

# **SEPARATE AND UNEQUAL IS ILLEGAL:**

a discussion guide for health care providers  
on discrimination in the health care system

## **INTRODUCTION**

In the CNN news story you just watched, several Bronx residents who were on Medicaid or had no insurance experienced long delays in getting doctors' appointments, were shuffled between doctors, and got little face-to-face time once they actually saw a doctor—often with very troubling results. Some were even asked to participate in clinical experiments or trials without full disclosure of possible side effects.

### **Purpose of this discussion guide**

The purpose of this discussion guide is to promote a conversation among health care providers about the important and often difficult issue of health disparities and health care discrimination.

The objectives of the guide are to:

- Facilitate discussion on what health disparities are and why they exist.
- Identify policies and practices in your own health care facility that cause or perpetuate health disparities.
- Develop strategies to ensure that your facility provides integrated care to all patients, regardless of race or insurance status.
- Strategize with other providers to change systemic barriers to integrated care.

We hope that these materials will be useful to you as you think about how to foster productive conversations about health disparities and discrimination within the health care system.



Making Health Equality a Reality



## BACKGROUND

### What are health disparities?

As the health of all Americans improves, the gap between the health of whites and minorities still remains. Health disparities exist for many reasons. One reason, documented in the CNN news story, is when patients with the same medical condition are treated differently by a hospital based on factors such as their race or insurance status. For example, the patients interviewed by CNN were steered to a hospital-based clinic for treatment because they were on Medicaid or were uninsured. If they had private insurance, they would have been seen in a “faculty practice,” which is essentially a private doctor’s office within the hospital.

**Question:** Do you see this kind of steering happening in the hospital where you work? Do you think this kind of steering happens because Medicaid is a bad insurance, or because hospitals’ systems are structured to treat Medicaid patients differently?

Significantly more blacks and Latinos are on Medicaid or are uninsured in New York City than whites. As a result, when hospitals decide where to treat patients based on the type of insurance they have, they are also separating patients based on their race. Black and Latino patients tend to be seen in the hospital clinics, while white patients are treated in the faculty practices. Hospital waiting rooms may no longer have “Whites Only” signs on their doors, but racial segregation is nevertheless achieved when hospitals treat patients differently based on the type of insurance they have, or if they have no insurance at all.

**Question:** Do you notice a racial or demographic difference in the patients seen in the teaching clinics at your hospital?

### Why do health disparities matter?

Differences in the quality of care a patient has access to impacts her health outcomes.

- **Patients receive care from less experienced doctors if they are seen in a hospital-based clinic.** Hospital clinics are often staffed by residents and student doctors, who are new to the field and less experienced. Doctors in faculty practices are experts in their fields, and have years of medical experience.
- **Patients seen in a clinic have to wait longer for an appointment, and get less face-to-face time with the doctor once they are seen.** Hospital clinics are often busier than faculty practices, and so patients referred to clinics may have to wait longer for appointments than patients referred to a faculty practice and tend to have less face-to-face time with their doctor than a patient referred to a faculty practice. This can lead to delays in terms of when patients are diagnosed, or impact whether they are diagnosed at all.

- **Patient care is disrupted when patients are seen by a different clinic doctor each time.** Patients who are seen in a hospital clinic often do not get to see the same doctor each time they have an appointment. This makes it harder to ensure that the medical provider fully understands the patient's medical history and needs.

The result is **separate and unequal** care based on health insurance status and race. Over time, patients who receive worse care are likely to have higher rates of preventable conditions such as diabetes, obesity, heart disease, etc. **This means that low-income patients of color live sicker and die younger than affluent white patients.**

**Question:** As a provider, do you agree that the quality of care provided in clinics is not as high as the quality of care provided in faculty practices for the reasons described above? If not, why not? Are there other factors influencing the quality of care in hospital-based teaching clinics?

### **Separate and unequal is illegal**

A medical provider that segregates patients based on whether they have private insurance or Medicaid or are uninsured are in violation of federal civil rights law as well as state and local laws. Hospitals are bound by the following laws:

- Federal civil rights laws prohibit policies and practices that have a discriminatory effect on people because of their race or ethnicity.
- Federal and state law prohibits hospitals from treating patients differently based on if they have public health insurance such as Medicaid.

If a medical provider violates these laws, government agencies such as the state Attorney General have the power to investigate and pursue solutions. And solutions are available. Some of the country's most well-respected health care institutions, such as the Mayo Clinic in Rochester, Minnesota, do not separate their patients based on the type of insurance they have. Also, some departments within New York City hospitals have voluntarily integrated their practices because the leadership in those departments felt it was wrong to segregate patients. These integrated practices provide top quality of care to all of their patients without compromising their bottom line or their training of residents and medical students. **Simply put, integrated health care delivery means that all patients are treated to the same high quality health care in the same place, at the same time.**

**Question:** What do you think are some of the barriers or challenges to integrating the delivery of specialty care in academic medical centers? Why do you think some providers are successful in doing so?

## DISCUSSION

**Reminder:** The purpose of the conversation is not to point fingers or blame any particular medical facility.

### I. Survey participants' reactions

Here are some questions to get the conversation going:

- What were your reactions, as health care providers, to the stories you just heard?
- Do you think the patients profiled in the story received inadequate care?
- Do you think you would feel differently if you didn't work in the health care field?
- Is your reaction to the story influenced by your own race, ethnicity, or socioeconomic background, or that of your family?
- Is your reaction to the story influenced by the field of medicine or setting in which you practice? (E.g. primary care versus specialist? Teaching hospital versus community-based clinic?)
- Are the experiences of the patients in the news story familiar to you? If no, then why do you think these particular patients received the kind of treatment they did?
- What were your reactions to the characterization of the health care system as racist?
- Are there other reasons the patients profiled in the story may have received inadequate care besides their lack of insurance or Medicaid status?
- Were health disparities discussed in any part of your medical/nursing education? Do you think this topic would have been helpful to include in your education as a health care provider?

### II. What are some of the effects of health disparities?

Ask whether the members of the group have seen patients who would have benefitted from preventative care or earlier medical treatment? Or from elective procedures and treatment not covered by Medicaid or unavailable to uninsured patients? Examples of immediate repercussions are: less access to preventative health care, higher rates of illness or conditions going undetected, lower rates of access to elective procedures, etc. Examples of long-term consequences are: lower life expectancy for blacks than for whites, higher rates of obesity, diabetes, and heart disease, etc.

Statistics from the federal government's Office of Minority Health about the effects of health disparities:

- Compared to whites, people of color and people whose first language is not English often receive lower quality or no health care. As a result, as a group they have less health and die younger than whites.
- African Americans, Latinos, Asians, and Native Americans have higher rates of diabetes, heart disease, and obesity than whites.

- Though the health of all Americans has improved over time, a gap between the health of minorities and whites still exists:
  - A black baby born today on average will live six years less than a white baby born today.
  - Latinas are four times as likely to die from AIDS as white women.
  - Latinos are almost twice as likely to die from diabetes as white males.
  - Almost two times as many African American men have diabetes as white men.

Source: Office of Minority Health, African American Profile, and Hispanic/Latino Profile, [www.omhrc.gov](http://www.omhrc.gov).

### III. Why do health disparities exist? And how do they affect your work?

Think of potential factors of health disparities broadly, including environmental and social causes, and consider whether disparities exist because of reasons beyond differential medical treatment and health care. What about income? Or access to healthy food, exercise, and other factors that affect a person's health?

Point out to participants some causes of health disparities that they didn't identify:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>▪ Race and ethnicity</li> <li>▪ Income</li> <li>▪ Language</li> <li>▪ Education</li> <li>▪ Insurance status</li> <li>▪ Access to healthy food</li> </ul> | <ul style="list-style-type: none"> <li>▪ Access to parks and walking spaces</li> <li>▪ Access to quality health care</li> <li>▪ Intentional or unintentional discrimination</li> <li>▪ Housing</li> <li>▪ Poverty</li> </ul> |
|---|--|

Are health disparities the result of intentional discrimination by individual providers? Have members of the group seen a nurse, doctor, or resident treat a patient differently based on her race, income, or insurance? Have *they* treated a patient different based on her race, income, or insurance?

Even if health disparities are not the result of intentional discrimination, the effect of policies and practices that separate patients based on insurance may be the same. Structural discrimination—the legitimization of a discriminatory practice over time—occurs in hospitals through practices like when a medical provider adopts a policy or practice that segregates patients based on insurance status. While the decision to treat patients differently based on their health insurance may be motivated by a legitimate concern, such as reducing overall costs, the result is racial segregation of white patients and patients of color.

Consider the following questions:

- What practices or policies at your hospital or medical facility cause patients with the same diagnosis or condition to be treated differently? On what basis are they treated differently? Is it income, health insurance, race?

- Who “created” these policies? Are they required, or are they an unspoken policy followed by all staff?
- What are the justifications or benefits to having this policy? Is it still justified if it results in patients receiving a different level of care even though they have the same medical needs?

Ask participants to consider how a hospital’s practice that segregates patients might negatively impact their work. For example, if residents and student doctors/nurses are working in the clinics, are they missing out on learning about interesting or complicated cases that are usually referred to the faculty practice? Are they losing the opportunity to work directly with faculty doctors who are experts in their field? How does the segregation of patients influence students’ and residents’ perceptions and treatment of different types of patients?

#### **IV. Strategies to address health disparities in your facility**

Ask participants to strategize how, as health care providers, they can change policies or practices in their own hospital to prevent patients from being segregated based on insurance or race.

Suggested questions:

- How would you change the current policy so that your hospital can provide the same treatment to all patients who have similar conditions or needs?
- What are some challenges to changing that policy? Would there be resistance from hospital administration or staff? How could those challenges be addressed?
- If the policy or practice comes from the director of a department, or from the hospital administration, what are ways that you can influence management to change the policy?
- If the policy is an unwritten or unofficial mandate, or just a practice that all hospital staff follow, how can you change that?

One of the challenges individual health care providers face is affecting administrative policy or management decisions at their hospital. Understandably, employees may be afraid of angering a supervisor, or worry about “rocking the boat.” If those concerns arise, it may be helpful to brainstorm ways in which concerned staff members can involve other hospital workers or create a larger group so that individuals are less afraid of retaliation.

Some suggestions to advocate for change within your medical facility are:

- Educate yourself about the policy or practices in your hospital that result in patients receiving different levels of care. Ask colleagues and supervisors how long the policy has been in place, and reasons for why the policy exists.

- Talk with your colleagues about how the policy may perpetuate structural discrimination, even if no discrimination is intended. Be sensitive about pointing fingers, as people can become defensive if they feel they are being accused.
- Collaborate with other concerned colleagues to approach your supervisors or the administration to discuss your concerns with the policy or practice.

**V. How can you advocate for change so that all patients get good health care?**

Ask participants for suggestions of ways to raise awareness and end disparities on a broader scale. Have participants used creative advocacy strategies in other campaigns? Could those strategies be helpful here? What would or wouldn't work?

Discuss where advocacy efforts should be focused, and how providers could use their leverage as health care providers who have a unique perspective on this issue.

Some possible suggestions include:

- Write a letter to your local newspaper. You don't have to identify where you work to make the point that health disparities exist in many New York City hospitals and medical facilities.
- Set up a meeting with your local elected official to tell them about this issue.
- Work with your professional organization or other employee group to galvanize support.
- Ask other hospital departments and facilities that have deliberately chosen to integrate their health care for advice on how to push your facility to do the same.
- Engage in research that helps the health care community and the community at large to understand how health care discrimination occurs, intentionally or unintentionally. Disseminate that research through conferences and other public fora to foster conversation and collaboration on solutions.
- Remind colleagues and other health care providers that we, or someone we know, are also health care consumers at some point in our lives. These issues affect all of us.

**Questions? Concerns? Want more information? Contact:** Bronx Health REACH (212-633-0800) or the Health Justice Program at NYLPI (212-244-4664).