Disparities in Health Care:
Focusing Efforts to Eliminate Unequal Burdens

By
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Abstract & Objectives

Disparities in health and health care have been around for more than two centuries. Evidence suggests that health disparities in ethnic and racial minorities continue to be problematic, with little progress made to eliminate them over time. Ethnic and racial disparities exist for multiple and complex reasons. However, new solutions are needed to resolve some of these old problems. Framing the debate and discussion around the distinctiveness related to disparities in health and health care is a necessary beginning in eliminating unequal burdens in health status. Focusing efforts to eliminate unequal burdens can strengthen existing solutions and policy formation related to this issue. This article defines disparities in health and health care, describes current health disparities impacting ethnic/racial groups, reviews historical factors associated with existing disparities in ethnic/racial groups, and concludes with challenges and solutions to alleviate these disparities.

Objectives

At the completion of this CE Module, the participant will be able to:

1. Describe historical and current factors leading to disparities in health care for minority groups.
2. Identify the challenges in providing health care to serve ethnic and racial minorities.
3. Discuss solutions in providing health care to decrease health disparities.

Key words: health disparities; diversity; ethnic and racial minorities; unequal burden

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Demographics show that the color of America is changing. According to the 2000 Census data, 25% of the U.S. population is composed of racial-ethnic minorities: 12.1% African

American, 9% Hispanic, 2.9% Asian and Pacific Islander, and 1.0% Native Americans. If current birth and immigration trends continue, it is expected that the Hispanic population will increase by 21%, Asian 22%, African-Americans 12% and the White population 2% by the year 2040 (U.S. Bureau of the Census, 2000). These demographic changes combined with the fact that many minorities are overly burden with disease suggest that health care systems in the future will experience a much more diverse clientele and sicker population.

It is well documented that ethnic/racial minorities are disproportionately affected by many health care conditions that impact their health in comparison to their white counterparts. Many reasons are cited for these disparities, including socioeconomic status (United States Department of Health and Human Services [USDHHS], 2000), health behaviors of the minority groups (Satel, 1997), access to health care (USDHHS, 2000), environmental factors (USDHHS, 2000), and direct and indirect manifestations of discrimination (Williams, 1999). Other reasons cited for health disparities include lack of health insurance (Collins, Hall, & Neuhaus, 1999), over dependence on publically funded facilities by minority groups, and barriers to health care such as insufficient transportation, geographical location (not enough providers in an area), and cost of services (Collins et al., 1999).

While the above disparities are not new and have been around for more than two centuries, framing the debate and discussion around the distinctiveness related to disparities in health and health care is a necessary beginning to finding effective solutions in eliminating unequal burdens in health status. Focusing efforts to eliminate unequal burdens in health and health care can strengthen existing solutions and policy formation related to this issue. Therefore, the purposes of this article are to (a) define disparities in health and health care, (b) describe current health disparities impacting ethnic/racial groups, (c) review historical factors associated with existing disparities in ethnic/racial groups and (d) present challenges and solutions to alleviate these disparities.

Definitions of Disparities in Health and Health Care

The four major ethnic/racial groups frequently cited in the literature and addressed in this article include, African Americans, Hispanics, Native Americans, and Asian Pacific Islander. Traditionally these four groups, together with immigrants, the poor, mentally ill, and mentally retarded, have experienced unequal treatment in health and health care reflected by high morbidity and mortality rates. While much has been written about health disparities between the four groups cited above and their white counterparts, African Americans represent the largest minority group and have experienced much discrimination in this country. As a result, more citations can be found in the literature about disparities and discrimination in this population group than for other ethnic/racial groups. This article mirrors that propensity, but also illuminates some disparities and issues associated with other ethnic and racial minorities and disenfranchised groups.

Disparities in health are defined as unequal burdens in disease morbidity and mortality rates experienced by ethnic/racial groups as compared to the dominant group (USDHHS,

2000). Causes of health disparities include poor education, health behaviors of the minority group, poverty (inadequate financial resources), and environmental factors (USDHHS). Most of these factors are access related. "Disparities in health care are defined as 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, Stith, & Nelson, 2002, p. 4). While disparities in health and health care can be inextricably tied to one another, distinguishing between these two definitions can help to focus the discussions and develop appropriate interventions.

Causes of disparities in health care relate to quality and include provider/patient relationships, health providers of the future, provider bias and discrimination, and patient variables such as mistrust of the health care system and refusal of treatment.

Current Health Disparities in Ethnic and Racial Groups

The most commonly reported health disparities are seen in cardiovascular disease, cancer, and diabetes.

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Other illnesses include cerebrovascular diseases, unintentional injuries, and HIV/AIDS. According to the former Surgeon General, David Satcher, (2000), mortality rates in heart disease are more than 40% higher in African Americans than for whites. The death rate for all cancers is 30% higher for African Americans in comparison to whites, with African American women experiencing a higher mortality rate from breast cancer than White women despite increased screening rates in this group. Prostate cancer is more than double in African American men compared with whites. HIV/AIDs for African Americans is more than seven times that for whites; and the rate of homicide is six times higher in African Americans than for whites (Satcher, 2000).

Other minorities experience similar results. For example, Hispanics in this country experience higher mortality rates in diabetes and are twice as likely to die from this disease as non-Hispanic Whites. Hispanics also have higher rates of hypertension and obesity in comparison to their white counterparts. American Indians and Alaska Natives also have a higher rate of diabetes, a rate that is more than twice as whites. Further, it is reported that American Indians have a life expectancy that is five years less than the national norm. Asian and Pacific Islanders, while viewed as one of the healthiest population groups, have great diversity within their population with regard to health outcomes. For example, the mortality rate for Vietnamese women with cervical cancer is five times than that for white women, and new cases of hepatitis and tuberculosis are higher in Asians and Pacific Islanders (Satcher, 2000).

Historical Overview

What historical perspectives are associated with racial-ethnic disparities in health and health care? Clearly, society's view of minority groups, enactment of civil rights' legislation, and health financing movements have played major roles. During the late 19th and at the turn of the 20th century, middle-class White Americans, imbued with the spirit of social Darwinism, tended to regard the lower classes, particularly recently arrived immigrants, as the "losers" in the struggle for survival. Poverty, sickness, disease, drunkenness, laziness and immorality were all identified at one time or another with different immigrants and ethnic/racial groups" (Jones, 1981, p. 21). Poor people regardless of their race were seen as always having poor health outcomes and suffering from a disproportionate number of illnesses and deaths (Jones). However, for African Americans, they were viewed as having earned their illness as just cause for their immoral lifestyle. By defining the health problem in racial terms, physicians absolved themselves of responsibility for what they saw as the "Negro deterioration" (Jones, p. 22).

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According to Smith (1999) at the beginning of the 20th century two major social transformations emerged that created unequal health care delivery systems: (a) development of facilities that provided advancements in medical and surgical services and payment of these services by middle and upper class citizens, and (b) enactment of Jim Crow laws that legally separated facilities for black and white communities. Many of these facilities also excluded minority physicians and nurses from practicing in these institutions, which led to the creation of all-black-operated institutions. Nevertheless, from these movements, ideologies and theories that predict and explain the inferiority of certain groups, such as immigrants, the poor, African Americans, and the mentally ill emerged and became a way of life (Smith, 1999).

Later movements, such as the passage of the civil rights bill, led to the integration of health care and other facilities. However, a major consequence of these actions resulted in the closure of many community-based, minority-operated health care facilities (Smedley, Stith, & Nelson, 2002; Smith, 1999). Closure of these facilities created a lack of access to care for minority clients. Minorities had to travel away from their communities to receive health care. As a result, receiving health care in predominantly majority settings led to exposure of a limited number of minority health physicians and nurses and culture-specific health services, such as lack of linguistic/interpretive services for those with English as a second language.

Meanwhile the 1965 Medicaid and Medicare legislation also created a restructuring of the health care delivery system (Smith, 1999). While minority hospitals were closing and moving their health care service sites to majority hospitals, those without health

insurance coverage were relegated to public institutions that served the indigent and impoverished (Smedley, Stith, & Nelson, 2002; Smith, 1999). Because private insurance coverage was associated with jobs and employment status, many minorities who were unemployed or in low paying jobs had to receive their health care from public institutions (Smith, 1999).

Lastly, the education of physicians, nurses, and allied health professions has profoundly shaped and influenced health care delivery in this country. Since physicians and nurses serve as the largest health care provider groups, they are the only ones cited herein. Currently, minority graduates from medical schools represent only 9% of the country physicians (Association of American Medical Colleges, 2000; Smedley et al., 2002). Within this 9 %, 33% are African Americans, 40.1% are Asian Americans, 24.9% are Hispanics, and 1.8% are Native Americans (Association of American Medical Colleges, 2000; Smedley et al., 2002). On the other hand 12.3 % of registered nurses have been documented as racial and ethnic minorities. This 12.3% includes African Americans (5%), Asian Americans (3.5%), Hispanics (2%), Native Americans (0.5%), and Native Hawaiian/Pacific Islander (0.2%). Others (1.2%) reported being of two or more racial backgrounds. Further, it has been reported that both minority nurse and physician provider groups tend to practice in their respective communities after completing medical and nursing school (Smedley et al., 2002)

The Challenges and Solutions

Existing solutions, such as assuring that all Americans have access to basic health care at affordable cost (USDHHS, 2000); promoting wellness and healthy lifestyles (Satcher, 2000); and addressing the determinants of health, especially those related to personal choices (behaviors) and the social environment (USDHHS, 2000) need heightened and continued dialogue. This next section will discuss the challenges of enhancing these solutions, along with the challenges of improving the quality of care given to minority groups, and the challenges of meeting the need for more minority care providers.

Access to affordable health care includes having health insurance, sufficient income to purchase health care, and a regular primary care provider (USDHHS, 2000). It has been reported that more than 44 million Americans (17% of the population) are without health insurance coverage, with this number rapidly escalating. "Health insurance provides access to health care. Persons with health insurance are more likely to have a primary care provider and to have received appropriate preventive care" (USDHHS, p. 45). Many minorities disproportionately receive their medical care in hospital emergency settings, care that is more costly than routine medical care (Smedley et al., 2002). Multiple visits to the emergency room suggest that minority groups may not have a medical home (primary care physician). Therefore, ensuring that all patients have medical homes, and creating prevention programs in the community that are affiliated and connected to a hospital or care giving institution may prove to be less costly to the patient as well as the local health care agency (Smedley et al.).

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Prevention, a major focus of the federal government and public health departments across the country, has gained national momentum. It has been documented that health education programs, expansion of disease control programs, and immunization programs offered in the first decades of the 20th century by public health facilities proved to be effective in reducing deaths from infectious diseases (National Institutes of Health [NIH], 2002). Recent evidence affirms the benefits of focusing on wellness and education programs related to chronic health conditions as an approach for increasing the public understanding in making the connection between health status and lifestyles in decreasing mortality and morbidity rates in minorities (Satcher, 2000). Satcher argues "the future health of America as a whole will be influenced substantially by the success in improving the health status of our racial and ethnic minorities" (Satcher, p. 4). He believes that eliminating disparities in ethnic and racial minorities is not only a public health problem, but a civil rights problem as well. That is, one cannot be fully successful by focusing on one area (public health) and ignoring the other (civil rights). Strengthening the infrastructure of communities and Public Health systems is an important step, he believes, in eliminating disparities. Following up on discriminatory practices by the U.S. Office of Civil Rights is also critical (Smedley et al., 2002).

Personal choices and the social environment, including interactions with family, friends, and the community are important factors to consider in eliminating disparities in the health of ethnic/racial minority groups (USDHHS, 2000).

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People can do much to improve their health status including eating a healthy diet with 5 daily fruits and vegetables, engaging in a regular exercise program to prevent obesity, assuring cardiovascular fitness, and aiming for a healthy weight (Hogue, 2000). There are other things people can do to build a healthy lifestyle, including getting involved in community activities. The social environment has a profound effect on individuals' health, including establishing safe places for exercise programs and creating violence-free neighborhoods and places to worship (USDHHS). Satcher (2000) believes that health is not only a personal matter; rather, it is a community problem as well. Communities can and should do more to help address the problems and benefits of healthy living for its citizenry (Satcher).

The quality of health services provided to minority groups remains a major challenge. There are several variables that impact the quality of care, including health care systems' variables such as health care services delivered to minorities, the quality of the patient-

provider relationship, health care providers of the future, health care provider prejudice or bias, and patient level variables, such as, mistrust of the system and refusal of treatment (Smedley et al., 2002).

According to a recent report by the Institute of Medicine (IOM) on Unequal Treatment (2002), "a large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are White Americans" (p. 3). The report cites studies such as Herhjolz et. al., (1996); Ayanian, Udvarhelyi, Gatsonis, Pashos, & Epstein, (1993); and Hannan et. al., (1999) that suggest that African Americans, and in some cases, Hispanics, are less likely to receive appropriate cardiac medication or to undergo coronary artery bypass surgery.

Further, the quality of the patient-provider relationship needs to be closely examined. Under the existing Managed Care system, many patients complain that their health care providers fail to provide complete information, are hurried in the provision of their care, and lack sufficient time to spend with them (Barlett, 1999). Other patients complain that doctors do not listen to their concerns and believe that this insensitivity is the result of racial bias and discrimination (Baldwin, 1996). Many physicians believe that they make decisions under time pressure with limited information and clinical uncertainty (Smedley et al., 2002). To strengthen doctor-provider relationships with ethnic/racial minorities, much research needs to be done on the quality of the interaction and the providers' awareness of disparities. This means that an examination needs to be done not only on the health care providers' competency (skill level), but also on their understanding of social, cultural and economic factors that impact the health status of their patients (Smedley et al.). Health care systems that create programs to help their providers and staff to become culturally competent and sensitive in the provision of care will be able to attract more diverse clients to their institutions. In return, their minority clients will be perhaps more satisfied with the care they receive. A recent study by Brand, Cronin, and Routledge (1997) showed that minority clients when judging the quality of health care they received, believed that quality was related to how satisfied they were with the interaction they had with their provider, rather than on the providers' skill or competency level.

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The decline in the number of underrepresented minority students in the health care field has reached alarming magnitude and atrocity. This reality "raises significant concerns regarding the ability of the health care workforce to address the nation' future heath service needs" (Smedley et al., 2002, p. 98). According to Smith (1997), ethnic and racial minorities are more likely to receive their health care from nonwhite providers. Leonard (2001) suggests that a lack of minority health care providers has a trickle down effect on the health care of ethnic and racial minorities. Given the fact that ethnic and racial minorities are already disproportionately impacted by morbidity and

mortality rates (USDHHS, 2000), receive a lower quality of health care than non minorities (Smedley et al.) and experience a lack of access to health care (Smith, 1997), these groups are at a greater risk for declining health due to the low numbers of minority health care providers (Leonard, 2001). "The belief that increasing the representation of racial/ethnic populations as doctors will provide increased access to health care for these same populations is supported by data on black physicians" (NIH, 2002, p.135). In fact, the federal government has designated several groups as underrepresented among physicians and other health care providers, and has offered incentives to increase representation based on the dual belief that health care providers belonging to ethnic/racial groups tend to locate in underserved areas and that they provide care to the underrepresented minority group they serve (NIH). Continuous recruitment and retention of ethnic and racial minorities in medical and nursing schools is greatly needed.

Health care provider prejudice or bias has been given little attention in relation to addressing disparities in ethnic/racial groups.

Discourse on provider bias has been silent in the health care literature. Medicine and nursing as predominantly white professions have failed to acknowledge the White domination inherent in and perpetuated by its research, clinical, and educational practices (Byrne, 2000; Feagin & Vera, 1995). The topics of discrimination, bias, or racism are forbidden and uncomfortable subjects for many people, and give rise to difficult dialogues because the topics challenge personal assumptions and conjure up the concepts of power and domination, differences, and the unknown (Baldwin & Nelms, 1993; Byrne). In a study conducted by Hogue and Hargraves (2000), "almost one-fourth of African Americans and one-sixth of Hispanics felt that they would have received better care if they had been of a difference race or ethnicity" (p. 14).

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Many minority patients mistrust the health care system and refuse treatments for various reasons, including dissatisfaction with the patient/provider relationship. In a study by Baldwin (1996), findings revealed that patients mistrusted the system because of the treatment they received once they arrived at the health care facility. For example, some patients felt doctors did not want to treat them or the doctor did not listen to them in terms of their chief complaint. Cooper-Patrick et al. (1999) noted that problems in communication due to cultural differences between patients and physicians often contribute to disparity in the understanding that patients and physicians have regarding the cause of disease and the effectiveness of available treatment. They reported that African American patients rated their visits as less participatory than whites, suggesting that African American patients desired more involvement in their care and preferred being an active consumer of care by participating in the decision making of their care. Harris, Mungai and Tierney (2000) argue that to achieve quality in health care from the patient’s perspective, the patient’s needs and expectations must be met, with success measured not only in improved health status but also in increased patient satisfaction with care.

Solutions to Health Care Disparity Through Research

Areas of research activity that can help eliminate disparities in health and health care include focusing research questions on minority health and collecting data to assess improvements in care. One goal of research in minority health is to increase health care providers' knowledge and be sensitive to minority culture so that they can effectively manage and treat diseases related to ethnic and racial minorities. Another goal is to also inform the development of policies and standards of practice from which all ethnic/racial groups can benefit (NIH, 2002). A research focus on diseases that impact ethnic and racial minorities disproportionately is needed in order to provide insight into ways in which to close the gap and eliminate unequal burdens in mortality and morbidity rates. Also needed are more studies that give voice to the client in the development of intervention strategies designed to improve the quality of care to minorities. Ethnic/racial diversity is evident when people of different ethnicities and various races are an integral part of that system with equal consideration given to them in the decision making process (Grant & Ladson-Billings, 1997). Historically ethnic/racial minorities have not had major demonstrative and significant input into the delivery of care that they receive. Therefore, those qualitative and quantitative studies that support the integration and analysis of cultural, psychological and economical influences in relation to health outcomes of minorities should prove beneficial.

Additionally, methods designed to measure the progress toward eliminating racial and ethnic disparities in health care are greatly needed (Smedley et al., 2002). A recent IOM (2002) report on unequal treatment experienced by ethnic and racial minorities in health care suggested that an important step in monitoring the nation's progress in eliminating racial and ethnic disparities is data collection and reporting of health care information by patient race and ethnicity. The report asserts that "such efforts will assist consumers and purchasers in making better informed choices about health plans, will help plans and providers to identify effective intervention strategies, and will identify practice settings where disparities occur and assist efforts to monitor compliance with civil right laws" (p. 189). The report also suggests that more research is needed on ethnic and racial minorities other than African-Americans (Smedley et al.).

Conclusion

In conclusion, health disparities have been around for more than two centuries. Evidence suggests that health disparities continue, with little progress made to eliminate them over time. Ethnic and racial disparities exist for multiple and complex reasons. However, new solutions are needed to resolve some of these old problems. Framing the debate and discussion around the distinctiveness related to disparities in health and health care is a necessary beginning for finding effective solutions to eliminate unequal burdens in health status. Finding effective solutions, organized around these definitions, is critical for the improvement of both the health of ethnic and racial minorities and the health of the nation.

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Internet Resouces

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NursingWorld

- Discrimination and Racism in Health Care: ANA Position Statement
  (Must log in to Members Only section of www.NursingWorld.org to view the position statement.)

- Diversity: A continuing challenge
  S. Trossman. The American Nurse, *January/February, 1998*
  Nursing Around the World: Cultural Values and Ethical Conflicts

R. Ludwick & M. Cipriano Silva, OJIN

- Cultural Diversity in Nursing Practice: ANA Position Statement
(Must log in to Members Only section of www.NursingWorld.org to view the position statement.)

- Rethinking the relationship between Nursing and Diversity: Creating a Culture of inclusion?
M. Gooden, C.Porter, R. Gonzalez, B.Mims, *The American Journal of Nursing (AJN)* Jan 2001 Vol 101(1)

Foundations/Organizations/Centers
Groups that promote diversity

- DiversityRx
Site developed to provide information about the importance of diversity in America and the health care setting. The site also includes models and practices for diversity in health care, policies in diversity in health care, legal issues related to diversity and resources for diversity resources.
Retrieved on January 30, 2003 from:
www.diversityrx.org
- DiversityWeb: Resource Hub for Higher Education
Center for practice and references about diversity in higher education.
Retrieved on January 30, 2003 from:
www.diversityweb.org/
- Sigma Theta Tau International: Diversity Resources
A diversity statement from the honor society of nursing, Sigma Theta Tau, as well as articles on diversity topics and diversity resources.
Retrieved on January 30, 2003 from:
www.nursingsociety.org/about/diversity.html
- Southern Regional Education Board: acial/Ethnic and Gender Diversity in Nursing Education
This site provides a summary of activities to increase diversity in nursing and nursing education specifically in the southern regions of the USA.
Retrieved on January 30, 2003 from:
www.sreb.org/programs/Nursing/publications/Diversity_in_Nursing.asp
- Cultural Competence
Site produced by the Center for Effective Collaboration and Practice to provide resources about cultural competence.
Retrieved on January 30, 2003 from:
http://cecp.air.org/cultural/default.htm
- Effective strategies for increasing diversity in nursing programs.
American Association of Colleges of Nursing (AACN) Issue Bulletin, December 2001

Retrieved on January 30, 2003 from:
www.aacn.nche.edu/Publications/issues/dec01.htm

- National Center for Cultural Competence (NCCC)
  The NCCC is a part of Georgetown University Center for Child and Human Development
  Retrieved on January 30, 2003 from:
  www.georgetown.edu/research/gucdc/nccc/faqs.html
- The Cross Cultural health Care Program
  The site addresses broad cultural issues and its impact on the health of individuals and families in ethnic minority communities nationwide.
  Retrieved on January 30, 2003 from:
  www.xculture.org
- Transcultural Nursing Society (TCNS)
  Website of TCNS with links to Dr. Leininger's Web Pages
  Retrieved on January 30, 2003 from:
  www.tcns.org/

Government Sites

Sites related to Governments of countries and their states/provinces

- US Department of Health and Human Services Health Resources and Services Administration (HRSA) Bureau of Health Profession
  The National Advisory Council on nurse education and practice presents issues related to racial/ethnic diversity in nursing education and practice in the USA.
  Retrieved on January 30, 2003 from:
  http://bhpr.hrsa.gov/nursing/nacnep/divrepex.htm
- Equal Employment Opportunities Commission (EEOC)
  The EEOC is the USA government equal employment law enforcement agency.
  Retrieved on January 30, 2003 from:
  www.eeoc.gov
- National Institute of Nursing Research Diversity Programs and Resources
  Opportunities, research, and resources related to diversity within research for the National Institute of Nursing Research.
  Retrieved on January 30, 2003 from:
  www.nih.gov/ninr/research/diversity.html
- Multicultural Health Resources
  Provides a variety of cultural and health links including fact sheets, guidelines, and assessments by Queensland government, Australia.
  Retrieved on January 30, 2003 from:
  www.health.qld.gov.au/hssb/cultdiv/cultdiv/home.htm
- The Office of Minority Health
  US Department of Health and Human Services (HHS) office that advises on public health program activities affecting American Indian and Alaska native, African American, Asian American and Pacific Islander and Hispanic populations.

Retrieved on January 30, 2003 from:
www.omhrc.gov

Commercial Sites
Business sites focused on diversity

- Cultural Diversity in the Health Care Field Jamarda Resources.Inc.
  The site specializes in providing educational products, resources and training for health care providers.
  Retrieved on January 30, 2003 from:
  www.jamardaresources.com
- Diversity and Health Care Resource Center
  The site helps to provide health care providers with access to information about culturally competent care and increases the effectiveness of diversity in the health care workplace.
  Retrieved on January 30, 2003 from:
  www.diversityresources.com/health.htm
- Workforce development Group/Diversity in Health Care: A Summary
  I. Lahiri & A Sedicum. The article is a summation of a thirteen part series that has examined the role of diversity in the health care industry.
  Retrieved on January 30, 2003 from:
  www.workforcedevelopmentgroup.com/news_eighteen.html
- **Minority Nurse**
  Resources about and for diversity in nursing. Information on how to access Minority Nurse Magazine.
  Retrieved on January 30, 2003 from:
  www.minoritynurse.com/
- IMDiversity?The HealthCare Industry Channel
  Links to diversity in health care and an online article
  Retrieved on January 30, 2003 from:
  www.imdiversity.com/Article_Detail.asp?Article_ID=8078

Other
Articles and information from a range of sources

- Diversity: Task Forces and Councils Foster Diversity Success
  L. M. Baytos.HR Magazine. October 1995
  This site contains selections from the book *Designing and Implementing Successful Diversity Programs*, co-published by Prentice-Hall and the Society for Human Resource.
  Retrieved on January 30, 2003 from:
  www.shrm.org/hrmagazine/articles/10diversity.html
- The Provider's Guide to Quality & Culture
  The site provides health care providers the ability to provide high quality, culturally competent services to multi-ethnic populations.
  Retrieved on January 30, 2003 from:

http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

- Transcultural Nursing: Basic Concepts & Case Studies
  The site provides information and testimonials on how to provide understanding on caring for people with diverse cultural backgrounds.
  Retrieved on January 30, 2003 from:
  www.culturediversity.org/index.html
- Transcultural and Multicultural Health Links
  Links created by E. Bosman at Indiana University
  Retrieved on January 30, 2003 from:
  www.iun.edu/~libemb/trannurs/trannurs.htm
- Transcultural C.A.R.E Associates
  Private consultation service by Dr. Campinha-Bacote. Has extensive reference list including links to web sites on culture.
  Retrieved on March 19, 2003 from:
  hwww.transculturalcare.net/