Racial and Ethnic Disparities in Health Care

During the last half century, the health of the American population has generally improved. Since 1950, the overall infant mortality rate has declined from 29.2 per thousand to 7.1 per 1,000, while life expectancy has increased from 68.2 years to 76.7 years. Although these improvements cut across racial and ethnic groups, a marked gap remains between whites and minorities. Life expectancy among whites, for example, increased from 69.1 years to 77.3 years, while the improvement among blacks was from 60.8 years to 71.4 years.

Research shows that members of ethnic and racial minorities are less likely to receive routine medical procedures, suffer from more preventable conditions and tend to receive lower quality care compared to their non-Hispanic white counterparts. African Americans and Hispanics are also less likely to receive appropriate cardiac medications, undergo cardiac bypass surgery or receive hemodialysis and kidney transplantation and are more likely to receive lower quality clinical services, even when factors such as insurance status, age, income, comorbid conditions and symptomatology are taken into account.

Disparate Coverage

What contributes to this difference? Perhaps the most obvious link to disparate access is insurance coverage. Minority Americans are twice as likely to be uninsured as whites, with Latinos being the most likely to be uninsured (1 in 3 Latinos report they have no health insurance coverage). Adults without health insurance are less likely to receive appropriate preventive, chronic and acute care services and are more likely to have poorer health and die prematurely than are their insured counterparts. Research shows that uninsured patients with colon or breast cancer are 50 percent more likely to die than are their insured counterparts.

Although health insurance may alleviate the financial barriers to care, it does not address other individual and societal determinants of poor health and disparate care that are experienced by ethnic minorities and the economically disadvantaged—such as low literacy skills, health beliefs, life-style practices and environmental influences. Low educational attainment, poverty and economic hardship are associated with high rates of infectious diseases, chronic conditions, self-reported self-health, disability and lower life expectancy.

Disparate Process

Even at the same income and insurance levels, various groups experience a range of other barriers to care, including language, geography and cultural familiarity. Results from the Commonwealth Fund survey (see abstracts) show that African Americans, Asian Americans and Hispanics are more likely than whites to experience difficulties in communicating with their physicians and feel that they are treated with disrespect when receiving care. Moreover, minorities often believe that the quality of their care is compromised because of their racial status.

Federal and State Agendas

In 1984, the U.S. Department of Health and Human Services released a report on the health of the nation, concluding that major disparities existed “…in the burden of death and illness experienced by Blacks and other minority Americans” compared to the rest of the nation. In response, the Department of Health and Human Services, for the first time, established a task force to examine minority health problems. As a result of the task force findings, the Office of Minority Health was established to address minority health issues through a network of federal, state and territorial offices of minority health.

The Minority Health and Health Disparities Research and Education Act of 2000 created a new center on minority health at the National Institutes of Health and expanded research and demonstration projects at the Agency for Healthcare Research and Quality and the Health Resources and Services Administration. In addition, Healthy People 2010 includes the explicit goal of eliminating racial and ethnic disparities in health and access to health care by the year 2010, focusing on six targeted areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS, and immunizations.

Racial disparities recently have received renewed attention. State activities center on revitalizing offices of minority health, building programs to address disparities in the conditions identified in Healthy People 2010, and Medicaid contracting that addresses disparate outcomes. More details on these actions can be found in this digest in “On the Horizon” and “What Works.”
In The Abstract

The Insurance Gap and Minority Health Care, 1997-2001: Tracking Report No. 2

STUDY AND RESULTS: Researchers from the Center for Studying Health System Change (HSC) surveyed approximately 60,000 individuals in 33,000 families to determine the frequency of doctor visits in the past year and the presence of a regular health care provider. According to this study, “... gaps in access to medical care among working-age white Americans, African Americans and Latinos failed to improve between 1997 and 2001.” Two trends were evident: from 1997 to 2001, African Americans and Latinos have less access to health care than do whites, and uninsured minorities have more difficulty obtaining care than do uninsured whites. This report uses four measures to assess access among whites, blacks and Latinos:
· Presence of a regular health care provider,
· Visit to doctor in the last year,
· Access to specialists, and
· Use of emergency room for outpatient care.

WHAT'S IMPORTANT: The presence of health insurance was responsible for a large portion of disparities in access. Uninsured minorities earn less than uninsured whites, which suggests that income also is a factor. Rising costs of health care and prescription drugs may lead to a greater number of uninsured people. If disparities between those who are uninsured compared to those insured continues and insurance coverage declines, closing the gap may continue to be a challenge for policymakers.


LIMITED ENGLISH PROFICIENCY

What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency

STUDY AND RESULTS: This study is based on a survey of uninsured respondents who received health care at 23 primarily safety net hospitals in 16 U.S. cities. The report compares the perceptions and experiences of adults who needed and easily got an interpreter with those who needed and did not get an interpreter (or had difficulty getting one), and with other uninsured who did not need an interpreter. Overall, the uninsured who had access to an interpreter had similar or more positive experiences at the hospital than the uninsured who had no language barrier. Adults who needed and did not get an interpreter had more negative experiences at the hospital than those who did receive interpreter services or did not need them.

WHAT'S IMPORTANT: The study found that a significant portion of respondents who needed but did not get an interpreter reported leaving the hospital without understanding how to take prescribed medications. This suggests a need for improving oral and written communication about medication instructions for uninsured who have limited English proficiency. In addition, improving communication about financial information with non-English-speaking patients may benefit hospitals, as well as patients, by expanding hospitals' ability to collect some payment for services provided. Finally, the report suggests that states may want to take advantage of the federal Medicaid and SCHIP matching funds available to help health care institutions cover the cost of providing language assistance.


MENTAL HEALTH

Mental Health: Culture, Race, and Ethnicity (A Supplement to Mental Health: A Report of the Surgeon General)

STUDY AND RESULTS: The report, released in 2001 as a supplement to the Surgeon General's mental health report, focuses on the mental health of the four most recognized racial and ethnic minority groups in the United States—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans (Latinos). The supplement documents the existence of disparities affecting mental health care of racial and ethnic minorities compared with whites: minorities have less access to, and availability of, mental health services; minorities are less likely to receive needed mental health services; minorities in treatment often receive a poorer quality of mental health care; and minorities are underrepresented in mental health research.

WHAT'S IMPORTANT: The report recommends improving access to treatment through increased geographic availability of mental health services, improving language access, and integrating mental health and primary care. The report highlights common barriers to receiving mental health care, such as the cost of services, the fragmented organization of services, and the societal stigma toward mental illness. Other recommendations include expanding research on racial and ethnic minority mental health, supporting mental health professionals to develop their skills in addressing minority health care, and prevention of mental illness and promotion of mental health.


NATIVE AMERICAN HEALTH

Urban Indian Health

STUDY AND RESULTS: This issue brief describes the large and growing urban Indian population, their health status, and the major federal health programs and federal-state programs that are available to improve Native Americans' access to needed health services.

WHAT'S IMPORTANT: The majority of Native Americans in the United States live in American cities, not on reservations. However, federal health care policy largely focuses on the needs of those who live on reservations in rural areas. The report raises several important issues for policymakers to consider: the need for improved data on the health status of urban Indians and their access...
Quality innovations. The report further suggests that a combination of language training and multi-cultural interaction training would improve patient experience and health care outcomes.


Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care

**STUDY AND RESULTS:** This ground-breaking report cites extensive research showing disparities in treatment—and outcome—for a host of conditions, including heart disease, cancer and HIV infection. The report moves beyond documenting disparities to weigh explanations of the differences experienced after people enter the health system. The report highlights the critical importance of patient-physician interactions in disparities, focusing on the treatment of minority patients and the outcomes of care.

**WHAT’S IMPORTANT:** Although much of the documented disparity is associated with socioeconomic factors, persistent differences remain even after these are adjusted for. Patient-level and system-level remedies are recommended. The study emphasizes nurturing strong and sustained patient-provider relationships, and supporting objective clinical decision-making. The 21 recommendations address legal and policy protections, health system interventions to improve communication, trust and access; patient education and empowerment; cross-cultural education for providers; data collection and monitoring; and more research.


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**PHYSICIANS’ PERSPECTIVES**

National Survey of Physicians Part I: Doctors on Disparities in Medical Care

**STUDY AND RESULTS:** This survey, conducted from March through October 2001, is based on a sample of 2,608 physicians whose primary professional activity is direct patient care. The study presents data about the following topics: perspectives of physicians on disparities in the health care system; perspectives of physicians of different racial and ethnic backgrounds; female and male physician’s perspectives on disparities in the health care system; and treating gay and lesbian patients.

**WHAT’S IMPORTANT:** The majority of African American (77 percent) and Latino (52 percent) physicians polled say that unfair treatment based on race or ethnicity happens at least “somewhat often.” A majority of all physicians, regardless of race or gender, believe that racial disparities in care do exist in terms of access to treatment for heart disease and HIV/AIDS. The study found that female and male physicians express different perspectives on disparities in care, with female physicians more likely to believe that disparities happen “very often” or “somewhat often.” Overall, doctors are more likely to say that the health care system treats people unfairly “very often” or “somewhat often,” based on health insurance status than on any other factor.

**FIND THIS STUDY:** The Henry J. Kaiser Family Foundation (March 2002), National Survey of Physicians Part I: Doctors on Disparities in Medical Care, http://www.kff.org/content/2002/0020321a/Physician_SurveyPartI_disparities.pdf.

Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans

**STUDY AND RESULTS:** This study reports findings from the Commonwealth Fund 2001 Health Care Quality Survey. Researchers asked patients for their experiences with, and outcomes from, health care delivery in the United States. Results are broken down in the report by ethnic and racial group and into sub-groups such as national origin. The study finds some progress but notes continued gaps in how many minority group members receive care.

**WHAT’S IMPORTANT:** The study found that broad categories mask significant variation within Hispanic and Asian American communities. Three key concerns need to be addressed to reduce—and eventually eliminate—disparities in care: patient-doctor communication, cultural and linguistic barriers, and access to affordable health insurance. Other recommendations suggest changes in where care is given and the need for better continuity and more equal access to quality innovations. The report further suggests that a combination of language training and multi-cultural interaction training would improve patient experience and health care outcomes.

In regard to the elimination of racial and ethnic disparities in terms of health care access, of what accomplishments as surgeon general are you most proud? After we completed our report on oral health, pointing out the great disparities in access to oral health care that disproportionately affect African Americans and Hispanics, several states throughout the country have increased their Medicaid reimbursement to try to increase access. Congress is looking at the same thing.

The CDC now has funded 46 communities to develop models for improving or working to eliminate disparities in health care and access. Each community is different. For example, one community might be looking at infant mortality and therefore, it would be concerned about access to prenatal care. Flint, Michigan, is an example of that. A project in east Los Angeles is looking at diabetes in Hispanics. One of the real issues with diabetes is how early it’s diagnosed; also important is how well people get treated—how tightly their blood sugar is controlled. So, access is really critical for preventing the complications of diabetes—blindness in many cases, end stage renal disease, and, sometimes, a need for lower limb amputation.

I’m really pleased with the actions that have been taken in both the public and the private sectors to work toward eliminating disparities. Several foundations have made elimination of disparities their priority project. The Robert W. Johnson Foundation, Kellogg, Commonwealth and others are funding programs.

What do you think that state legislatures can do to be more active in decreasing disparities? First, I think that state legislators ought to become informed about disparities in their particular state and about what the major issues are in relation to those disparities. If you are in a state such as Minnesota or Oklahoma where you have more American Indians than many other states, you ought to be concerned with those disparities that especially affect native Americans. You should go beyond that and ask the question, “What are the barriers to American Indians getting access to quality health care?”

Sometimes you’re going to find that the barriers are financial; and other times you’re going to find that they are cultural. Hispanics often complain about people not speaking Spanish, and we need to get more people on the health care team that do that. We also need to look at the issue of culture because different cultures between providers and patients also can inhibit access to care. The bottom line is that state legislators are in a position to become informed about disparities and to fund programs that are geared to eliminating disparities, especially in the area of access. One good example is Medicaid reimbursement. If you look at the state of Georgia, I think it was a legislator who himself was a dentist, Dr. Jackson, who educated his colleagues and got them to support significantly increasing the reimbursement for Medicaid for dental healthcare and therefore providing access to many more children.

Do you think that, in this time of state budget crises, states can do anything to reduce disparities without increasing spending? I think that everything starts with education—[legislators] educating themselves and then educating their constituents about disparities. Just by educating people, you can go a long way toward improving access. All the barriers to access are not in the system; some of them are in the people. Not just cultural—some people aren’t informed. Some people aren’t inspired. Some people aren’t trusting of the health system. So there are a lot of things that you can do to mobilize people to improve their own health.

I think that one of the major weaknesses of the health system in this country—and one that disproportionately affects minorities—is a lack of emphasis on health promotion and disease prevention. We need to put more emphasis on that. We need to put out more resources. The first step is educating people about the importance of regular physical activity, eating at least five servings of fruits and vegetables per day, responsible sexual behavior, avoiding toxins like tobacco, and so forth.

We spend $120 billion a year in this country to treat the consequences of obesity. If we were to embark upon programs to get people to be more physically active and to eat right, in time—and it’s not going to be right away—we are going to see the results of that in terms of reduced costs. Perhaps the most important thing, however, is not the reduced costs, but the fact that it is one way of eliminating unnecessary pain and suffering.

Are there any parting words or wisdom that you would like to impart to state legislators? Access to health care is a very important issue, but beyond access is the quality of care that people receive once they have access. Someone needs to be paying attention to that. Someone needs to be paying attention to lifestyles in the community. Someone needs to be working with the schools and the communities to make sure that there are places for people to be physically active. It really pays off in the long run.

Someone ought to be concerned about environmental quality and the reason that so many of our children are getting asthma. Why is asthma increasing, especially in the inner city? Someone needs to be working to support research in other things. There is no excuse for children being exposed to high lead levels in the home or in the community. So someone ought to be paying attention to that. We need research in all those areas and programs. I hope that we will take a balanced approach to eliminating disparities in health. If so, we can be successful.
Officials with the structure development grants. federal Office of Minority Health State Partnership Initiative infra-
states are enhancing their ability to collect and distribute data using
conditions, states cannot pinpoint interventions, justify expendi-
Without baseline and follow-up data on racial and ethnic health
Data Collection
access, cultural competence, and diversified health professions.

 Officials with the Ohio Commission on Minority Health partnered
with the National Council of La Raza, state agencies and commu-
nity organizations to develop the first demographic overview of
Ohio's Latino population—everything from history and heritage to
educational attainment and health status.

 South Carolina's Budget and Control Board linked data from state
agencies and the private sector to create a fuller picture of various
populations served in the state. The board's Office of Research and
Statistics linked Medicaid edicaid, child care vouchers, education,
welfare, vocational rehabilitation, mental health services, motor
vehicle crashes, juvenile justice, private inpatient hospitalizations,
emergency room visits and admissions, home health visits, and other
services. The data system uses unique person numbers rather than
personal identifiers to ensure confidentiality.

Linguistic Access
According to the 2000 census, more than 20 million people living
in the United States are less fluent in English. Many rely on
family and friends to act as medical interpreters—a situation that
compromises patient confidentiality, hinders the physician-patient
bond, and may result in incomplete or inaccurate patient care
instructions. Brandeis University researchers who surveyed more
than 4,000 uninsured people with limited English language profi-
ciency found that 27 percent of those who needed but did not get
an interpreter did not know how to take their prescribed medica-
tion. Despite the need, only five states (Hawaii, Maine, Minnesota,
Utah and Washington) use available federal Medicaid and SCHIP
matching funds to assist health care institutions with the cost of
providing interpreter services, according to the Brandeis report.

The Forum for State Health Policy Leadership

Continued Inside
On The Horizon

All differences in such conditions as cancer, diabetes and infant mortality will not be eliminated before the Healthy People 2010 deadline for zero disparities. Nonetheless, new insights are leading to new approaches. In the future, expect more nuanced understanding of groups, more focus on providers' roles in disparate access, attention to program design, and a view of disparity as a sign of poor quality.

- Whose disparities?
  Past studies of disparity focused on shortfalls in access and outcomes for African Americans and Hispanics. Census codes lump professionals with advanced degrees with non-literate refugees.
  Today, newcomers from all corners of the globe confront a range of medical problems and linguistic and cultural barriers to care.
  Recent research has highlighted important differences within census categories—such as "Hispanic" and "Asian"—while market research has produced tools for pinpointing messages. Even with detail about subgroups, states have difficulty using national data to understand challenges to access that face specific groups, such as tribal entities and refugee communities. In the future, expect more carefully targeted programs that take into account health, linguistic and cultural needs of affected groups, including medical translation and innovative culturally congruent outreach—promotora programs, for example.

- The provider matters.
  The IOM report, Unequal Treatment, and recent studies from Kaiser and Commonwealth highlight the critical importance of patient-physician interactions in disparities (see "In the Abstract"). Patients' and providers' expectations, uncertainty and failure to communicate hurt the quality of care; stereotyping and bias lead to poorer outcomes. As the health care community absorbs the lessons and recommendations of these studies, look for a renewed emphasis on recruiting and training minority providers and more training for all practitioners on cultural competence, bias and the need to communicate effectively across racial, ethnic and other group membership.

- Design in equity.
  The studies point out that health care disparities are part of a broader societal context of discrimination and persistent inequality that drive a cycle of poverty, low expectations and poor health. A health system that makes poorer patients deal with a fragmented system and episodic care undercuts efforts by individual providers to build rapport with their patients. Reducing disparities requires strategies that compensate for—or at least do not worsen—the effects of poverty, poor education and diminished access. One recommendation: changes in reimbursement and provider incentives should not fall the hardest on the poorest groups. This will be a challenge to states that are struggling with budget and Medicaid shortfalls.

- Quality of fairness.
  Expect more accountability at every level for differences in care. Health plans can combat disparities if they have incentives and information; quality activities and problem solving can find and address differences in the rates at which various groups receive appropriate care. The Agency for Healthcare Research and Quality (AHRQ) is measuring racial disparity as part of a national health care quality report. More Medicaid and Medicare plans may accept the invitation to benchmark progress in eliminating disparities as part of their quality assurance activity as data become available from state agencies and civil rights liability concerns are addressed.

Digging Deeper

The National Conference of State Legislatures (NCSL) co-sponsors DiversityRx, http://www.diversityrx.org, a Web site that deals with cultural competence issues in health.

The Association of State and Territorial Health Officials (ASTHO) (http://www.astho.org/access/documents.html), A Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health offers information about federal, state and local programs that address health care disparities, including provider training and preventive care.

The National Health Law Program (NHeLP) (http://www.healthlaw.org/race.shtml) has links to a number of publications on immigrant health, cultural/lingual access, and health disparities.
