



Statement before the United States Commission on Civil Rights

Health Disparities

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Chairman Reynolds, Vice-Chairman Thernstrom, and other esteemed members of the Commission, thank you for the invitation to address you on the nature of health disparities.

My name is Sally Satel. I am a resident scholar at the American Enterprise Institute and a physician practicing part time at a local methadone clinic. At AEI, much of my work has focused on the interface of medicine and culture and the politicization of science. I have been particularly interested in the manifestation of identity politics within medicine. Until several years ago, the subject of health disparities has been an exceptionally rich example of this phenomenon.

Today I would like to present an overview of health disparities as a discrete topic within the domain of health policy. I will briefly trace the evolution of the conceptual underpinnings of the health disparities issue from its origins as an epidemiological phenomenon with no posited cause, to a civil rights problem presumably driven by bias among physicians, and then to a public health concern stemming from socio-economic factors. Unsurprising, as the causal orientation shifts from civil rights to public health, proposed remedies must realign as well. The themes in this statement are elaborated in greater depth in *The Health Disparities Myth – Closing the Treatment Gap* (AEI Press 2006) which has been distributed to all members of the Commission and is available online at: http://www.aei.org/docLib/20080630_HealthDisparitiesMyth.pdf.

Health Disparities Emerges as a Policy Issue

One of the earliest appearances of the term “health disparity” was in the 1985 *Report of the Secretary’s Task Force on Black and Minority Health*, published by the U.S. Department of Health, Education, and Welfare (now HHS). There the term referred to “excess deaths”— that is, the difference between the number of deaths observed in a racial/ethnic group and the number of deaths that would have occurred in that group if it had the same death rate as the non-Hispanic white population. This definition of “disparity” was purely descriptive; it was silent on the question of what *produces* these differences.

In 1999, the National Institutes of Health devised a similar definition of health disparities: “Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” Similarly agnostic definitions have been issued by other government agencies and offices.

Although allusions to “racism” in the healthcare system had been made during the 1990s, the idea was catapulted into public consciousness by a much-cited 2002 report from the Institute of Medicine (IOM), part of the National Academy of Sciences, called *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The report defined disparities as, “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and

appropriateness of intervention.”¹ Emphasis was placed on the doctor-patient relationship, which, the report said, is marked by “bias,” “prejudice,” and “discrimination.” The report claimed that the clinical encounter itself – more specifically, the inferior treatment that white doctors gave minority patients -- fueled the treatment differential and, by extension, the poorer health of minorities.

Media coverage of the IOM report was extensive and sensational: “Color-Blind Care . . . Is Not What Minorities Are Getting” (*Newsday*); “Fed Report Cites ‘Prejudice’ in White, Minority Health Care Gap” (*Boston Herald*); and “Separate and Unequal” (*St. Louis Post-Dispatch*). The IOM report was a watershed event. It transformed the concept of “disparity” from an epidemiological phenomenon into a civil rights matter. The word *disparity* now connoted unfair difference due to a patient’s race or ethnicity. As epidemiologist Olivia Carter-Pokras at the University of Maryland observed, the word *disparity* “has begun to take on the implication of injustice.” Accordingly, remedies proposed by the IOM experts and others have emphasized race-based prescriptions--most prominently, workforce diversity initiatives and cultural competence training. I will begin by focusing on the questionable rationales behind these initiatives.

Assumptions of the Health Disparities Project

Three bedrock assumptions of the health disparities project warrant mention.

Assumption #1: “Bias” can be proven.

A key premise of disparities research is that the existence of bias can be established through retrospective research. Yet the myriad factors that contribute to doctors’ thinking cannot be inferred from large databases. Nuanced research on physician behavior requires prospective work conducted in the clinical setting; it cannot be divined from after-the-fact inferences about how doctors behave or sterile questionnaires that do not (cannot) capture the complexity of the clinical decision-making process. Quantitatively trained sociologists would need to play a larger role in these investigations.

Assumption #2: Measuring the relative health of groups is an optimal strategy.

The health disparities project is concerned primarily with relative health. A fundamental research query is whether certain ethnic groups are receiving more or less healthcare than other groups. While this approach may have an intuitive appeal, it is problematic for several reasons and should thus be only one of many metrics for measuring improvement in minority health.

First, it can mask absolute improvements in care.² Consider this illustrative example:

Black patients with diabetes who attended a Bronx clinic were tested for diabetic control 53 percent of the time; whites were tested 57 percent of the time. This difference of four percentage points was smaller than the testing differential of fourteen percentage points found at a Washington, D.C., clinic. The smaller gap could be seen as indicative of a better overall situation. But a closer look shows that 59 percent of blacks in the Washington clinic were tested, versus 73 percent of whites.

In absolute terms, the D.C. diabetics—both black and white—received better care than their Bronx counterparts, but a narrow judgment based on racial comparison alone would conceal this reality. Indeed, absolute improvements in treatment—if they occur in all groups—will not close a gap but should still be recognized as valuable.

Second, focusing on narrowing disparities can obscure deficiencies in care.

Amal Trivedi and colleagues at Harvard found greater improvements in black patients than whites in the receipt of necessary tests and treatments (for example, eye exams for diabetics or beta-blockers after heart attacks) over a six-year period. Just looking at the narrowed black-white differentials would conceal the fact that both white and black patients, all of whom were enrolled in Medicare managed-care plans, received the tests with sub-optimal regularity.

Assumption #3: Health gaps can be closed.

Pragmatically, it will be impossible to eliminate health differences without first eliminating the other disparities in society (e.g., early education, family stability, income, and so on) that are linked with health status. Though some public health experts would argue otherwise, reorganizing the socioeconomic sphere of our nation is a mission that transcends the purview of the public health profession. The questions about societal leveling: how to execute it; whether to pursue it at all and, if so, in which domains -- are best left to politicians, voters, and social welfare policy experts. Nonetheless, if eliminating disparities is the goal of the health disparities project, it will be an elusive one indeed.

Do Minority Patients Fare Better with Minority Physicians?

Considerable emphasis is placed on the importance of physician workforce diversity (based upon the notion that race concordance between patient and doctor will improve minority health) and cultural competence training as ways to close the health gap. This contention has weak empirical basis, however. Perhaps more data will prove their virtues, but at present, they seem driven more by intuition than fact.

Do the data support the claims that minority patients fare better with physicians of their own race?

Only a handful of studies have been devoted to the question of whether patients' outcomes are better if they and their clinicians are of the same race. Some of these were conducted with psychiatric patients, and most showed that clinician race had a minimal impact on how black patients fared in their treatment and recovery. One large study that appeared in the journal *Psychiatric Services* involved more than 1,700 homeless individuals participating in an intensive services program. Each person was randomly assigned a case manager with whom he worked closely. Over the course of a year, improvement in dimensions like the number of days a patient worked at a job, whether he had drug problems, and the number of days he spent homeless bore no relationship to whether he and the case manager were of the same race. A 2005 study from the University of North Carolina found that physician race had little effect on the successful management of high blood pressure in elderly black and white patients. Seeing the same physician, however, was a key factor in attaining good outcomes.

What do patients want?

A comprehensive review of the literature published in the *Journal of Health Politics, Policy and Law* found that "racial/ethnic concordance holds little salience in the minds of most black and Latino patients and that discordance has little effect."³ This is consistent with a poll of 4,000 respondents published by The Commonwealth Fund – one of the largest, most detailed and most ethnically diverse surveys ever conducted. In that survey, the main complaint of almost every patient, regardless of ethnic or racial group, was the doctor's "failure to spend enough time with me." When asked to cite the factors that "influence your choice of doctor," the physician's "nationality/race/ethnicity" ranked twelfth out of thirteen possible options.

Other data reinforce the importance of adequate physician-patient contact. A number of studies show that patients report having more say in their treatment (and, presumably, have better compliance with treatment although the studies did not address that question) when the doctor, regardless of race, spent more time with them. A study by Lisa Cooper-Patrick and others found that the amount of time the doctor spent with the patient was a stronger determinant of patients' "participatory" ratings -- indicating patients' perceptions of how involved they were in treatment decisions -- than was racial concordance. Thus, it appears that the length of doctor-patient contact overwhelms whatever concordance effect may exist in leading to patients' enhanced sense of participation.

Sherrie Kaplan and her colleagues also observed that the amount of time the patient spent with the doctor helped determine the participation score. In the one study, visits of less than twenty minutes were found to be too brief to involve patients in treatment decisions. In another analysis, physicians who had "high-volume" practices were rated as less participatory than those who saw fewer patients but spent more time with each. Given the value patients place on face-to-face time with their physician, irrespective of the physician's race, the real problem seems to be that an average

primary care visit is fifteen minutes for everyone—rather than its being a few minutes shorter for black patients.

It is important to note, however, that the Cooper-Patrick study is widely cited as support for doctor-patient race concordance. But a closer reading is repaid. Cooper-Patrick reported that black patients rated their visits to doctors as more participatory when their doctors were black.⁴ Yet the clinical significance of this is hard to interpret in light of the fact that patients rated their interactions with same-race physicians (a participation score of 62.6 out of a possible 120) as barely different from interactions with different-race physicians (60.4 out of 120). What's more, when Sherrie Kaplan and her colleagues employed the same survey instrument, they discovered that minority patients who saw minority doctors had *lower* scores on the questions of participation than those who saw white doctors. The small volume of evidence on this topic indicates that race concordance between patient and physician has no reliable relationship to doctor-patient interactions, let alone to the quality of patient care as a function of race.

The Limits of *Unequal Treatment*

In view of the deference accorded the IOM report, *Unequal Treatment*, as a “landmark” document, it is important to ask whether the evidence put forth by the report justifies its conclusions about the significance of physician bias in generating health differentials.

The *Health Disparities Myth* presents a lengthy critique. (Note that “myth” refers to the allegation of bias as a major cause of disparities, not to the existence of differentials themselves.) Consider one major limitation of the report: the fact that it did not have enough information to rule out other important determinants of treatment differentials between black and white patients.

This is because most of the studies reviewed by the IOM experts were retrospective, relying upon chart review or large Medicare administrative databases that do not capture many variables that influence the type and frequency of care given. As the IOM report itself acknowledged, the more confounding variables were identified, the smaller the differential between whites and minorities became: “Almost all of the studies reviewed here find that as more potentially confounding variables are controlled, the magnitude of racial and ethnic differentials in care decreases.” Some studies were more scrupulous than others in accounting for confounding determinants of treatment, but even so, a treatment differential often remained.

Cardiovascular illness is one of the most commonly studied conditions because it is a major cause of morbidity and mortality among African Americans. The studies of cardiovascular care described in the IOM report were generally able to account for co-morbid conditions and severity of disease at the time care was sought. But a number of important clinical variables that influence physician decision-making were often missing from administrative databases—for instance, EKG subtleties, position

of occlusion in carotid and coronary vessels, coronary ejection fraction, and pulmonary function test performance. Further, variables such as patient preference and enrollment in supplemental insurance (which can influence whether a certain procedure is administered) are rarely recorded.

Moreover—and this is key—the unrecorded variables tend to vary by race and ethnicity. Consider, again, an example from cardiac care. Much evidence and experience confirms that coronary angiograms of black patients often show less anatomical suitability for intervention than in their white counterparts—either lesions in their vessels are too diffuse for angioplasty, or the patients have a higher incidence of normal-appearing vessels, despite the clinical appearance of having suffered acute myocardial infarction (heart attack). An examination of records, therefore, could suggest a racial bias in treatment simply because coronary angiograms are less often given to black patients. Detailed rationales for treatment choices could explain the differential but these nuances are not reliably indicated in the records themselves.

After Unequal Treatment

In the years following the IOM report, a cascade of studies has demonstrated the vital importance of key variables in health differentials. The result has been less overt talk of “racism” and less insistence that the doctor’s office is a particularly promising place to find a significant cause of health differentials. The current view is that wider, systemic factors underlie health differentials. These factors -- the role of geography, hospital quality, and physician quality -- overwhelm the influence of bias, to the extent it meaningfully exists at all, within the clinical encounter.

Geography- Health care varies a great deal depending on where people live, and because blacks are overrepresented in regions of the United States that are burdened with poorer health facilities, disparities are destined to be, at least in part, a function of residence.⁵

Hospital Quality - Minority patients are more likely to receive care in lower-performing hospitals than are white patients. Hospitals that treat greater numbers of minority patients generally offer poorer-quality service than those that treat fewer minorities. Yet, within hospitals, the quality of care is generally comparable between whites and minorities when they are admitted for the same reason or receive the same procedure.⁶

Physician Quality - White and black patients, on average, do not visit the same population of physicians—making the idea of preferential treatment by individual doctors an improbable explanation for disparities. Doctors whom black patients tend to see may not be in a position to provide optimal care. For example, they report having less access to high-quality colleague-specialists, such as cardiologists or gastroenterologists, to whom they could refer their patients, or to nonemergency hospital services, diagnostic imaging, and ancillary services, such as home health aid.

In addition, physicians of any race who disproportionately treat black patients are less likely to have passed a demanding certification exam in their specialty than physicians treating white patients.⁷

Identity Politics Linger

The concept of “cultural competence” is fundamental to the health disparities project. Most medical schools have some kind of cultural competency training. New Jersey was the first state to pass a law requiring doctors to receive so-called “cultural competency” training as a condition of obtaining or renewing their licenses to practice medicine; California and Washington followed. All major agencies within HHS have offices of minority health that, among other things, champion cultural competence. Over forty states have an office dedicated to health disparities, minority health, or multicultural health. The Health Equity and Accountability Act of 2007 and the Minority Improvement and Health Disparity Elimination Act (neither has been re-introduced this session) contained ambitious cultural competence initiatives.

But what exactly is cultural competence? Consider the sprawling definition from the Department of Health and Human Services.

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. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘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.

-- CLAS Standards Report (U.S. Department of Health and Human Services Office of the Secretary, 2000)

In practice, cultural competence refers to a range of interventions. It can include useful, practical accommodations intended to help health providers care for unacculturated or immigrant populations—such as translation services or education of medical staff about local healing customs and commonly used remedies. But it can also entail blatant, patronizing racial sensitivity training. Accordingly, some observers worry that cultural competence could deteriorate into an oversimplified, stereotyped, paint-by numbers affair that purports to teach students and physicians “how to treat” African-Americans, Asians, Latinos, and others. Others recoil at the specter of a clinical milieu in which black patients will be assigned to black doctors, gay patients to gay doctors, and so on.

At its most constructive, cultural competence is a variant of standard training in doctor-patient communication—a course that is required by all medical schools within the first two years of study. Joseph Betancourt, a physician at Harvard Medical School, describes an universal form of cultural competence that has “evolved from the making of assumptions about patients on the basis of their background to the implementation of the principles of patient-centered care, including exploration, empathy, and responsiveness to patients’ needs, values, and preferences.”⁸ In the end, Betancourt is simply describing competent care—one wonders why this requires a separate course.

Does cultural competence training have any effect on disparities? A literature search revealed no rigorous evaluations of cultural competency training that attempted to answer whether it improves quality of care, let alone reduces disparities.⁹

Conclusion

The health disparities discussion has matured over the years as volumes of data on geographical and economic factors accumulate. Though the bias theme lingers in academic quarters it appears to play a much less dominant part in the discussion of minority health than it in the years following the IOM report. This is a welcome development.

Not only are charges of bias divisive, pursuing them as a priority siphons energy and resources from endeavors targeting system factors that are more relevant to improving minority health: expanding access to high-quality care and facilitating changes in individuals’ lifestyles and their capacity to manage chronic disease.

From this perspective, proposed race-based remedies for the treatment gap -- such as racial preferences in admission to medical school to increase diversity, and racial sensitivity training for doctors -- become trivial or irrelevant at best, and potentially harmful at worst.

A true public health solution to inadequate care—one that seeks to maximize the health of all Americans—would more properly target all underserved populations, irrespective of group membership. Success would be reflected in the improved health of these communities; and, because many of them happen to comprise large numbers of minorities, racial and ethnic care differentials would diminish as well.

Selected endnotes (For version of this statement with full citations see sallysatelmd.com)

¹ Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. 4. (Washington, D.C.: National Academy of Sciences, 2002)

² David Mechanic, “Policy Challenges in Addressing Racial Disparities and Improving Population Health,” *Health Affairs* 24, no. 2 (2005): 336.

³ Jason Schnittker and Ka Liang, “The Promise and Limits of Racial/Ethnic Concordance in Physician-Patient Interaction,” *Journal of Health Politics, Policy and Law*, 31 (2006): 811-838.

⁴ Lisa Cooper-Patrick and others, "Race, Gender and Partnership in the Patient-Physician Relationship," *The Journal of the American Medical Association* 282, no. 6 (1999): 583–89.

⁵ R. Hasnain-Wynia, DW Baker, D. Nerenz, J. Feinglass, AC Beal, MB Landrum, R. Behal, JS Weissman, "Disparities in health care are driven by where minority patients seek care: Examination of the hospital quality alliance measures." *Archives of Internal Medicine* 167, no. 12 (2007): 1233-1239; Katherine Baicker, Amitabh Chandra, and Jonathan S. Skinner, "Geographic Variation in Health Care and the Problem of Measuring Racial Disparities," *Perspectives in Biology and Medicine* 48, no. 1, supp. (2005): S42–53.

⁶ Katherine Baicker and Amitabh Chandra, "Myths and Misconceptions About Health Insurance," *Health Affairs* 27, no. 6 (2008): w533-w543.

⁷ Peter B. Bach and others, "Primary Care Physicians Who Treat Blacks and Whites," *New England Journal of Medicine* 351, no. 6 (2004): 575–84; JD Reschovsky, AS O'Malley, "Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?" *Health Affairs* 23, no. 3 (2008): 222-231 (Web Exclusive).

⁸ Joseph R. Betancourt, "Cultural Competence—Marginal or Mainstream Movement?" *New England Journal of Medicine* 351, no. 10 (2004):953.

⁹ "Does Cultural Competency Training Improve Quality of Care?" *MDNG New Media*, June 11, 2008 http://www.hcplive.com/mdnglive/webexclusives/Cultural_Competency_Training