

# Chapter 1: Racial/Ethnic Disparities in Health Care

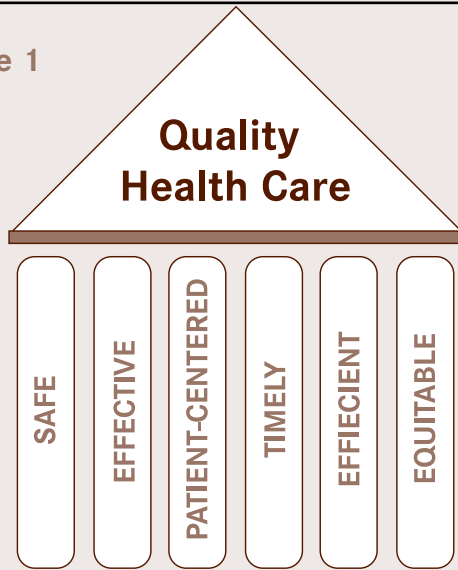
The Institute of Medicine Report *Unequal Treatment* found that even with the same insurance and socioeconomic status, and when comorbidities, stage of presentation and other confounders are controlled for, minorities often receive a lower quality of health care than do their white counterparts.

For instance, Table 1 lists several examples of where disparities are found.

Table 1	
WHERE DISPARITIES ARE FOUND	EXAMPLES FROM RESEARCH
Utilization of cardiac diagnostic and therapeutic procedures in the Emergency Department	African-Americans being referred less than whites for cardiac catheterization <sup>37</sup> and bypass grafting <sup>16, 38</sup>
Administration of analgesia for pain control	African-Americans and Latinos receiving less pain medication than whites for long bone fractures in the Emergency Department <sup>39</sup> and for cancer pain on the floors <sup>40, 41</sup>
Surgical treatment of lung cancer	African-Americans receiving less curative surgery than whites for non-small cell lung cancer <sup>42</sup>
Referral to renal transplantation	African-Americans with end-stage renal disease being referred less to the transplant list than whites <sup>43</sup>
Treatment of patients hospitalized with pneumonia and congestive heart failure	African-Americans receiving less optimal care than whites when hospitalized for these conditions <sup>44</sup>
Outcomes of myocardial infarction	Elderly African-American women having the highest adjusted in-hospital mortality <sup>45</sup>

Our nation’s annual *National Healthcare Disparities Report* released by the Agency for Healthcare Research and Quality further reinforces the persistence of these trends.<sup>46</sup> The examples provided here not only highlight lapses in quality of care, but also have significant clinical consequences and are directly linked to known racial/ethnic disparities in health outcomes. There is little doubt that social determinants – such as lower levels of education, overall 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.<sup>47-53</sup> Similarly, lack of access to care, a particular problem for minority populations, also takes a significant toll, as uninsured individuals are less likely to have a regular source of care,<sup>54, 55</sup> are more likely to report delaying seeking care,<sup>56, 57</sup> and are more likely to report that they have not received needed care.<sup>58</sup> This results in an increasing amount of avoidable hospitalizations, use of emergency hospital care, and ultimately adverse health outcomes for minorities in the US.<sup>59, 60</sup> Yet *Unequal Treatment* clearly stated that racial/ethnic disparities in quality of care contribute to disparities in health outcomes, and stressed the need for leaders of health care organizations nationwide to engage in activities to identify and address them.

Figure 1



## Six Principles of Quality Health Care

**SAFE** Avoiding injuries to patients from the care that is intended to help them

**EFFECTIVE** Providing services based on scientific knowledge and avoiding underuse and overuse, respectively

**PATIENT-CENTERED** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

**TIMELY** Reducing waits and harmful delays for both those who receive and those who give care.

**EFFICIENT** Avoiding waste, including waste of equipment, supplies, ideas, and energy.

**EQUITABLE** **Providing care that does not vary in quality because of personal characteristics such as ethnicity, gender, geographic location and socioeconomic status.**

## Why Equity is an Essential Component of Quality

*Crossing the Quality Chasm* highlights that quality is a system property, and that our current system of health care delivery is in need of redesign. To truly achieve quality of care, health care systems must focus on six key elements – efficiency, effectiveness, safety, timeliness, patient-centeredness, and *equity* (see Figure 1).

Equity is achieved by providing care that does not vary in quality by personal characteristics such as ethnicity, gender, geographic location, and socioeconomic status. Over the last few years, there has been an increased focus by hospital leadership on improving quality by responding to the six key elements proposed by *Crossing the Quality Chasm*. There is no doubt that significant gains have been made in this effort, particularly in the area of patient safety.<sup>61, 62</sup> However, one key pillar of quality – achieving equity – has remained elusive and garnered significantly less attention than the others. This is despite robust evidence that demonstrates the existence – and persistence – of racial and ethnic disparities in health care, and how the inattention to the root causes of these disparities can have a significant impact on quality, cost, and risk management.<sup>63-65</sup>

Despite this, few hospital leaders have the issue of equity, and identifying and addressing disparities, prominently on their radar screen. For example, preliminary results from an organizational assessment survey distributed to approximately 150-200 executives, physicians and hospital management at 10 hospitals across the country found that only 3% of executives agreed or strongly agreed that disparities in health care were a major problem in their hospital; 85% disagreed or strongly disagreed that disparities were a major problem (12% were neutral).<sup>66</sup>

So why might this be the case? Two primary hypotheses emerge:

- First, as reflected in research to date, health care leaders may be reluctant to believe that racial/ethnic disparities exist, and perhaps more importantly, that they do not exist in the institution they are overseeing. This perspective, referred to as the “not me!” phenomenon takes root in health care providers’ reluctance to believe that patients might receive a different quality of care based on their race/ethnicity.<sup>67</sup> For example, when doctors were asked in a large survey: “Do you think people are treated unfairly in the health care system based on their race/ethnicity?” approximately 14% said

never, and 55% said rarely. In another Web-based survey of 344 cardiologists, only 12% felt disparities existed in their own hospital setting, and only 5% thought disparities existed in the care of their own patients.<sup>68</sup> This viewpoint, although inaccurate in the face of a breadth of evidence on disparities, is understandable as the concept of unequal treatment runs counter to what health care providers are taught (that they shouldn't treat people differently based on personal characteristics) and is conceptually anathema to them.

- Second, given the multiple competing interests on the leadership agenda, the issue of equity may have yet to bubble to the top. Whether it is an issue of limited resources, an uncertain business case, or lack of rigorous quality measures or accreditation standards, equity remains a lower priority in practice than safety, for example, where some of the aforementioned conditions (e.g. accreditation standards) are more mature.

No matter what the reason, the evidence is clear – equity has yet to take its place among the pillars of quality. However the tide is turning, as there is now a persuasive quality, business and risk management case to be made for identifying and addressing disparities, not to mention impending quality measures<sup>69</sup> and accreditation standards<sup>70</sup> that will move the issue of assuring equity from the “optional” to the “mandatory” column of hospital leaders’ to-do list. Our *Improving Quality and Achieving Equity: A Guide for Hospital Leaders* provides leaders with the “case” for addressing disparities, as well as the knowledge and know-how to initiate a portfolio of activities related to improving quality and achieving equity. Ultimately, this guide will assure that hospital leaders can improve quality, achieve equity, and be responsive to the impending levers that will move this issue from the margins to the mainstream.