

An Ethical Analysis of Ethnic Disparities in Health Care

***A Report by the National Ethics Committee
of the Veterans Health Administration***

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Founded in 1986, the National Ethics Committee (NEC) of the Veterans Health Administration (VHA) is an interdisciplinary group authorized by the Under Secretary for Health through the National Center for Ethics. The NEC produces reports on timely topics that are of significant concern to practicing health care professionals. Each report describes an ethical issue, summarizes its historical context, discusses its relevance to VHA, reviews current controversies, and outlines practical recommendations. Previous reports have been useful to VHA professionals as resources for educational programs, guides for patient care practices, and catalysts for health policy reform. Scholarly yet practical, these reports are intended to heighten awareness of ethical issues and to improve the quality of health care, both within and beyond VHA.

Executive Summary

This report from the National Ethics Committee of the Department of Veterans Affairs (VA) begins with an overview of the current knowledge of ethnic disparities in health care in the United States, demonstrating the existence of disparities in utilization, processes and outcomes of care, and patient satisfaction. Next the report outlines potential causes of ethnic disparities – socioeconomic factors, genetic factors, geographic factors, patient values and preferences, communication, and provider bias – and analyzes each cause from an ethical perspective. The report then describes various efforts to address ethnic disparities in health care by the federal government and by the VA. The report concludes with recommendations for VA and other health care systems that will enable them to reduce and eliminate disparities.

Introduction

The quality, quantity, and accessibility of health care in the United States vary according to patient ethnicity across a wide spectrum of health care services and settings.¹⁻⁸ These ethnic disparities have raised significant concern within the Department of Veterans Affairs (VA) and the rest of the American health care system. While the exact causes of the disparities remain unclear, there is a common belief that they are inappropriate and undesirable. However, careful analysis and articulation of when, why, and how ethnic disparities are “wrong” have been lacking.

The VA National Ethics Committee drafted this report in response to a charge from the Under Secretary for Health. This report uses information drawn from existing literature, interviews with key informants within VA, and discussions of the Task Force on Ethnic Disparities in Health Care to: review what is known about ethnic disparities in health care; outline the potential causes of disparities; analyze these causes from an ethical perspective; describe efforts by VA and other federal agencies to address ethnic disparities; and make recommendations for how VA and other health care systems can enhance efforts to reduce and ultimately eliminate ethnic disparities in health care.

While we acknowledge that the terms “race” and “ethnicity” are not entirely interchangeable, we will preferentially use the term “ethnicity” in this report. Most studies of disparities in health care have examined differences between populations that more closely mirror racial rather than ethnic groups. Genetic studies, however, reveal that the phenotypic distinctions that served as the original basis for racial classification are arbitrary and have little or no biologic significance.⁹ In short, race is a scientifically imprecise term. Race retains validity predominantly as a sociological construct, in that people of the same race tend to share similarities in culture, life experience, and social status.¹⁰ Ethnicity similarly refers to common culture, language, religion, nationality, and/or tribal affiliation.¹¹ Race and ethnicity, therefore, represent a similar array of characteristics, each of which may mediate disparities in health care. Race, however, has a troubling legacy as a construct used to classify certain human populations as inferior to others. By using the term “ethnicity,” we aim to describe human diversity without implying inequality and therefore to promote the same values to which disparities in health care stand in contrast.

Current Knowledge of Ethnic Disparities in Health Care in the United States

Published studies have documented ethnic disparities in health care both within and outside VA. This report describes a sampling of published studies to provide an overview of current knowledge on ethnic disparities in health care and to illustrate the complex relationships between ethnicity and health. For a more extensive review of the literature on ethnic disparities, the reader is referred to a recent article by Mayberry et al.¹²

Utilization

Numerous studies of ethnic disparities in health care have demonstrated differences in the utilization of various health care technologies across a wide range of services. For instance, among Medicare beneficiaries in 1986, African-Americans were less likely to receive 23 different services, ranging from chest X-rays to cardiac surgery.² The largest variations in utilization tended to occur with the most advanced, invasive, or expensive technologies.

Other studies have confirmed ethnic differences in the use of health care procedures. In an analysis of hospital discharge abstracts in California, whites, when compared to African-Americans, Hispanics, and Asians with similar diagnoses, were those most likely to receive a variety of hospital-based procedures, including kidney transplantation, cardiac defibrillator implantation, and carotid endarterectomy.³ Variability in the management of chest pain and coronary artery disease has been the best studied and deserves special mention. Studies have repeatedly demonstrated that minorities, particularly African-Americans, are less likely than whites to be admitted to the hospital when

presenting to emergency departments with chest pain¹³; to receive care in a specialized coronary care unit¹³; and to undergo thrombolytic therapy,¹⁴ coronary angiography^{4, 15-19} or bypass surgery.^{4, 13, 15, 20-28} Taken together, these studies suggest that when compared to whites, minorities receive less aggressive cardiac care.

In some instances, however, minorities receive more procedures than whites. One study found that African-American Medicare beneficiaries underwent more leg amputations and bilateral testicle removals than whites.²⁹ This finding may partly reflect the higher prevalence and incidence of diabetes and prostate cancer – conditions in which these procedures are often used – among African-Americans. It probably also reflects less access to routine care and screening, since these procedures represent treatment for late complications of each disease. It may also reflect differing access to alternative (and in some cases more desirable) treatment options.³⁰

Ethnic disparities are not confined to the use of technologically advanced procedures. Minorities also tend to receive less ambulatory care than whites.³¹⁻³³ For example, among inner-city patients with human immunodeficiency virus (HIV) infection, African-Americans were less likely than whites to receive life-prolonging antiretroviral therapy or prophylactic antibiotics.³¹ Another study found that in a teaching hospital emergency department, Hispanic patients with long-bone fractures were less likely than whites to receive pain medications.³³ These studies suggest that minorities receive not only less aggressive care, but less care overall.

Although most studies examining health care delivery across ethnic groups have found disparities in utilization, there are a few exceptions.³⁴⁻³⁷ In the realm of mental health care, for instance, studies demonstrated that African-Americans and Hispanics used fewer outpatient services than whites in the early 1980s,^{34, 35} but these disparities were no longer apparent in the 1990s.³⁵ Within VA, minority veterans from the Vietnam era, for whom military service was seen as particularly alienating, use VA mental health services as frequently as whites.³⁶ Furthermore, program participation for such services as residential treatment for addictive disorders is similar across ethnicities.³⁷

Processes and Outcomes of Care

Many studies have examined the association between ethnicity and processes of health care delivery, and at least three of these studies found that processes of care associated with improved outcomes were performed less frequently for African-American patients than for white patients.^{5, 38, 39} For instance, African-American patients with pneumonia were less likely than white patients to receive antibiotics within six hours of admission to a hospital.⁵

Several recent studies have also demonstrated ethnic disparities in health outcomes. For example, one study found that African-Americans were more likely than whites to be hospitalized for exacerbations or progression of conditions in which hospitalization is considered to be avoidable through timely and appropriate ambulatory care.⁴⁰ Another study examining differences in coronary artery disease management found that African-Americans had worse 5-year outcomes than whites.²⁰ Yet another study showed that although the incidence of breast cancer is lower among African-American women than white women, African-American women present on average with later-stage disease and consequently experience higher breast cancer mortality.⁴¹ This phenomenon has been shown to be partly attributable to lower breast cancer screening rates among African-American women, confirming that differential utilization of health services contributed to disparities in health outcomes.⁴² Finally, an analysis of cancer registry data demonstrated that stage for stage, African-Americans suffered higher mortality from lung cancer, a difference that was largely attributable to lower rates of curative surgery among African-Americans.⁴³

Not all studies have demonstrated inferior health outcomes for minorities compared with whites. One study of patients hospitalized for six common conditions in 30 hospitals found that in-hospital mortality rates were lower for African-Americans than for whites, even after adjusting for severity of illness.⁴⁴ A similar pattern was demonstrated in a recent VA study.⁴⁵ The explanation for these findings remains unclear.

Satisfaction

The relationship between ethnicity and satisfaction is complex. For example, one study demonstrated that Asians rated physician performance less favorably than whites and Hispanics rated physicians' accessibility less favorably than whites.⁴⁶ On the other hand, in the same study, African-Americans rated physicians' psychosocial and health promotion practices higher than whites, while compared to whites, Pacific Islanders felt that they received more preventive care.

Nonetheless, multiple studies have found that minority groups tend to express lower levels of patient satisfaction than whites. Ethnic disparities in satisfaction have been observed in inpatient and outpatient settings, for individual visits as well as health care overall, and with regard to both access and quality of care.^{6, 7, 46-48}

Summary of Findings

The studies we have discussed represent only a subset of the vast literature documenting ethnic disparities in health care. They do, however, illustrate certain patterns. First, minorities tend to receive fewer and less technologically advanced health care services than whites. Second, studies of health care processes and outcomes mostly demonstrate worse care for minority patients. Third, minority patients are often less satisfied than whites. Taken as a whole, these findings suggest that the quality of health care in the U.S. is worse for ethnic minority populations than for whites.

Ethnic Disparities in VA

Ethnic disparities appear to exist in VA to an extent similar to that found in other health care systems. Studies of VA health care have demonstrated, for example, that minority veterans are less satisfied with their care than white veterans,⁴⁸ and that African-American veterans are less likely than whites to receive invasive procedures for the management of coronary disease.^{4, 15, 24}

The patient population served by VA is ethnically diverse, and the percentage of minority veterans has increased significantly since World War II. African-Americans account for 6.1% of World War II veterans, 8.3% of Korean Conflict veterans, 8.6% of Vietnam Era veterans, and 17.1% of post-Vietnam veterans. Similarly, Hispanic-American veterans make up 3.4% of World War II veterans and 5.7% of post-Vietnam veterans.⁴⁹ As the number of World War II veterans shrinks, VHA's population will have increasing percentages of minority veterans.

Reducing undesirable variability in health care practices – such as those relating to ethnicity – is central to the mission of the VA. The Veterans Health Administration's (VHA) top strategic goal is to “put quality first until we are first in quality.” VHA has developed sophisticated systems for monitoring and evaluating the quality of care it delivers and for applying the principles of continuous quality improvement.

Ethnic disparities are also of particular concern to VA because the health care system serves a unique patient population. The mission of the VA is “to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support and recognition earned in service to this Nation.” Thus, veterans are viewed as deserving special consideration and respect. Moreover, veterans who use VHA, as compared to veterans who do not, have significantly fewer financial resources and less supplemental health insurance,^{50, 51} and report meaningfully lower scores on health related quality of life measures.^{52, 53} The fact that VHA's

patients are often disadvantaged and have few alternatives for their health care creates a further obligation for VHA to address ethnic disparities.

Ethical Analysis of Ethnic Disparities in Health Care

Although disparities by definition represent *inequality*, they do not necessarily represent *inequity*. Inequality means that patients receive different care; inequity means that the difference is a result of injustice or unfairness. Understanding whether ethnic disparities in health care represent inequities requires understanding the causes of disparities. This section reviews the potential causes of ethnic disparities in health care and explores when and why ethnic disparities are ethically problematic.

Socioeconomic Factors:

Whites in the U.S. have proportionately higher incomes and more wealth than other groups and enjoy greater access to health care. They are more likely to be insured, to have private insurance, and to have supplemental insurance when covered by Medicare.^{54, 55} But differences in insurance coverage appear to explain a portion, but not the majority, of observed ethnic disparities.^{29, 56-58} Studies within VA have demonstrated that eliminating differences in financial access due to insurance coverage does not fully eliminate ethnic disparities.^{4, 15, 24, 59}

Even for patients who are eligible for the comprehensive benefits package VA provides, financial factors may have significant effects on health. For example, indigent patients enrolled in VA may not be able to afford over-the-counter remedies or exercise equipment. Other socioeconomic factors such as education level, occupation, access to transportation, and social support may also affect health care utilization, but have not been adequately studied within VA.

Ethical Implications:

Ethnic disparities resulting from socioeconomic factors raise ethical concerns. From one perspective, this type of disparity may suggest that the health care system is devoting insufficient attention or resources to the special needs of some of its most vulnerable patients. Although a health care system cannot be expected to cure all of society's ills, it can make great strides toward overcoming the adverse health effects of socioeconomic factors by making special accommodations for disadvantaged patients.

From a different ethical perspective, it is not the results that are of concern as much as the methods and criteria used to allocate resources. Some consider socioeconomic factors to be unjust or unfair criteria on which to base access to health care or decisions about allocation of health care resources. For example, the Council on Ethical and Judicial Affairs of the American Medical Association argues that "[t]he patient has a basic right to have available adequate health care."⁶⁰ This suggests that everyone should have access to "adequate" or basic health care, regardless of their ability to pay.⁶¹ However, the belief in a right to basic health care is not universal. In practice, market-based strategies are widely used as methods to allocate health care services. Moreover, there are strong societal pressures to increase reliance on these methods for controlling costs even though they disproportionately burden the disadvantaged.⁶²

Genetic Factors:

A variety of studies have demonstrated an association between ethnicity and certain genetic traits such as the predisposition to particular diseases. For example, African-Americans and Ashkenazi Jews are at increased risk of sickle cell anemia and Tay-Sachs disease, respectively. Ethnic disparities in the prevalence of these two diseases appear to be genetically based.

In general, however, attributing ethnic disparities in health status to genetic factors alone is a mistake. For example, the prevalence of diabetes varies widely across ethnic groups.⁶³ In the past this variation was presumed to be genetically based, but now genetics is thought to be only a small part of a complex set of factors contributing to these differences.⁶³ Similarly, higher mortality rates from prostate cancer among African-American men as compared to white men are commonly assumed to be due to a genetic predisposition to more aggressive types of tumors. Recent studies, however, have demonstrated that most of this difference in mortality is related to the fact that African-Americans tend to have a more advanced tumor stage when diagnosed,⁶⁴ which is at least partly attributable to a lack of access to care.^{65,66}

These examples illustrate that attributing ethnic disparities to genetic factors without attention to other potential causes should be avoided. In addition, clinicians should critically examine the basis for any claim that disparities are genetically based, recognizing the potential influence of confounding variables.

Ethical Implications:

To the extent that ethnic differences in health status are based on genetic factors beyond human control, they may not seem ethically problematic. However, the tendency to attribute ethnic disparities to genetic differences may be problematic for several reasons. First, attributing ethnic disparities to genetic differences may cause preventable or correctable causes of disparities to be ignored. It may also reinforce certain misconceptions or biases. For example, it may reinforce the misconception that ethnic distinctions are based on genetics, whereas in fact they are arbitrary and largely based on other factors.⁹ Clinicians should bear in mind that while certain genetic traits linked to illness may occur with increased frequency within certain ethnic groups, ethnicity is fundamentally a sociological and not a scientific construct.¹¹

Geographic Factors

People of similar ethnicity often cluster within specific neighborhoods and regions. This geographic segregation may result in a tendency for minority communities to use particular health care facilities. Geographic factors can lead to ethnic disparities in health status if the facilities used by different ethnic communities vary in quality. Geographic factors may also influence the health status of minority populations due to exposures to environmental health hazards, such as pollutants. While several studies of Medicare patients have found that geographic differences alone do not account for ethnic disparities,^{26,39,67} one recent VA study found that African-American veterans were less likely than whites to be transferred to a regional tertiary care center for cardiac procedures when their local hospitals did not offer those procedures.⁶⁸ These findings raise concerns that concentrating certain procedures within regional centers may exacerbate ethnic disparities in procedure use.

Ethical Implications:

Geographic factors raise ethical concerns when they are associated with inequitable allocation of health care resources. For example, medical facilities in areas with high concentrations of ethnic minorities may lack advanced diagnostic equipment compared to facilities in areas with high concentrations of whites. Consolidation of health care services into regional centers in order to improve resource utilization and quality may at times exacerbate this problem. Although it is not always possible to eliminate ethnic disparities based on geographic factors, decisions about where to locate facilities or programs should take into account positive and negative effects on various ethnic populations of patients.

Patient Values and Preferences:

Cultural differences across ethnic groups are sometimes associated with differences in health care values and preferences.⁶⁹⁻⁷² To the extent that disparities in health care are attributable to patient values, they may reflect appropriate, patient-centered care. For example, if individuals from a particular ethnic group tend to share certain health care preferences, then a pattern of utilization reflecting those differences would be expected. Most studies in this area suggest that while health care disparities are often attributed to ethnic differences in values and preferences, these preferences explain only a part of the disparity.^{73, 74} For example, one study revealed that African-Americans with end-stage renal disease desired renal transplantation less often than whites.⁷⁴ However, when compared to whites, a much higher percentage of African-Americans who were clinically eligible for transplantation and wanted it were never referred to a transplant center for evaluation or put on a waiting list for a kidney. Before accepting cultural factors as an explanation for disparities it is necessary to assess such a claim carefully and critically.

Ethical Implications:

Differences in care that exist because of divergent values and preferences of patients may not be ethically problematic. To the contrary, they may be desirable. One important component of culturally competent care is the ability to demonstrate respect for patients' individual values and preferences. To the extent that patients in a particular ethnic group share similar values and preferences, respect for individual patients will on occasion lead to systematic differences in patterns of care. Clinicians should be wary, however, of making assumptions about patient values or preferences on the basis of ethnicity alone.

Communication:

Cultural and ethnic differences may create barriers to communication between minority patients and clinicians.⁷⁵⁻⁷⁷ Several studies of clinician-patient interactions have shown significant differences in communication styles between physicians and patients from different ethnic or cultural backgrounds.^{76, 78, 79} For example, white physicians are often perceived by African-American patients to have a less participatory decision-making style than African-American physicians.⁷⁶ Language differences may also create barriers, particularly for Hispanic and Asian-Americans.⁸⁰⁻⁸⁵ Studies suggest that patients from ethnic minorities tend to prefer physicians from similar ethnic backgrounds⁸⁶ and to be more satisfied with care they receive from those physicians.⁷⁵

Barriers to communication may also be associated with lack of trust.^{87, 88} For example, patients may not trust their physician to uphold the "fiduciary" relationship in which physicians have a duty to act in the best interests of their patients.⁸⁹ Communication may be compromised if patients believe that physicians are placing their own interests (e.g., making money, enrolling patients in research, protecting themselves from liability) above the interests of their patients. The history of discrimination in the American health care system and research enterprise has contributed to the lack of trust in physicians remaining faithful to the fiduciary relationship.⁹⁰

Communication barriers may also result from the lack of another aspect of trust: confidence in the competence of clinicians.⁸⁹ One study found, for example, that some African-Americans agreed with the statement, "White doctor[s] might not have the knowledge and understanding of the problems faced by black people from a biological and life situation perspective."⁹¹

Ethical Implications:

Communication barriers between clinicians and patients threaten the quality of informed decision making. The goal of informed decision making is to foster the participation of the patient in

clinical decisions. In order to promote informed decision making, clinicians have an obligation to take steps necessary to remove barriers to communication. As part of culturally competent care, clinicians should make every effort to present health care information and advice in ways that are understandable and meaningful to the patient. In addition, resources must be made available to support this effort, including trained translators, written materials in the patient's primary language, and other specialized communication aids. Efforts must also be made to overcome factors that negatively influence trust between patient and clinician. Good communication skills, including effective listening, demonstrating empathy, and sharing decision-making, can all improve trust.⁹² In addition, a health care institution can demonstrate that it deserves minority patients' trust by making a strong, public commitment to overcoming ethnic disparities.

Provider Bias:

Consciously or unconsciously, stereotypes may affect the way physicians and other health care providers perceive and interact with minority patients. It has commonly been hypothesized that disparities may be attributable, at least in part, to biases among health care providers. Recently, studies using standardized illness scenarios have begun to validate this hypothesis, confirming that patient ethnicity affects physicians' perceptions in complex ways.^{93,94} For example, when faced with identical presentations of patients with chest pain, as portrayed by actors of different gender and race, physicians were less likely to refer an African-American woman, as compared to a white woman, for further testing. Several studies examining the process of care delivery within hospitals have provided evidence that ethnic disparities in health care are sometimes best explained by bias on the part of health care providers.^{5,38,39} More studies are needed to better document the effects of bias on clinical decision making and to elucidate approaches to reduce and eliminate this bias.

Ethical Implications:

Prejudice against minority patients is ethically objectionable for several reasons. Whether or not a clinician is aware of subconscious biases, treating patients differently based on clinically irrelevant distinctions such as ethnicity violates the clinician's ethical obligation to treat patients fairly and with respect and to promote the best interests of each patient. Bias potentially deprives a patient of the full value of the clinician's expertise and suggests that the clinician has placed a higher value on one patient's intrinsic worth than that of another.

Federal Government Efforts to Address Ethnic Disparities

The federal government has several initiatives to address ethnic disparities in health care. In 1985 the Office of Minority Health (OMH) was created within the Department of Health and Human Services (HHS). OMH is responsible for reducing disparities in health care and for improving the health of minorities and ethnic populations and serves a variety of functions, including development and coordination of HHS and federal agency policies, gathering and analyzing data, supporting community program development through grants, and provision of technical expertise and information to the public.⁹⁵

The activities of HHS and other federal agencies to reduce disparities in health care were expanded with the development of the President's Initiative on Race in 1998. The Initiative was a broad effort to address racial problems in all sectors of American society, including health care. The initiative strongly influenced the development of *Healthy People 2010*.⁹⁶

Healthy People 2010 is an overall plan for improving public health in the United States. Its two overarching goals are to increase quality and years of life and to eliminate health disparities relating to gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation by 2010. While *Healthy People 2010* is focused on the activities of federal agencies, it is

informed by the *Healthy People Consortium*, a coalition of more than 350 state and local government agencies, and national organizations from the voluntary, professional, and business sectors.⁹⁷

Federal activities also include the development of a national research agenda on elimination of ethnic disparities in health care. The National Institutes of Health (NIH) recently developed the *NIH Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities*.⁹⁸ This five-year plan reflects a significant commitment to research, research infrastructure, public information and community outreach. In addition, every office within NIH has developed its own strategic plan for reducing health care disparities.

Federal programmatic initiatives were strengthened by legislation in November 2000. The Minority Health and Health Disparities Research and Education Act of 2000⁹⁹ provides funding for biomedical and behavioral research on minority health and health disparities, establishes the National Center on Minority Health and Health Disparities at NIH, and calls for implementation of specific research agendas for both NIH and the Agency for Healthcare Research and Quality. The law also provides funding to the Health Resources and Services Administration for research and demonstration projects on educating health professionals about disparities in health care and provides resources to the Institute of Medicine to produce a report on the topic.

VA Efforts to Address Ethnic Disparities

VA has also made several efforts to reduce disparities in health care. The Center for Minority Veterans (CMV) is the lead organization within VA responsible for addressing the needs of minority veterans. The CMV was established in 1994,¹⁰⁰ with the objectives of promoting the use of VA programs and services by minority veterans, assessing their needs, and proposing new programs, benefits and services for minority veterans. The CMV serves as the principal advisor to the Secretary of Veterans Affairs on minority issues, and provides support for the Minority Veterans Advisory Committee, which also advises VA on issues for minority veterans. The CMV has worked with two of VA's three component organizations, VHA and the Veterans Benefits Administration, to create a comprehensive data set to track utilization of health care and benefits by minority veterans. CMV oversees a group of Minority Veterans Coordinators based at VA medical centers, and provides oversight, training, and support for their activities.

The CMV addresses the special needs of African-Americans, Asian-Americans, Hispanic-Americans, Native Americans, and Pacific Islanders. The CMV works with veterans service organizations, community organizations, civil rights groups, and other federal agencies such as HHS and the Indian Health Service to improve services for minority veterans. However, reducing health care disparities is not the primary focus of the CMV.

Although VHA does not have a specific strategic plan, an identified national program office, or a coordinated system-wide effort to address ethnic disparities in health care, some VHA offices have made significant contributions in this area. The Veterans Readjustment Counseling Service (RCS), for example, oversees 200 Vet Centers across the country, including six located on Native American tribal lands. The Vet Centers focus on reaching out to minority veterans at risk for certain diseases such as Hepatitis C and diabetes mellitus, and regularly sponsor programs targeting minority and underserved communities. RCS Working Groups have published reports on the cultural beliefs and special needs of American Indian Vietnam Era veterans,¹⁰¹ Asian and Pacific Islander veterans,¹⁰² and Hispanic veterans.¹⁰³

VA has also made a strong commitment to research on the causes of ethnic disparities. Many of the most significant studies in the field of ethnic disparities have been supported by VA. Studies within the Health Services Research and Development service have focused on a wide array of topics, including racial variations in cardiac procedures, cultural factors in adaptation to chronic

illness, and ethnic/cultural variations in osteoarthritis treatment.¹⁰⁴ The Health Services Research and Development service recently awarded \$3 million over five years to support a new Center for the Study of Health Disparities that will strengthen and coordinate VA research into causes of disparities and methods to reduce and eliminate disparities.

VA has not yet made a similar commitment to a national educational effort. A search of the Employee Education System's national database revealed very few programs, mostly targeted at improving mental health programs for Native American veterans. Although Minority Veterans Coordinators do provide some educational programs for clinicians and veterans, the extent and scope of these programs has varied widely across the system.

Recommendations

VA, as the largest integrated health care system in the country, has the opportunity to build on its strengths and become a leader not only in research into health care disparities but also in implementing successful programs to reduce and eliminate disparities. The following recommendations from the VA National Ethics Committee warrant consideration by all health care systems attempting to reduce ethnic disparities:

- 1) Health care leaders must make the issue of ethnic disparities in health care a priority and communicate this commitment throughout their organizations. Correcting existing inequities requires an organization-wide, multifaceted approach and a corresponding commitment of staff and resources. A statement that ethnic disparities must be reduced and inequities eliminated should be part of organizational strategic plans. Responsibility for reducing disparities should be assigned to an identifiable office that will provide leadership and planning, coordinate efforts to reduce disparities, identify and disseminate best practices, provide necessary content expertise, and interact with key elements of the health care organization and important stakeholders. Centralization of responsibilities will enable the organization to achieve the concerted and continuous effort needed to tackle this problem.
- 2) Health care organizations should create policies that explicitly commit the organization to reducing and eliminating ethnic disparities in health care. There should be zero tolerance for prejudice against minorities, and processes need to be in place to address and correct these situations if they do occur.
- 3) Health care organizations should give high priority to the education of clinicians about how to treat patients from diverse backgrounds. Cultural competency is mandatory for achieving high quality health care in a diverse society. VA and other health care systems should make cultural competency a priority area and create programs to educate and support administrators and clinicians at all levels of the organization. Staff should also be educated about policies related to disparities.
- 4) Finally, model programs for improving quality and access to care for ethnic minorities should be developed and evaluated. Innovative programs should be developed and expanded, such as outreach efforts to minority populations sponsored by the VHA Readjustment Counseling Service. Collaborations between private sector and governmental health care systems should also be sought and strengthened.

Conclusion

VA's ethical obligation to provide the highest quality of care to all veterans includes reducing and eliminating health care disparities due to ethnicity. Because of its national scope, diverse patient population, specialized resources, and proven record of making systemic changes to address complex problems, VA should play a leadership role in reducing and eliminating ethnic disparities in health care and thereby serve as a model for other health care systems and the nation.

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