Gender and racial issues that affect delivery of care: are we prepared for the future changes?

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Provider/consumer racial and gender issues

Many who practice in an urban clinic setting or in a teaching institution are very familiar with the statistics we have heard and the problems of health care disparities rooted in the racial or ethnic differences of our patient population. For the large majority of pediatric dentists who are in private practice, I want to stress that we should remain keenly aware that almost 4 out of every 10 of our patients belong to a so-called "minority culture" and that their proportion will grow steadily in the future. I already see significant changes, perhaps because I practice in a suburban area, but I believe that the fast changes in the demographics of our patients will affect all of us.

Many in private practice spend a significant amount of money, time, and effort in marketing techniques. My question is, do you understand the populations' culture and needs in order to attract them and retain them as patients? Are you doing anything different to assure their satisfaction with the care and services you provide? Or, putting it a different way, depending on the area where you practice, can your practice afford to lose up to 40% of its present or potential patient base?

Makeup of American families and their children

In 1999, children comprised 27% of the total population of the United States. Racial/ethnic minorities currently account for 37% of the children and up to 39% of the preschool population.[1] This proportion of minorities is higher than any other age group. Although the number of children in the United States is actually projected to grow rather slowly in the immediate future, the composition of the child population will change significantly.

In 1999, the white majority accounted for 63% of children. This number is projected to decrease steadily to 54% by 2025. The number and proportion of African American children will decrease slightly from 16% to 14% in 2025. The Asian Pacific child population will grow from 4% to 7%. The growth of Hispanic children will be even more rapid shifting from the current 16% to 25% of all children in this country by 2025.[1]

Providers' makeup and expected trends

Diversity among health care professionals has changed steadily over the past 2 decades. Health care providers have shifted from being predominantly white male to a more diverse gender, racial, and ethnic makeup.[2-4]

The proportion of women dentists was 37% in the 1990s. The number of white graduates has decreased from 87% in 1980 to its present 68%. Currently, only one-third of graduates is identified as being part of a minority group, but this change does not reflect the patterns of change in the total population. The primary increase has been among Asian/Pacific Islanders, who have grown from 5% in 1980 to 22% of dental graduates, while the total population of Asian/Pacific Islanders is 4%. The percentage of African American graduates has shown a slight decrease to about 5%, and the percentage of Hispanic graduates has remained at about 5%. The percentage of Native American graduates has always been less than 0.5%.[2,4] If we look at the numbers of students enrolled in pediatric dentistry residences, we can see that these proportions have only minor variations.[5]

Women consist of 32% of the American Academy of Pediatric Dentistry (AAPD) membership.[6] These figures should rise in the near future, because from 1997 to 2000, women comprised 56% of students enrolled in pediatric dentistry programs, which is a higher percentage of women than in any other specialty.[5]

We must exercise caution when interpreting these statistics. Most of the data is gathered through surveys that only include the racial/ethnic choices that I have chosen to mention. It is a fact that populations from Arab and other Muslim descents have been growing steadily in this country, as well as groups from Eastern European ancestry. However, in most surveys, they are usually grouped as whites. Similarly, Asian/Pacific Islanders are grouped under the same category when we should identify them by their diverse ethnicity, not only their race. If we are to develop cultural sensitivity as a first step to improving provider-patient relationships, we must first fine-tune our

data gathering to establish the real composition of our consumer/provider bodies.

Delivery of care

The number of under-represented minority dentists in the United States is remarkably low compared with their proportions in the overall population and sorely inadequate to meet the needs of rapidly growing ethnic and minority groups. It is a fact that minority dentists and physicians are the chief source of health care delivery in minority communities and that utilization of dental services increase when there is access to same-culture dentists in their geographic area[4,7,8] The African American population accounts for 12% of the total population. Only 2% of active dentists are African American, but they provide dental care for 62% of the African American population. While the Hispanics account for 13% of the total population, only 3% of active dentists are Hispanic, but they care for 45% of the Hispanic population.[7] From these figures, we can deduce that half of the minority populations will have to seek care through white, or other minority providers. If we add the fact that the percentage of graduating dentists declined by 40% between 1986 and 2000, we can easily see that decline in dental personnel and services may have far-reaching consequences among indigent populations, particularly for children from low-income families.[2,3]

We know that the youngest population with the highest needs and least access to care should be serviced by the highest-trained professionals in the field.[9,10] However, it is still a fact that there are opportunities for less than 5% of graduating dentists to enter into postdoctoral programs in the specialty of pediatric dentistry.[3]

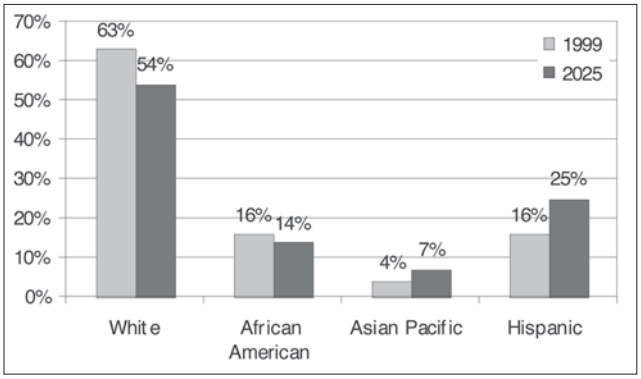

Figure 1. Children population trends by ethnic type.

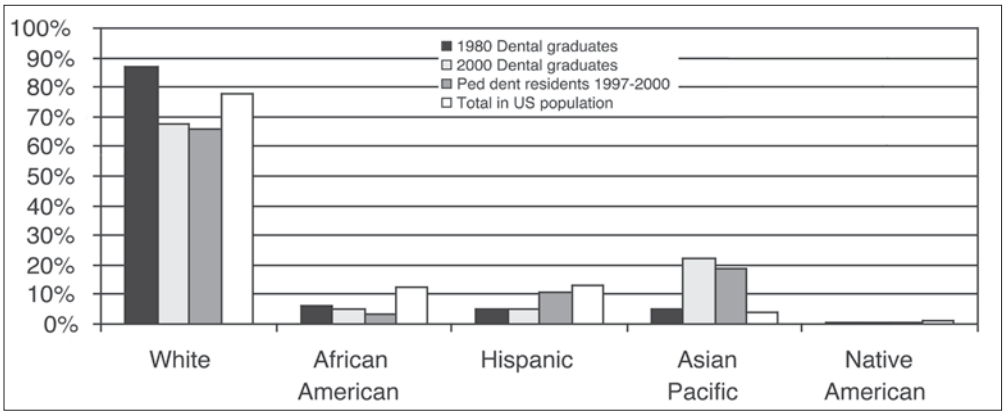

Figure 2. Ethnicity/race of dental providers compared with percentage in total population.

Cross-cultural relations

Many studies have shown that ethnic/racial minorities are less likely to receive the best treatments independent of clinical appropriateness, payer, and treatment site. Evidence indicates that gender, age, sexual orientation, and race/ethnicity influence the patterns of interaction between health care providers and patients. All these factors can also influence provider beliefs about and expectations of patients.[11]

Gender and racial influences that could affect provider patient relationships

Even within the same culture, men and women grow up in different worlds, experience different socializing messages, learn to talk differently, and have different expectations for interpersonal interactions.[12] Some authors have even proposed that gender functions as culture in physician-patient interaction. For example, it is a fact that physicians spend more time with female patients because they talk more, ask more questions, and get more information than men.[12] So far, we know that male and female physicians may react differently to gender and/or racial cues and that these interactions may significantly influence physicians perceptions and even diagnostic and treatment decisions. [13] We need more research to understand these interactions.

With respect to parents' gender, it has been found in multicultural populations that female gender, higher educational attainment, and better self-rated health are significant indicators of more positive oral health beliefs.[14] New mothers are usually more open to information and strategies to reduce the prevalence of dental disease.[15]

What we know is that each one of the minority groups is going to bring into the doctor-patient relationship many of the traditions of their background, and we must know and learn how to work with them to optimize this relationship. For example, "respect" and "personal relationships" are features of Mexican American and other Hispanic cultures. "Respect" dictates appropriate deferential behavior toward others on the basis of a position of authority. They see their health care providers as authority figures and will not be likely to question you or disagree with your suggestions, even if

they have doubts and hesitations that will later make them unhappy with your treatment. It is important to understand this and encourage these parents to express their questions and their views.[16]

How these changes and interactions impact the way we deliver appropriate care

The majority of studies find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors.[13]

We know that education alone is insufficient to produce behavior change. Specifically, we know that parents who have high scores on dental knowledge can still have children with high caries levels.[17] Developing pamphlets in different languages is not going to significantly improve the dental status of these minority patients. We must put aside our prejudice and understand their culture to be able to break through gender and ethnic barriers that may negatively affect the way we deliver care.

I agree with my colleagues that we must all try to do our best to improve access to care for the 1 in 5 children that live in poverty in this country, most of whom are part of an ethnic minority. Regardless of the setting of our practices, we must do our best to address the need to reduce the oral health disparities among our children. We definitely need to attract and train more specialists that come from the specific minority groups with the highest needs.[4,5] However, I want to emphasize again that the changes in demographics in this country will affect every practitioner. For immigrant populations, this country is still, "the land of opportunity." Most of them are very hard working, and, although they will keep many of their traditional cultural values and customs for a long time, their integration into the socioeconomic system happens very rapidly. For example, in the Mexican American community, the family structure and roles are becoming more diverse. Women are assuming more authority for decision making within the family and are seeking opportunities for education and employment outside the home.[16] With both parents working, many of these families soon integrate into the middle class and their purchasing power increases. Evidence of this is the large amounts of money that big companies are spending in advertising targeted to Spanish-speaking minorities.

In my practice, it is not uncommon to see patients from different minority groups—who were uninsured on their first visit and seeking only emergency care—return a year later with insurance coverage. They become great patients, and it is very rewarding to see their appreciation for the treatment you provide.

So I raise the question again: Are you doing everything possible to make sure all your patients get equal care? And are you doing something in your practice to face the changes and needs of our patient populations?

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