12-17-2010

Racial Disparities in Healthcare: Challenges Faced by Hispanic Populations

Kaitlin McDowell
Grand Valley State University

Racial Disparities in Healthcare: Challenges Faced by Hispanic Populations

Kaitlin McDowell
Dr. Jane Toot, PhD.

12/17/2010

TABLE OF CONTENTS

Review of Literature

I. Purpose

The purpose of this paper is to develop and introduce a simple model for the exploration of ethical disparities in healthcare. The problems in receiving care that are faced by Hispanic populations are multi-faceted, and understanding these problems will help lead to further development of viable solutions.

II. Introduction

The history of health and healthcare is long and complex, and in no way is the growth of the system complete. There are still numerous issues that must be addressed in order to bring healthcare into a new era; one surrounded by ethics such as equity, justice, and beneficence. In order to discuss ethics, some definitions should be clarified. First, equity of care is the responsibility to "provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status (SES)" (Mayberry, 2006). Sir George Alleyne declared that "every person should, in terms of equity, have the opportunity to access those sanitary and social measures necessary to protect, promote and maintain or recover health." Each person deserves an equal opportunity to be healthy. On a similar plane is patient-centeredness, which is the responsibility to "provide care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions" (Mayberry, 2006). The keyword in the above definition is "individual." Each patient is an individual and should be treated as such. Equity in healthcare is lost when patient-centeredness includes stereotypes and biases based upon an entire group.

Some discrepancy in care is unavoidable from patient to patient. However, the issue of equity arises when disparity is "not justified by differences in patients' medical conditions, needs and preferences" (Balsa, Seiler, McGuire, & Bloche, 2003). At the point that preconceived notions about a patient due to their gender, geographic location, or other sociological group are used in developing a treatment plan, an inequity has arisen, which also raises "moral, ethical, economic and, perhaps, legal issues for healthcare system operations" (Mayberry, 2006). This could become problematic for the functionality of the organization.

One major issue that has arisen is that of the discrepancies in care between ethnic or racial groups. This becomes a very complicated issue to address, as disparities can naturally be very subjective, and it can become tricky first to recognize, and then to address these issues in order to reduce their prevalence. The recognition of racial bias is very difficult to recognize; however, "whether conscious or unconscious, [stereotypes] can shape the exercise of discretion in systematic fashion and result in disparities" (Balsa, Seiler, McGuire, & Bloche, 2003). Some may believe ethnic disparities do not cause great problems within healthcare, but "A healthcare system cannot claim to provide 'best care'—or hope to achieve it—if subgroups of the population are receiving suboptimal care or care that does not meet the healthcare system's promulgated standards" (Mayberry, 2006). Therefore a healthcare system that is striving to provide the "best care" must address the issue of ethnic disparities in order to even dream of meeting their goal.

It can truly prove to be a challenge to confirm that racial and ethnic disparities exist. One technique in discovering the underlying factors is to first look for general discrepancies within care:

> "Much of the variation in what happens to patients—in how their evaluation and treatment is managed—is associated with clinical discretion. Evidence for racial and ethnic disparities in healthcare is essentially a demonstration that such variation systematically correlates with the race and ethnicity of patients" (Balsa, Seiler, McGuire, & Bloche, 2003).

The amount to which healthcare is lacking also varies widely– no consistent pattern can be found concerning a type of treatment that is effected more than any other (Baicker, Chandra, & Skinner, 2005). It was found in the 2005 National Healthcare Disparities Report "that disparities related to race, ethnicity, and SES 'pervade the American healthcare system'" (Mayberry, 2006). Various hospitals and regions of the country vary in the amount of discrepancy that is experienced, but this has become a nationwide problem which needs to be addressed.

It becomes difficult to tackle these issues before there is adequate awareness on the subject. At this point, "The general public has a marginal awareness of the nature of racial/ethnic disparities and equity issues… If misperceptions about the existence and nature of inequities are common, it is not only difficult to change practice behavior and institutional policies but also difficult to allocate resources to address the problem" (Mayberry, 2006). Therefore advocates of equitable healthcare cannot immediately begin trying to change the system; they will not have the public's support, either emotionally or financially. They must first raise awareness and support of the issue. The issue becomes further complicated when it is found that the public is not the only group of people who are not aware of these issues. An Institute of Medicine report found that "healthcare providers, like other members of society, may not recognize manifestations of prejudice in their own behavior" (Balsa, Seiler, McGuire, & Bloche, 2003). This is a serious problem, as healthcare providers can be part of the problem. If they are not

aware of the unfair decisions they may be making, they cannot even conceive addressing this issue. With every study and academic paper, the process is beginning that will change the public's views and eventually their practices.

III. Causes of Ethnic Disparities

There have been multiple studies completed which demonstrate some of the disparities experienced by racial groups, especially for Hispanics. It has been found that "health indicators of Hispanics suggest that health outcomes continue to lag behind other population groups… the population is faced with barriers to health access" (Butler, Kim-Godwin, & Fox, 2008). In terms of difficulty, "the language barrier negatively impacts healthcare for 50 million (19%) U.S. residents who do not speak English at home and the 22 million (eight percent) with limited English proficiency" (The language barrier negatively impacts health care for 50 million U.S. residents, 2006). There are many United States immigrants who experience the negative impacts of trying to learn English as a second language. Especially when confronted with a hospital situation in which many of the words sound foreign even to native English-speaking patients, a patient who does not speak English may easily be overwhelmed by his or her own lack of understanding. There are specific instances of Hispanics receiving less care than other majority groups; for example, "Hispanics were significantly less likely to receive aspirin at discharge as a preventive measure… Hispanics were less likely to receive appropriate antibiotics for surgical infection prevention" (Mayberry, 2006). Something as simple as aspirin can be overlooked and that is not appropriate care when it is generally accepted as the best method of treatment for a condition such as a heart attack.

It is important to note that as much as health stereotypes and bias can be very dangerous, there may be a place for it in medicine. "Skin color can sometimes be a surrogate for genetic

differences that influence disease and the response to treatment" (Satel, 2001) and doctors who know how to integrate these particularities can "focus their attention on specific defects or the constellation of abnormalities that produce it" (Satel, 2001). Having such heuristics in place can be helpful when a medical professional is faced with a difficult case in the sense that it gives an appropriate starting point for a patient's treatment. A problem arises when stereotypes are used as the basis of treatment and not merely as a primary base at which to begin diagnosis. The question then is this: what is an appropriate balance between using genetic differences as a medical model and treating every patient as truly individual? The implications of this idea are vast, and require much more time and research in order to understand the true underlying factors. As this will not be fully addressed in this study, it is something to keep in mind.

Even though a disparity in care for Hispanics is one problem, there are many facets and causes of these differences, and addressing each is the best plan for eradicating the problem entirely. Some accepted influences of care quality are "SES, income inequality, social stress (including crowding, family instability and violence), and social cohesion" (Galarneau, 2002) and specifically "language barriers [and] cultural differences" (Butler, Kim-Godwin, & Fox, 2008). Considering each aspect individually is important in the effort to solve observed disparities in healthcare.

Arguably one of the greatest stressors on equitable care are discrepancies in communication because healthcare professionals know that "poorer communication between doctors and minority patients will lead doctors to depend less on symptoms and other individualized clinical information and more on heuristics…" (Balsa, Seiler, McGuire, & Bloche, 2003) as well as "reducing the likelihood of appropriate follow-up, and may undermine the trust in the quality of care received" (Mayberry, 2006). The language barrier creates the

gateway that patients and doctors use to start making assumptions about the situation rather than making the effort to fully understand what the other person is trying to say. Within a relationship where communication is difficult, more time is necessary, as well as more resources, due to lengthier appointments, the required use of interpreters, and the "more" phenomenon (Butler, Kim-Godwin, & Fox, 2008). The more phenomenon is due to the fact that "higher uncertainty ensuing from poorer communication can also lead to disparities whereby disadvantaged groups get 'more' healthcare than Whites" (Balsa, Seiler, McGuire, & Bloche, 2003). Not all of the procedures ordered by physicians are necessary, and this tends to be more common when a medical professional does not fully understand a patient's history or illness due to lapses in communication. In order to further explore the barriers caused by discrepancies in communication, the issue can be further segmented to separately discuss the expectations of patients as well as language or cultural barriers.

In terms of patients' assumptions about healthcare, upon entering a hospital the average patient will assume that he or she will be made well again. However, there are instances in which a physician cannot immediately diagnose and treat an illness, in which cases the patient must wait for test results before receiving treatment. Many patients who have difficulty understanding do not get a clear picture: "their perception of care included the expectation that diagnostic tests and short-term treatment would result in wellness. This perception has resulted in apparent dissatisfaction with the healthcare system" (Butler, Kim-Godwin, & Fox, 2008). Many ethnic patients also rely on their own personal or cultural practices as the first response to illness and perceive healthcare as a last resort instead of the first choice or even as a resource for preventive care (Butler, Kim-Godwin, & Fox, 2008). All of the assumptions patients make that are not addressed lead to a void between the quality of care they perceive and that which they receive.

There is also the direct barrier that is built when a medical professional and his or her patient cannot communicate properly due to language or cultural barriers. This can happen in direct, verbal ways, such as women who "had difficulties explaining her husband's symptoms to healthcare providers, and were not able to understand the treatment plans since interpreters were not utilized" (Butler, Kim-Godwin, & Fox, 2008). There are also instances of nonverbal miscommunication: "Different perceptions of similar signals emitted by patients of different ethnic or racial groups, due to language or cultural differences between patient and doctor, can lead doctors to make different decisions about diagnoses and treatments" (Balsa, Seiler, McGuire, & Bloche, 2003). These can be dangerous because doctors will not recognize the failure right away, as in the case of patients who have difficulty verbally conveying their message. However, "even with the language barrier breached, healthcare providers still have to deal with other cultural differences that may affect the proper delivery of care" (Northway, 2006). Patients of differing backgrounds will convey their meaning differently which can cause misunderstandings between healthcare providers and their patients.

Healthcare outcomes can also be influenced by the geography of the populace. Areas of the country are not equal in terms of living conditions and resources available to them. Groups of Hispanics tend to settle together in areas separate from non-Hispanic white populations. Thus a patient's location can have a large impact on the quality or amount of healthcare he or she receives. This is an important and very difficult factor to address: What can health providers do to reduce the geographic disparities that are contributing to ethnic disparities among Hispanics? (Baicker, Chandra, & Skinner, 2005)

Doctors can also contribute to some of the disparities experienced by Hispanic patients based on the inferences they make in diagnosis. This method has been termed "Bayesian

decision-making" and occurs when "doctors supplement the information gained from evaluating a patient with ideas (accurate or otherwise) about the overall prevalence of the disease and/or expected benefits from treatment among social groups to which the patient belongs" (Balsa, Seiler, McGuire, & Bloche, 2003). This is not a form of direct bias on the part of the physician, but is simply a response to clinical uncertainty. However, it still has the power to create unwanted disparities in healthcare that can be a detriment to positive outcomes for Hispanic populations.

A major cause for disparities within healthcare can be socioeconomic status (SES). This can be difficult for many different groups, but in many cases "race and ethnicity are correlated with economic status, insurance coverage, health-seeking behavior, and preexisting disease burden" (Mayberry, 2006). Determining whether the cause of inequality is based on a patient's SES or their race can be difficult, but it is necessary in order to know which needs must be addressed to reduce the disparities in healthcare. In the case of SES there are many factors which influence a patient's SES, including their geographic location, community and culture, or any possible language barriers, all of which are factors that have previously been discussed. More exploration must be done in order to make definitive conclusions about the effects of socioeconomic status on the prevalence of disparities within healthcare.

Finally, patient care may also be affected by the politics and institutional racism of the healthcare system. It is important to remember that "bias within the healthcare system or the impact of social hierarchy and income inequality on health are susceptible to politicization" (Satel, 2001). Policymakers must be very careful that they are developing laws with the intention of reducing ethnic disparities as opposed to building them in. The American Public Health Association believes that "'institutional racism has been an important contributor to racial

disparities in health and economic status as well as a barrier to their elimination'" (Satel, 2001). The problem with institution-wide disparities is that they pervade the system and therefore can be hard to address. Once the policies are changed, it can also prove difficult to establish those new procedures.

IV. Research

The research that has been completed in this area in order to give medical professionals a clearer picture of the current situation is not widespread. In-depth research is only just recently beginning to appear in medical journals. It has started slowly with some commercial healthcare organizations, Medicare, and Medicaid, which have "conducted externally funded demonstration projects to collect data on race/ethnicity directly or use geocoding and surnames to prepare Health Plan Employer Data and Information Set (HEDIS) reports stratified by race/ethnicity" (Mayberry, 2006). This data has been very useful in opening up discussion and starting the task of building a healthcare system focused on equity. Also, in 2001 Congress used over $100 million for the funding of a new agency called the Center for Health and Health Disparities. Then in 2002 they developed the Healthy People 2010 initiative, which was devoted to the "elimination of racial and ethnic health disparities" (Satel, 2001). Private steps have been taken as well, in the case of private and religious organizations setting up facilities for those who face disparities in care from major public organizations (Galarneau, 2002). The introduction of these new programs will help to increase awareness and help with further research and advancements in the future.

As health professionals look ahead the effects of knowledge need to be realized. First, awareness of the problem is very important, because with misperceptions about the nature of healthcare disparities it becomes difficult to both change the practices and to receive the funding

in order to effectively do so. However, "general efforts… that bring attention to racial/ethnic inequities in healthcare are not expected to eliminate the inequity gap" (Mayberry, 2006). There must first be awareness before there can be change; the two ideas are closely linked. Also, general nationwide change is a very lofty goal. If made in steps, change can more effectively be made. One way to address this is by focusing on different regions in making policy changes: "interventions focused on the overall quality of hospitals in a few regions of the country could dramatically reduce racial disparities in care" (Baicker, Chandra, & Skinner, 2005). By also reducing the size of the population to regions, more community groups can be involved in the decision-making process which will help to eradicate problems with politicization and group bias. In terms of concrete ways to reduce disparities: "large-scale clinical outcomes research, efforts to standardize diagnostic and therapeutic judgment when evidence so permits and steps designed to improve provider-patient communication are among the strategies that should be pursued" (Balsa, Seiler, McGuire, & Bloche, 2003).

One important concept that has become popular recently is that of competency. "Competence implies that an organization has the capacity to function effectively within the context of cultural beliefs, behaviors, values, social norms and needs of the patients and their communities of origin, affiliation or residence" (Mayberry, 2006). A culturally competent health system would more efficiently eradicate ethnic disparities from its function and therefore would be one step closer to true equity. The advantages of cultural competence include greater healthcare outcomes, higher patient satisfaction, and increased efficiency and effectiveness of staff. There are many requirements to have a system that functions with competence: "Interpreter services, recruitment and retention efforts, training, use of community health workers, culturally competent health promotion, and administrative and organizational accommodation" (Mayberry,

2006). Cultural competence is very important as the preparation as well as the solution to the Hispanic healthcare disparity; it will increase awareness of racial problems while simultaneously addressing and potentially eliminating them.

There have been many theories on the best actions to be done in the future. Some are more generalized, such as allowing each local healthcare system develop its own solutions (Mayberry, 2006) and increasing cultural knowledge including cognitive understanding of the client's culture (Butler, Kim-Godwin, & Fox, 2008). However, there are also very small, concrete steps that can be enacted immediately, such as hiring patient navigators within the healthcare system (Mayberry, 2006) and having patients receive treatment by physicians of the same race or ethnicity (Balsa, Seiler, McGuire, & Bloche, 2003). Both of the latter solutions include an expansion of a health organization's employment which would increase costs, and therefore would require resources or other solutions to offset the increased costs. Where there are problems, there are solutions that require compromise in order to see positive results.

V. Conclusion

The United States healthcare system is experiencing a serious problem because it has not found a way to eliminate the disparities in treatment to which Hispanic populations are faced. Some generally accepted causes of healthcare disparities for Hispanics include communication failures, geography, patient and doctor assumptions, socioeconomic status, politicization, and systemic racism. There has been some research done to increase awareness and begin to propose solutions, but so far a widespread initiative has not been introduced. Some proposed solutions include increasing awareness of the problem, then addressing the issue of cultural competency. Further research can help to further correlate the causes of healthcare disparities, as well as

reviewing new methods in order to develop a good resolution. Please see figure 1 for a graphical representation of some of the causes and solutions of ethnic disparities in healthcare.

Bibliography

Baicker, K., Chandra, A., & Skinner, J. S. (2005). Geographic variation in healthcare and the problem of measuring racial disparities. *Perspectives in Biology and Medicine*, S42-S53.

Balsa, A. I., Seiler, N., McGuire, T. G., & Bloche, M. G. (2003). Clinical uncertainty and healthcare disparities. *American Journal of Law & Medicine*, 203-219.

Butler, C., Kim-Godwin, Y., & Fox, J. A. (2008). Exploration of healthcare concerns of Hispanic women in a rural southeastern North Carolina community. *Online Journal of Rural Nursing and Healthcare*, 22-32.

Galarneau, C. (2002). Healthcare as a community good: Many dimensions, many communities, many views of justice. *Hastings Center Report*, 33-40.

Mayberry, R. N. (2006). Improving quality and reducing inequities: a challenge in achieving best care. *Baylor University Medical Center Proceedings*, 103-118.

Northway, W. (2006, June 26). Language, cultural barriers challenge healthcare providers. *Mississippi Business Journal*, p. B17.

Satel, S. (2001). Medicine's race problem. *Policy Review*, 49-58.

The language barrier negatively impacts healthcare for 50 million U.S. residents. (2006, August 13). *Aging & Elder Health Week*, p. 97.

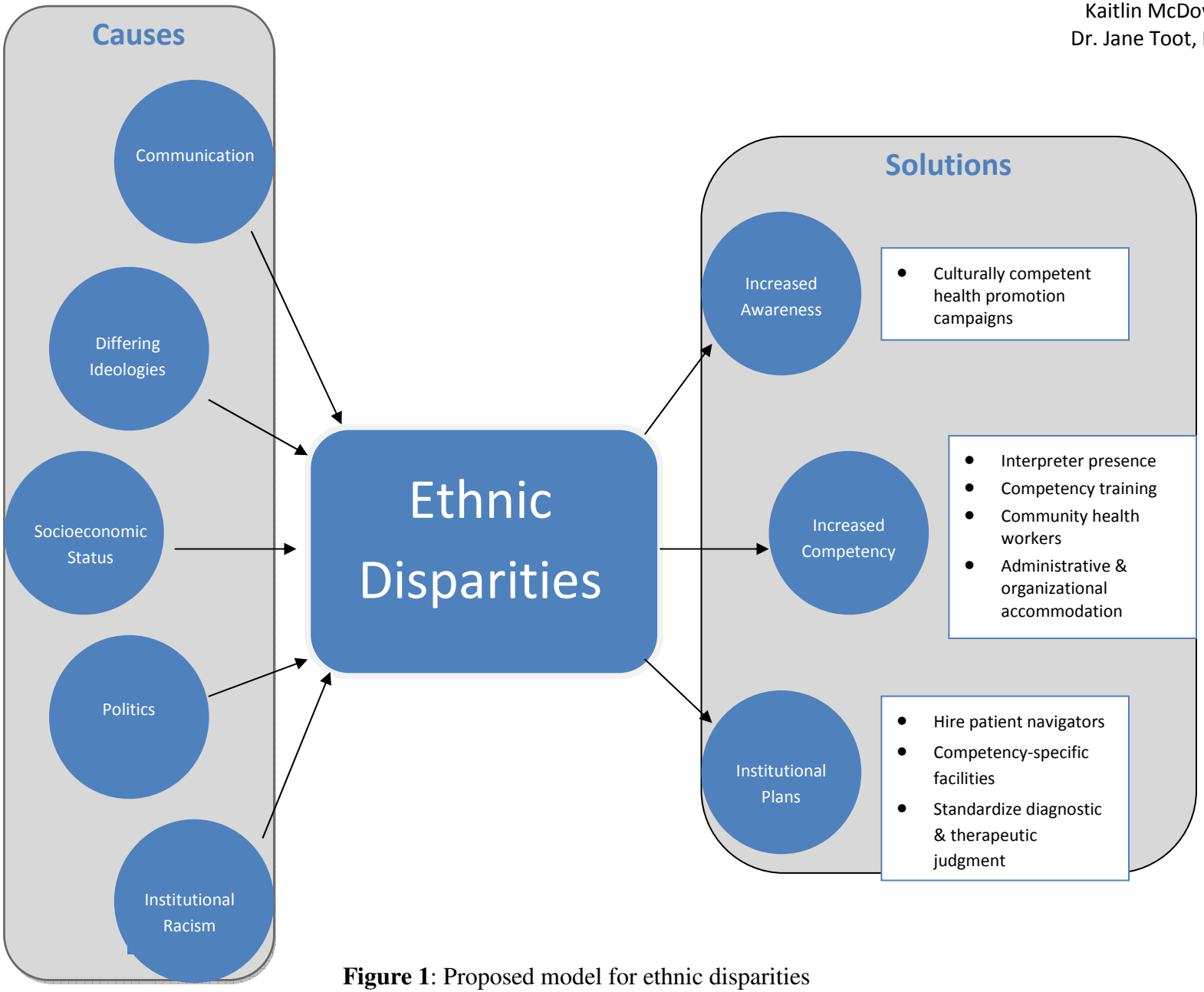

Figure 1: Proposed model for ethnic disparities

Author's Note

This project, as a whole, did not turn out as it was initially planned. That being said, it was a great experience and opportunity for learning. Having never dealt with an institutional review board before, the lessons of getting a head start and being thorough were very important. It was disheartening that the time ran out for conduction of data collection.

Nevertheless, the development of the paper was very interesting. Finding the sources and developing a full literature review was a useful skill to learn. The project also took an interesting turn when the development of a model was added. Drawing and redrawing the figure until the data was concise and understandable was certainly a task not undertaken lightly, and the final project cannot fully describe the ideas discussed. Hopefully, however, it can be a reference for any reader who may become lost in the amount of information in the review.

In conclusion of this project, at least for the time being, I would like to express my gratitude to Dr. Jane Toot, who remained very patient through numerous office visits. It was she who suggested the model which helped to bring the project together in the end. Her wisdom in completing research has been, and will be, invaluable.

Thank you,

Kaitlin McDowell