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Review

Do attitudes and behavior of health care professionals exacerbate health care disparities among immigrant and ethnic minority groups? An integrative literature review

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ABSTRACT

Objectives: Recent investigations of ethnicity related disparities in health care have focused on the contribution of providers' implicit biases. A significant effect on health care outcomes is suggested, but the results are mixed. The purpose of this integrative literature review is to provide an overview and synthesize the current empirical research on the potential influence of health care professionals' attitudes and behaviors towards ethnic minority patients on health care disparities.
Design: Integrative literature review.
Data sources: Four internet-based literature indexes – MedLine, PsychInfo, Sociological Abstracts and Web of Science – were searched for articles published between 1982 and 2012 discussing health care professionals' attitudes or behaviors towards ethnic minority patients.
Review methods: Thematic analysis was used to synthesize the relevant findings.
Results: We found 47 studies from 12 countries. Six potential barriers to health care for ethnic minorities were identified that may be related to health care professionals' attitudes or behaviors: Biases, stereotypes and prejudices; Language and communication barriers; Cultural misunderstandings; Gatekeeping; Statistical discrimination; Specific challenges of delivering care to undocumented migrants.
Conclusions: Data on health care professionals' attitudes or behaviors are both limited and inconsistent. We thus provide reflections on methods, conceptualization, interpretation and the importance of the geographical or socio-political settings of potential studies. More empirical data is needed, especially on health care professionals' attitudes or behaviors towards (irregular) migrant patients.

What is already known about the topic?

- Ethnic minority patients face disparities regarding access to health care, health outcomes, and mortality.
- Recent studies suggest that low to moderate levels of implicit bias against ethnic minorities is present among many health care professionals.

What this paper adds

- This review examines various barriers to health care for different ethnic minority groups that are related to health care professionals' attitudes and behavior.
- Six potential barriers for ethnic minority patients to access high quality health services were identified.
- Certain features render the claim of strong evidence of the barriers difficult.

1. Introduction

Even though there is considerable evidence that ethnic minority populations differ from ethnic majority populations regarding access to health care, health outcomes, and mortality in many countries, the potential influence of health care professionals (HCPs) on such disparities is until now only partly explained. Compared with members of the majority society ethnic minorities face more barriers to accessing health care services, including lower rates of health insurance, lower rates of having a regular doctor, and lower use of care (Derose et al., 2009). It is also well examined that some ethnic minorities experience worse health problems compared to the majority population (Heffernan et al.,

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2011; Smedley et al., 2003; Solé-Auró and Crimmins, 2008; van Ryn, 2002; van Ryn et al., 2006). Under some circumstances ethnic minorities are at higher risk for infectious diseases like tuberculosis, HIV, and hepatitis B and C (Brodhun et al., 2015), or higher premature death rates from heart disease and stroke (Hall et al., 2015). While many factors, such as behavioral patterns or environmental exposure, can contribute to differences in *health outcomes*, another factor is gaps in the delivered quality of care (Kilbourne et al., 2006). This turns the attention to disparities in *health care*. The Institute of Medicine (IOM) provides a frequently cited report in which the most commonly accepted definition of ethnic health care disparities is: "(. . .) racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention" (Smedley et al., 2003).

Recent studies of the HCPs' share of responsibility for such disparities have been especially interested in implicit provider biases towards ethnic minorities, which carry the potential to influence medical encounters (Hall et al., 2015; Sabin and Greenwald, 2012; Shavers et al., 2012). Implicit attitudes and beliefs refer to unconscious cognitive constructs that are outside of conscious awareness, and that are not available to report, in contrast to explicit attitudes which are consciously held and can be expressed in words (Sabin and Greenwald, 2012). Such implicitly held constructs, which often project dubious if common stereotypes, exist even among individuals who explicitly claim to hold egalitarian or cosmopolitan worldviews (Sabin and Greenwald, 2012). Moreover, explicit and implicit attitudes are not necessarily related (Sabin et al., 2009; Sabin and Greenwald, 2012). Results of a recent systematic review investigating implicit bias in medical encounters in the USA suggest that low to moderate levels of implicit bias against ethnic minorities is present among many HCPs of different specialties and that they have a significant effect on health care outcomes. However, the results of the review were mixed and it remained unclear how implicit biases concretely affect health care outcomes. Some studies reported that health care outcomes were influenced by implicit ethnic biases and others found no significant correlation (Hall et al., 2015).

One possible explanation for these mixed results is that implicit biases may interact with other characteristics that overlap with ethnicity such as national origin (Hall et al., 2015), language abilities (Fiscella et al., 2002), or residence status (Schenk, 2007), thus conflating the results by not including and discriminating between the different categories. More open questions remain: Have similar studies been performed in other countries too and are results comparable? Do other factors than implicit bias lead to disparities in health care that can be related to HCPs' attitudes and behaviors?

In order to continue examining better the potential influence of HCPs' attitudes and behaviors on health care disparities we conducted an integrative review of the literature (Torraco, 2005). For our search strategy we specifically applied a rather broad definition of the term "ethnic minority": we included all groups that, due to ethnicity, place of birth, citizenship, residence status or the like, have minority status in the country in which they reside (Scheppers et al., 2006). According to this definition "ethnic minorities" are highly heterogeneous, with varying degrees of duration of stay and of acculturation: the term e.g. applies to newly arrived immigrants as well as to communities that have been present in a country for several generations. We further searched for results also in non-US-contexts and searched for potential barriers related to HCPs' attitudes and behaviors that go beyond implicit biases.

This review thus seeks to answer the following main research questions: Do empirical studies report potential concrete barriers that can lead to health care disparities for different groups of ethnic minorities that can be related to HCPs' attitudes or behaviors and if yes which kind of barriers can be identified?

2. Methods

2.1. Literature search

Four internet-based literature indexes – MedLine, PsychInfo, Sociological Abstracts and Web of Science – were searched for articles discussing HCPs' attitudes or behaviors towards ethnic minority patients. The study team and an invited expert confirmed that the search term strings constituted a valid transformation of the research question into a search algorithm, which was then tailored to each database. Titles and abstracts were searched for keywords and Mesh terms relating to health care disparities (prejudice, racism, healthcare disparities, stereotyp*, attitude of health personnel, attitude of physicians, discrimination), minority groups (minority groups, ethnic groups, transients and migrants, migrant*, refugee*, asylum seek*, sans papiers, illegal migrant*, illegal immigrant*, undocumented migrant*, undocumented immigrant*), and health care personnel (medical staff, health personnel, health care workers, nurs*, physician*). The initial pool of resulting papers ($n = 2040$) were categorized by DD as 'relevant', 'potentially relevant' or 'irrelevant' for the following predefined in- and exclusion criteria: (1) qualitative or quantitative study design, (2) study sample of health care personnel only, (3) data reporting health care disparities of ethnic minorities caused by attitudes or behaviors of HCPs, and (4) published in English or German. Studies were excluded if they were theoretical or conceptual or if the study population were patients.

VW assessed a random sample of approximately ten percent of the 'relevant' and 'potentially relevant' hits. The inter-rater reliability score, expressed in Cohen's Kappa, was .704 ($n = 227$; 220 agreements, 7 disagreements). The disagreements were discussed until agreement was reached.

2.2. Quality assessment

The relevant hits ($n = 141$) were assessed for quality based on the Critical Appraisal Skills Program (CASP) tool for qualitative research and cohort studies (Critical Appraisal Skills Programme (CASP), 2013). The CASP tools provide a systematic approach to assess the degree of evidence in a transparent and systematic way. The tools for cohort and qualitative studies have 11 and 10 questions respectively. Originally the tool for cohort studies has 12 questions. However, we excluded the question on follow-ups of study subjects, because it was not relevant for our assessment. Following Jun et al. (2016) we assigned numeric values to the assessment tools ("yes = 2″, "can't tell = 1″, "no = 0″) to provide a systematic quality index of the studies. This resulted in a possible value range between 0 and 20 for the assessment of the qualitative studies and 0 and 22 for the assessment of the quantitative studies, respectively. The quality assessment is an essential step in conducting an integrative review since the inclusion of poor quality studies can influence the validity of the review and weaken the overall conclusions (Cameron et al., 2011). Using this assessment method, studies with scores below 9 were assessed as lacking sufficient quality and were thus excluded. Thirteen studies were excluded based on this assessment for methodological reasons (sample size, lack of documentation of used methods, sample bias).

Tables 1 and 2 provide the summary of the quality assessment for the included qualitative and quantitative studies.

2.3. Data analysis

Methodologically as well as related to study settings and aims, the final sample of 47 relevant studies was diverse (see Table 3). In light of this diversity we chose a thematic analysis approach to