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Racial and Ethnic Health Disparities

Introduction

As the U.S. population becomes more diverse, health and human service providers and others involved in health care delivery will interact with persons from a variety of different cultural and linguistic backgrounds. Disproportionate access to care, fragmented health care systems, lack of cultural sensitivity among providers, cultural beliefs and behaviors, and unequal (differential) treatment of persons who receive care are key determinants of racial/ethnic disparities in health care and health status. The elimination of racial/ethnic disparities in health status will require important changes in the ways health care is delivered, financed, and documented.

Race and Ethnicity

A challenge in defining racial and ethnic differences in health is the nature of the social construct of race. While race has often been distinguished by physical characteristics, including skin color, ethnic differences usually focus on cultural characteristics, such as beliefs, language, history, religion, behaviors, and customs. What begins as an ethnic or cultural distinction often becomes racial, and racial groups are often identified with reference to customs and behaviors. We generally refer to racial and ethnic groups, without making any sharp distinction between race and ethnicity.¹ Even though members of a particular ethnic group seem to exhibit common patterns of behaviors and beliefs, not all members express the same degree of ethnicity. Generalizations can serve as

a basis for health care providers to learn more about an ethnic group. However, "ethnic generalizations are not absolutes!"² Stereotyping results when one does not recognize individual preferences, beliefs, and behaviors. Inaccurate diagnoses and treatments can result from stereotyping a specific ethnicity.

Culture

Culture is defined as the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. For health care, culture defines how health care information is received; how rights are exercised; what is considered to be a health problem; how symptoms and concerns about the problem are expressed; who should provide treatment for the problem; and what type of treatment should be given. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves, the unique needs of populations whose cultures may be different from the prevailing culture.³

Demographic Characteristics of Minority Populations

Five races are currently distinguished in official U.S. government statistics: white, Black (African

American), American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Islander. An additional distinction is made between Hispanics or Latinos and all others, this being designated as an “ethnic” distinction that crosscuts the racial classification. The 2000 U.S. Census followed this classification but also allowed multiple choices by the individual. As self-identification becomes the norm, multiple and interracial identification was made in the U.S. 2000 Census.⁴ However, these categories are not entirely adequate as the basis of assessing disparities, and there is a need to delve behind the numbers to identify the “diversity among the diversity.”

Recent census reports indicate that about 1 in 3 residents of the U.S. self identify as Black (African American), American Indian/Alaska Native (AI/AN), Asian/Pacific, or Hispanic or Latino. By the year 2050, minorities and AI/ANs are expected to represent nearly half of the U.S. population. Health data reveal that there are disparities in the health status of minority groups compared to that of the population as a whole. If these populations continue to experience poor health status, the expected demographic changes will amplify the adverse impact of disparities on public health in the United States.⁵

Table 1: Distribution of U.S. Population by Race/Ethnicity⁴

U. S. Total	2000	2050
White (non-Latino)	69.1 %	52.8%
Latino	12.5%	4.3%
Black (non-Latino)	12.1%	13.2%
Asian/Pacific Islander	3.7%	8.9%
American Indian/Alaska Native	0.7%	0.8%
Other	1.8%	-

Note: Data does not include residents of Puerto Rico, Guam, U.S. Virgin Islands or Northern Marina Islands. “Other” category includes Non-Latino individuals who reported “Some other race” and “Two or more races.” 2050 data does not include estimates for people identified in the “Other” category.

Health Disparities

According to P.L. 106-525, the Minority Health and Health Disparities Research and Education Act of 2000, health disparity populations refer to “a population where there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.”⁶ Racial and ethnic minority health disparities means that these populations experience shorter life spans, higher rates of infant mortality, higher incidences of diabetes, heart disease, cancer, and other diseases and conditions, and poorer general health than the white population. In the US, Blacks, AI/ANs, Asian/Pacific and Hispanics, bear a disproportionate burden of disease, injury, premature death, and disability.

Health disparities are a result of a complex interplay of many factors including racism, access to health care, the organization of health care, and health beliefs. Additionally, socioeconomic factors (e.g., education, employment, and poverty), lifestyle behaviors (e.g., physical activity, alcohol intake, and tobacco use), social environment (e.g., educational and economic opportunities and neighborhood and work conditions), and access to clinical preventive services (e.g. cancer screening and vaccination) contribute to racial/ethnic health disparities.⁶

Research conducted by the Centers for Disease Control (CDC) and others confirm that health status may be determined in large part by factors that exist outside the health care system such as employment, race and racism, behavior, genetics, and other environmental factors. The physical, social, and economic environments — air and water quality, housing, and social connections — have an affect over time on health status. Therefore, improving the health system can reduce disparities, but it can do little to eliminate them. A focus on community and prevention may improve health status and reduce health disparities.⁷

Disease Conditions Related to Health Disparities

The health disparities that afflict ethnic and racial minorities as well as other underserved populations are not limited to one or two disease categories. They apply to a broad spectrum of disease types and also exist within different geographic regions of the United States. A brief sample of relevant diseases follows:⁶

Infant Mortality – Over the last decade, the infant mortality rate remains more than twice as high among Blacks as compared to whites, even when controlling for socioeconomic factors. American Indians and Alaska Native infants also have a death rate almost double that of whites.

Heart Disease and Stroke – Coronary heart disease mortality is 20 percent higher for Blacks than whites. Fewer Blacks survive severe cardiomyopathy as compared to whites – a difference that is attributed to both biological and socioeconomic factors. The incidence of stroke is disproportionately high in Blacks, where the mortality rate is nearly 27.5 percent higher than in whites.

Cancer – Minority groups suffer disproportionately from cancer, and disparities exist in both mortality and incidence rates. Blacks have both a higher overall incidence and a higher death rate than any other racial or ethnic

group. The difference in cancer mortality is about 12 percent higher for Hawaiian men and 20 percent higher for Hawaiian women than that of white Americans.

Mental Health – Disease burden associated with mental disorders falls disproportionately on ethnic minority populations. American Indian and Alaska Natives not only suffer disproportionately from depression, but this population also experiences a higher rate of suicide.

Diabetes – The prevalence of diabetes in Blacks is twice as high as in whites. Blacks, Hispanic Americans, American Indians (291 percent higher), and Pacific Islander and Asian American populations as well as economically disadvantaged or older people, suffer disproportionately compared to white populations.

HIV and AIDS – AIDS incidence is disproportionately higher in Blacks than for other populations. Black females are diagnosed with AIDS at a rate that is nearly four times higher than for Hispanic American females, 10 times higher than for AI/AN females and 24 times more often than white females. Black males experience a rate of AIDS incidence that is almost three times higher than for Hispanic males, nearly six times greater than for AI/AN males and nearly eight times higher than for white males.

Table 2: Health Disparities of Certain Diseases in Selected Populations. ⁸⁻¹³

HEALTH DISPARITIES OF CERTAIN CONDITIONS IN SELELCTED POPULATIONS					
HEALTH CONDITION AND SPECIFIC EXAMPLE	INDEX IN SELECTED POPULATIONS				
	White	African American	Hispanic or Latino	Asian or Pacific Islander	AI/AN
Infant mortality rate per 1000 live births	5.9	13.9	5.8	5.1	9.1
Cancer mortality rate per 100,000	199.3	255.1	123.7	124.2	129.3
Coronary Heart Disease mortality rate per 100,000	206	252	145	123	126
Stroke mortality rate per 100,000	58	80	39	51	38
Diabetes diagnosed rate per 100,000	36	74	61	DSU	See note
End-Stage Renal Disease rate per million	218	873	DNA	344	589
AIDS – diagnosed rate per 100,000 Female	2	48	13	1	5
AIDS – diagnosed rate per 100,000 Male	14	109	43	9	19

Note: Available data on AI/AN underestimates the true prevalence of diabetes; 40 to 70 percent of the 45 to 74 age group were found to have diabetes. DSU = Data are statistically unreliable; DNA= Data have not been analyzed

Socioeconomic Status and Health Disparities

Across all causes of mortality, economic status is the leading indicator of poor health. Access to care is largely a function of health insurance coverage, which is largely a function of employment status, which is largely a function of educational attainment.¹⁴

Reducing disparities in health will not occur without recognition of the corresponding disparities in education and employment and attention to overall rural development. Two of the most profound treatments for disparity are better education and better jobs; not just health service-related spending.

People of color and AI/ANs are more likely to have family incomes less than 200 percent of the federal poverty level than are whites. Over half of Latinos, Blacks, and AI/ANs

Table 3: Poverty Rate by Race/Ethnicity, U.S. 2003¹⁶

United States Percent in Poverty	
White	11%
Black	35%
Hispanic	24%
Other	10%

are poor or near poor, compared with 25 percent of whites and 32 percent of Asian/Pacific Islanders.¹⁵

Lack of Health Insurance and Health Disparities

One factor that continues to show disparities in the quality of care is embedded in a system that leaves many Americans lacking adequate, if any, health insurance. Racial and ethnic minority Americans make up about one-third of the U.S. population, but disproportionately comprise 52 percent of the uninsured – 23 of the 45 million uninsured in 2003. When compared with the insured, the uninsured are less likely to have a regular doctor or to get timely and routine care, and are more likely to be hospitalized for preventable conditions. This disparity is even more evident among minorities who live in rural America.¹⁶

Table 4: Non-Elderly Uninsured Rates, by Region and Race/Ethnicity, 2002-2003¹⁶

	U.S Total Non-elderly	Northeast	South	Midwest	West
White (non-Latino)	12.7%	11.2%	14.6%	11.2%	13.2%
Latino	34.2%	28.0%	40.5%	29.3%	32.1%
Black (non-Latino)	21.3%	21.6%	22.1%	18.8%	18.8%
Asian/Pacific Islander	20.1 %	23.7%	24.0%	15.2%	18.3%
American Indian/Alaska Native	28.3%	11.5%	27.0%	25.6%	31.7%

Note: **Northeast** includes: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; **South** includes: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; **Midwest** includes: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; **West** includes: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Of particular note, is that data reflected in uninsured rates for AI/ANs is sometimes skewed because the majority of AI/ANs rely on the federal government to fulfill its legal obligation for provision of health services. In essence, this arrangement is sometimes confused as “having health insurance” and is reported as such in various state data bases. Therefore, the actual rates of AI/ANs who have private insurance is difficult to determine and certainly higher than is reflected in most analyses.¹⁶

Other Factors Related to Health Disparities¹⁷

Major factors in health disparities have been categorized in the following way:

Macrosocial influences such as culture, media, socioeconomic status, place of residence, family, and institutions and politics

Behavioral risk factors that result in chronic disease include alcohol, diet, smoking, and exercise

Risk taking and abusive behaviors related to infectious disease and injury refer to sexual practices, injury risk behavior, violent behavior, and drug abuse

Adaptive health behaviors consist of coping strategies, protective cultural practices, social support

Healthcare behavior which encompasses utilization or avoidance of health care, health care seeking behavior, self-care practices, provider behavior, the doctor-patient relationship, and adherence to medical regimens

Provider factors such as bias and negative racial stereotyping by physicians, most often without conscious awareness and lack of cultural competence

Patient factors such as minority and AI/AN mistrust of the health care system often because of perceived past discrimination, cultural beliefs about illness and health, and language barriers

Health Care Quality and Health Disparities

There is a second category that involves the quality, intensity, and comprehensiveness of diagnostic procedures and treatment choices offered to minority and AI/AN patients. Blacks and Hispanics were found, even with similar health insurance as whites, to receive substandard care. *The Right to Equal Treatment: An Action Plan to End Racial and Ethnic Disparities in Clinical Diagnosis and Treatment in the United States Report*¹⁷ and the Institute of Medicine (IOM) Committee¹⁸ investigated the quality of health care for various racial and ethnic minority groups. Many studies controlled for variations in insurance status, income, 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, (e.g., age and gender). The results showed that even among the better-controlled studies, most indicated that minorities and AI/ANs are less likely than whites to receive needed services, including clinically necessary procedures. These disparities exist in a number of disease areas and are found across a range of procedures including routine treatments for common health problems. The authors noted that the evidence of differences by race and ethnicity in the quality, intensity and comprehensiveness of medical care was substantial, beyond a reasonable doubt, and occurring across a wide spectrum of medical and surgical procedures.

Other factors may also contribute to health care disparities. Researchers suggested subtle differences in the way that persons of different racial and ethnic groups respond to treatment, especially with regard to 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 studies that the IOM Committee¹⁸ reviewed suggested 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 found that Blacks are slightly more likely to refuse medical recommendations for some treatments, but these differences in refusal rates are generally small (Blacks are only three to six percent more likely to refuse recommended treatments). For AI/ANs, there is a concern that health care providers' cultural insensitivity and the lack of acceptance of traditional healing practices and traditional medicine may create barriers to receiving care.

Two other sets of factors were considered by the IOM Study Committee¹⁸ that may be associated with disparities in healthcare, assuming that all populations have equal access to care.

The first set of factors is related to the operation of healthcare systems and the legal and regulatory climate in which they operate. These include:

- Cultural or linguistic barriers (e.g., the lack of interpretation services for patients with limited English proficiency)
- Fragmentation of healthcare systems (e.g., the possibility that minorities are disproportionately enrolled in lower-cost health plans that place greater per-patient limits on healthcare expenditures and available services)
- Types of incentives to contain costs (e.g., incentives to physicians to limit services)
- Location 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).

The second set of factors emerges from the clinical encounter. Three mechanisms might come into play in healthcare disparities from the provider's side of the exchange:

- Bias (or prejudice) against minorities and AI/ANs
- Greater clinical uncertainty when interacting with minority and AI/AN patients.
- Beliefs (or stereotypes) held by the provider about the behavior or health of minorities and AI/ANs

Minorities and AI/ANs patients might react to providers' behavior associated with these prac-

tices in a way that contributes to disparities. Research on how a patient's 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.¹⁹ Health care providers typically assume they are color blind in their delivery of services. Few providers have thought about the biases they bring to patient encounters or about their own cultural/ethnic backgrounds, health beliefs, and health practices. These biases often result in both the system and its providers attempting to get the patient to conform to the mainstream instead of meeting a patient on her or his own cultural ground. Yet patient attitudes about health, religious views, and concepts of death often influence compliance, affect disease management, and alter health outcomes.¹⁹

Race, ethnicity and language-based barriers are also related to medical errors. Studies have documented that adverse medical events often occur in connection with patient-provider communication problems, especially with minority patients.²⁰ Researchers found that doctors were less likely to engage their Black patients in conversation when compared to the conversations they had with white patients. This finding is noteworthy because other studies have shown a link between participation in medical visits and better health care outcomes. Interventions that increase physicians' patient-centeredness and the awareness of affective cues with Black patients that encourage them to participate in their health care are important strategies for addressing racial/ethnic disparities in health care. Findings show that providers may be talking at their Black patients and **with** their white patients. Moreover, if Blacks talk less and ask fewer questions when seeing a provider, this could explain why they are less likely to report positive experiences in health care. Past studies have shown that patient-centered communication is associated with better patient recall of information, treatment adherence, and satisfaction with care and health outcomes.²¹

Literacy, Health Literacy and Health Disparities

Recently, attention has focused on the level of literacy among health care consumers. Health care consumers are expected to actively participate in their health care by making informed decisions and partnering with their clinicians to arrive at treatment decisions and to manage their chronic conditions. Those who have poor literacy and health literacy skills may be at risk of making decisions that could adversely affect their health.²² One goal of Healthy People 2010 is to improve the health literacy of persons with inadequate literacy skills. The IOM identified health literacy as a high-priority area for improvement in health care quality.²³

Minority and Multicultural Workforce Issues and Health Disparities

Blacks, Hispanic Americans, and AI/ANs as a group comprise nearly 25 percent of the U.S. population. However, these three groups account for less than nine percent of nurses, six percent of physicians, and only five percent of dentists. Similar disparities are found in the faculties of health professional schools. For example, minorities and AI/ANs make up less than 10 percent of baccalaureate nursing faculties, 8.6 percent of dental school faculties, and only 4.2 percent of medical school faculties. Support for a direct link between poorer health outcomes for minorities and the shortage of minority health care providers came from the IOM's landmark study, *Unequal Treatment*.²⁴ The lack of minority and multicultural health professionals is adding to the nation's persistent racial and ethnic health disparities.

The Sullivan Commission's²⁵ recommendations, were developed to attract broad public support and to encourage academic and professional leadership to share the Commission's vision for a health system modeled on excellence, access, and quality for all people. Three overlying principles are noted to fulfill that vision.

- 1) To increase diversity in the health professions, the culture of health professions schools must change.

- 2) New and nontraditional paths to the health professions should be explored.
- 3) Commitments must be at the highest levels.

Change can happen when institutional leaders support the change. In 1966, Duke University School of Medicine was one of the last two medical schools in the South to admit a black student. Today, Duke University School of Medicine has become a model of diversity and has used its leadership to bring other institutions along a new and inclusive path toward excellence.²⁵

The IOM recommended increasing the number of minority health professionals as a key strategy to eliminate health disparities. A number of strategies were identified to make education and training in the health professions more attainable and affordable for minority students, including shifting from student loans to scholarships; reducing dependency on standardized tests for admission to schools of medicine, nursing, and dentistry; and enhancing the role of two-year colleges.²⁵

To strengthen patient-provider communication and relationships, the IOM committee also recommended developing provider training programs and tools in cross-cultural education. These recommendations are rooted in evidence that minority providers are more likely than whites to practice in minority and medically underserved areas, and that when patient and providers are of the same race there is greater satisfaction and adherence to treatment.¹⁸

Rural and Rural Minority and Multicultural Populations and Health Disparities

Disparities in health among rural residents are well documented. Living in a rural area is in itself a health risk factor due to numerous factors that can adversely influence health and access to health care. Minorities and AI/ANs living in rural areas face the double burden of health risk factors based on rural residence and health disparities related to race and ethnicity.²⁶ Although increasing attention has been and is being given to health disparities; disparities among rural minorities and AI/ANs is just starting to be addressed. Racial and ethnic minori-

ties represent about 17 percent of the non-metropolitan population.²⁷ Many rural minority and multicultural populations were found to have higher poverty rates and less education than their more urban counterparts with inadequate or no insurance available with their jobs. Health care utilization (patient visits) is frequently reduced when one does not have adequate health insurance. While 13 percent of rural whites are poor, the numbers for rural minorities are two to almost three times higher (34 percent for Blacks, 25 percent for Hispanics, and 34 percent for American Indians).²⁸

With regard to access to care, three of five rural white Americans live in Health Professions Shortage Areas (HPSAs), while three out of four rural minority Americans do (71 percent Blacks, 76 percent Hispanics, 73 percent American Indians). Twenty percent of Americans live in rural areas, while only nine percent of the nation's physicians practice in these areas.²⁸

Further, many rural minority group members are employed in occupations that involve exposure to environmental hazards and injury. These problems are made more severe by a shortage of health care providers and limited access to health care. Research that documented patterns of minority and rural disadvantage showed that Blacks and Hispanics tend to have limited access to health care services, lower health care utilization rates, and lower rates of insurance than whites. Higher rates of certain diseases and disabling conditions, such as heart disease, asthma, obesity, and infant mortality are most common in low-income communities and communities of color. Blacks, AI/ANs, and Latinos are more likely to rate their health as fair or poor than are whites and Asians. Racial and ethnic minorities also tend to receive a lower quality of health care than non-minorities and experience barriers (such as language, geography, and cultural familiarity) to accessing health care.²⁶ In addition to education and income, another aspect of the residual effect of rurality is physical environment. In some rural communities, water quality, agricultural methods, forestry, or mining complicate the effect of place of residence. Real or perceived isolation can affect one's health.²⁹

The Rural and Urban Health Chartbook (2001)³⁰

provides regional data for the Northeast, Midwest, South, and West showing that rural residents in each of these regions were worse off than those in other regions on one or more of the population health indicators. For example, rural residents who lived in the South had higher rates of poverty, adult smoking, physical inactivity, death to ischemic heart disease, and births to adolescents; rural residents who lived in the West had higher rates of alcohol abuse and suicide; and rural residents who lived in the Northeast had higher rates of total tooth loss.

Challenges and Opportunities in Addressing Health Care Disparities

Attention to racial and ethnic disparities in care has increased among policymakers; however, there is little agreement on what can or should be done to reduce these disparities. The U.S. Congress legislatively mandated the Institute of Medicine study on health care disparities and created the National Center on Minority Health and Health Disparities at the National Institutes of Health. Congress also required DHHS to produce an annual report, beginning in 2003, on the nation's progress in reducing health care disparities. These efforts have provided an important basis for addressing health care disparities.³¹

The IOM Study Committee for *Unequal Treatment*¹⁸ recommended the use of a comprehensive, multi-level strategy to address potential causes of racial and ethnic disparities in care that arise at the level of the patient, provider, and health care system. The recommendations point to five broad areas of policy challenges:

- 1) Raising public and provider awareness of racial and ethnic disparities in care
- 2) Expanding health insurance coverage
- 3) Improving the number and capacity of providers in underserved communities;
- 4) Improving the quality of care
- 5) Increasing the knowledge base on causes and interventions to reduce disparities

With regard to rural minorities, many even though "insured" by Medicaid still have profound access problems that are not entirely

related to insurance. Likewise, the issue is not only increasing the number and capacity of providers, but recruiting rural providers who are willing to provide access to these targeted populations.

Other Strategies to Address Health Disparities

Telemedicine Telemedicine is one way to provide access to rural minorities. While there are limited efforts to accelerate making telemedicine widely available and easily accessible for communities in remote areas, much more work needs to be done in this area. Careful attention should be given to allow for tailoring of systems to overcome the challenges related to the lack of affordable telecommunications in some areas, reluctance on the part of service providers to utilize telemedicine technology, and concerns about providing culturally sensitive health services.³²

Community Involvement The concept of community is important to the stability of eliminating health disparities by building the capacity of local grassroots organizations and citizens and developing partnerships or collaborations to create greater access to health care and prevention services and afford buy in from local communities that promotes a system-wide approach to address health disparities. Further commitment to community involvement is essential to community-focused educational and economic development, the procurers of better literacy, health literacy, jobs, and employment-based insurance.

Better Data Collection Efforts to improve the quality of care and eliminate disparities are hindered because of a lack of good data on patient race, ethnicity and primary language. This has become a widely acknowledged problem. Federal legislative proposals from both Democrats (HR 3459 and S 1833, the Healthcare Equality and Accountability Act) and Republicans (HR 2091 and S 2217, Closing the Health Care Gap Act of 2004) support the collection of better quality race and ethnicity data.²⁰ Federal agencies could involve communities in collecting and monitoring community health data by partnering communities with

researchers, colleges, universities, and others with technical expertise on health disparities. Federal agencies could also increase the technical assistance available for developing and writing grants to communities, including conducting health research and data collection.

Cultural Competency Training Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.³⁴ Sensitivity, empathetic listening, and a little extra effort often go a long way to bridge the gap between the staff of health care organizations and patients who bring cultural differences to the health encounter. Given that stereotypes, bias, and clinical uncertainty may influence clinicians' diagnostic and treatment decisions, education may be one of the most essential tools as part of an overall strategy to eliminate healthcare disparities.

The aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans. The collective set of 14 Culturally and Linguistically Appropriate Health Services (CLAS) standards mandates guidelines and recommendations issued by the HHS Office of Minority Health to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (see Appendix for CLAS Standards).³⁴ In rural communities, state offices of minority health should provide technical assistance to assist health care organizations in establishing cultural competency standards.

Summary

The elimination of racial/ethnic disparities in health status will require important changes in the ways health care is delivered, financed, and documented. Unequal access to care, fragmented healthcare systems, lack of cultural sensitivity among providers, cultural beliefs and behav-

iors, and unequal treatment of persons who receive care are key determinants of racial/ethnic disparities in health care and health status.

Despite improvements in the overall health of the Nation in the last two decades, there continues to be noticeable disparities in the burden of illness and death among ethnic and racial minorities and underserved groups such as disadvantaged rural whites. The diversity of the nation brings with it many opportunities and challenges that are experienced with increasing frequency in health care facilities, community services, and home services; from small rural clinics to large urban medical centers, to small rural towns (pop.<1000) and villages. Even more diverse are the environments that makeup communities. These complexities are integral to the understanding of how efforts that affect different populations of people must apply to any planning or policy development.

While access to health care is important to health status, it is not the only factor that influences minority and AI/ANs differential health status and outcomes. It is critical that we expand the science base for medicine by increasing providers' understanding of sex and gender differences and the interplay of race and culture in disease processes. Therefore, providers can make reliable diagnoses and give effective treatment and prevention strategies for all their patients, regardless of their ethnic, racial, or socioeconomic backgrounds. Research affords the scientific foundation for changes and improvements in health practices and health care policies.

Policy Recommendations

The NRHA will:

- Continue to advocate for access to health care for all Americans, especially ethnic and minority populations living in rural and medically underserved areas, since universal access is essential to achieve equity and quality.
- Support organizations and form partnerships with those who are promoting rural education and economic development.
- Seek to identify expanded approaches for

creating economic and non-economic incentives for rural providers to care for minority and multicultural populations.

- Support the use of health and culturally appropriate language interpretation services in rural and medically underserved communities.
- Encourage AHECs and other community-based recruitment programs to create opportunities for racial and multicultural rural middle and high school students to learn about and be exposed to health careers.
- Support increased availability of math and science classes in rural elementary, middle, and high schools for racial and multicultural students to successfully compete for educational slots in health professions schools.
- Support the inclusion of cultural competency training at all levels of curriculum and training programs in educational institutions for health professionals.
- Work to assure ongoing funding for programs designed to increase diversity in the health workforce such as Title VII and Title VIII programs.
- Work to assure that agencies receiving federal funds collect data on race, ethnicity and primary language in clinical patient records in rural healthcare systems according to standards established by the Office of Management and Budget.
- Support a mandate that the Centers on Medicare and Medicaid Services and other federal agencies that finance health care services engage in systematic, periodic analysis of rural racial and ethnic disparities in clinical care programs they support, using standard quality assurance measures.
- Support required cultural competency training in rural and medically underserved health care agencies and practice sites. federal and state Offices of Minority Health should be available to offer technical assistance.

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APPENDIX

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)³⁴

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bi-lingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated in to the organization's management information systems, and periodically updated.

Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

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