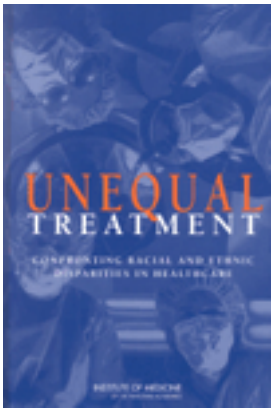

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (with CD)

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The Healthcare Environment and Its Relation to Disparities

Many aspects of the healthcare environment influence the quality of care received by U.S. racial and ethnic minority groups. The historical evolution of healthcare for persons of color, the current financial and organizational structures of health systems, the settings in which care is delivered, and the nature of the workforce providing care may, both independently and jointly, influence the quality of care that minorities receive. This chapter describes some of these environmental factors and the influences they may have on healthcare for racial and ethnic minorities.

The first two sections of this chapter describe aspects of the social and economic contexts in which racial and ethnic minority groups live in the United States. These sections review: a) the health, health insurance, and linguistic status of these groups, and b) racial attitudes and patterns of segregation and discrimination in various sectors of American life. The third section reviews the history of segregated healthcare and contemporary settings in which racial and ethnic minorities receive healthcare, including the influence and importance of community health centers. The last section focuses on the healthcare workforce in minority communities—how this workforce originated, where individuals practice, who they serve, and the influence of international medical graduates on healthcare in minority communities. The chapter concludes with a discussion of medical education, how affirmative action has served to increase the presence of underrepresented minorities in the health professions workforce, and how recent legal challenges to affirmative action have affected and may have a future impact on the healthcare workforce.

Much of the data presented in this chapter are drawn from available literature and large national data sources, such as the U.S. Census and the National Center for Vital and Health Statistics. Where possible, data on subpopulations of racial and ethnic groups (e.g., Cuban American, Puerto Rican, Mexican American, and other subgroups of the Hispanic population) are presented. This information is supplemented, where appropriate, by qualitative data regarding the experiences of racial and ethnic minority patients and healthcare professionals. These data, presented in individuals' own words, are offered as a means of understanding some of patients' and providers' experiences and perceptions of how race or ethnicity may affect both care processes and the systems and settings in which care takes place. As such, these data are not intended to substitute for empirical findings. Rather, they serve to "give voice" to the experiences of key actors in healthcare disparities, and illuminate how healthcare disparities are perceived by patients and their providers. Qualitative data were gathered via three mechanisms:

- Roundtable discussions with minority healthcare consumers, professionals and advocates at one of two large national conferences (the Asian American and Pacific Islander Health Forum conference and the Indian Health Service Research Conference, both held in April, 2001);
- Liaison panel discussions with consumer and professional groups, federal agency representatives, and minority health advocates held in the spring and summer, 2001;
- Focus group sessions conducted during this same time period; and interviews with American Indian and Alaska Native tribal leaders and a cadre of healthcare providers serving American Indian and Alaska Native communities (Joe, this volume).

For more information on these data collection activities and a summary of focus group and liaison panel findings, please see Appendixes A and D.

THE HEALTH, HEALTH INSURANCE, AND LANGUAGE STATUS OF RACIAL AND ETHNIC MINORITY POPULATIONS

This section provides an overview of factors that influence healthcare and healthcare needs of minority populations—including their health and insurance status, and linguistic barriers to care.

Health Status

Some racial and ethnic minorities experience higher rates of chronic and disabling illnesses, infectious diseases, and mortality than white

Americans. As depicted in Figure 2-1, African Americans have the highest rates of morbidity and mortality of any U.S. racial and ethnic group. The mortality rate for African Americans is approximately 1.6 times higher than that for whites—a ratio that is identical to the black/white mortality ratio in 1950 (Williams and Rucker, 2000). American Indians and Alaska Natives also experience higher mortality rates than whites, accompanied by low life expectancy. And while other racial and ethnic minorities experience lower overall mortality rates than whites, these data mask both inter-group variation (e.g., among Hispanics, Puerto Ricans experience higher infant mortality rates than whites [National Center for Health Statistics, 2000]), and an elevated burden of disease among some groups for specific causes of mortality. As depicted in Figure 2-2, some causes of mortality, such as diabetes, disproportionately affect African-American, Hispanic, and American Indian/Alaska Native populations. In addition, some subpopulations of racial and ethnic groups experience an elevated incidence and mortality due to specific diseases. Alaska Natives experience the highest rates of colon and rectal cancers of any racial or ethnic group in the United States (Institute of Medicine, 1999b). Korean Americans have the highest rates of stomach cancer (48.9 per 100,000 population) among U.S. males, followed by Japanese Americans (30.5 per 100,000 population; Institute of Medicine, 1999b). Similarly, Vietnamese-American women experience the highest incidence of cervical cancer in the United States, at rates nearly six times higher than that of white women (Institute of Medicine, 1999b).

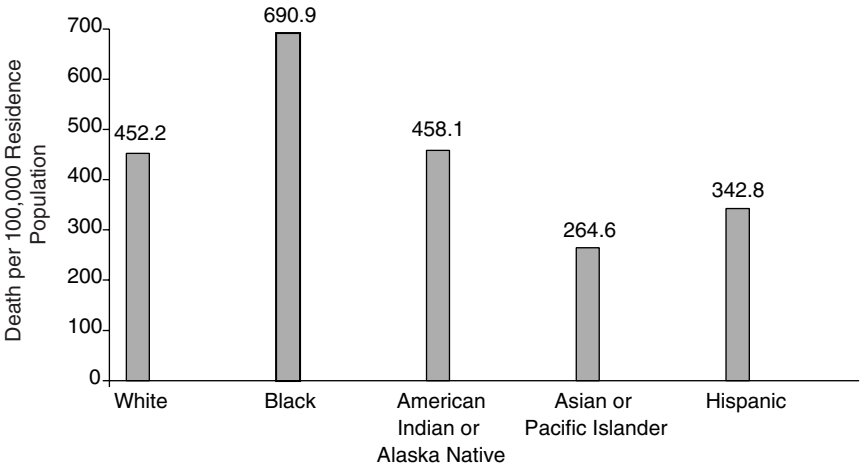

FIGURE 2-1 Age-adjusted death rates for all causes of death by race and Hispanic origin: United States, 1950-1998. SOURCE: Health, United States, 2000 (2001).

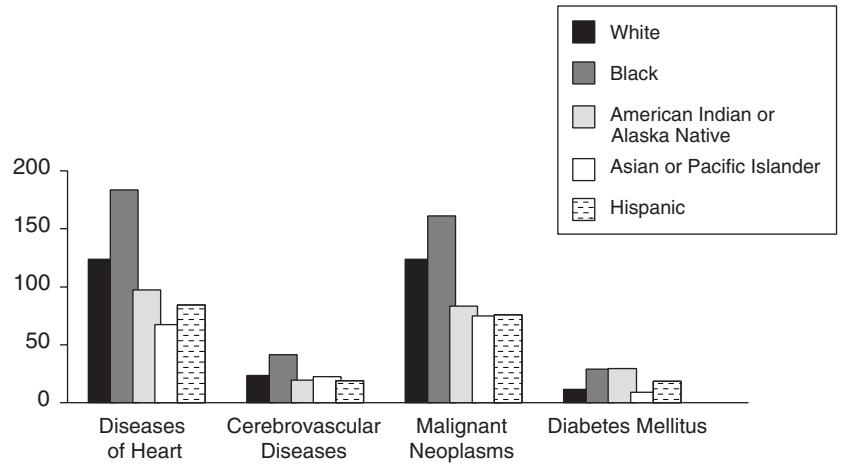

FIGURE 2-2 Age-adjusted death rates for selected causes of death by race and Hispanic origin: United States, 1950-1998. SOURCE: Health, United States 2000 (2001).

Insurance Status

Racial and ethnic minority Americans are significantly less likely than white Americans to possess health insurance (see Figures 2-3 and 2-4). The problem is particularly acute among the working poor and individuals who have no employment-based insurance, and among whom minori-

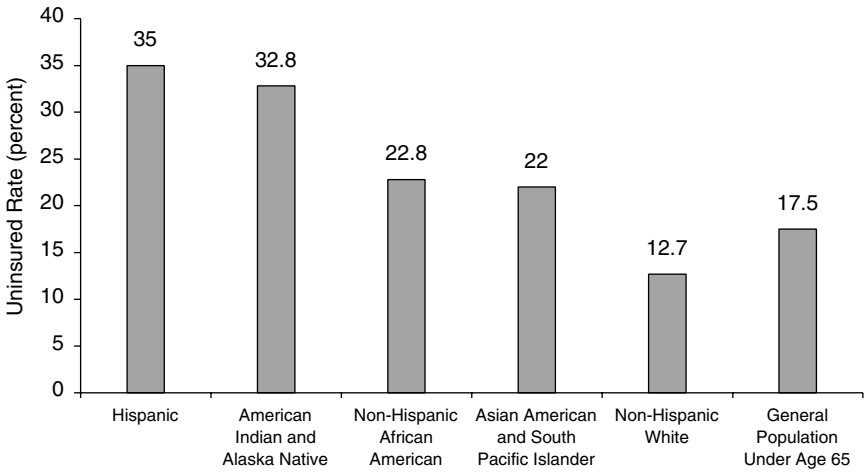

FIGURE 2-3 Probability of being uninsured for population under age 65, by race and ethnicity. SOURCE: Hoffman and Pohl, 2000.

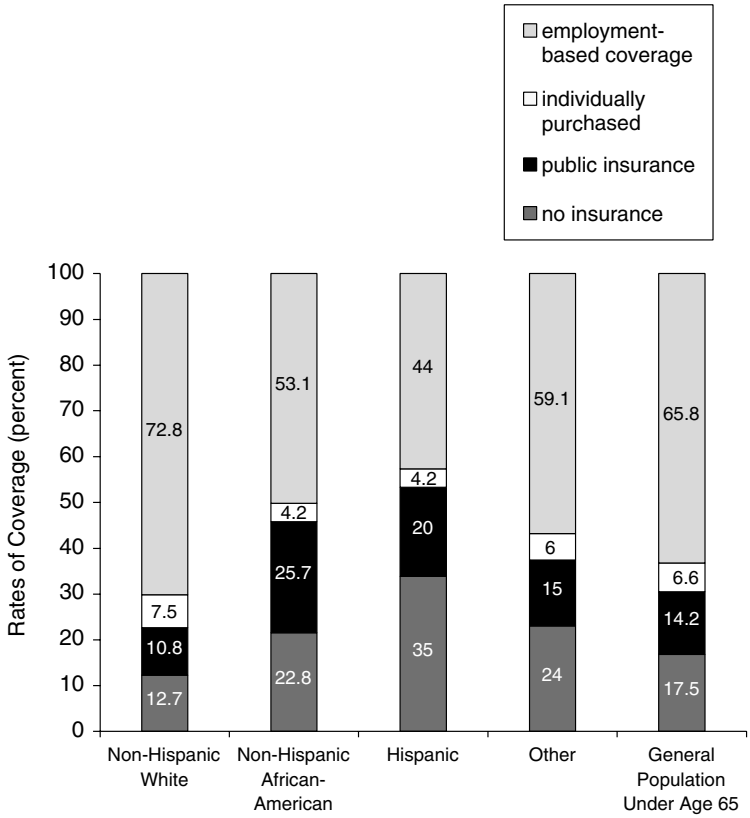

FIGURE 2-4 Sources of health insurance for population under age 65, by race and ethnicity, 1999. NOTE: Numbers may not add to 100 percent due to respondents reporting more than one source of coverage and due to rounding. SOURCE: Fronstin, 2000.

ties, particularly Hispanic Americans, are over-represented. Lack of insurance poses the most significant barrier to care. Insurance status, perhaps more than any other demographic or economic factor, determines the timeliness and quality of healthcare, if it is received at all (Institute of Medicine, 2001b).

African Americans

African Americans are less likely to possess private or employment-based health insurance relative to white Americans, and are more likely to be covered via Medicaid or other publicly funded insurance (see Figure

2-4). In addition, African Americans are almost twice as likely as non-Hispanic whites to be uninsured. High rates of uninsurance among this population occur despite the fact that over 8 in 10 African Americans are in working families, as a disproportionate percentage of African Americans work in jobs that provide no heath insurance (The Henry J. Kaiser Family Foundation, 2000a). As illustrated in Figure 2-3, the probability of being without health insurance coverage for African Americans is 22.8 percent, compared with 17.5 percent in the general population.

American Indians and Alaska Natives

The U.S. government is obligated through treaty and federal statutes to provide healthcare to members of federally recognized American Indian tribes. This trust, however, has not been fully met, for several reasons. The federal Indian Health Service (IHS) provides healthcare services primarily on Indian reservations, which are home to only a minority of American Indians (as few as 30%), as the majority of the population currently lives in urban or other non-reservation areas (Brown et al., 2000). To obtain IHS care, Indians must travel to their home reservation. Not surprisingly, a large majority (80%) of American Indians and Alaska Natives report no access to IHS facilities (The Henry J. Kaiser Family Foundation, 2000a). Although the federal government contracts with a number of urban Indian health organizations to provide services, such federal support is often limited. In general, the agency's resources (slightly over $2 billion was appropriated to the agency in fiscal year 1998) are far below needs. In fiscal year 1997, for example, the agency reported $1,430 in per capita expenditures, a figure that is 1.4 to 2.8 times below the per capita spending of other federal health programs and agencies such as Medicaid ($3,369) and the Veterans Administration ($5,458) (National Indian Health Board, 2001).

Figure 2-3 indicates that nearly one-third of American Indians and Alaska Natives (32.8%) lack health insurance, compared with 17.5% in the general population. Slightly less than half of American Indians and Alaska Natives have job-based health insurance, while one quarter receive Medicaid insurance and a similar proportion are uninsured or report only IHS coverage (The Henry J. Kaiser Family Foundation, 2000).

Asian Americans and Pacific Islanders

Some of the ethnic subgroups among Asian Americans and Pacific Islanders (API) have disproportionately high rates of uninsurance (Brown et al., 2000; Hoffman and Pohl, 2000). Rates vary considerably, although

generally, only 64% of API populations have job-based health insurance, compared with nearly three-fourths of whites (73%). Nearly one-fourth of API populations are uninsured (see Figure 2-3). Generally, rates of public insurance are lower for Asian Americans and Pacific Islanders, except for some Southeast-Asian subpopulations (Brown et al., 2000).

Within API subgroups, Korean Americans are least likely to have health insurance. Less than half have job-based insurance (49%), while over one-third (34%) are uninsured and 14% receive Medicaid or other publicly funded insurance. Similarly, South East-Asian (e.g., Vietnamese, Cambodian, Laotian) and South-Asian (e.g. Indian, Pakistani, Bangladeshi) populations are disproportionately uninsured (27% and 22%, respectively). Less than half (49%) of South East-Asians have job-based insurance, while nearly seven in ten South-Asians (69%) have job-based insurance. Two in ten Chinese-American and Filipino-American families are uninsured (The Henry J. Kaiser Family Foundation, 2000b). These data are depicted in Figure 2-5.

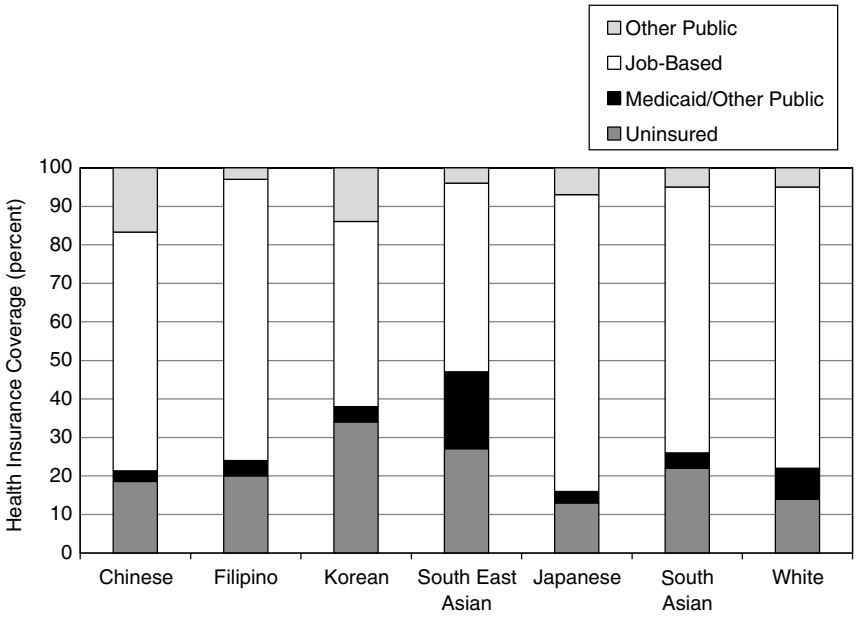

FIGURE 2-5 Health insurance coverage by Asian-American and Pacific-Islander subgroups vs. whites (Ages 0-64), 1997. SOURCE: The Henry J. Kaiser Family Foundation, 2000b.

Hispanic Americans

Hispanic Americans face greater barriers to health insurance than all other U.S. racial and ethnic groups. The probability of being uninsured among Hispanic Americans is 35 percent, compared with 17.5 percent for the general population (Hoffman and Pohl, 2000). This disparity, depicted in Figures 2-3 and 2-4, largely results from the lack of job-based insurance provided to Hispanic Americans, who disproportionately work in blue-collar and service-oriented jobs. The vast majority (87%) of uninsured Hispanics are in working families, yet only 43% of Hispanics receive health insurance through work. Further, nearly one-third of Hispanics (30%) work for an employer who does not offer health insurance to workers (The Henry J. Kaiser Family Foundation, 2000b). The high rate of uninsurance among Hispanics is also a reflection of a lower-than-average rate of participation in publicly funded health plans. In families with incomes less than the federal poverty level, 45 percent of all Hispanics are uninsured, compared with 32 percent of non-Hispanic whites (Fronstin, 2000). Differing eligibility standards may play a significant role in the lower rates of coverage for Hispanics under some publicly funded insurance plans, as many state and federal guidelines do not permit coverage for extended family members or families where married spouses live in the same household.

Hispanic subgroups vary in rates and sources of insurance coverage. Cuban Americans experience the highest rates of job-based or other private insurance (65%), and along with Puerto Ricans, are least likely to be uninsured (21%). Less than half of Puerto Rican, Central and South American-descendent, and Mexican Americans have job-based or other private insurance (45%, 46% and 44%, respectively), and over one-third of Puerto Rican Americans (34%) are insured by Medicaid or other publicly funded programs. More than 4 in 10 Central and South American descendent-Americans are uninsured (42%), as are 38% of Mexican Americans. These data are displayed in Figure 2-6.

Linguistic Barriers

Many racial and ethnic minority Americans experience language barriers. These barriers range from low or no English proficiency to limited proficiency in speaking, reading or comprehending English. In healthcare settings, these linguistic barriers can present significant challenges to both patients and providers, despite federal regulations that encourage and support the use of interpreters (Office of Civil Rights, U.S. Department of Health and Human Services, 2000). According to the 1990 U.S. Census, 14 million people living in the United States have no or limited English-language skills

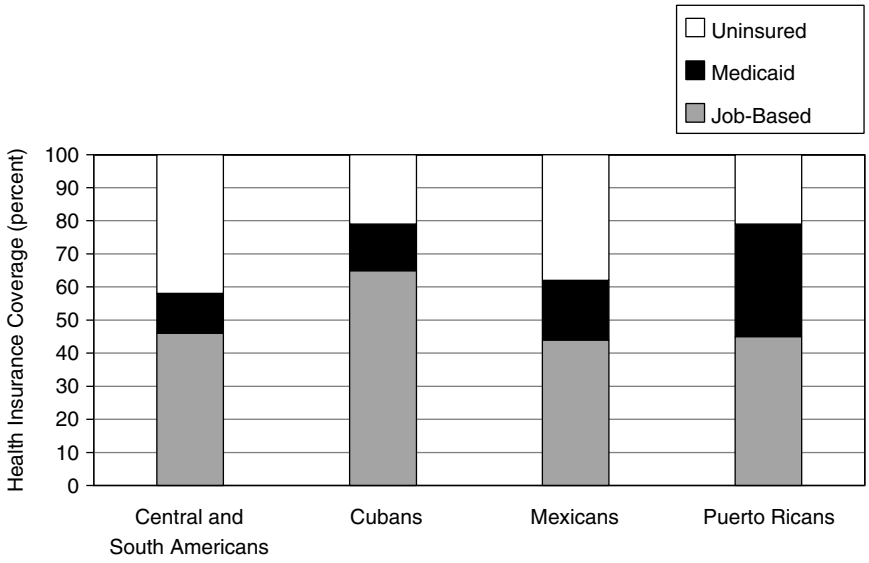

FIGURE 2-6 Health insurance coverage among Latino subgroups (Ages 0-64), 1997. SOURCE: The Henry J. Kaiser Family Foundation, 2000b.

(data from the 2000 Census are not available as of this writing). These populations can be found throughout the United States, although they are disproportionately represented in large urban centers and in five states (more than 10% of the population in California, New York, Texas, New Mexico, and Hawaii have limited English-language skills [Woloshin et al., 1995]). Nearly 8 million individuals (7,741,259) live in linguistically isolated households, e.g., households in which no person over age 14 speaks English "very well" (U.S. Bureau of the Census, 1993). The percentage of individuals living in linguistically isolated households for each racial and ethnic group is depicted in Figure 2-7.

Hispanic or Latino

More than 1 in 4 (25.3%) Hispanic individuals in the United States live in a linguistically isolated household. These include 4,560,000 individuals in over 1.5 million households. In addition, nearly 8 million Hispanic Americans (7,716,000) do not speak English "very well" (U.S. Bureau of the Census, 1993). Given recent population shifts (e.g., an increase in foreign-born Hispanic immigrants), it is likely that these figures grossly underestimate the number of Hispanic Americans with limited or low English proficiency.

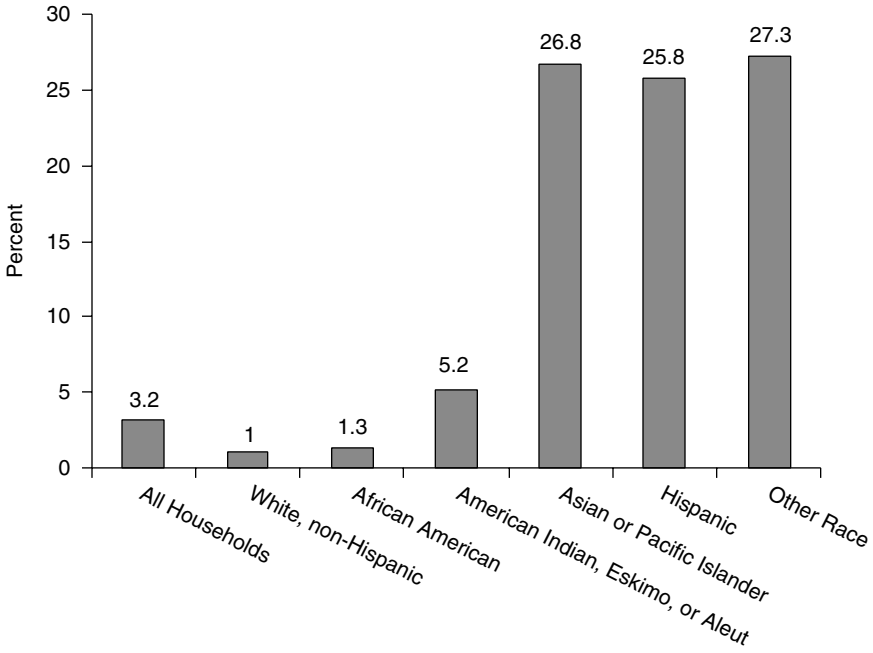

FIGURE 2-7 Percentage linguistically isolated households, by race and ethnicity, United States, 1990. SOURCE: U.S. Bureau of the Census, 1993.

American Indian and Alaska Native

More than one in 20 American Indians or Alaska Natives lives in a household in which no adolescent or adult speaks English "very well." According to the 1990 U.S. Census, 281,990 persons aged five years or older speak one of the American Indian languages at home; half of these (142,886) speak Navajo. Nearly 170,000 American Indians or Alaska Natives do not speak English "very well," and over 32,000 American Indian or Alaska Native households are linguistically isolated (U.S. Bureau of the Census, 1993).

Asian Americans and Pacific Islanders

Large segments of Asian-American and Pacific Islander communities face linguistic isolation. According to 1990 U.S. Census estimates, more than 1.5 million Asian or Pacific Islander Americans live in linguistically isolated households. Over half of Laotian, Cambodian, and Hmong families are linguistically isolated, while between 26%-42% of Thai, Chinese,

Korean, and Vietnamese families live in similar conditions. Figure 2-8 displays the percentage of Asian American households that are linguistically isolated.

Healthcare Providers

Many healthcare providers are acutely aware of the impact of language barriers and other cultural differences and how these factors affect their healthcare practice. In a recent survey of physicians who participate in the "Healthy Families" programs, L.A. Care (the local health authority of Los Angeles County) found that 71% of providers believe that language and culture are important in the delivery of care to patients. Slightly over half (51%) believe that their patients did not adhere to medical treatments as a result of cultural or linguistic barriers. Yet, over half of these providers (56%) report not having had any form of cultural competency training (Cho and Solis, 2001).

RACIAL ATTITUDES AND DISCRIMINATION IN THE UNITED STATES

"There are those that don't get promoted because of their race or whatever. The reason [may be because] they're not well liked by administration or it may be just that they [administrators] don't want that person in that setting because of their race—that is out there. Racism is alive and well, and those of us who think that it's not are living in some kind of dream world." (African-American nurse)

"I've had both positive and negative experiences. I know the negative one was based on race. It was [with] a previous primary care physician when I discovered I had diabetes. He said, 'I need to write this prescription for these pills, but

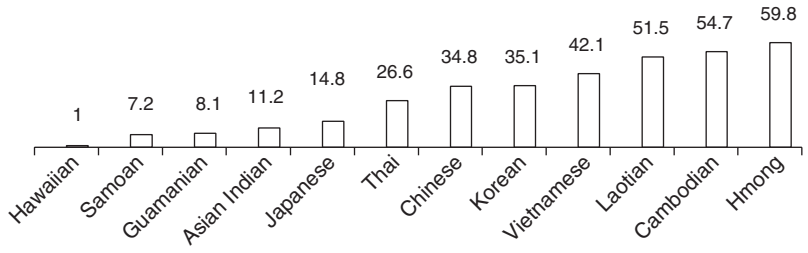

FIGURE 2-8 Percentage of Asian Americans that are linguistically isolated, by subgroup. SOURCE: U.S. Bureau of the Census, 1990 General Population Characteristics.

you'll never take them and you'll come back and tell me you're still eating pig's feet and everything…then why do I still need to write this prescription.' And I'm like 'I don't eat pig's feet.'" (African-American patient)

"My name is . . . [a common Hispanic surname] and when they see that name, I think there is some kind of prejudice [against] the name . . . we're talking about on the phone, there's a lack of respect. There's a lack of acknowledging the person and making one feel welcome. All of the courtesies that go with the profession that they are paid to do are kind of put aside. They think they can get away with a lot because 'Here's another dumb Mexican.'" (Hispanic patient)

"If you speak English well, then an American doctor, they will treat you better. If you speak Chinese and your English is not that good, they would also kind of look down on you. They would [be] kind of prejudiced." (Chinese patient)

The first chapter reviewed evidence of disparities in the process, structure, and outcomes of healthcare. This information alone presents an incomplete picture of the social, political, and economic contexts in which racial and ethnic disparities occur. In particular, to understand the question of whether discrimination occurs in healthcare, it is necessary to review what is known about racial attitudes and racial discrimination in other aspects of American life. This section reviews this evidence, with the goals of:

- illuminating trends in racial attitudes that may be assumed to carry over into healthcare settings; and
- understanding the persistence and pervasive quality of discrimination that has characterized the American racial and ethnic minority experience.

Indeed, towards this latter goal, it is useful to consider that the concept of "race" depends fundamentally on the existence of social hegemony. As Michael Omi (2001) notes, "[t]he idea of race and its persistence as a social category is only given meaning in a social order structured by forms of inequality—economic, political, and cultural—that are organized, to a significant degree, by race" (Omi, 2001, p. 254).

Racial Attitudes and Relations

"Often times, the system gets the concept of black people off the 6 o'clock news, and they treat us all the same way. Here's a guy coming in here with no insurance. He's low breed." (African-American patient)

Racial attitudes and relations in recent decades have been characterized by both progress and strife. Sociologist Lawrence Bobo (2001) notes five trends regarding racial attitudes and race relations in this period that offer, at times, a conflicting picture of race in America. The first, more positive trend is that Americans' attitudes toward the goals of integration and equality have improved steadily over the past three decades. Second, this trend has not resulted in increasing public support for policies or other significant efforts to improve educational, employment, housing, and other opportunities for U.S. racial and ethnic minorities. Third, white Americans continue to express support for negative stereotypes of minority groups in surprisingly large numbers, even though few of these individuals would identify themselves as bigoted or racist. Fourth, white and non-white Americans differ significantly in their perception of the prevalence of racial discrimination in the United States. Finally, minorities' attitudes regarding race relations suggest a deepening level of alienation from U.S. society.

Regarding the first trend, Bobo notes that racial attitudes in America have improved significantly over the past 50 years. In the 1940s, for example, opinion surveys indicated that over two-thirds of white Americans endorsed the view that African-American and white children should attend separate schools, a view that was reflected in both formal policy and practice. Over half of respondents felt that public transportation should be segregated by race, and that whites should receive preference over minorities in access to jobs. By 1995, 96% of white Americans expressed the view that black and white children should be allowed to attend the same schools. Similarly, by the 1970s, few whites endorsed the view that public transportation should be segregated, or that whites should receive preferential treatment in hiring. In 1965, slightly more than 60% of whites stated that they would not move if a black family moved next door; by 1995, well over 90% shared this belief. Bobo concludes that over time, "support for principles of racial equality and integration has been sweeping and robust. So much so, that it is reasonable to describe it as a change in fundamental norms with regard to race" (Bobo, 2001, p. 273).

Despite these positive overall trends, Americans' attitudes cannot be characterized as wholly egalitarian with regard to racial minorities, particularly when asked about policies and practices that might increase their direct contact with minority groups. For example, while the vast majority of Americans support school integration in principle, when asked whether they would send their own children to integrated schools, support declines as the degree of contact with minorities increases. When asked if they would object to sending their children to a school with a "few" black children, over 90% of whites report no objection. If black children consti-

tuted half of the school enrollment, support dips to approximately three-quarters of respondents. If the school is presented as "mostly black," support falls to below 50%. While these trends have remained fairly stable since the mid-1970s, white support for sending their children to "mostly black" schools has fallen to below 40% at various points, particularly in the early and mid-1980s. Similarly, the percentage of white respondents who report that they would move should their neighborhood become integrated increases linearly with the proportion of blacks as residents (Bobo, 2001).

In addition, a substantial proportion of white Americans continue to endorse negative stereotypes about minorities. The 1990 General Social Survey (GSS) revealed that whites viewed blacks more negatively relative to whites on a number of dimensions, including intelligence (54% rated blacks as less intelligent in relation to whites), industriousness (62% rated blacks as lazier than whites), propensity towards violence (56% rated blacks as more prone to violence), and preference for living on public assistance (78% rated blacks as preferring to live off of welfare as compared with whites). Whites also rated Hispanics more negatively in relation to whites along the same dimensions, as 31% of whites gave Hispanics a low rating relative to whites in intelligence, 47% rated Hispanics as "lazier" than whites, 54% rated Hispanics as more prone to violence, and 59% believed that Hispanics are more likely than whites to prefer to live off of welfare (Bobo, 2001). It should be noted, however, that these percentages may be conservative due to tendencies among the general public to respond in a socially desirable, non-racist manner.

Negative stereotyping of minorities is not limited to African Americans and Hispanics. A recent survey commissioned by the Committee of 100 to study Americans' attitudes toward Asian Americans found that at least 1 in 4 Americans holds decidedly negative attitudes toward Chinese Americans, and an additional 43% hold "somewhat negative" attitudes. Many responses suggested that a significant segment of Americans fear Chinese Americans' influence and power; over one-third (34%) of respondents believe that Chinese Americans have "too much influence in the U.S. high technology sector," while 23% believe that Chinese Americans have "too much power in the business world." Nearly one in three (32%) respondents believe that Chinese Americans "always like to be at the head of things," and nearly 1 in 4 believes that Americans are losing jobs at the hands of Chinese Americans. Nearly 1 in 3 believe that Chinese Americans are more loyal to China than to the United States, and 46% of those surveyed believe that "Chinese Americans passing on information to the Chinese government is a big problem." Respondents who endorsed 5 or more of the 12 negative stereotypes posed about Chinese Americans—25% of the sample—were found to hold overwhelmingly negative atti-

tudes toward Chinese Americans. These respondents, who tended to have lower levels of education, lower incomes, and were more likely from the South, believe in large majorities—ranging from 68% to 73%—that Chinese Americans "don't care what happens to anyone but their own kind," and are "taking away too many jobs from Americans" (Edsall, 2001).

Not surprisingly, white and non-white Americans hold widely diverging views of the prevalence of racial discrimination. A 1995 poll, for example, found that nearly nine in ten African Americans (88%) felt that police treat blacks unfairly, compared with 47% of whites (Schuman et al., 1997). In another poll, slightly over one in five whites (22%) but 57% of African Americans endorsed the view that blacks are discriminated against "a lot" (ABC News/Lifetime Television, 1999). Bobo (2001) cites a survey that finds African Americans to be three times as likely as whites to feel that there is "a lot" of discrimination against blacks in attaining "good-paying" jobs. Nearly 70% of African Americans endorsed this view, compared with slightly more than 20% of whites. Interestingly, 40% of Hispanics and slightly over 10% of Asian Americans supported this view. When asked whether Hispanics face "a lot" of discrimination in getting good-paying jobs, Hispanics (60%) were three times as likely as whites (20%) and one and a half times as likely as African Americans to endorse this view. Bobo (2001) summarizes these data, stating, "[minorities] not only perceive more discrimination, they also see it as more 'institutional' in character . . . [whereas] many whites tend to think of discrimination as either mainly a historical legacy of the past or as the idiosyncratic behavior of the isolated bigot" (Bobo, 2001, p. 281).

Strikingly, white Americans' perceptions of minorities appear to be based on inaccurate notions of racial progress. A national survey conducted by the Washington Post, The Henry J. Kaiser Family Foundation, and Harvard University revealed that "whether out of hostility, indifference or simple lack of knowledge, large numbers of white Americans incorrectly believe that blacks are as well off as whites in terms of their jobs, incomes, schooling, and healthcare" (Morin, 2001, p. 1). Over seven in ten (71%) white Americans surveyed expressed the view that African Americans enjoy the same or greater opportunities than whites; 65% of whites endorse this view with respect to Hispanics. In terms of income, 42% of whites surveyed believe that African Americans are better off or about the same as the "average white person," and nearly half (49%) believe that African Americans have similar or higher levels of education. Half of surveyed whites endorsed the view that African Americans hold similar or better jobs than whites. More than six in ten (61%) whites believe that African Americans have equal or better access to healthcare as whites, and nearly half (48%) of these respondents believe than Hispanics have equal or better access to healthcare (Morin, 2001). All of these responses are inaccurate

with respect to major demographic data collected by the U.S. Bureau of the Census and other data sources, as outlined in this chapter.

The following sections illustrate that despite the more optimistic view of some that unfair treatment on the basis of race is rare, racial discrimination persists in a wide range of important aspects of American life.

Racial Discrimination

> *"I felt that because of my race that I wasn't serviced as well as a Caucasian person was. The attitude that you would get. Information wasn't given to me as it would have [been given to] a Caucasian. The attitude made me feel like I was less important. I could come to the desk and they would be real nonchalant and someone of Caucasian color would come behind me and they'd be like 'Hi, how was your day?'" (African-American participant)*

What Is Discrimination?

Discrimination, the differential and negative treatment of individuals on the basis of their race, ethnicity, gender, or other group membership, has been the source of significant policy debate over the past several decades. Federal and state laws adapted since the landmark 1964 Civil Rights Act outlaw most forms of discrimination in public accommodations, access to resources and services, and other areas. While this legislation appears to have spurred significant change in some segments of American society, such as in the overt behavior of lenders and real estate agents, debate continues regarding whether and how discrimination persists today. Conservative legal scholars and social scientists argue that discrimination has largely been eliminated from the American landscape (Thernstrom and Thernstrom, 1997; D'Souza, 1996), while others argue that discrimination has simply taken on subtler forms that make it difficult to define and identify. Complicating this assessment is the fact that while individual discrimination is often easier to identify, *institutional discrimination*—the uneven access by group membership to resources, status, and power that stems from facially neutral policies and practices of organizations and institutions—is harder to identify. Further, it is difficult to distinguish the extent to which many racial and ethnic disparities are the result of discrimination or other social and economic forces.

There is little doubt among researchers who study discrimination, however, that the United States' history of racial discrimination has left a lasting residue, even in a society that overtly abhors discrimination. "Deliberate discrimination by many institutions in American society in the past had left a legacy of [social and] economic inequality between whites and minorities that exists today . . . [but] legal evidence of discrimination

in specific cases is not the same as statistical measures of the overall level at which discrimination exists" (Turner and Skidmore, 1999, p. 5-6).

Mortgage Lending

African-American and Hispanic applicants for conventional home mortgages are rejected at rates greater than twice that of white applicants (U.S. Department of Housing and Urban Development, 1999). But are these disparities due to minorities' generally lower credit ratings and lower income—important predictors of loan outcomes that are themselves by-products of past discrimination?

After controlling for measures of creditworthiness, such as loan type, property and credit, data compiled by the Federal Reserve Bank of Boston revealed large differences in loan denial rates between minority and white applicants. Hispanic and African-American applicants faced an 80% greater likelihood of loan denial. The Urban Institute reanalyzed these data and replicated the finding that creditworthiness or technical factors could not explain the disparity. These researchers concluded that "the Boston Fed Study results provide such strong evidence of differential denial rates (other things being equal) that they establish a presumption that discrimination exists, effectively shifting the 'burden of proof' to lenders" (Turner and Skidmore, 1999, p. 12).

A 1999 Urban Institute study of mortgage lending practices found that minorities face discrimination in several stages of the mortgage lending process. Paired testers sought loans using similar credit histories, incomes and financial histories, and presented the same mortgage needs. Overall, minorities received less information about loan products and were accorded less time with lending officers. Further, they were quoted higher lending rates than whites in most of the cities where tests were conducted. Potentially discriminatory practices began at early stages of the loan process, such as pre-application inquiries, and persisted through to the loan approval stage (Turner and Skidmore, 1999).

Housing Discrimination

Despite the presence of fair housing and anti-discrimination laws, American cities remain starkly segregated by race. Massey (2001), in an analysis of the largest 30 U.S. cities, finds that residential segregation is most profound and consistent over time among African Americans, and is less prominent, but still significant among Hispanic and Asian-American families. Using the indices of dissimilarity (the relative number of minorities who would have to change geographic locations so that an even racial distribution could be achieved) and isolation (the percentage of mi-

norities residing in the geographic unit of the average minority individual), Massey found that, on average, African Americans live in communities that are overwhelmingly African American, with dissimilarity indices averaging 77.8 in northern cities and 66.5 in southern cities (indices above 60 are considered high). In six metropolitan areas (Chicago, Cleveland, Detroit, Gary, New York, and Newark), isolation indices for African Americans are 80 or more, indicating that in these cities, the average African American lives in a neighborhood that is more than 80% black. Further, other measures indicate that many African-American communities are characterized by "hypersegregation;" that is, African Americans tend to be concentrated in compact, densely packed, contiguous tracks in central cities. Black residents in these areas are unlikely to ever come into contact with non-blacks in their neighborhoods or in adjoining neighborhoods, and would have "little direct experience with the culture, norms, and behaviors of the rest of American society, and have few social contacts with members of other racial groups" (Massey, 2001, p. 410).

Patterns of segregation among Hispanic and Asian-American populations, in contrast, are less stark than that of African Americans. The dramatic increase of both Asian and Hispanic immigrants to the United States has led to large concentrations of these populations in some urban areas, but other segments of these populations have achieved remarkable levels of integration with whites. In several cities with large Hispanic populations, such as Brownsville and McAllen (Texas) and Miami (Florida), Hispanic segregation is high, with isolation indices averaging 77.2. This suggests that more than 3 of 4 Hispanics lacks regular neighborhood contact with individuals from other racial and ethnic backgrounds. In cities that are not majority Hispanic, concentration of Hispanics is less likely, with dissimilarity indices averaging 49.6 (suggesting that about half of communities in these cities are segregated by race and ethnicity) and isolation indices averaging 45.1 (both are in the moderate range). Asian-American segregation indices are quite moderate, with dissimilarity indices averaging 40.6 and isolation indices averaging 20.6 (Massey, 2001).

These patterns of segregation are not merely the product of socioeconomic differences, Massey notes. Segregation of African Americans, for example, occurs independently of social class. African-American families earning at least $50,000 annually are as likely to live in neighborhoods as segregated as those in which African-American families earning less than $2,500 per year reside. Further, the most affluent African Americans are even more segregated than lower-income Asian-American and Hispanic families; blacks earning more than $50,000 annually live in more segregated conditions than Asian-American or Hispanic families earning less than $2,500 annually (Massey, 2001).

Importantly, segregation does not appear to result merely from the choices of African-American and other minority groups to live apart from white Americans. Polling data indicate that African Americans strongly endorse the idea of residential integration, and would prefer to live in racially mixed neighborhoods. Virtually all African Americans endorse the statement that "black people should have a right to live wherever they can afford to," and over 70% would vote for a community law to enforce this right (Bobo, Schuman, and Steeh, 1986). Nearly 90% of African Americans state that they would be willing to live in any racially mixed area (Farley et al., 1994).

Similarly, most white Americans endorse the view that housing opportunities should be open to all and that housing discrimination should be abolished. In practice, however, white Americans' attitudes shift significantly with increasing residential segregation, as measured by polling data and patterns of movement after previously all-white neighborhoods become integrated. Farley et al. (1994) asked white residents in the Detroit metro area if they would feel uncomfortable in a neighborhood where 7% of the residents were black; 13% of respondents reported that they would be unwilling to enter such a neighborhood. When the percentage of black residents is presented as one-fifth of the total, one-third of whites reported that they would be unwilling to enter. If 30% of residents are African American, 59% of whites reported that they would be unwilling to move in, 44% reported that they would feel uncomfortable, and 29% reported that they would try to leave if they lived in such a neighborhood. If 50% of residents are African American, 73% of whites report that they would not want to live in the neighborhood, 65% reported that they would feel uncomfortable, and 53% would try to leave. In actual practice, the presence of smaller percentages of African Americans in previously all-white neighborhoods initiates a pattern of destabilization whereby whites tend to leave in large numbers. Summarizing studies of neighborhood racial transformation, Massey (2001) notes that the presence of one African-American family among every five white families tends to fuel a process of neighborhood turnover; in some cases, this turnover has accelerated when African Americans have numbered as few as three percent of a neighborhood (Massey, 2001).

Despite the existence of federal laws barring discrimination in housing, racial discrimination appears to be a key mechanism preventing neighborhood integration. Prior to passage of the 1968 Fair Housing Act, racial discrimination was institutionalized in the real estate industry and was widely practiced. Today, Massey (2001) states, minority home seekers, particularly African Americans, are more likely than not to face discrimination when attempting to purchase or rent a home. This discrimination occurs largely in the form of subtle, covert barriers. Housing audit studies, for example, provide a powerful means of assessing the likeli-

hood of discriminatory practices. Auditors are trained to present comparable needs and desires in home purchases or rental properties, and are provided with similar socioeconomic traits. These studies, according to Massey, consistently indicate that housing discrimination has persisted in the years following passage of the Fair Housing Act. The U.S. Department of Housing and Urban Development's (HUD) Housing Discrimination Study, for example, was conducted in 20 audit sites around the United States and revealed that white auditors were, on average, provided with 45% more housing options in the rental market and 34% more options in the sales market than black auditors. In addition, whites were shown additional units 65% more often than blacks. Subtle "steering" of minority auditors away from predominantly white neighborhoods increased the likelihood of discrimination to 60%; in total, between 60% and 90% of the housing shown to white auditors were not shown to comparable black auditors (Yinger, 1995). For Hispanics, the likelihood of discriminatory treatment was equally high, as Hispanic auditors faced unfavorable treatment 43% of the time when seeking rental units, and 45% of the time when seeking to purchase a home (Fix, Galster, and Struyk, 1993).

White auditors also received greater assistance in obtaining credit; in 46% of encounters, whites received more favorable credit assistance in sales transactions and were offered more favorable terms in 17% of rental transactions. In addition, greater credit assistance was provided to whites; of all instances in which agents discussed a fixed-rate mortgage, 89% were with white auditors, as were 91% of instances in which adjustable-rate loans were discussed (Yinger, 1995).

These findings have been replicated in several other housing audit studies conducted in different locations in the United States. Galster (1990) found that racial steering occurred in approximately 50% of transactions, and that "selective commentary" from agents was common (including positive comments provided to white auditors regarding predominantly white neighborhoods that are not provided to African-American auditors). While housing audits have largely focused on the possibility of discrimination against African Americans, a few studies suggest that Hispanics face similar discrimination, particularly among darker-skinned Hispanics or those who identify themselves as mixed European and Indian ancestry (Massey, 2001). The consistency of these findings, coupled with data noting persistent racial segregation in the vast majority of American communities, prompts Massey to conclude, "rather than declining in significance, race remains the dominant organizing principle of U.S. urban housing markets" (2001, p. 420).

The consequences of such segregation for individual health status are significant (Williams, 2001; Massey, 2001). Many community resources that affect health, including access to employment and educational opportunities, are inequitably distributed; a close association exists between

a group's spatial position in society and its socioeconomic opportunities. For example, some communities are characterized by better schools, safer streets, better public services, fewer environmentally based health hazards, and better access to quality healthcare. African Americans, regardless of income, tend to be segregated in neighborhoods characterized by fewer of these resources and higher levels of health risks. "Compared with whites of similar socioeconomic status," Massey (2001) notes, "blacks tend to live in systematically disadvantaged neighborhoods, even within suburbs" (2001, p. 392).

Employment

Audit studies using matched pairs of minority and non-minority auditors have also revealed consistent patterns of discrimination in hiring. As in housing audit studies, these studies carefully match testers on such attributes as educational level and personality characteristics, and carefully coach testers to ensure consistent responses to typical job interview questions. Fix, Galster, and Struyk (1993), for example, report findings from two studies of housing discrimination that assessed unfavorable treatment encountered by qualified job applicants responding to advertisements in major newspapers for entry-level positions. The first, conducted in San Diego and Chicago, assessed unfavorable treatment of Hispanics compared with white applicants. Because this study was part of a larger project assessing the potential adverse impact of new immigration legislation that banned the hiring of undocumented aliens, Hispanic testers were selected who "looked Hispanic and had definite accents" (Fix, Galster, and Struyk, 1993, p. 19). The second study, conducted in Chicago and Washington, D.C., assessed potential discriminatory treatment of African-American applicants relative to whites. Findings revealed that opportunity denial (defined as the denial of opportunity to obtain an application, obtain an interview, or receive an offer of employment) occurred 20% of the time in black-white audits and 31% of the time in Hispanic-Anglo audits, across all study sites. In other words, in nearly one-third of instances Hispanic applicants were denied an application, denied an interview, or did not receive an offer of employment while the matched white auditor received the opposite outcome.

Criminal Justice

Minority Youth in the Juvenile Justice System

Minority youth are overrepresented in the juvenile justice system in the United States. While minorities (African Americans, Hispanics, Asian

Americans, and American Indians) constituted only about one-third of juveniles in the United States in 1997, they represent two-thirds of detained and committed youth in juvenile facilities. These disparities are most pronounced among African-American youth; while they comprise 15% of the juvenile population, they account for more than one in every four juvenile arrests and 45% of delinquent cases involving detention. Further, nearly half (46%) of juvenile cases waived to criminal courts in 1996/7 involved African American youth (Office of Juvenile Justice and Delinquency Prevention, 1999).

Overrepresentation of minority youth in juvenile justice systems occurs in all 50 states and the District of Columbia. According to data collected by the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP), minority youth face a higher probability than white youth of being arrested, referred to court intake, held in short-term detention, petitioned for formal processing, adjudicated delinquent, and confined in a secure juvenile facility. While these disparities may reflect a greater level of involvement in crimes (e.g., African-American youth are involved in 39% of violent crimes, as reported by victims), African-American youth disproportionately account for juvenile arrests for violent crime (44%) and confinement (45%), suggesting differential treatment by race (U.S. Office of Juvenile Justice and Delinquency Prevention, 1999).

A growing number of well-controlled studies demonstrate that minority youth are treated differently in the juvenile justice system than white youth, even considering the severity of crime and differences in rates of offenses. Minority youth, for example, are more likely than whites to be placed in public secure facilities, while white youth are more likely to be housed in private facilities or diverted from the juvenile justice system (U.S. Office of Juvenile Justice and Delinquency Prevention, 1999). These disparities are most pronounced at the beginning stages of processing within the juvenile justice system, but tend to accumulate as juveniles move through stages of the juvenile justice system. OJJDP researchers note that approximately two-thirds of studies of racial differences in processing demonstrate that race influences decision-making in the juvenile justice system, leading researchers to conclude that "there is substantial evidence that minority youth are treated differently from majority youth within the juvenile justice system" (U.S. Office of Juvenile Justice and Delinquency Prevention, 1999, p. 3).

What Is the Relationship Between Racial and Ethnic Disparities in Healthcare and Broader Racial Attitudes and Discrimination?

The study committee considered studies of racial and ethnic discrimination in sectors outside of healthcare as an important aspect of the evi-

dence base to better understand the contexts in which care is delivered to racial and ethnic minority patients. These data are not meant to imply that inferences can be drawn from this literature regarding possible discrimination in healthcare settings. To the contrary, most social scientists agree that individuals with higher levels of education (such as healthcare professionals) generally hold more egalitarian attitudes than less educated individuals and abhor racial or ethnic prejudice and discrimination. In addition, as will be noted in later sections of this report, healthcare professionals are sworn to beneficence, and the vast majority are drawn to their disciplines out of feelings of compassion and a strong desire to heal. Data on the persistence of racial and ethnic discrimination in other sectors of American life are important, however, because they are likely to affect the clinical encounter and process of healthcare delivery in at least three ways:

- experiences of discrimination, whether real or perceived, are experiences that minority patients are likely to bring to the clinical encounter, and are thereby likely to shape their expectations, attitudes and behaviors toward providers and health systems;
- minority patients encountering health systems are likely to interact with many individuals in addition to healthcare providers, such as administrative and clerical staff, who may be expected to mirror social attitudes and trends regarding race and ethnicity; and
- healthcare providers, like all other individuals, are likely influenced in their racial and ethnic attitudes by broader social trends.

THE CONTEXT OF HEALTHCARE DELIVERY FOR RACIAL AND ETHNIC MINORITY PATIENTS—AN HISTORICAL OVERVIEW

> *"What would you recommend (to the IOM) to better understand what minorities experience in getting healthcare?" (Focus Group Moderator)*
>
> *"Understand what the past healthcare history has been to Native Americans. Maybe just having an understanding of how Native American healthcare has been across the U.S., not just here in the Southwest, but everywhere. I think that would make [healthcare providers] effective because they would know what's happened in the past and not repeat the same mistakes." (American Indian healthcare consumer)*

This section presents a discussion of the history of healthcare service delivery for racial and ethnic minority populations in the United States. The discussion is focused on the experience of African Americans only because historical documentation of healthcare for this group is more extensive than for other racial and ethnic minorities. It is not meant to exemplify other groups' healthcare experiences and histories (for a discus-

sion of aspects of the history of U.S. healthcare for American Indians and Alaska Natives, see Joe, this volume). An historical account of the healthcare experience of African Americans is illustrative, however, of how the historic context shapes the contemporary structure of and access to care for racial and ethnic minorities. This section will discuss how the legacy of segregated and inferior healthcare for African Americans continues to reverberate in today's healthcare settings. Important factors such as the makeup of the healthcare workforce, primary settings in which racial and ethnic minorities receive care, opportunities for training of minority healthcare providers, and other aspects of the structure and delivery for healthcare for many African Americans are shaped by these historical trends.

A BRIEF HISTORY OF LEGALLY SEGREGATED HEALTHCARE FACILITIES AND CONTEMPORARY *DE FACTO* SEGREGATION

From the earliest periods in America's history, sharp divisions across racial and ethnic lines were customary in virtually all sectors of society, including healthcare. The origins of racially segregated healthcare systems can be traced back to slavery. While these systems were loosely organized, plantation health services were the earliest and one of the only systems comparable to today's managed-care plans (Smith, 1999). Plantation owners, as employers, had a significant financial interest in preserving the health of their employees (Byrd and Clayton, this volume). Slaves received care in hospitals-of-sorts on plantations. In some states, white physicians organized hospitals for slaves, or contracted with plantation owners to provide care to their slaves (Smith, 1999).

The early and mid 1800s also saw the emergence in America of scientific theories about race. Polygenism, and movements such as anthropometry, phrenology, and craniometry (theories that human races were distinct and hierarchical biological species) were at the forefront of scientific inquiry. Black soldiers during the Civil War were often used as subjects in studies comparing races to demonstrate black inferiority (Byrd and Clayton, this volume).

After emancipation, the plantation system of medical care ended and the Freedmen's Bureau was established by the federal government to provide assistance to former slaves. The medical department of the Bureau established nearly 100 hospitals for freed slaves, However, by 1868 only one (Howard University Medical Center) remained (Smith, 1999). After this point, African Americans received healthcare in segregated facilities in northern hospitals created by local governments. In the south, where most African Americans resided, local municipalities and states began to provide payments to hospitals to subsidize care for the underserved,

which included segregated care for the poor (Smith, 1999). American Indians, who experienced displacement and high mortality, had little contact with health systems until the second half of the 19th century. This healthcare, administered by the government, was also poor, inadequately funded, and not sensitive to culture (Byrd and Clayton, this volume).

As the country approached the 20th century, two major social transformations converged to sharpen the racial divisions in healthcare services (Smith, 1999). First, with the development of surgical and other medical advances, both public and voluntary hospitals became important practice sites. Middle- and upper middle-class citizens began paying for services at these facilities, shifting power away from hospital boards to medical staff, who decided who received what kind of care. Second, the passage of Jim Crow laws solidified racial divides by legally separating facilities that provided care to black and white communities. In the scientific community, theories such as Darwinism, eugenics, and later, psychometric testing were developed to explain and predict the inferiority of certain groups, such as immigrants, African Americans, the poor, and the mentally retarded (Byrd and Clayton, this volume).

As hospital facilities became more important to the practice of medicine, organizations such as the American College of Surgeons sought to standardize hospital practices, which enabled medical staffs at hospitals to become more organized and exercise control over practices in their facilities (Smith, 1999). This essentially resulted in the exclusion of minority physicians from practicing in these institutions. Marginalized groups, including African Americans, American Indians, Hispanic Americans, and others from racial or religious minority groups were isolated, excluded from training, and professionally segregated (Byrd and Clayton, this volume). The response by minority physicians was to create their own facilities. American Indians and Alaska Natives, by treaty agreements, in large part received their healthcare through the Federal government. However, the diversity and dispersion within the Native American community made it difficult to provide consistent and reliable care (Byrd and Clayton, this volume). In a parallel movement, issues of payment for medical care became prominent as these services became increasingly important in peoples' lives. Questions about whether care should be based on need or ability to pay became influenced, in part, by race (Byrd and Clayton, this volume).

The passage of civil rights legislation in 1964 and Medicare and Medicaid legislation in 1965 stimulated profound changes in the structure of healthcare. With mandated integration, one of the most significant changes was the closing of black hospitals (Smith, 1999). Between 1961 and 1988, 70 black hospitals either closed or merged with white facilities. This transformation was taking place while white hospitals were experi-

encing growth and financial prosperity. While on the surface these closings may have seemed like a mere shifting of service sites, they had quite profound and devastating effects in minority communities. These closings meant a loss of geographic convenience and accessibility to care, a sense of safety with known institutions, and a loss of a major source of employment in the community (Smith, 1999). In addition to the loss of these facilities, a similar fate was befalling many public facilities that had provided access to many minority patients.

Another major, and more recent, shift in healthcare structure began in the late 1980s with the rise of managed care. This movement was initiated as both private and public payers were overwhelmed by rising costs and were searching for alternative ways to control their expenditures. By 1996, two-thirds of African Americans and Latinos with private insurance were enrolled in managed care plans. The transformation of Medicare programs to managed care formats led to further downsizing of large urban hospitals (Smith, 1999).

Historical Determinants of the Contemporary Minority Health Professions Workforce

During the post-Reconstruction period, several "Negro" medical schools and hospitals emerged. Eight medical schools for African Americans were established between 1865 and 1910 [Howard University Medical School, Washington, D.C. (1868); Meharry Medical College, Nashville, Tennessee (1876); Leonard (Shaw) Medical School, Raleigh, North Carolina (1882-1915); Louisville National Medical College, Louisville, Kentucky (1887-1911); Flint Medical College, New Orleans, Louisiana (1889-1911); Knoxville Medical College, Knoxville, Tennessee (1895-1910); the Medical Department of the University of West Tennessee (1900-1923); and Chattanooga National Medical College, Chattanooga, Tennessee (ca. 1902)] (Cobb, 1981). At least nine northern medical schools had admitted blacks by 1860. As a result, by 1895 there were approximately 385 black doctors, 7% of whom had been trained in white medical schools. Numbers of African Americans graduating from white institutions gradually increased, and in 1905, 14.5% of the country's 1,465 black physicians were from white medical schools (Duke University Medical Center, 1999).

Training black health professionals was essential to African-American communities during the prolonged post-Reconstruction period of crushing poverty, poor health status and inadequate or absent healthcare (Byrd and Clayton, this volume). Abraham Flexner's 1910 report on the status of minority health and minority health professionals reinforced this need. Flexner severely criticized medical education in the United States, noting that many U.S. medical schools had poor facilities, inadequate fac-

ulty with little scientific basis for instruction, and functioned principally as "diploma mills." These proprietary schools offered after-hours education and training, and contributed to the tension regarding the social and professional place for inexpensive medical education and primary care (Martensen, 1995). These tensions have not been completely resolved today. In this climate, the medical establishment was agitating for control and educational reform. More than 200 medical schools were founded in the United States between 1800 and 1900 (Stevens, Goodman, and Mick, 1978). At the end of the 20th century, the United States had the highest physician-to-population ratio in the world (Smith, 1999). Flexner believed strongly in the German scientific tradition he had experienced at the new Johns Hopkins University and suggested in the report that only university-based medical schools were appropriate for the responsibility and challenge of training physicians. Regarding the education of Negro physicians, he reports:

> "The medical care of the Negro race will never be wholly left to Negro physicians. Nevertheless, if the Negro can be brought to feel a sharp responsibility for the physical integrity of his people the outlook for their mental and moral improvement will be distinctly brightened. The practice of the Negro doctor will be limited to his own race, which in turn will be cared for better by good Negro physicians than poor white ones. But the physical well-being of the Negro is not only of moment to the Negro himself. Ten million of them live in close contact with sixty million whites. Not only does the Negro himself suffer from hookworm and tuberculosis; he communicates them to his white neighbors, precisely as the ignorant and unfortunate white contaminates him. Self-protection not less than humanity offers weighty counsel in this matter; self-interest seconds philanthropy. The Negro must be educated not only for his sake, but for ours. He is, as far as human eye can see, a permanent fact in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion.
>
> The pioneer work in educating the race to know and practice fundamental hygiene principles must be done largely by the Negro doctor and Negro nurse. It is important they both be sensibly and effectively trained at the level at which their services are now important. The Negro is perhaps more easily 'taken in' than the white; and as his means of extricating himself from a blunder are limited, it is all the more cruel to abuse his ignorance through any sort of pretense. A well-taught Negro sanitarian will be immensely useful; an essentially untrained Negro wearing an M.D. degree is dangerous." (Flexner, 1910, as quoted in Smith, 1999, p. 15).

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The Flexner report had an enormous impact on medical education and the entire healthcare delivery system. The American Medical Association and major philanthropic organizations closed ranks behind the report. The AMA's Council on Medical Education pushed states to restrict eligibility for state licensure to physicians graduating from approved medical schools (Smith, 1999). Within a few years the number of medical schools was reduced from approximately 155 to 70 (Smith, 1999). The curriculum was lengthened, entrance requirements were raised, and the scientific content of the curricula was increased (Byrd and Clayton 2001). These reforms were costly and many institutions were unable to survive the changes demanded by reformers. These changes, however, forever altered the class background of those trained to become physicians. Many poorer, part-time, and night students found economic barriers to medical education insurmountable, and the proportion of students from working-class and poor families remained steady at approximately 15% for most of the 20th century (Ziem, 1977). Medical education therefore was largely limited to a predominantly upper-class, white, and male population (Ziem, 1977).

This increase in training costs had profound effects on the availability of doctors, particularly in the African-American community. In fact, the physician-to-population ratio among black Americans in 1974, twenty years after the *Brown v. Board of Education* Supreme Court decision that outlawed segregation in schools was worse than in the 1940s (Blackwell, 1977). Further hampering black progress, integration of the nation's medical schools was not seriously addressed until a decade after the 1954 *Brown v. Board of Education* decision. In 1948, for example, one-third of all medical schools were officially closed to blacks and many more failed to accept a single black student until two decades later (Raup and Williams, 1964).

By 1920, only two black medical schools remained, Howard University Medical School and Meharry Medical College (Smith, 1999). The closure of the other black medical schools dramatically reduced the community resource that produced many of their primary care physicians. These closures ensured that the segregation of healthcare in hospitals, in the health professions, and the professional societies would become entrenched in U.S. society. While the black population made up about 10% of the total population in the mid-1950s, for example, black physicians made up only about 2.2% of all physicians (Reitzes, 1958). The nation's overall physician-to-population ratio was 1 to 770. For the nonwhite population, however, the physician-to-population ratio was 1 to 4,567, and the black physician-to-population ratio was 1 to 3,736 (Reitzes, 1958). This disparity was not surprising, given that the burden of training black healthcare professions increasingly fell to only a few institutions. In 1956,

74% of all black medical students attended Howard or Meharry (Ziem, 1977). It was not until 1969 that all of the nation's medical schools enrolled more black students than did Howard or Meharry alone (Ziem, 1977).

During the late 19th and early 20th century, black physicians and community leaders had built their own hospitals in several cities around the country. Many of these hospitals served as major training centers for black health professionals. Medical specialists were in very short supply in the black communities, and access to white hospitals—even for those doctors who graduated from white medical schools—was limited. For African-American physicians, acquiring specialty training or hospital expertise was rare, because these doctors were denied opportunities to access specialty training (Byrd and Clayton, 2001). Failure to acquire the requisite credentials automatically excluded blacks from academic medicine and prestigious hospital staff appointments.

To compound these problems, organized medicine and local specialty societies failed to open doors for minorities to gain equal footing in the profession. The American Medical Association's (AMA) refusal to require its affiliates to desegregate until the mid-1960s made it virtually impossible for most black physicians to gain privileges at white hospitals because local society membership was a prerequisite (Byrd and Clayton, 2001). Smith (1999) described a fear among black medical leaders that the American College of Surgeons standardization efforts could eventually eliminate black hospitals and black medical professionals. In response, the black medical leadership formed its own organization, the National Medical Association (NMA), which was founded in 1895. Blacks were, in effect, excluded from AMA affiliates and the existing medical establishment, unable to fully open the doors to training opportunities until the Civil Rights Era.

THE SETTINGS IN WHICH RACIAL AND ETHNIC MINORITIES RECEIVE HEALTHCARE

"So you're talking about [the] hospital. I think [large] hospitals, their equipment, [they have] more equipment, I'm talking about [a] large hospital, a hospital versus clinics. I like to go to a place where they have more, a lot of equipment, and complete their services so I don't have to go to different places. I can go to . . . a central place where they'll be able to take care of everything. And then language again, that's important. A Chinese interpreter [is necessary]." (Asian-American patient)

The legacy of racial segregation of healthcare is, in many respects, mirrored in stark racial and ethnic differences in the contexts in which

care is received. Rates of health insurance vary greatly among racial and ethnic groups, as do primary sites where care is received, and who delivers this care. Most of these racial and ethnic differences are due to socioeconomic factors. For example, as will be discussed in Chapter 3, patients with Medicaid have difficulty accessing private sector office-based care (Lillie-Blanton et al., 2001) and are more often relegated to public hospitals and clinics. New studies indicate, however, that even when income and education are controlled, minorities are more likely to receive care in the lowest quality facilities with the least likelihood of appropriate follow-up.

Minorities have more difficulty than the majority population in locating a "usual source" of medical care (see Figure 2-9). African-American and Latino patients report greater difficulty than whites obtaining medical care at a consistent location. In 1996, for example, almost a third of Latino patients reported having a regular healthcare provider. Similarly, more minority patients report having little or no choice in where to go for medical care. Twenty-eight percent of African Americans and 30% of Hispanics report this difficulty, compared with 16% of whites and 21% of Asian-American adults (Lillie-Blanton et al., 2001).

In the 1980s, African Americans and Latinos were more likely than their white counterparts to receive care in hospital outpatient departments (particularly teaching and public hospitals), community-based clinics, and emergency rooms as usual sources of care (Lillie-Blanton et al., 2001; Smith, 1999; Gaskin, 1999). Persons with public or no insurance were also more likely to receive care in these settings (Cornelius et al., 1991, as cited

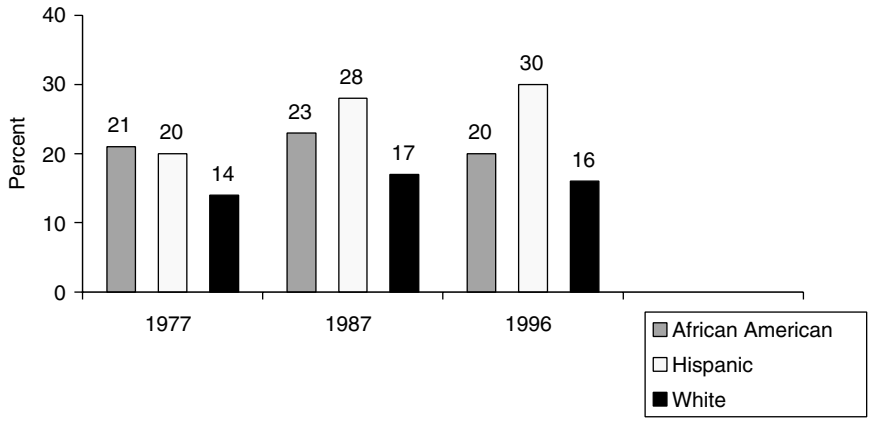

FIGURE 2-9 No usual source of medical care. SOURCE: 1996 Medical Expenditure Panel Survey, as cited in Lillie-Blanton et al., 2001.

in Lillie-Blanton et al., 2001). In a study to assess whether ethnicity is associated with site of care beyond insurance coverage, Lillie-Blanton, Martinez, and Salganicoff (2001) analyzed data from the 1996 Medical Expenditure Panel Survey (MEPS), and found that African Americans and Latinos, regardless of insurance coverage, were almost twice as likely as whites to receive care from a hospital-based provider (Figures 2-10 and 2-11). Those who were uninsured were also more likely to rely on hospitals for care.

Many people from racial and ethnic backgrounds are disproportionately served by safety net urban hospitals, defined as those facilities whose Medicaid utilization rate exceeds one standard deviation above the mean Medicaid utilization rate for urban hospitals in the state. Ethnic minorities comprise 43% of patients seen at these hospitals, but make up only 19% of patients seen at other urban hospitals (Collins et al., 1999). Approximately half of African-American (47%) and Hispanic (53%) adults under age 65 report relying on safety net emergency rooms, outpatient departments, or clinics for their healthcare, compared with 30% of whites.

Children's healthcare service use reveals similar patterns. White children see physicians at twice the rate of minority children (Collins et al., 1999). However, African-American and Latino children are over-represented in emergency rooms and hospital outpatient departments (Table 2-1; Lillie-Blanton et al., 2001). Even across type of insurance, African-

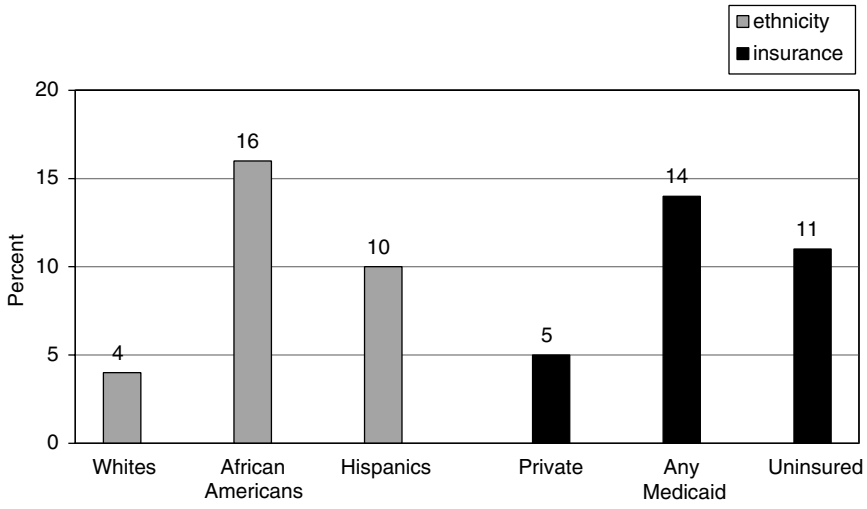

FIGURE 2-10 Site of care: Hospital outpatient departments and emergency rooms.
SOURCE: Medical Expenditure Survey, 1997, as cited in Lillie-Blanton et al., 2001.

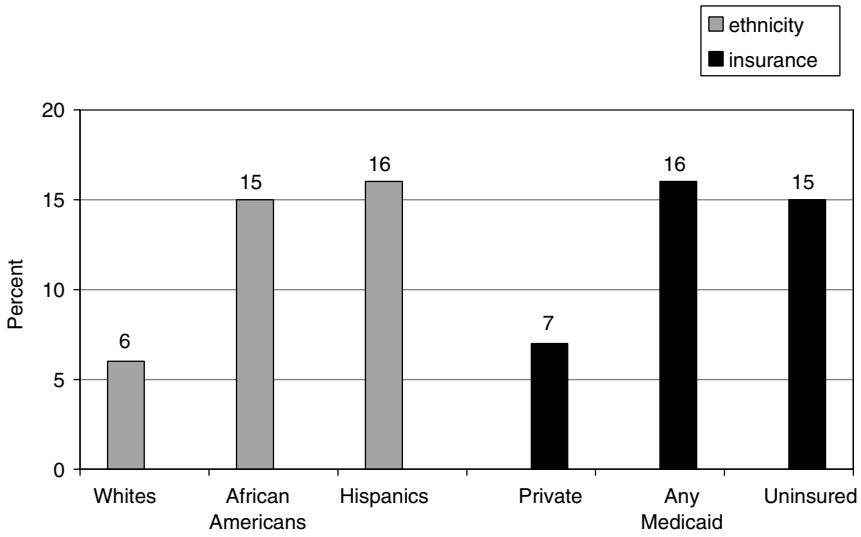

FIGURE 2-11 Site of care: Other non-hospital facilities. SOURCE: Medical Expenditure Survey, 1997, as cited in Lillie-Blanton et al., 2001.

TABLE 2-1 Site of Usual Source of Care by Insurance and Race/Ethnicity, Children 0–17, 1996

	Office-based		Hospital Clinic or Outpatient Dept.		ER	
	%	(SE)	%	(SE)	%	(SE)
Private Health Insurance						
White	93.6	(0.8)	6.3	(0.8)	0.1	(0.1)
African American	89.5	(2.3)	10.1	(2.2)	0.4	(0.4)
Latino	85.9	(2.4)	13.7	(2.4)	0.4	(0.3)
Medicaid						
White	90.1	(2.3)	9.9	(2.3)	0.0	(0.0)
African American	74.6	(3.8)	22.8	(3.7)	2.7	(1.8)
Latino	80.3	(3.2)	18.8	(3.1)	0.9	(0.6)
Uninsured						
White	90.8	(2.3)	8.3	(2.1)	0.9	(0.6)
African American	73.7	(6.1)	24.1	(6.2)	2.2	(1.9)
Latino	81.6	(3.2)	17.2	(3.1)	1.2	(0.8)

SOURCE: Medical Expenditure Panel Survey, 1996, as cited in Lillie-Blanton et al., 2001.

American and Latino children are more likely to receive care in these settings than their white counterparts.

Racial and ethnic minority patients are also more likely to report experiencing difficulty in accessing specialists. Eight percent of whites, 16% of blacks, 22% of Hispanics, and 26% of Asian Americans report this difficulty (Collins et al., 1999). Within the Asian-American community, Chinese Americans indicated the most difficulty (21%). Among Medicare beneficiaries age 65 and older diagnosed with diabetes, black patients were less likely to have had an office visit with a cardiologist or eye specialist (Collins et al., 1999).

Impact of Community Health Centers on Healthcare in Minority and Medically Underserved Areas

During the 1960s, several new federal efforts were developed to increase healthcare services in poor communities. To this end, services such as the National Health Service Corps and the Community and Migrant Health Centers Program were initiated to help strengthen the workforce in medically underserved communities (Heinrich, 2000). By 1996, 625 community health centers (CHCs) provided services at over 3,900 sites (COGME, 1998). Today, these facilities serve underserved rural areas, migrant and seasonal farm worker communities, and urban communities. These federally funded CHCs include four programs: community health centers, migrant health centers, healthcare for the homeless, and healthcare for residents of public housing (COGME, 1998). CHC services are provided by primary care and other physician specialists, nurse practitioners, physician assistants, certified nurse midwives, dentists, and psychiatrists.

The vast majority (approximately two-thirds) of patients served by CHCs are non-white (COGME, 1998). In some communities, CHCs are the predominant source of care. In others, local governments have created and funded primary care clinics using the federal CHC model, helping to fill the void left by a lack of office-based providers. By the mid-1990s, rates of Hispanic visits to community health centers were 700% higher than for whites. For black, non-Hispanic individuals, visits to CHCs were 550% higher than white, non-Hispanic visits (Table 2-2).

The CHC model has proven effective not only in increasing access to care, but also in improving health outcomes for the often higher-risk populations they serve. The continuity of care has been found to be better in CHCs than in hospital outpatient departments or physician offices, and a study examining preventable hospitalizations among medically underserved communities found that in communities served by federally qualified health centers, rates of preventable hospitalizations

TABLE 2-2 Number of Primary Care Visits Made to Primary Care Delivery Sites in the United States in 1994

	Overall			Community Health Centers			Physician's Offices			Hospital Outpatient Departments		
	In Thousands		Per 100 Persons Per Year	In Thousands		Per 100 Persons Per Year	In Thousands		Per 100 Persons Per Year	In Thousands		Per 100 Persons Per Year
Race/Ethnicity												
Hispanic	28,087	(8.6)	109.1	3608	(31.7)	14.0	21,205	(7.3)	82.4	3275	(15.3)	12.7
Black, non-Hispanic	27,425	(804)	91.0	3356	(29.5)	11.1	19,930	(6.8)	66.1	4140	(19.4)	13.7
Asian/Pacific Islander	11,910	(3.7)	141.0	539	(4.7)	6.4	10,903	(3.7)	129.1	468	(202)	5.5
White, non-Hispanic	257,622	(79.2)	134.9	3891	(34.1)	2.0	240,265	(82.2)	125.8	13,466	(63.1)	7.0
Health Insurance Payer												
Medicare	49,117	(15.1)	N/A	1375	(10.6)	N/A	44,899	(15.4)	N/A	2843	(13.3)	N/A
Medicaid	38,120	(11.7)	N/A	5151	(39.7)	N/A	26,367	(9.1)	N/A	6602	(30.9)	N/A
Private	190, 681	(58.7)	N/A	2754	(21.2)	N/A	180,226	(62.0)	N/A	7701	(36.1)	N/A
Uninsured	33,376	(10.3)	N/A	3339	(25.7)	N/A	27, 458	(9.4)	N/A	2579	(12.1)	N/A
Other payment	13,758	(4.2)	N/A	350	(2.7)	N/A	11, 758	(4.1)	N/A	1623	(7.6)	N/A

SOURCE: Forrest & Whelan, 2000.

Visit counts were multiplied by sampling weights, which account for the multistage sample design and nonresponse of in-scope practitioners, to obtain national estimates. Rates were based on the U.S. Bureau of the Census estimates of the U.S. civilian noninstitutionalized population as of July 1, 1994. N/A indicates that visit rates were not calculated by health insurance payer because denominators were not available.

were lower than in communities not serviced by these centers (Epstein, 2001). Patients in underserved areas served by these centers had 5.8 fewer preventable hospitalizations per 1,000 population over three years than those in underserved areas not served by a federally qualified health center.

While CHCs were developed on the premise that they would service all patients regardless of their ability to pay, limited federal subsidies have forced many clinics to reduce the amount of uncompensated care they provide. Between 1981 and 1991, federal funding increased at half the rate of increase in the urban consumer price index for medical care (Rosenbaum and Dievler, 1992, as cited in COGME, 1998). Changes in the cost of medical technology, shift of services from inpatient to outpatient settings, and Medicare's Prospective Payment System have placed a strain on many hospitals. While most have remained operational, approximately 5% of non-federal community hospitals closed between 1985 and 1988, a rate two to three times higher than in the preceding four years (GAO, 1990). Concerned about loss of their Medicaid patient base, many CHCs have begun participating in managed care arrangements. By 1996, almost half (45%) of CHCs participated in such arrangements (Shi et al., 2000). This shift has generated fears among some that these centers will be less able to serve patients who need care the most, with declines in Medicaid reimbursement and increased difficulty providing non-reimbursable services under managed care (GAO, 1995; Shi et al., 2000). In fact, recent studies suggest that CHCs provide care to a smaller proportion of uninsured patients, while they are serving increasing proportions of Medicaid patients under managed care (Shi et al., 2001).

THE HEALTHCARE PROFESSIONS WORKFORCE IN MINORITY AND MEDICALLY UNDERSERVED COMMUNITIES

Demographics of Healthcare Providers

The historical antecedents of physician and other healthcare provider training, as discussed above, significantly shape the current landscape of health professions education and the healthcare workforce. In this section, data on the demographic profile of healthcare providers that work primarily in racial and ethnic minority communities is reviewed.

Physicians

Minority medical graduates, including African Americans, Asian Americans, Hispanics, and American Indians, represent 9% of the country's physicians. Of these 9%, one-third (33.3%) is African American, 40.1% are

Asian American, one-fourth (24.9%) is Hispanic, and 1.8% is American Indian (AAMC, 2000). These minority graduates are more likely to work in states with large minority populations, such as California, New York, and Texas (AAMC, 2000). Underrepresented racial and ethnic minorities (African Americans, Mexican Americans/Chicanos, mainland Puerto Ricans, and American Indians/Native Americans) represent a smaller subset of this population, as less than 6% of the U.S. physician workforce is composed of individuals from these backgrounds. Significantly, well over 1 in 4 Americans is African American, Hispanic, or American Indian/Alaska Native (U.S. Bureau of the Census, 2000).

Minority physicians are more likely than their non-minority peers to work in hospital-based practices. Whereas only 1 in 5 (21.4%) of all physicians nationally work in hospital-based practices, nearly one-third (32.1%) of African American physicians, over half (50.3%) of Asian American physicians, over 1 in 3 (35%) of Hispanic physicians, and nearly 2 in 5 (39.3%) of American Indian/Alaska Native physicians work in such settings. Non-minority physicians are more likely to work in office-based practices, as 3 in 5 (60.5%) work in such settings, compared with 55.7% of African Americans, 40.8% of Asian Americans, 54.8% of Hispanics, and 53.1% of American Indian/Alaska Natives. Minority physicians are far more likely than non-minorities to be residents or fellows, owing to the generally younger age of minority physicians (AAMC, 2000). In terms of specialty practice, minorities are more likely to be found in family practice (11.5% of African American, 12.7% of Hispanic, and 24.7% of American Indian/Alaska Native physicians are family practitioners, compared with 9.9% of all physicians), obstetrics-gynecology (12.1% of African American, 8.3% of Hispanic, and 7.3% of American Indian/Alaska Native physicians are found in OB/GYN, compared with 6% of all physicians), and pediatrics (10.1% of African American and 11.1% of Hispanic physicians are pediatricians, compared with 8.7% of all physicians), but are poorly represented in other specialties, such as cardiology, surgery, and psychiatry (AAMC, 2000).

Among physicians participating in managed care arrangements, Asian-American physicians are more likely to be in solo practice (56%), while African-American physicians are more likely to practice in staff-model HMOs (19%), white physicians are more likely to be in group practice (45%), and Latino physicians were more likely to be in a hospital- or clinic-based practice (25%). Latino physicians are least likely to have managed care patients compared with physicians of other racial or ethnic groups, even after controlling for their lower rate of board certification. Twenty-six percent of Latino physicians had no managed care patients compared with 10% for African-American physicians, 13% for white physicians, and 14% for Asian physicians (Mackenzie et al., 1999).

Nurses

In 2000, 12.3 percent of registered nurses were racial and ethnic minorities. Nearly 5% of all nurses self-reported as African American, 3.5% as Asian, 2% as Hispanic, 0.5% as American Indian/Alaska Native, 0.2% as Native Hawaiian/Pacific Islander, and 1.2% reported being of two or more racial backgrounds. A larger percentage (86.4%) of minority nurses were employed in nursing, as compared with 81% of white, non-Hispanic nurses. Minority nurses were also more likely to work full-time (U.S. Health Resources and Services Administration, 2001).

Geographically, there are distinct patterns of practice between the minority and non-minority nursing workforce (Table 2-3). Recent estimates revealed that black nurses were more likely to practice in the south and middle Atlantic regions of the country. Hispanic nurses were represented in higher proportions in the west and east south-central areas. Asian/Pacific Islander nurses were more likely to be found practicing in the Pacific and mid-Atlantic states. The west south-central and Mountain areas of the United States were the sites with the highest percentages of American Indian and Alaskan Native nurses. The most common employment setting for minority as well as non-minority nurses was in hospitals (U.S. Health Resources and Services Administration, 2001).

Impact of International Medical Graduates (IMGs) on the Workforce in Minority Communities

An important phenomenon began to emerge during the 1930s and 1940s that would have a profound effect on the healthcare provided to racial and ethnic minorities, as the numbers of international medical graduates (IMGs) securing residency training positions in U.S. hospitals, especially those serving underserved urban and rural communities, began to increase sharply. Between 1933 and 1940, the composition of the 5,056 immigrant physicians admitted to the United States was predominantly European (Stevens, Goodman, and Mick, 1978). By the 1960s, however, immigration policies had changed such that visas were easily attainable and institutions were beckoning Third World IMGs to the United States for training because of a perceived short supply of physicians (Stevens, Goodman, and Mick, 1978). This movement was occurring as courts ended federally sponsored hospital segregation and as Medicare and Medicaid legislation was passed by Congress. Concurrently, the Civil Rights era laid the groundwork for significant changes in access to healthcare facilities and services for racial and ethnic minorities as well as for the poor and elderly.

TABLE 2-3 Percent Distribution of Registered Nurse Population in Each Geographic Area by Racial/Ethnic Background: March 1996

Race/Ethnicity	U.S.	New England	Middle Atlantic	South Atlantic	East South Central	West South Central	East North Central	West North Central	Mountain	Pacific
Estimated RN population in area	2,558,874	176,951	443,846	460,460	141,705	215,200	452,080	198,952	137,739	331,941
White (non-Hispanic)	89.7	96.5	86.8	87.4	92.1	85.6	93.9	96.6	92.4	83.5
Black (non-Hispanic)	4.4	1.3	5.6	7.3	6.3	5.0	2.8	1.4	1.1	3.1
Asian/Pacific Islander	3.4	0.8	5.4	2.7	0.5	3.8	2.0	0.5	1.7	8.3
American Indian/Alaska Native	0.5	0.1	0.2	0.2	0.3	1.3	0.3	0.6	1.4	0.7
Hispanic	1.6	0.4	1.2	1.4	0.5	3.7	0.7	0.5	**2.5**	**3.5**
Other	0.7	0.8	1.0	1.0	0.2	0.5	0.4	0.4	0.8	1.0

SOURCE: National Sample Survey of Registered Nurses, March 2000.

The 1967 report of the National Advisory Commission on Health Manpower (NACHM) sparked renewed efforts to recruit IMGs when it declared a national shortage of physicians (COGME, 1998). The geographic maldistribution of physicians that had been systematically discussed for over 30 years as a problem became a public agenda item. By and large, health professionals had chosen to locate and practice in affluent urban and suburban communities, while large numbers of minorities and the poor had limited access to care. The NACHM report was one of several that led to the rapid expansion of existing undergraduate medical education programs as well as the creation of new medical schools.

Three decades later, the number of students graduating from United States medical schools doubled and the number of IMGs who entered residency training programs each year almost doubled between 1988 and 1994, from 3,600 to 6,700 (COGME, 1996). The number of first-year residency positions filled increased to 140% of the yearly U.S. medical school graduates. The physician-to-population ratio (excluding resident physicians) increased by 65%, from 115 to 190 physicians per 100,000 (COGME, 1996). Most of this increase was in the medical specialties, increasing the specialist physician-to-population ratio 121% from 56 to 123 specialists per 100,000 population (COGME, 1996).

Healthcare expenditures also rose dramatically during this period. Federal spending for all health services just before Medicare and Medicaid was enacted in 1965 was $4 billion, rising to $15.7 billion in 1970, $33.8 billion in 1975, and $65.7 billion in 1980. During the same period of time, state and local spending increased from the pre-Medicare/Medicaid level of $4.8 billion to $31.3 billion. The poor greatly increased their use of healthcare services. By 1976, poor children averaged 65% more physician office visits, poor adults averaged 27% to 33% more visits, and the elderly poor averaged 18% more visits than in 1964. In fact, the poor in each age group increased their use of health facilities more than the non-poor (U.S. Department of Health and Human Services, 1980), contributing to the increased demand for healthcare professionals.

Today, IMGs are a significant part of the U.S. health workforce. The number of residency positions filled by IMGs in 1998-99 was 25,415, or more than one-fourth (26%) of all residents on duty in U.S. hospitals in 1998-99 (COGME, 1999). Many work in minority and medically underserved communities, where few other physicians choose to practice. Verghese (1994) and White (1993) concluded that individual IMGs have established themselves as critical providers of healthcare services in selected rural underserved areas. Most, however, locate in large cities, and practice in urban underserved areas. They are disproportionately distributed in teaching hospitals with high percentages of Medicaid low-pay or no-pay patients. Sixteen percent of all teaching hospitals had an entire

resident staff consisting of greater than 40% IMGs (MedPAC, 1999). A detailed survey of the healthcare providers working in nine of the poorest neighborhoods in New York City revealed that greater than 70% of the physicians were graduates of foreign medical schools (Bellochs and Carter, 1990). The data also revealed that only 24% of the practicing physicians were board certified, while the citywide average was 64%. Many other investigators (Fosset et al., 1990; Mitchell, 1991; Mitchell and Cromwell, 1980; Perloff et al., 1986a) have documented that physicians in urban areas who accept Medicaid patients are more likely to be foreign medical graduates and are less likely to be board certified than those who do not accept Medicaid. Ginzberg (1994) summarized his study of healthcare for the poor in four of the nations largest cities:

> A long-term trend of abandonment and avoidance by physicians had drained the low-income neighborhoods in all four metropolitan areas of private practitioners; physician-population ratios were as low as 1: 10,000 to 1: 15,000, in contrast to affluent neighborhoods with ratios of 1: 300 or even higher. Moreover, the majority of practitioners serving the poor consisted of foreign medical graduates, many with indifferent professional competence and language problems that impeded effective communication. Deterred by the low reimbursement rates paid by state Medicaid programs…the majority of U.S. trained physicians refused to accept Medicaid patients or limited the numbers they were willing to treat, leaving the field to group practices with questionable standards (Medicaid mills) that thrived on volume throughput (Ginzberg, 1994, p. 1465).

While from varied geographic locations around the globe, the largest share of IMGs working in the United States today are from South Asian nations. Table 2-4 illustrates the country of origin for the top 10 countries with the highest number of medical graduates in the United States.

TABLE 2-4 Top 10 Countries with Highest Proportion of Medical Graduates in the United States

Country	Percentage of the U.S. IMG Population
India	19.5%
Pakistan	11.9%
Philippines	8.8%
Ex-USSR	3.1%
Egypt	2.6%
Dominican Republic	2.5%
Syria	2.5%
United Kingdom	2.4%
Germany	2.3%
Australia	2.1%

SOURCE: The Educational Commission for Foreign Medical Graduates, 1992.

The cultural, racial, and ethnic diversity of IMG healthcare providers, who constitute more than 25% of the resident physicians in the United States, is broad. Most are new to this country and are learning to live within its vast sociocultural complexities, while also trying to learn to deal with an ambiguous welcome into the U.S healthcare delivery system with its own rigid, complex and demanding subculture (Stevens, Goodman, and Mick, 1978). As these authors note, two-thirds of IMGs are unprepared for the experience, having relied upon friends or family for advice. Many do not have the luxury of selecting a hospital in which to practice; rather, they accept the job that is offered. Often IMGs enter the United States thinking of themselves as "internationally mobile scientists" with knowledge and skills that are transferable anywhere in the world, only to be jolted by the reality of being treated as an alien or outsider inside the hospital (Stevens, Goodman, and Mick, 1978). In one survey (Stevens, Goodman, and Mick, 1978), 13% of IMGs felt that they were inadequately informed about the location of the American hospitals, including the fact that many large hospitals are in high-poverty areas of major cities. For others, complex malpractice claims and standards may pose problems, as well as large caseloads, documentation requirements, long hours, a fast pace, and language difficulties.

The 12th CoGME Report (1999) observed that "when physician and patient differ with respect to race, ethnicity, language, religion and values, ensuring fair, equitable, and culturally sensitive care is more challenging." The opportunity for miscommunication and cultural gaffes between IMGs and minority patients abound and could be manifest in the way healthcare services are provided or received by the communities served. This cultural configuration has existed for nearly 50 years in many of the largest metropolitan teaching hospitals serving millions of racial and ethnic minorities. However, this racial/ethnic interface has been inadequately studied to determine the impact it has on minority patients' perceptions of their healthcare experience, utilization of services, trust, compliance, health status, and quality of care.

THE PARTICIPATION OF RACIAL AND ETHNIC MINORITIES IN HEALTH PROFESSIONS EDUCATION

"I heard an Anglo doctor complaining that his daughter is having trouble getting into medical school. Then another doctor jumps in, another Anglo, "Oh don't worry about it. I know the admissions coordinator. I'll get her in. I'll give him a call and she'll be in." When does a Hispanic or black student have those advantages, the connections? I certainly didn't have any connections, and I still don't have any connections. I couldn't get my son into medical school if I tried." (Hispanic physician)

"When I was in medical school I had a racist comment by one of the white students. He said the only reason why you're here, it wasn't said to me but I overheard it, the only reason why black students are here is because they're black and this that and the other. What was really interesting was that OK, sure I'm black, but I don't take the black test, I don't take the black boards, we take the same exams." (African American physician)

In the late 1960s, many U.S. medical colleges and other health professions organizations began a concerted effort to expand opportunities for careers in the health professions to ethnic minorities who, for a variety of historic, social, political, and economic reasons, had not previously enjoyed such opportunities. The Association of American Medical Colleges (AAMC) and other groups actively encouraged member institutions to improve outreach programs and matriculation efforts targeted to minority students, in the hope that their rates of participation in health professions would achieve parity with the proportion of racial and ethnic minorities in the U.S. population (Nickens and Ready, 1999). This goal was established not only because its attainment would help to rectify inequities in educational opportunities, but also because of a growing appreciation that minority healthcare professionals are more likely to work in minority and medically underserved communities, thereby addressing a growing public health need.

By 1974, 10% of all medical school matriculants were underrepresented minorities (AAMC, 2000). This proportion decreased significantly in the wake of the U.S. Supreme Court's *Bakke* decision in 1976, but other efforts, such as AAMC's "Project 3000 by 2000," initiated in 1990, resulted in significant increases that exceeded 1974 levels. Between 1990 and 1994, the number of underrepresented minority (URM) students increased 36.3% to 2014 students, or 12.4% of the total number of medical school matriculants. Since that time, however, the number and proportion of new URM medical school enrollees has declined significantly. Enrollment of African-American students in medical schools, for example, declined 8.7% between 1994 and 1996 (Carlisle and Gardner, 1998). The greatest declines have occurred in public medical schools, which prior to 1996 enrolled a greater proportion of URM students than private institutions. Over 60% of public institutions experienced declines in URM student enrollment since 1994—a collective decrease of 9.1% in minority student matriculation at these institutions—while only 44% of private medical schools experienced such declines (Carlisle and Gardner, 1998).

While the reasons for these declines are complex, some evidence indicates that the declines have immediately followed significant policy shifts regarding affirmative action and higher education admissions procedures. Several legislative and judicial challenges to affirmative action

policies in 1995, 1996, and 1997 (notably, the Fifth District Court of Appeals finding in *Hopwood v. Texas*, the California Regents decision to ban race or gender-based preferences in admissions, and passage of the California Civil Rights Initiative [Proposition 209] and Initiative 200 in Washington state) have forced many higher education institutions to abandon the use of race and gender as factors in admissions decisions. Subsequently, public medical schools in California, Louisiana, Mississippi, and Texas (the latter three states are subject to the *Hopwood* ruling) accounted for 44% of the decrease in URM matriculation in medical schools nationwide (Carlisle and Gardner, 1998a). In 1997, African-American student enrollment in Texas' public medical schools dropped 54% (Carlisle and Gardner, 1998b). And among California's public and private medical schools, URM enrollment declined 32% in 1998 from its peak in the mid-1990s (Grumbach et al., 2001). Because of the large minority populations in these states, much of the nationwide decline in URM enrollment reflects the trends noted above, while more modest minority enrollment declines in states unaffected by legislative or judicial rulings may reflect administrators' greater caution or perceived pressure to scale back affirmative admissions policies.

This decline in the numbers of underrepresented minority students in health professions education programs raises significant concerns regarding the ability of the healthcare workforce to address the nation's future health service needs. Racial and ethnic minorities are four times more likely to receive care from non-white physicians than white physicians (Moy and Bartman, 1995). Further, racial and ethnic minority physicians are more likely to practice in minority and medically underserved communities. A study of physicians' practices in California found that on average, over half (52%) of patients in the practices of African-American physicians were African American, compared with nine percent among non African-American physicians. Among Hispanic physicians, average caseloads approached 55% Hispanic patients, compared with 20% among non-Hispanic physicians (Komaromy, Grumbach, Drake, et al., 1996). Yet African-American and Hispanic physicians constitute less than 6% of the physician workforce.

The racial/ethnic diversity of health professionals also has broader implications for health service costs and improvements in the quality of care. For example:

- Healthcare professionals from racial and ethnic minority groups have generally been more successful in recruiting minority patients to participate in clinical research. Such efforts are critical to link scientific advancements with quality service delivery in underserved communities.

• The quality of healthcare depends as much on physicians' scientific competence as on an understanding of cultural, social, and economic factors that influence the health of patients, the ways in which they seek care, and their response to medical treatment. Racial and ethnic diversity of health professions faculty and students helps to ensure that all students will develop the cultural competencies necessary for treating patients in an increasingly diverse nation (Association of American Medical Colleges, 1998).

• Racial and ethnic minorities disproportionately receive medical care in hospital emergency settings. Such care is more costly than routine medical care and preventive health services. Healthcare professionals from minority and underserved communities may be better poised to tailor preventive health and primary care programs and services to minority populations, thereby reducing associated costs.

SUMMARY

Racial and ethnic disparities in healthcare emerge from an historic context in which healthcare has been differentially allocated on the basis of social class, race, and ethnicity. Unfortunately, despite public laws and sentiment to the contrary, vestiges of this history remain and negatively affect the current context of healthcare delivery. And despite the considerable economic, social, and political progress of racial and ethnic minorities, evidence of racism and discrimination remain in many sectors of American life. This persistent pattern of inequality suggests that interventions to eliminate disparities must be comprehensive and sustained, and that raising public and healthcare provider awareness of the problem is an important first step. Toward this end, a number of public and private organizations have developed educational campaigns targeted toward healthcare consumers, their providers, policymakers, and other "stakeholders." These efforts include, but are not limited to: the public education efforts of U.S. DHHS, which recently launched its "Closing the Health Gap" campaign to heighten awareness of health disparities; Diversity Rx, which provides a clearinghouse of information on language, culture, and improving healthcare services for minorities; and The Henry J. Kaiser Family Foundation, which has developed a number of publications targeted to the general public regarding healthcare disparities.

Finding 2-1: Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.

Recommendation 2-1: Increase awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders.
Public education to increase awareness of racial and ethnic disparities in healthcare is an important first step toward eliminating these disparities. Media campaigns and other educational efforts to increase awareness of disparities should be targeted to broad audiences, including healthcare consumers, payors, providers, and health systems administrators.

Recommendation 2-2: Increase healthcare providers' awareness of disparities.
Organizations responsible for the education, training, and licensure of health and medical professionals should develop special initiatives to increase levels of awareness of healthcare disparities among current and future healthcare providers.