

The Institute of Medicine Report “Unequal Treatment”: Implications for Academic Health Centers

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Abstract

Background: The United States has achieved dramatic improvements in overall health and life expectancy, largely due to initiatives in public health, health promotion and disease prevention. Academic health centers have played a major role in this effort, given their mission of engaging in research, educating health professionals, providing primary and specialty medical services, and caring for the poor and uninsured. However, national data indicate that minority Americans have poorer health outcomes (compared to whites) from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, cancer and HIV/AIDS. Two factors contribute heavily to these racial and ethnic disparities in health: minorities are subjected to adverse social determinants, and they are disproportionately represented among the uninsured. In the last twenty years, however, the literature has highlighted the fact that racial and ethnic disparities occur not only in health, but also in health care.

The Institute of Medicine Report, “Unequal Treatment.” The Institute of Medicine (IOM) was asked to determine the extent of racial and ethnic disparities in health care. Their report, entitled “Unequal Treatment,” found that racial and ethnic disparities in health care do exist, and that many sources, including health care systems, health care providers, patients and utilization managers, are contributors.

Recommendations from “Unequal Treatment”: Implications for Academic Health Centers. The IOM Report, “Unequal Treatment,” provides a series of recommendations to address racial and ethnic disparities in health care, targeted to a broad audience (the executive summary and full IOM Report can be found at www.nap.edu under the search heading “Unequal Treatment”). Several of the recommendations speak directly to the mission and roles of academic health centers, and have clear and direct implications for patient care, education, and research.

These recommendations include collecting and reporting health care access and utilization data by patient’s race/ethnicity, encouraging the use of evidence-based guidelines and quality improvement, supporting the use of language interpretation services in the clinical setting, increasing awareness of racial/ethnic disparities in health care, increasing the proportion of underrepresented minorities in the health care workforce, integrating cross-cultural education into the training of all health care professionals, and conducting further research to identify sources of disparities and promising interventions.

Conclusion: “Unequal Treatment” provides the first detailed, systematic examination of racial/ethnic disparities in health care, and provides a blueprint for how to address them. The report’s recommendations are broad in scope, yet have direct implications for academic health centers.

Key Words: Institute of Medicine Report, unequal treatment, racial disparities, ethnic disparities, health care, racial minorities, ethnic minorities, minority health, academic health centers.

Background

OVER THE PAST TWO HUNDRED YEARS, the United States has achieved dramatic improvements in

overall health and life expectancy, largely due to initiatives in public health, health promotion and disease prevention. Academic health centers have played a major role in this effort, given their mission of engaging in research, educating health professionals, providing primary and specialty medical services, and caring for the poor and uninsured (1). Nevertheless, despite interventions that have improved the overall health of the majority of Americans, racial and ethnic minorities have benefitted significantly less than others from these advances. National data indicate that minority Americans

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have poorer health outcomes (compared to whites) from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, cancer, and HIV/AIDS (2).

Multiple factors contribute to these "racial and ethnic disparities in health." First and foremost, research has demonstrated that social determinants such as lower levels of education, lower socioeconomic status, inadequate and unsafe housing, racism and living in close proximity to environmental hazards disproportionately impact minority populations and thus contribute to their poorer health outcomes (3–7). One unfortunate example of the impact of social determinants is the fact that three of the five largest landfills in the country are in African-American and Latino communities, thus contributing to some of the highest rates of pediatric asthma among these populations (8). Second, lack of access to care also takes a significant toll, as uninsured individuals are less likely to have a regular source of care and are more likely to report that they delay seeking care or that they have not received needed care—all resulting in experiencing avoidable hospitalizations, emergency hospital care and adverse health outcomes (9–11). Also, minorities are more likely to be uninsured than their white counterparts, with data from the US Census Bureau demonstrating that in 2002, 32% of Hispanics and 20% of African-Americans were uninsured, compared to only 11% of whites (12).

In the last twenty years, however, the literature has highlighted the fact that racial and ethnic disparities occur not only in health, but also in health care. In fact, these disparities in quality of care for those with access to the health care system contribute to the larger issue of racial and ethnic disparities in health. Research in this area has shown that minorities receive a lower quality of care when they are in the health care system, even when controlling for social determinants and insurance status. For instance, disparities have been shown to exist in the utilization of cardiac diagnostic and therapeutic procedures (African-Americans are referred less often than whites for cardiac catheterization and bypass grafting) (13–17); prescription of analgesia for pain control (African-Americans and Latinos receive less pain medication than whites for long bone fractures and cancer) (18–20); and surgical treatment of lung cancer (African-Americans receive less curative surgery than whites for non-small-cell lung cancer) (21). Disparities have

also been seen in referral for renal transplantation (African-Americans with end-stage renal disease are referred less often than whites to the transplant list) (22); treatment of pneumonia and congestive heart failure (African-Americans receive less optimal care than whites when they are hospitalized for these conditions) (23); and the utilization of general services covered by Medicare (i.e., immunizations and mammograms) (24). Again, perhaps the most important issue that should be noted about all of these studies is that disparities occurred even when variations in such factors as insurance status, income, age, co-morbid conditions and symptom expression are taken into account. Racial/ethnic disparities in health are unacceptable, yet understandable, given the persistent racial and socioeconomic inequalities in the US today (which include minorities, on the whole, having lower levels of education and lower annual incomes than whites) (25). Research highlighting racial/ethnic disparities in health care sheds light on a heretofore less visible crisis that has until recently been given little national attention.

As a result of this work, in 1999 the United States Congress commissioned the Institute of Medicine (IOM) to further study the issue of racial/ethnic disparities in the health care system. The IOM, part of the National Academy of Sciences and chartered by Congress to advise the federal government on issues of health policy, medical care, research, and education, was asked to:

- Assess the extent of racial/ethnic differences in health care that are not otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage);
- Evaluate potential sources of racial and ethnic disparities in health care, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional and health systems levels; and
- Provide recommendations regarding interventions to eliminate health care disparities.

The Institute of Medicine Report, "Unequal Treatment"

To study this issue, the IOM convened a committee of academicians, medical educators, health service researchers, health policy makers, economists, social psychologists, social scientists, lawyers, practicing physicians and

nurses—some with experience and knowledge in the area of disparities, and others with expertise and proven leadership in other aspects of health care delivery and research. This approach is consistent with the goal of the IOM to assemble an objective and open-minded group of committee members who can effectively evaluate the evidence and come up with findings and recommendations. Given that the charge of the committee was limited to disparities in health care (versus the larger issue of health outcomes) once access had been achieved, specific areas of exploration included: health system factors (financial and institutional arrangements, structural processes of care, etc.); provider factors (communication in the medical encounter, the effect of race/ethnicity on clinical decision-making, etc.); and consumer factors (patient preferences). To carry out its responsibilities over the 18 months of the study, the committee reviewed a significant amount of evidence from five main sources, including a review of the literature (with strict inclusion and exclusion criteria), commissioned papers (on topics ranging from an exploration of health care disparities to the economic, ethical and legal ramifications of disparities in health care), expert testimony, focus groups of patients and providers, and a public workshop. The final report, entitled “Unequal Treatment: Confronting Racial/Ethnic Disparities in Healthcare” (26) was released on March 20, 2002. The major findings were as follows:

- Racial and ethnic disparities in health care exist and, because they are associated with worse health outcomes, are unacceptable.
- Racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality, and there is evidence of persistent racial and ethnic discrimination in many sectors of American life.
- Many sources—including health systems, health care providers, patients, and utilization managers—may contribute to racial and ethnic disparities in health care.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care.
- A small number of studies suggest that certain patients may be more likely to refuse

treatments, yet these refusal rates are generally small and do not fully explain health care disparities.

Recommendations from “Unequal Treatment”: Implications for Academic Health Centers

The IOM Report “Unequal Treatment” provides a series of recommendations to address racial and ethnic disparities in health care, targeted to a broad audience (the executive summary and full IOM Report can be found at www.nap.edu (27) under the search heading “Unequal Treatment”). Several of the recommendations speak directly to the mission and roles of academic health centers, and have clear and direct implications for patient care, education, and research.

Improving Systems to Address Disparities: Recommendations for Patient Care

Collect and report health care access and utilization data by patient’s race/ethnicity. One of the foremost challenges in the effort to eliminate racial/ethnic disparities in health care is to detect these differences when they are present. Many of the findings in “Unequal Treatment” were based on national studies or regional studies that utilized data that was readily available (e.g., hospital discharge data), but they were not designed to capture health care disparities based on race and ethnicity. As a result, the report cannot give a local “snapshot” of the issues facing a particular health care system or hospital. This limitation is compounded by the fact that race and ethnicity data collection systems, when present (such as in Medicare databases), have only recently begun to collect data on patient groups outside the standard categories of “white,” “black,” and “other” (28). Consequently, not only do we lack the appropriate systems to track and monitor racial and ethnic disparities in health care, but we also know little about the disparities that other minority groups (Hispanics, Asian-Americans, Pacific Islanders, Native Americans and Alaska Natives) may be experiencing. In sum, standardized data on racial and ethnic disparities in care are generally unavailable. Federal, private, and state-supported data collection efforts are scattered and unsystematic, and most health care systems, hospitals, and health plans (with a few notable exceptions) do not collect data on patients’ or enrollees’ race, ethnicity, or primary language.

It is clear that our ability to track and eliminate racial and ethnic disparities centers on our ability to collect race and ethnicity data in a systematic and standardized fashion. This highlights the pivotal role academic health care centers could play in the systematic collection of the necessary data. This would enable us to effectively identify disparities locally, and then implement strategies to monitor and eliminate them as part of quality improvement and performance measurement efforts. This leads us directly into our next recommendation.

Encourage the use of evidence-based guidelines and quality improvement. "Unequal Treatment" highlights the subjectivity of clinical decision making as a potential cause of racial and ethnic disparities in health care. Specifically, this occurs when clinicians offer different diagnostic and treatment options to different patients (consciously and unconsciously) based on their race or ethnicity, even in the presence of well-delineated practice guidelines. To remedy the problem, the authors recommend the widespread adoption and implementation of evidence-based guidelines. For instance, there now exist evidence-based guidelines for the management of diabetes, HIV/AIDS, cancer screening and management, and asthma—all areas where significant disparities exist. As part of ongoing quality improvement efforts in academic health centers, particular attention should be paid to implementing of evidence-based guidelines for all patients, regardless of their race and ethnicity, and monitoring progress accordingly. The goal of evidence-based guidelines is to ensure that all patients get the highest quality of care, regardless of race, ethnicity, culture or class. Academic health centers can play a major role in achieving this.

Support the use of language interpretation services in the clinical setting. The lack of interpreter services in health care systems can lead to patient dissatisfaction, poor comprehension and compliance, and ineffective/lower quality care for patients with limited English proficiency (29–37). Doctor-patient communication without an interpreter, in the setting of even a minimal language barrier, is recognized as a major challenge to effective health care delivery (29–31). Research in this area has shown that Spanish-speaking patients discharged from the emergency room are less likely than their English-speaking counterparts to understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care (32);

less likely to be satisfied with their care or willing to return if they have a problem; more likely to report problems with their care (33); and less satisfied with the patient-provider relationship (33). In addition, Hispanic patients whose physicians don't speak Spanish are more likely to omit medication, miss office appointments, and visit the emergency room for care (36). The report's recommendation to support the use of interpretation services has clear implications for health care delivery in academic health centers.

Addressing Disparities through Training: Recommendations for Education

Increase awareness of racial/ethnic disparities in health care. Recent surveys have shown that neither physicians nor patients are aware of the extent, or the severity, of racial and ethnic disparities in health care in the US. For example, a national mail survey of 2,608 physicians (whose primary activity is patient care) conducted by the Kaiser Family Foundation in 2001 found that a majority of those surveyed (mainly white) said that the health care system "never" (14%) or "rarely" (55%) treats people unfairly based on race/ethnicity (38). In contrast, a similar phone survey of 3,884 members of the public, conducted by the Kaiser Family Foundation in 2000 found that 36% of Hispanics and 35% of African-Americans (compared to 15% of whites) felt that they were treated unfairly in the health care system based on their race or ethnicity. Perhaps even more revealing, 65% of African-Americans and 58% of Hispanics (compared to 22% of whites) were afraid of being treated unfairly in the future, based on their race/ethnicity. Increasing awareness of racial and ethnic treatment disparities among health care professionals is an important first step in addressing disparities in health care. Academic health centers can increase awareness and education regarding health disparities through several venues, including grand rounds, public relations campaigns and newsletters, and as part of educational curricula (38).

Increase the proportion of underrepresented minorities in the health care workforce. Recent data available from the American Medical Association indicate that of the 70.5% of US physicians whose race and ethnicity is known, Hispanics make up 3.5%, African-Americans 2.6%, and American Indian and Alaska natives less than 0.5%. Minority physicians are also poorly represented in specialties

such as cardiology, surgery, and radiation oncology (40). Data regarding the racial/ethnic composition of medical school faculty is no different, with minorities comprising only 4.2% nationally. Moreover, approximately 20% of this latter group are located at three historically black medical schools (Howard University School of Medicine, Meharry Medical College, and Morehouse School of Medicine), and three Puerto Rican medical schools (Universidad Central del Caribe School of Medicine, Ponce School of Medicine, and the University of Puerto Rico School of Medicine) (41). The situation with regard to the future health care workforce is only slightly brighter. Despite comprising 30% of the population, minority students accounted for approximately 10% of medical school graduates in 2001. A majority of these students were African American (65%), with smaller percentages of Mexican American students (22.6%), mainland Puerto Ricans (6.4%) and Native Americans (5.9%) (42). Among medical school graduates in 2001, nearly half of minority graduates indicated plans to practice in underserved areas, compared to less than one-fifth of non-minority students. In sum, given the important role academic health centers play in training our future health care workforce, it is increasingly important that recruitment, retention and promotion of minorities at all levels of the academic ladder become an integral part of human resources policy. The goal of this recommendation is to develop a diverse health care workforce that can meet the needs of an increasingly diverse population, not only from the standpoint of direct clinical care, but also from the standpoint of leadership, health system design, and research.

Integrate cross-cultural education into the training of all health care professionals. There is a growing literature that delineates the impact of sociocultural factors, race, and ethnicity on health and clinical care (43). Health care professionals aren't shielded from diversity, as patients present varied perspectives, values, beliefs and behaviors regarding health and well-being. These sociocultural differences between patient and provider influence communication and clinical decision making, and are especially significant, given the evidence that links provider-patient communication to patient satisfaction, regimen adherence, and subsequently, health outcomes (44, 45). Thus, when sociocultural differences between patient and provider aren't appreciated, explored, understood or communicated effectively in the med-

ical encounter, patient dissatisfaction, poor adherence, poorer health outcomes and racial/ethnic disparities in care may result (46). Cross-cultural education is a strategy to address these issues directly. The goal of cross-cultural education is to improve providers' ability to understand, communicate with, and care for patients from diverse backgrounds. Training in this area focuses on enhancing awareness of sociocultural influences on health beliefs and behaviors, and providing skills to understand and manage these factors in the medical encounter.

Given the findings of "Unequal Treatment" and the description of how stereotyping by health care providers might lead to disparate treatment based on a patient's race or ethnicity, it is now felt that that cross-cultural curricula should be expanded to explore the roles of race, ethnicity, and culture in clinical decision-making. For instance, over the course of their medical education, doctors are taught the "prescriptive theory of clinical decision-making." Simply put, this theory states that clinical decisions should rely on the detailed exploration of two variables: the presentation of symptoms and the probability of disease (through the application of Bayes' theorem) (47). Simultaneously, doctors are taught a set of heuristics or "clinical gestalts" with the premise that there are certain "hallmark" symptoms for conditions. These heuristics then become shortcuts for clinical decision-making (for example, cough and fever probably equals bronchitis or pneumonia). Although this runs counter to what we are taught about generating a detailed review of symptoms and a broad differential diagnosis, as we practice under greater stress and time pressure we become more susceptible to using these "shortcuts" in our clinical decision-making.

Doctors are also taught that their own personal background, and the characteristics of the patient and the clinical setting, should be excluded from consideration in the formulation of clinical decisions. Social cognitive theory, however, has brought to our attention the ways in which natural tendencies to stereotype might influence clinical decision-making. Every day we are faced with enormous amounts of information that we must sift through in order to make decisions. As a result, we all share the subconscious strategy of attempting to simplify our decision-making process and lessen our cognitive effort by using "categories" or "stereotypes" in which we apply beliefs and expectations about groups of people to individuals from that group (48–50). Interestingly, we may

not be aware of our attitudes or consciously endorse stereotyping. Nevertheless, when individuals are mentally assigned to a particular class or group, the characteristics assigned to that group are subconsciously and automatically applied to the individuals. It should be emphasized that this is a normal, functional, adaptive cognitive process that is oftentimes automatic, and most likely centered on (in rank order) race, gender, and age—characteristics that manifest visually (49). Most important, we tend to activate stereotypes most when we are stressed, multitasking and under time pressure—the hallmarks of the clinical encounter.

For example, many medical students and residents are often trained—and minorities cared for—in academic health centers or public hospitals located in socioeconomically disadvantaged areas. As a result, doctors may begin to equate certain races and ethnicities with specific health beliefs and behaviors (e.g., “these patients” engage in risky behaviors or “those patients” tend to be noncompliant) that are associated more with the social environment (poverty, etc.) than their patients’ racial/ethnic backgrounds or cultural traditions. This “conditioning” phenomenon may also occur if doctors are faced with certain racial/ethnic patient groups who tend to avoid the more aggressive forms of diagnostic or therapeutic interventions. The result over time may be that doctors begin to believe that “these patients” don’t like invasive procedures, and thus the doctors may not offer them as options very ardently, if at all. In the case of African-Americans, for example, this opinion could become a self-fulfilling prophecy. Based on historical factors of segregation and medical experimentation, African-Americans have been more mistrustful of the health care system than any other racial or ethnic group (with Latinos not far behind) (46). This mistrust may contribute to wariness in accepting or following recommendations, undergoing invasive procedures, or participating in clinical research. This in turn may lead doctors to believe that African-Americans are less adherent or less interested in aggressive treatments. Again, this stereotyping is a natural and expected—but no less dangerous—phenomenon that may affect the way doctors make decisions and offer specific interventions to various patients based on their race or ethnicity.

In summary, cross-cultural curricula should provide an overview of health care disparities, a framework for understanding and improving the clinical decision-making process (including

strategies to avoid stereotyping), and skills for effectively communicating and negotiating across cultures. These curricula could be incorporated into the training for all health care professional.

Identifying Strategies to Eliminate Disparities: Recommendations for Research

Conduct further research to identify sources of disparities and promising interventions. While the literature that formed the basis of the findings and recommendations of “Unequal Treatment” provided significant evidence for racial and ethnic disparities, additional research is needed in several areas. First, most of the disparity literature focuses on differences between African-Americans and whites; much less is known about the experiences of other minority groups. This may be due to the way data has been collected, and the fact that information on health access and utilization may not be as readily available for other subgroups (Hispanics, Asian-Americans, Native Americans, etc.). Improving our ability to collect racial and ethnic patient data should facilitate this process, but in instances where those systems are not yet in place, racial and ethnic patient data may be collected prospectively in the setting of clinical or health services research. Second, until now much of the literature on disparities has focused on defining areas where they exist, but much less has been done to identify the multiple factors that contribute to disparities, and very little has been done to test specific interventions to address them. Future health disparities research should focus on these steps, and academic health centers can be at the cutting edge of this agenda.

Conclusion

The Institute of Medicine Report “Unequal Treatment” provides the first detailed, systematic examination of racial/ethnic disparities in health care, and provides a blueprint for how to address them. The report’s recommendations are broad in scope, yet have direct implications for academic health centers, given their mission of engaging in research, educating health professionals, providing primary and specialty medical services, and caring for the poor and uninsured. The strategies presented here will improve the care of all patients, not just those who are members of racial and ethnic minorities. As such, the IOM’s recommendations should inform the quality improvement, educa-

tion and research agendas of academic health centers in the future, and thus help to bridge the “quality gap.” Eliminating disparities should no longer be considered a marginal or “add-on” issue, but instead a critical part of the mission of academic health centers. Ultimately, academic health centers can ill afford to have patients sustain complications of long-term, treatable chronic conditions because of inability to provide the highest quality of care to all patients who enter their doors, regardless of race, ethnicity, culture, class, or language proficiency.

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