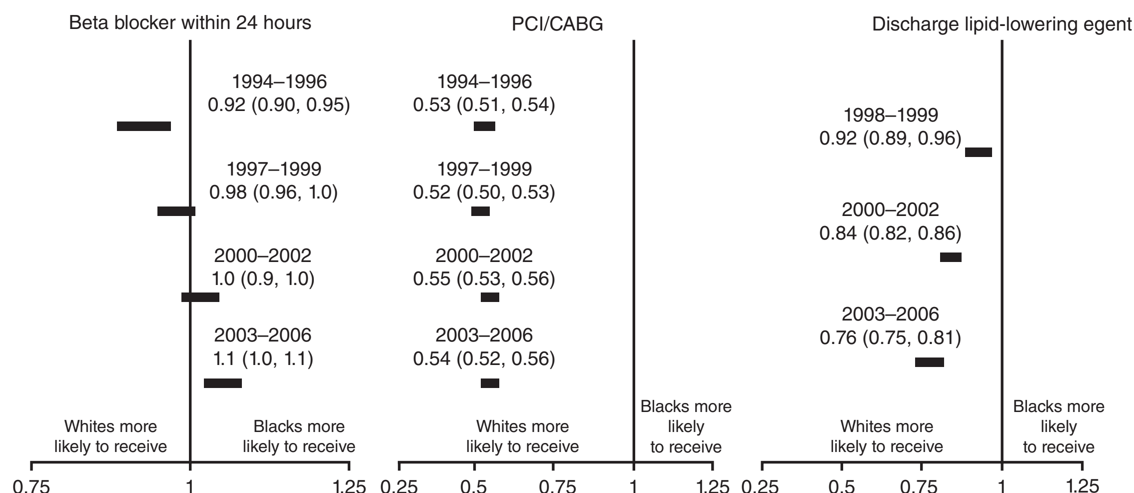

FIGURE 16e-4 Racial differences in guideline-based treatments for acute myocardial infarction (AMI). The reference population consisted of 2,515,106 patients with AMI admitted to U.S. hospitals between July 1990 and December 2006. CABG, coronary artery bypass grafting; PCI, percutaneous coronary intervention. *(From ED Peterson et al: Am Heart J 156:1045, 2008.)*

- *Patient-level factors:* These include patients' mistrust of the health care system leading to refusal of services, poor adherence to treatment, and delay in seeking care.

A more detailed analysis of these root causes is presented below.

Health System Factors • *HEALTH SYSTEM COMPLEXITY* Even among persons who are insured and educated and who have a high degree of health literacy, navigating the U.S. health care system can be complicated and confusing. Some individuals may be at higher risk for receiving substandard care because of their difficulty navigating the system's complexities. These individuals may include those from cultures unfamiliar with the Western model of health care delivery, those with limited English proficiency, those with low health literacy, and those who are mistrustful of the health care system. These individuals may have difficulty knowing how and where to go for a referral to a specialist; how to prepare for a procedure such as a colonoscopy; or how to follow up on an abnormal test result such as a mammogram. Since people of color in the United States tend to be overrepresented among the groups listed above, the inherent complexity of navigating the health care system has been seen as a root cause for racial/ethnic disparities in health care.

OTHER HEALTH SYSTEM FACTORS Racial/ethnic disparities are due not only to differences in care provided within hospitals but also to where and from whom minorities receive their care; i.e., certain specific providers, geographic regions, or hospitals are lower-performing on certain aspects of quality. For example, one study showed that 25% of hospitals cared for 90% of black Medicare patients in the United States and that these hospitals tended to have lower performance scores on certain quality measures than other hospitals. That said, health systems generally are not well prepared to measure, report, and intervene to reduce disparities in care. Few hospitals or health plans stratify their quality data by race/ethnicity or language to measure disparities, and even fewer use data of this type to develop disparity-targeted interventions. Similarly, despite regulations concerning the need for professional interpreters, research demonstrates that many health care organizations and providers fail to routinely provide this service for patients with limited English proficiency. Despite the link between limited English proficiency and health-care quality and safety, few providers or institutions monitor performance for patients in these areas.

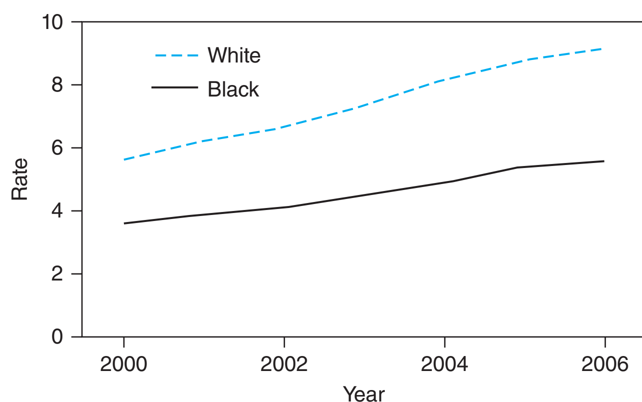

FIGURE 16e-5 Racial trends in age-adjusted total knee replacement in Medicaid enrollees from 2000 to 2006. The reference population consisted of Medicaid part A enrollees ≥65 years of age who were not members of a managed-care plan. *(From the Centers for Disease Control and Prevention, 2009.)*

Provider-Level Factors • *PROVIDER–PATIENT COMMUNICATION* Significant evidence highlights the impact of sociocultural factors, race, ethnicity, and limited English proficiency on health and clinical care. Health care professionals frequently care for diverse populations with varied perspectives, values, beliefs, and behaviors regarding health and well-being. The differences include variations in the recognition of symptoms, thresholds for seeking care, comprehension of management strategies, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to preventive measures and medications. In addition, sociocultural differences between patient and provider influence communication and clinical decision-making and are especially pertinent: evidence clearly links provider–patient communication to improved patient satisfaction, regimen adherence, and better health outcomes (Fig. 16e-6). Thus, when sociocultural differences between patient and provider are not appreciated, explored, understood, or communicated effectively during the medical encounter, patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care may result.

A survey of 6722 Americans ≥18 years of age is particularly relevant to this important link between provider–patient communication and health outcomes. Whites, blacks, Hispanics/Latinos, and Asian Americans who had made a medical visit in the past 2 years were asked whether they had trouble understanding their doctors; whether they felt the doctors did not listen; and whether they had medical questions they were afraid to ask. The survey found that 19% of all patients experienced one or more of these problems, yet whites experienced them 16% of the time as opposed to 23% of the time for blacks, 33% for Hispanics/Latinos, and 27% for Asian Americans (Fig. 16e-7).