

STATEMENT FOR THE RECORD
OF THE
AMERICAN COLLEGE OF PHYSICIANS
TO THE
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
“Addressing Disparities in Health and Healthcare: Issues for Reform”

June 10, 2008

As the largest medical specialty society and the second largest medical organization in the United States, the American College of Physicians (ACP) is committed to eliminating disparities in healthcare access and quality. ACP represents 125,000 doctors of internal medicine, residents and medical students. The College is addressing health care disparities in its public policy research, educational initiatives and foundation activities. ACP applauds Chairman Pete Stark for holding this hearing to improve understanding of the many factors that contribute to health disparities, including access to care. The College recognizes that addressing this issue is vital to improving the health status of Americans and achieving a highly performing health care system that is accessible to all.

Racial and ethnic disparities in health care are well-documented. Addressing these inequities became a national movement with the development of the Healthy People 2010 goals and objectives. In 2002 a landmark report was released by the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Since then, a significant amount of research has increased our understanding of the scope and causes of disparities. Despite these efforts, large gaps in access, quality of care and health outcomes still persist. Earlier this year, the Agency for Healthcare Research and Quality (AHRQ) released its annual *National Healthcare Disparities Report*, which found that disparities in health care quality and access have not decreased, and for many indicators, the gaps are expanding. Specifically, the 2007 report notes that:

1. Blacks had a rate of new AIDS cases 10 times higher than Whites.
2. Asian adults age 65 and older were 50% more likely than Whites to lack immunization against pneumonia.
3. American Indians and Alaska Natives were twice as likely to lack prenatal care in the first trimester, compared with Whites.ⁱ

Timely access to appropriate health care is critical to improving health outcomes. It is undeniable that uninsurance is a major barrier to eliminating health care disparities. According to the AHRQ report, individuals without health insurance fared worse than individuals with private insurance on all access measures and almost 90% of quality

measures. Compared with the insured, the uninsured are about six times as likely to lack a usual source of care and nearly three times as likely not to get care as soon as wanted for illness or injury. Unfortunately, the uninsured rates are high among many racial and ethnic minorities. In 2006, 49% of Hispanics and 28% of African Americans adults (ages 18 to 64) were uninsured, compared with 21% of whites and 18% percent of Asian Americans.ⁱ The College advocates that all Americans should have affordable health insurance coverage to eliminate the financial barriers to accessing care.

The College also recognizes that disparities exist even among the insured. It is for this reason that ACP is deeply committed to improving access to care through a delivery model called the patient-centered medical home. This team-based model of care, led by a personal physician, provides continuous and coordinated care to maximize health outcomes. Recent research has shown that many racial and ethnic disparities related to access and quality are reduced or eliminated when patients have a medical home. Among adults with a medical home, Blacks and Hispanics were just as likely as Whites to receive preventive care reminders, which have been proven to increase the rates of routine preventive screenings.ⁱⁱ Ensuring all individuals have a medical home will require restructuring of health care deliver systems, including payment structures to support patient-centered care.

Effective patient-provider communication increases patient understanding and is a critical component of patient-centered care. Unfortunately, racial and ethnic minorities are more likely to report poor communication with health providers than their White counterparts.ⁱ Approximately 52 million Americans speak a language other than English at home. Of these individuals, more than half speak English less than “very well” and are considered limited English proficient (LEP) patients.ⁱⁱⁱ Language barriers can result in the exchange of inaccurate or incomplete information, which can affect access to and delivery of care and health care costs. LEP patients disproportionately underutilize less costly preventive care.^{iv} However, when competent language services are available, LEP individuals can communicate effectively with their health care providers, improving their encounters and health outcomes. A number of federal and state policies require health care providers who receive federal funds to ensure access to services for patients with LEP. However, often times these services are not being offered because of time, costs, and availability of qualified interpreters.^v

An ACP survey found that the majority of practices represented by internists that have LEP patients provide language services. However, these services are limited and are typically provided by a bilingual physician or staff member and hardly any practices rely on external sources for language services or provide such services during off hours. In addition, few physicians perceived a need for tools or training to assist their practices in providing language services.^v A clearinghouse to provide translated documents and patient education materials would be useful, but providing reimbursement for the added costs of clinical time and language services would be the most effective means of expanding the use of language services.^v

Language is just one aspect of an individual’s culture that may affect patient-provider communication, quality of the encounter and patient outcome. Physicians and other health care providers must realize the impact of culture on health status.

There are many negative health consequences that could result from ignoring culture, including missed opportunities for screening because of a lack of familiarity with the prevalence of conditions among certain minority groups; failure to take into account differing cultural responses to prescription medication; lack of knowledge about traditional remedies, leading to harmful drug interactions; and diagnostic errors resulting from miscommunication.^{vi} Research has shown that quality health care requires attention to differences in culture—the “integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.”^{vii}

Eliminating health disparities will require an adequate supply of culturally-competent health care providers. Cultural competence in health care has been defined as the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural and linguistic needs. Cultural competence techniques have been shown to effectively change provider and patient behavior by improving communication, increasing trust, improving racially or ethnically specific knowledge of epidemiology and treatment efficacy, and expanding understanding of patients’ cultural behaviors and environment.^{viii} Accordingly, the College supports cultural competency training that is incorporated in the training and development of all health care providers, at all levels.^{ix}

A diverse workforce of health professionals is also an integral part of eliminating disparities among racial and ethnic minorities.^{ix-x} Currently, many racial and ethnic minority groups are poorly represented in the health professions, relative to their proportion in the overall U.S. population. Increasing the diversity of the health care workforce is a key to increasing access to care and improving the quality of care for minorities. Minority staff, because of shared cultural beliefs and common language, may improve communication, create a more welcoming environment, and structure health systems to better reflect the needs of minority communities. Also, racial and ethnic minorities are more likely to serve in a community of underrepresented individuals.^{xi-xii} National and local workforce policies are needed to:

- Strengthen the education of racial and ethnic minorities at all levels in the areas of math and science to create a larger pool of qualified minority applicants for medical school.
- Revitalize efforts to improve medical and health professional school matriculation and graduation rates of minority students. ACP supports the consideration of race and ethnicity in determining admissions to institutions of higher education.
- Expand programs that provide outreach to encourage minority enrollment in medical and health professional schools.

- Increase efforts to recruit and retain minority medical school faculty.
- Enhance funding for programs and initiatives that work to increase the number of health care providers in minority communities.^{ix}

Eliminating health disparities and improving quality of care requires evidence-based policies and programs. Research to identify sources of disparities, as well as effectiveness of initiatives targeted to eliminate disparities, will necessitate the collection of better data on race, ethnicity, and primary language using reliable and standardized measurement tools. Unfortunately, inadequate data continues to limit the analysis of health disparities.^{xiii} ACP supports efforts to improve collection of racial and ethnic information within the health care system. ACP has supported legislative efforts to eliminate disparities in health care, improve collection of racial and ethnic data from Medicare participants and to incorporate race, ethnicity, and primary language measures in quality improvement projects. The College regards research to be a vital part of identifying, monitoring, and addressing disparities in healthcare that disadvantage racial/ethnic minorities.

Conclusion

The American College of Physicians appreciates the opportunity to provide the Health Subcommittee with this summary of our views on eliminating health care disparities. We recognize that health disparities are multi-dimensional and will require comprehensive efforts to eradicate the gaps that currently exist. We urge the subcommittee to continue to address this critically important issue.

ⁱ Agency for Healthcare Research and Quality. 2007 National Healthcare Disparities Report. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; February 2008. AHRQ Pub. No. 08-0041.

ⁱⁱ Beal AC, Doty MM, Hernandez SE, Shea KK, and Davis K. Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund, June 2007.

ⁱⁱⁱ U.S. Census Bureau. Language Spoken at Home for the Population 5 Years and Over, Tbl B16004, data from 2005 American Community Survey.

^{iv} M. Doty. Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English. The Commonwealth Fund; February 2003.

^v American College of Physicians. Language Services for Patients with Limited English Proficiency: Results of a National Survey of Internal Medicine Physicians. Philadelphia: American College of Physicians; 2006: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.) Accessible at http://www.acponline.org/advocacy/where_we_stand/policy/lep_paper.pdf.

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- ^{vi} Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Med Care Res Rev.* 2000;57 Suppl 1:181-217.
- ^{vii} Betancourt JR, Green AR, Carillo JE. *The Commonwealth Fund: Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches.* New York: The Commonwealth Fund; October 2002.
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- ^{ix} American College of Physicians. *Racial and Ethnic Disparities in Health Care.* Philadelphia: American College of Physicians; 2003: Position Paper (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)
- ^x Association of American Medical Colleges. *Diversity in the Physician Workforce: Facts & Figures 2006.* Washington, D.C.: Association of American Medical Colleges;
- ^{xi} Komaromy M, Grumbach K, Drake M, et al. The role of Black and Hispanic physicians in providing health care for underserved populations. *NEJM.*1996;334(2):1305-10.
- ^{xii} Stinson MH, Thurston NK. Racial matching among African-American and Hispanic physicians and patients. *J Human Resources.*2002;37(2):410-28.
- ^{xiii} Billheimer LT, Sisk JE. Collecting Adequate Data on Racial and Ethnic Disparities in Health: The Challenges Continue. *Health Affairs.* 2008; 27 (2):383-391