

Providers Urged to Address Health Care Disparities

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WASHINGTON — Health disparities won't go away until the people and institutions that play a role in creating them are held accountable, Dr. Anne C. Beal said at a meeting sponsored by the Department of Health and Human Services and the Office of Minority Health.

"When you ask physicians if racial disparities in health care exist, about 65% say no," said Dr. Beal, senior program officer at the Commonwealth Fund. "So a lot of work needs to be done in terms of making sure we keep pushing for this agenda, that health disparities is a real issue."

Measures of health care disparity are essentially quality measures, Dr. Beal said.

"The collection of race and ethnicity data is the basic science of disparities," she said. Without such data, "we don't know

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where we're going, we don't know if we're improving, and we don't know if interventions we're trying to implement are making a difference."

Although health care quality measures were not initially designed to measure

disparities, "if you take standard quality measures and stratify them by race and ethnicity, it allows you to identify racial disparities and what I call 'potential accountability,'" she said.

For example, many people have heard that the infant mortality rate is higher for African Americans than it is for whites. "However, there's no sense of ownership when you hear that," Dr. Beal said. "You sit there and say, 'Um, um, um, that is a shame that we have this.'"

But if a physician gets a report that says his Hispanic patients are not getting immunized at the same rate as his African American patients, "then [he] has a sense of ownership and a sense of responsibility for those results," she said.

There are several problems with collecting racial and ethnic data, however. One of the problems is how it's done. Dr. Beal quoted a study by Romana Hasnain-Wynia, Ph.D., vice-president for research at the Health Research and Education Trust, which found that 79% of hospitals were collecting racial and ethnic data. However, nearly half of the hospitals collecting the data said the categorization was made by "an admitting clerk, based on observation."

A better method would be having patients self-identify, she continued. "In the emergency room or admitting area, there is a variety of other tasks you have to complete, not least of which is getting that all-important insurance card, so trying to ask about the patient's race probably falls very low on the list. But in order for us to see how we're doing, we need to develop standards not only in terms of the cate-

gories we use, but even with how we ask the question."

That includes which racial categories to list. "I'm still amazed that in the United States, there are people using 'black, white, and other' as categories," Dr. Beal said. "Only 80% of hospitals even include a Latino designation."

Ignatius Bao, director of culturally competent health systems at The California Endowment, said providers should pay more attention to the variety of racial and

ethnic groups. He noted that HHS is far behind in complying with standards issued in 1997 by the Office of Management and Budget that list a variety of racial categories government agencies are supposed to document when they issue data.

"I would argue, especially on behalf of Asian Americans, Pacific Islanders, and Native Americans, that we need to do better than these standards. We need to disaggregate the data even further," Mr. Bao said. "But at the very beginning, every

time HHS puts out data, it should have these categories, and if it doesn't, HHS should explain why the data are not there."

Racial and ethnic designations also need to be made part of any electronic health record (EHR) system, Dr. Beal noted. "Because it's really not high on the agenda of EHR [developers], 10, 15, or 20 years from now we're going to be right back where we started. If we build it in right now, we'll be able to have this capacity moving forward." ■

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