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Health Care Workers in Canada, the U.K., and the U.S. Report Racial and Ethnic Discrimination in the Health Care System

An ambulance crosses Westminster Bridge during a strike by junior doctors at St Thomas' Hospital in London, U.K., on Feb. 26, 2024. A recent study found that health care workers across the U.S., U.K., and Canada reported that patients of color most often received inferior care or treatment that was different from what white patients received. Photo: Jason Alden/Bloomberg via Getty Images

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TOPLINES

Across three countries, health care workers in the U.S., and primary care physicians in the U.K. and Canada, reported that patients of color received medical care inferior to what white patients received

To make access to care more equitable and to address the root causes of disparities, health workers say we need to reform how care is delivered, diversify the health care workforce, and improve education and training for physicians

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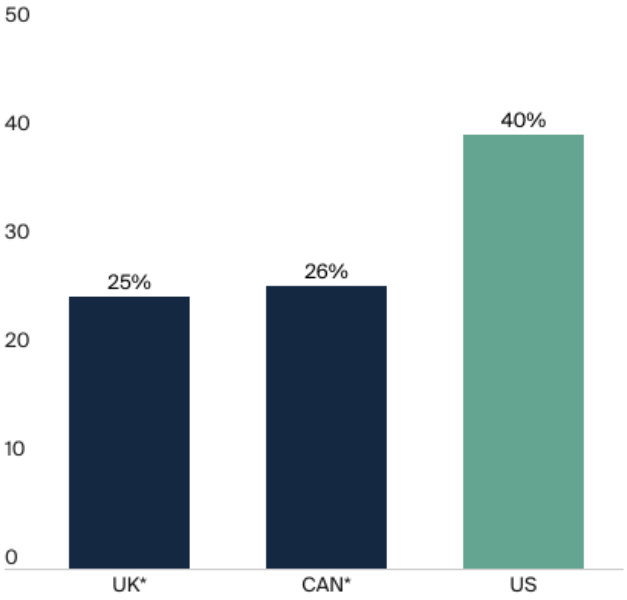
Revealing Disparities: Health Care Workers' Observations of Discrimination Against Patients

Racial and ethnic discrimination in health care settings contributes to poorer health outcomes in the United States and all over the world. In 2022, the Commonwealth Fund conducted two surveys, including qualitative components, to understand how U.S. health care workers view patient discrimination and explore potential solutions.

In the Commonwealth Fund's international survey of primary care physicians, up to 40 percent of physicians in the U.S. reported that the health system treats people differently based on their racial or ethnic background, compared to 26 percent and 25 percent in Canada and the United Kingdom, respectively. In the second survey, a collaboration with the African American Research Collaborative, health workers said racism against patients is a major problem or crisis.

Racial and ethnic discrimination in health care was reported to be highest in the United States.

Percentage of physicians who said the health care system treats people unfairly based on race or ethnic background "very often" or "often"



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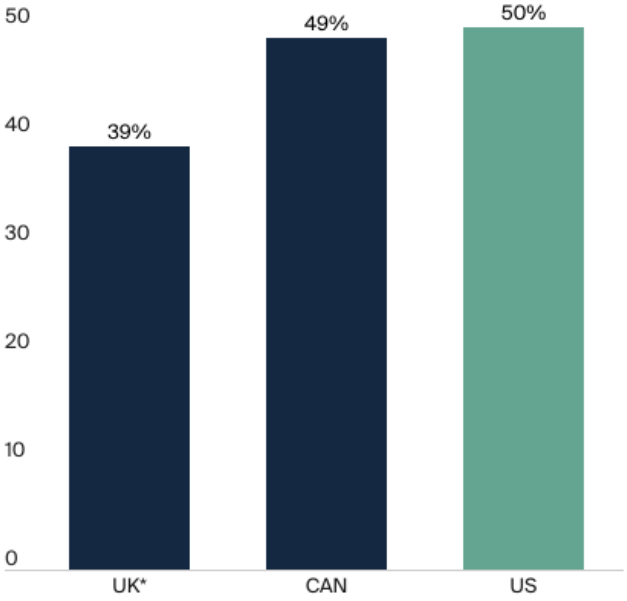
Percentage of physicians who responded "yes" when asked if their patients ever told them they felt they were treated unfairly, or their health concerns were not taken seriously, because of their race or ethnic background



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* Statistically significant differences compared to US at p<.05 level.

Note: Discrimination in the health system was defined as physicians who said the health care system "very often" or "often" treats people unfairly based on race or ethnicity or responded "yes" when asked if their patients have ever told them that because of their racial or ethnic background they felt they were treated unfairly or their health concerns were not taken as seriously by a health care professional.

Data: 2022 Commonwealth Fund International Health Policy Survey.

Source: Evan D. Gumas, Morenike Ayo-Vaughan, and Munira Z. Gunja, "Health Care Workers in Canada, the U.K., and the U.S. Report Racial and Ethnic Discrimination in the Health Care System," *To the Point* (blog), Commonwealth Fund, Jan. 27, 2025. https://doi.org/10.26099/vnmm-er89

The survey findings highlight that discrimination in health care is a common problem, but not a uniquely American phenomenon. However, the negative impact discrimination has on the health of Americans is exceptional, as evidenced by our wide disparities in health and health care by race.

What Does Racial and Ethnic Discrimination Look Like in the Health Care System?

Differences in Treatment

Across the U.S., U.K., and Canada, health care workers reported that patients of color most often received inferior care or treatment that was different from what white patients received. In the U.S., Black and Latino health care workers indicated that discrimination directly affects the quality of care provided to patients of color. Examples of mistreatment include patients of color being less likely to receive pain medication compared to white patients and experiences of long wait times in the emergency room compared to white patients.

Language and Cultural Differences

Language and cultural differences are key determinants of discrimination for non-English speakers across the three countries. Most U.S. health care workers confirm that speaking languages other than English may lead to different treatment from health care providers. Likewise, all physicians in the U.K. and Canada noted language being the largest reason for discrimination aside from race or ethnicity, while also noting that language and race and ethnicity are often intertwined.

Solutions from Health Care Workers

Delivery System Reforms

A reformed delivery system should focus on enhancing equitable access, reducing dependence on emergency services, and addressing the root causes of health disparities. Both U.S. and Canadian physicians highlighted historical racism's lasting effects on health care discrimination. A lack of trust in the system can cause missed diagnoses and preventable chronic disease progression.

In emergency room (ER) settings, where physicians noted decisions are made quickly, racial and ethnic biases can result in lower-quality care for some populations. In fact, 38 percent of U.S. health care workers reported witnessing care disparities due to racial or ethnic discrimination in these settings.

While there are also reports of racism in health care in both Canada and the U.K., their populations are guaranteed universal health coverage. Lack of universal coverage compounds these disparities in the U.S., where people of color and people from lower socioeconomic backgrounds are less likely to have comprehensive insurance. As a result, many are forced to seek care in ERs, placing them in environments where discrimination is more likely to occur. Addressing systemic issues that result in unequal treatment,

particularly for marginalized groups, should be paramount in reforming the health care delivery system.

Education and Training

Diversifying providers (in terms of race, ethnicity, language, cultural literacy, etc.) to reflect the populations they serve is key to building trust in communities. Across all three countries, health care workers indicated they preferred evidence-based trainings that account for real-life experiences and involve all personnel, from physicians to administrative staff. A diverse health care workforce has been shown to improve several aspects of care including patient access, experiences during care, and outcomes, particularly for patients of color.

Across both surveys, health care workers emphasized the need for medical, nursing, and other health professional schools to include courses on discrimination, race, and racism and to make them required for all students.

Changing the Culture

At the health system level, leaders can provide an easy way for patients and health care staff to anonymously report experiences of racism or discrimination. Health care organizations should regularly conduct comprehensive reviews of their policies and procedures to ensure they are oriented toward equitable health care outcomes for patients of color as well as equitable treatment of health care workers.

Additionally, health care workers emphasize the importance of top-down changes, including increased access to health care or universal health care.

HOW WE CONDUCTED THESE SURVEYS

International Health Policy Survey

The 2022 Commonwealth Fund International Health Policy Survey of Primary Care Physicians was administered to nationally representative samples of practicing primary care doctors in Australia, Canada, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, the United Kingdom, and the United States. These samples were drawn at random from government or private lists of primary care doctors in each country except France, where they were selected from publicly available lists of primary care physicians. Within each country, experts defined the physician specialties responsible for primary care, recognizing that roles, training, and scopes of practice vary

across countries. In all countries, general practitioners (GPs) and family physicians were included, with internists and pediatricians also sampled in Switzerland and the United States.

The questionnaire was designed with input from country experts and pretested in most countries. Pretest respondents provided feedback about question interpretation via semistructured cognitive interviews. SSRS, a survey research firm, worked with contractors in each country to survey doctors from February through September 2022; the field period ranged from eight to 31 weeks. Survey modes (mail, online, and telephone) were tailored based on each country's best practices for reaching physicians and maximizing response rates. Sample sizes ranged from 321 to 2,092, and response rates ranged from 6 percent to 40 percent. Across all countries, response rates were lower than in our 2019 survey. Final data were weighted to align with country benchmarks along key geographic and demographic dimensions.

SSRS coordinated 12 in-depth, follow-up interviews that were conducted by InsideOut Insights (IOI). These interviews followed up with primary care physicians in Canada, the U.K., and the U.S. who had answered that the health system "very often" or "often" treats people unfairly based on race or ethnicity or had answered "yes" when asked if their patients have ever told them that because of their racial or ethnic background they were treated unfairly or their health concerns were not taken as seriously by a health care professional when they completed the 2022 International Health Policy Survey.

U.S. Health Care Worker Survey

In partnership with the Commonwealth Fund, the African American Research Collaborative (AARC) conducted both qualitative and quantitative research. In November and December of 2022, AARC completed six focus groups with a total of 41 participants. The six groups comprised the following participants: community health clinic employees (n=8), hospital employees (n=8), Black health care workers (n=6), Latino health care workers (n=6), immigrant health care workers (n=6), and white health care workers (n=7). Participants in the race-, ethnicity-, and immigrant-specific focus groups were employed at the time in various health care workplaces, including private medical offices, outpatient facilities, hospitals, clinics, and dental offices. The hospital employees and community health clinic groups were racially and ethnically diverse. Participants were employed as nurses, administrators, mental health providers, medical technicians, pharmacists, primary care doctors, and specialist doctors. While there was not an Asian American–specific focus group, a total of six Asian Americans participated in the focus groups.

Topics explored in the focus groups included:

- participants' experiences with discrimination in health care settings
- impacts of racism and discrimination on patient outcomes
- whether existing systems may create disparate outcomes for patients of color
- impact of the COVID-19 pandemic on health care provision
- patient trust for health care institutions
- policies and procedures to mitigate discrimination in health care settings.

From March 14 to April 5, 2023, AARC fielded a survey of 3,000 health care workers. The survey oversampled Asian American and Pacific Islander (AAPI) health care workers (n=450), Black health care workers (n=549), and Latino health care workers (n=550). It also included a robust white health care workers sample (n=1,266). The remaining health care workers (n=185) identified as being part of another racial/ethnic group or did not identify their race or ethnicity. The blended phone and online survey has a margin of error of +/– 1.8 percent for the full sample. The margins of error for the Black and Latino samples are +/– 4.2 percent, for the AAPI sample is +/– 4.6 percent, and for the white sample is +/– 2.8 percent. Poststratification weights were implemented using a raking algorithm to balance the sample to the 2021 Census Bureau's American Community Survey estimates for gender, education, age, and race for health care workers.

An external advisory panel comprising experts and researchers from academic institutions, health care providers, and health care worker associations shared recommendations for the design of both the qualitative and quantitative research.

PUBLICATION DETAILS

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