Fellowship Program and the National Health Service Corps (NHSC), that help to increase the diversity and size of the health care workforce in minority communities are necessary to eliminate disparities in care. Graduates of programs authorized under Title VII and Title VIII of the Public Health Services Act, which trains underrepresented minorities and places health professionals in underserved communities, are 3 to 10 times more likely to practice in medically underserved areas than graduates of nonfunded programs (27).

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 (4). By increasing and improving community health centers in underserved 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.

Public Education Programs

Health education and promotion efforts are often not effectively targeted to minority populations. The College 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. 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 (28). In 1998, the U.S. Surgeon General released a report documenting how tobacco companies market cigarettes more heavily toward minorities (29). The density of cigarette advertisements on billboards, for example, is much higher in African-American, Asian-American, and Latino neighborhoods than in white neighborhoods (29).

According to the National Institutes of Health (NIH), members of many minority groups report higher rates of heavy drinking and alcohol-related problems than white persons (30). Alcohol—especially more harmful alcohol, such as malt liquor—is heavily marketed toward urban African Americans, Latinos, and Native Americans (31).

Firearm Injury Prevention

Racial and ethnic minorities have higher rates of firearms violence than white people. In 1998, 74% of African-American homicide victims were killed with a firearm, compared with 56% of white homicide victims (32). The total firearm injury rate for Latinos is almost 3 times higher than the rate for white people (32), while firearm-related suicides accounted for 96% of the increase in the suicide rate for African Americans age 10 to 19 years from 1980 to 1995 (33).

The College recognizes the public health effect that firearms have on racial and ethnic minorities and reaffirms its support for public policies to reduce injuries and deaths from firearms (34).

More Research Is Needed

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

Clinical research focused on minority populations is essential for comprehending how much biological versus environmental factors play into the high rates of diseases 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, and this makes it difficult to ascertain the exact nature and scope of disparities. Government programs, recipients of federal funding, and private organizations should collect such data for all beneficiaries,
members, and clinical encounters to measure and monitor disparities and improve quality of care.

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. For example, Asian Americans, as a minority group, tend to be healthier than Latinos, Vietnamese Americans, and Korean Americans (4).

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 U.S. Health and Human Services Office for Civil Rights, no such federal prohibition exists (35). Two states (South Carolina and Texas) have laws recommending or requiring health plans to collect data on race and ethnicity (36), while the SCHIP program requires states to collect and report data on the race, ethnicity, and primary language of enrolled children (37).

Cultural competency also must 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” (25).

The Agency for Healthcare Research and Quality (AHRQ) 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. The College feels that this initiative is a vital research endeavor that will help all involved in health care delivery to better understand disparities, as well as help develop effective initiatives that will lead to the elimination of disparities.

APPENDIX

In October 2000, the ACP Board of Regents produced a Statement of Core Policy Principles on Providing Access to Care for All Americans. The Regents identified as a core principle the elimination of disparities in medical care based on social, ethnic, racial, gender, sexual orientation, and demographic differences. In May 2002, the College’s Health and Public Policy Committee (HPPC) decided to make racial and ethnic disparities in health care a high priority for policy development. Shannon R. Lightner, MSW, MPA, Congressional Staffer, former ACP Health Policy Associate, acted as staff for this project. To prepare a list of issues, she used articles and documents in College files, articles identified in a computer search of the literature, key articles referenced in other materials, and articles suggested by HPPC members. After reviewing her list of issues for College policy development, Ms. Lightner was directed by the HPPC to prepare a position paper. On the basis of comments from HPPC members, she revised the position paper, which underwent a point-by-point discussion at an HPPC meeting early in 2003. The HPPC approved the paper, which was then posted on the College’s electronic information centers for comments by members of the Board of Regents, Board of Governors, and several other College committees and affiliated internal medicine organizations. On the basis of these comments, the HPPC again modified the paper and submitted it to the Board of Regents with a summary of the comments received. The Board of Regents approved the position paper on 31 March 2003. Rachel Groman, MPH, ACP Health Policy Associate, then prepared an abridged version of the position paper for publication in Annals of Internal Medicine. Jack Ginsburg, MPE, Director of Health Policy Analysis and Research for ACP, oversaw the entire process.


References
15. Kohn LT, Corrigan JM, Donaldson MS, eds. To Err Is Human: Building a