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**Ethical Issues: Narrowing the Disparity Gap**

In 2003 the Institute of Medicine, in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, reported a consistent body of research demonstrating significant racial variation in the access to and utilization of medical treatment, even when insurance status, income, age, and severity of conditions are comparable.[i] This report substantiated what has been known for many years, that in the U.S., racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health care, compared to the white majority. Former U.S. Surgeon General David Satcher, M.D., a recent guest of the University Of Missouri School Of Medicine, punctuated this claim by reporting in Health Affairs earlier this year that 84,000 black Americans die each year as a result of disparities in health care.[ii]

Though the issue of ethnic and racial disparity in health care, as with unequal access to many other social goods, remains complex as to the interplay of mistrust, cultural insensitivity, and illiteracy, there arguably may be hope that change toward greater equity in the provision of health care services is occurring—at least for those who already have access.[iii] A review of recent data extracted from HEDIS (Health Plan Employer Data and Information Set), measuring quality indicators for 1.5 million covered lives in 183 Medicare managed care plans from 1997 to 2003, revealed that across nine quality measures, care improved for all enrollees regardless of race, and in seven of the nine measures care became "more equal" between racial groups. For example, lipid management in diabetics and the use of beta blockers following heart attack or cardiac intervention rose in all patients, but to a greater extent in blacks compared to whites. Unfortunately in this study quality indicators for diabetes management improved to a lesser extent in blacks compared to whites.

Unfortunately two other studies published at the same time found that disparities still exist in populations where public reporting of quality measures is not required. From 1994 to 2002 researchers found that blacks, especially black women, were substantially less likely to receive reperfusion therapy or coronary angiography following myocardial infarction.[iv] Another study found that in elderly patients receiving nine major surgical procedures from 1992 through 2001, racial disparity widened for five, remained unchanged for three and narrowed for only one.[v]

The IOM's recommendations for reducing racial and ethnic disparities in health care include increasing awareness about disparities among the general public, health care providers, insurance companies, and policy-makers. Consistency and equity of care also should be promoted through the use of "evidence-based" guidelines to help providers and health plans make decisions about which procedures to order or pay for based on the best

available science. More minority health care providers are also needed, especially since minority providers are more likely to serve in minority and medically underserved communities. Greater access to interpreters is also needed in clinics and hospitals that serve ethnically diverse and therefore often underserved populations in order to overcome language barriers and illiteracy that may affect compliance, trust, and quality of care.

In addition, two crucial factors must be universally implemented in order for racial disparity in health care to be eliminated. These factors can only be implemented if individuals and systems function through partnership: 1) racial, ethnic, and cultural awareness and competency must be promoted individually amongst providers who provide care one patient at a time – greater understanding and forbearance is the key to trusting and successful healing relationships; 2) accountability and monitoring of health care systems that also require public reporting of quality will likely play a big role in reducing disparity. Ethical responsibility and accountability of individuals will only occur, however, within organizations that encourage nonpunitive remediation through education and training, and that provide an adequate infrastructure to enable success.

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[i] Smedley B, Stith A, and Nelson A, Editors, IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. 2003

[ii] Satcher D, Fryer, Jr G, McCann J, Troutman A, Woolf S, and Rust G. What if we were equal? A comparison of the black-white mortality gap in 1960 and 2000. *Health Affairs.* 2005; 24(2): 459-464.

[iii] Trivedi A, Zanslavsky A, Schneider E, et al. Trends in the quality of car and racial disparities in Medicare managed care. *NEJM*.2005; 353: 692-700

[iv] Vaccarino V, Rathore S, Wenger N, et al. Sex and racial differences in the management of acute myocardial infarction, 1994 through 2002. *NEJM*. 2005; 353: 671-682

[v] Jha A, Fisher E, Li Z, et al. Racial trends in the use of major procedures among the elderly. *NEJM*. 2005; 353: 683-691