Practice Paper of the American Dietetic Association: Addressing Racial and Ethnic Health Disparities

ABSTRACT

Minority populations have remained in relatively poor health compared to the majority population and continue to be underserved by the health care system. Racial and ethnic health disparities are not new phenomena. Understanding the causes of these disparities continues to evolve. Within the past decade researchers have looked more toward social determinants of health to explain the differences. The Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* provided documentation to shift the discussion from patient behaviors to the contributions of health care systems, including health care providers, that contribute to health disparities. The report was the first comprehensive study that documented racial and ethnic inequities within the US health care delivery system (ie, differential treatment on the basis of race and ethnicity). The authors of the IOM report indicated that they found some evidence to suggest that bias, prejudice, and stereotyping by providers may contribute to differences in care. It is possible that food and nutrition practitioners have the same biases and are presented with the same systems challenges as the health care providers referenced in the IOM report. It is, therefore, also possible that food and nutrition practitioners may be at risk of contributing to health disparities. This article provides an in-depth look at the recommendations put forth by the IOM, offers discipline-specific recommendations consistent with those outlined in the IOM model, and introduces other models that may be of use as food and nutrition practitioners move forward with developing strategies to eliminate racial and ethnic health disparities.

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Minority populations have a higher incidence of chronic disease, poorer health outcomes, and higher mortality compared to the majority population. Blacks* and Native Hawaiians are more likely to die from heart disease, cancer, and stroke when compared to their white counterparts (1). Blacks and American Indians† have higher rates of infant mortality with rates in black Americans being 2.5 times higher (2,3). Blacks and Hispanics have higher rates of human immunodeficiency virus with blacks having rates nine times higher (4). American Indian and Hispanics are twice as likely as non-Hispanic whites to have diabetes (2,5-7). Blacks and American Indians/Alaskan Natives have higher asthma rates (2). Blacks, Hispanics, and American Indians are bearing the brunt of the obesity epidemic (8,9). These racial and ethnic health disparities, defined as differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates, although deplorable are by no means new.

American Indians have experienced compromised health since colonization of their ancestral land during the 18th century (7). Many different explanations have been offered for the disparities, including God's wrath for their way of life, ill adaptation to the richer diet of the English, and poor health behaviors. However, it is more likely that the trauma of infectious diseases, disenfranchisement, and war has been difficult to overcome in light of the continued lack of access to health care (7).

Blacks have also experienced continued health disparities. During the late 1800s to early 1900s, the prevailing view was that differences in health outcomes that existed between white and African-American populations could be explained by differences in biologies (plural to reflect the difference in biology between the majority and minority populations). It was widely accepted that African Americans possessed inferior biology (9-11).

Hispanics are at risk of poor health outcomes as a result of their underutilization of preventative services (10). The underuse has been attributed to language barriers, cultural barriers, lack of employer-sponsored health care insurance due to immigration status, educational limitations, and employment in high-risk jobs with high rates of unintentional injuries and exposures to health hazards (12,13). Understanding the causes of these disparities continues to evolve. Within the past decade researchers have looked more toward social determinants of health; that is, external factors that influence health such as education, geographic location, sexuality, job status, and socioeconomic status, to explain the differences in health status (14,15).

Racial and ethnic health disparities were estimated to cost the health care system $23.9 million in direct costs in 2009 (16). Though this cost is staggering, it in no way captures all of the costs associated with racial and ethnic health disparities. Health disparities also have a great financial effect on society in terms of human potential and efficiencies lost as a result of increased morbidity and premature

**Blacks will be used throughout this article to represent the larger groups of Individuals of Black African descent and represents the three major groups in the United States of African Americans (blacks born in the United States, Black Africans [black immigrants from Africa], and Afro-Caribbean).*

†American Indians will be used in this article and the term will include persons who consider themselves Native Americans.

mortality. A study conducted by the Joint Center for Political and Economic Studies puts the cost of combined direct and indirect cost of health inequalities in the United States at $1.24 trillion in 2008 inflation-adjusted dollars (17). It has been estimated that the racial and ethnic demographics of the United States may be very different in the future. According to the US Census, by 2050, today's majority of non-Hispanic whites will comprise barely half of the US population (18). Meanwhile, the Hispanic population will increase from 13% in 2000 to more than 24% in 2050 of the population and people of Asian origin will increase from nearly 4% to 8% of the population during the same period (18). The number of foreign-born people, a large heterogeneous group of 33.5 million (11.7% of the US population) will continue to rise (18). In light of these predictions regarding future shifts in demographics, and the potential economic and human costs of health disparities, health care practitioners and participants in the health care system are becoming more focused on resolving these disparities.

In 2000, the US Department of Health and Human Services incorporated an overarching goal of eliminating health disparities into the Healthy People 2010 objectives (19). This was prompted by the 1998 congressionally mandated report of the Institute of Medicine (IOM) on health disparities. The report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* provided documentation to shift the discussion from patient behaviors to the contributions of the health care system, including health care practitioners who contribute to health disparities (20). The report documented racial inequities within the US health care delivery system (eg, differential treatment on the basis of race). Additional studies conducted by the Agency for Healthcare Research and Quality have found similar results (13).

The authors of the IOM report found evidence to suggest that bias, prejudice, and stereotyping by physicians may contribute to differences in health care outcomes. They proposed that the bias is not necessarily malicious in nature, but results from a lack of understanding of other cultures, time pressures, and uncertainty about a diagnosis or effect of a certain treatment (20). Though the IOM report specifically referenced physician and nurse behavior, all disciplines are prone to these biases. The IOM report provided recommendations for eliminating health disparities that include legal, regulatory, and policy interventions; health systems' interventions; patient education and empowerment; cross-cultural education in the health professions; data collection and monitoring; and research.

This Practice Paper focuses on racial and ethnic health disparities and offers discipline-specific recommendations consistent with those outlined in the IOM model that may be useful as food and nutrition practitioners move forward with developing strategies to eliminate racial and ethnic health disparities.

WHY SHOULD FOOD AND NUTRITION PRACTITIONERS BE INVOLVED?

According to the Centers for Disease Control and Prevention, the 10 leading causes of death for adults are: heart disease; cancer; stroke (cerebrovascular diseases); chronic lower respiratory diseases; unintentional injuries; diabetes; Alzheimer's disease; influenza and pneumonia; nephritis, nephrotic syndrome, and nephrosis; and septicemia. In each category, minority populations have higher age-adjusted mortality rates than the majority population (21,22). Racial and ethnic minorities also bear the greatest morbidity burden for these same diseases (23). Nutrition is an accepted component of either the treatment or the etiology of six of these diseases. For example, obesity, which is partially attributed to poor nutritional intake, has been implicated as a contributor to cancer, heart disease, stroke, and diabetes (24-26).

It is important to note that nutritious food is not equally available to everyone. Some people live in food deserts, where nutritious food is either very expensive or limited (27,28). Food and nutrition practitioners who are well versed in nutrition and chronic disease and who understand the food environment are therefore integral to health care teams. Accordingly, food and nutrition practitioners have an opportunity and an ethical obligation to positively influence the health care experience of individuals.

Finally, there are few factors more affected by culture than an individual's diet (29). Food and nutrition practitioners must be culturally competent to provide instructions that fully meet the nutrition needs of individuals while integrating these in the individual's traditional or cultural diet. Similar to other health care practitioners, food and nutrition practitioners must understand that cultural competence requires that patients/clients be included as an integral part of the health care team. Food and nutrition practitioners must understand the importance of culture on food behaviors and must develop eating plans that are culturally appropriate and nutritionally sound for the patient/client.

American Dietetic Association's (ADA's) Commitment

ADA actively identifies and offers opportunities to individuals with varied skills, talents, abilities, ideas, disabilities, backgrounds, and practice expertise. ADA has demonstrated its commitment to diversity and the reduction of health disparities through a variety of actions and initiatives, including, but not limited to, the diversity philosophy statement, the Commission on Dietetic Registration (CDR) Code of Ethics, the Commission on Accreditation for Dietetics Education standards, and ADA House of Delegates activities.

The diversity philosophy statement indicates: "the American Dietetic Association values and respects the diverse viewpoints and individual differences in all people" (30). This commitment is further exemplified in ADA's strategic plan (31). To achieve ADA's mission of empowering members to be the nation's food and nutrition leaders and ADA's goals, to "improve the health of Americans," the organization has included a strategy to, "strengthen cultural competence to address health disparities." In addition, the values included in the strategic plan—customer focus, integrity, innovation, and social responsibility—all support inclusivity.

ADA's and CDR's code of ethics (32), which provides guidance to food and nutrition practitioners in their conduct and practice, recognizes eth-