Chapter 10: Disparities

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Disparities in health care between whites and racial and ethnic minorities have persisted for decades, despite the earnest efforts of health services professionals, governments and non-government groups.

But a growing focus on the problem of racial and ethnic health care disparities offers promise that solutions do indeed exist.

About one-third of Americans identify themselves as racial and ethnic minorities.[1] This number is expected to climb to more than half of the population by 2042.[2]

Disparities between the care that racial and ethnic minorities receive and the care received by whites have been well documented for years, but the causes and solutions are harder to determine.

The annual National Healthcare Disparities Report (NHDR), published by the federal Agency for Healthcare Research and Quality, has consistently shown that blacks and Latinos suffer from poorer quality of care and worse access to care than whites on a number of indicators.[3,4,5] Yet, there is reason for hope that for some minorities, disparities are lessening. (See charts, "Core Quality Measures Improving vs. Worsening for Selected Groups as Compared to Whites" and "Core Access Measures Improving vs. Worsening for Selected Groups as Compared to Whites.")

CAUSES OF DISPARITIES

Disparities are attributed to a number of factors. Where a person lives, what language she speaks, and her household income are only some of the characteristics that can contribute to differences in the way different racial and ethnic minorities receive care.

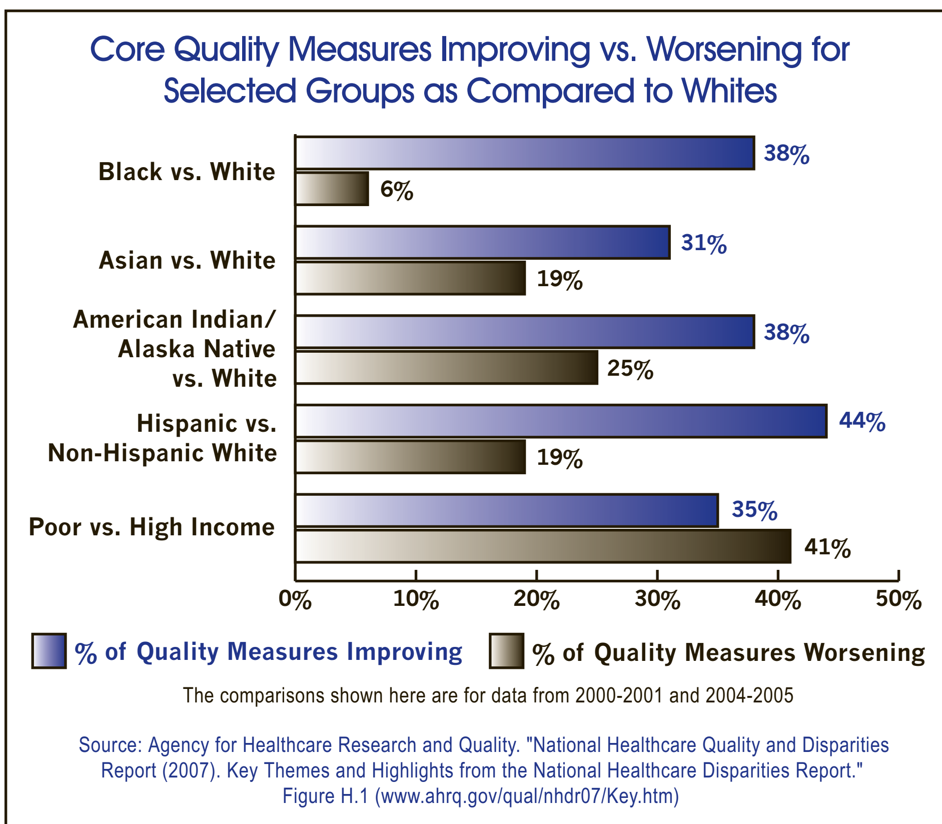
WHERE YOU GET YOUR CARE

While research suggests that some providers treat racial and ethnic minorities differently than whites, there is growing evidence that some disparities are largely the result of where minorities receive care. One study looked at 123 teaching hospitals and found clear disparities in the treatment of minorities. When the researchers dug deeper, they concluded that "an underlying cause of disparities may be that minority patients are more likely to receive care in lower performing hospitals."[6] Another study found that black Medicare beneficiaries are 35 percent more likely than whites to be admitted to hospitals with high mortality rates.[7]

For story ideas on disparities, see page 113. A list of experts and websites begins on page 114.

FAST FACTS

- About one-third of Americans identify themselves as racial and ethnic minorities. This number is expected to climb to more than half of the population by 2042.[a]
- The annual National Healthcare Disparities Report (NHDR), published by the federal Agency for Healthcare Quality and Research, has consistently shown that blacks and Latinos suffer from poorer quality of care and worse access to care than whites on a number of indicators.[b]
- People with higher degrees of education, income or occupational status tend to have better health status than others.[c] Blacks and Hispanics have lower income and less education on average than do whites.[d] One study showed that gains in life expectancy between 1981 and 2000 occurred almost exclusively among those with at least some college.
- The Office of Management and Budget determines basic racial and ethnic categories for federal statistics and programs.[e]



In other words, patients at a particular hospital were treated similarly, regardless of race. But minority patients were more likely than whites to go to hospitals that may have been short-staffed, had inadequate budgets or a lack of technical support. (See text box, "Variations by Race and by Place.")

Supporting this view, another study looking at hospital inpatient discharge data from 13 states found that blacks, Hispanics and Asians received the same standard of care as whites within the same hospitals.[8]

Nonetheless, some researchers believe physician behavior can contribute to disparities.[9] Studies have found evidence of racial bias in the treatment of patients in cardiac care, for example.[10]

Housing segregation between minorities and whites is a major contributor to disparities. For minorities, this leads to reduced opportunities for socioeconomic advancement, negative health behaviors, and more exposure to environmental hazards and segregated health care settings. Socioeconomic status does not completely account for housing segregation; blacks and Latinos have more limited choices of neighborhoods because of housing discrimination.[11]

LANGUAGE ACCESS BARRIERS

Linguistic and cultural barriers are another significant impediment to health care for those who don't speak English well, or at all. Title VI of the Civil Rights Act provides that any organization receiving federal funding must ensure that individuals with limited English proficiency have access to the organization's programs and services.

In 2000, the Department of Health and Human Services Office for Civil Rights issued "Standards for Culturally and Linguistically Appropriate Services." Four of the 14 standards are requirements for all recipients of federal funds, including this standard: "Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."[12]

But language services are underfunded compared to the need. Safety net providers serving linguistic minorities must deal with a host of challenges related to language, including lack of capable interpreters, problems in making referrals to specialists, and a lack of needed forms and patient education materials in the patient's language.[13]

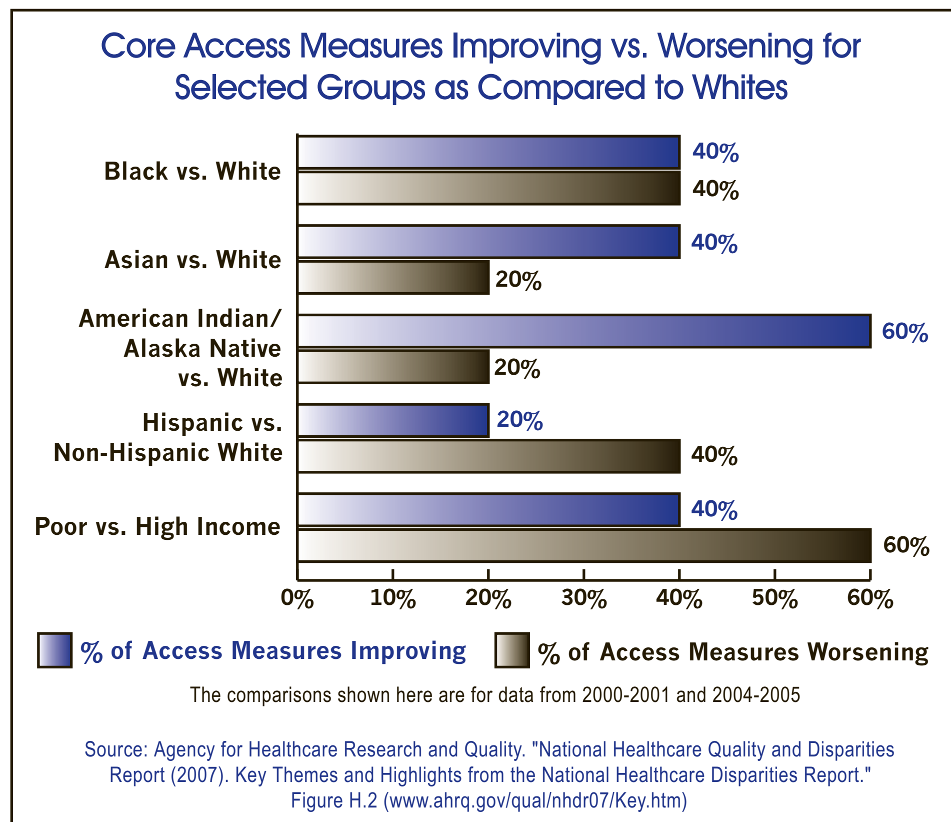
SOCIOECONOMIC STATUS

In addition to race and ethnicity, other factors contribute to disparities in care. Research demonstrates a positive correlation between socioeconomic status (SES) and health status. Those with higher income, education or occupational status tend to have better health status than others.[14] And blacks and Hispanics on average have lower income and less education than do whites.[15] (For a notable exception to this trend, see text box,

"Hispanic Epidemiological Paradox.")

One study showed that gains in life expectancy between 1981 and 2000 occurred mostly among those with at least some college. Life expectancy for those with less education largely stayed the same.[16]

Differences in health habits between the highly educated and the less educated is another factor that contributes to health disparities. Smoking and obesity, two health risks that often lead to higher incidence of disease and earlier death, are more common among groups with only a high school education or less.[17]



Another factor in racial disparities may be access to a "medical home," an approach to care in which patients are assigned to a physician or other primary care provider who is in charge of coordinating care among the many physicians and specialists that a patient might see.

In a 2007 study, “Closing the Divide: How Medical Homes Promote Equity in Health Care”, The Commonwealth Fund found that minorities with medical homes experienced no disparities in receiving preventive care reminders.[18] Congress may consider adopting policies that encourage practitioners to adopt this model of care, such as payment reforms that reward primary care providers for care coordination.

LIKELY POLICY DEBATES

DATA COLLECTION

Those hoping to reduce racial and ethnic health care disparities depend on accurate data to help them identify specific problems and subgroups facing them. Toward this end, there have been some efforts to standardize the way race and ethnicity data are collected. The Office of Management and Budget, for example, has determined basic racial and ethnic categories for federal statistics and programs.[19]

Despite this determination, federal programs face many barriers in obtaining this type of information. Medicaid, a joint state and federal program, must rely on states for race and ethnicity data, but states vary in the ability of their information systems to collect race and ethnicity data. States tend to collect the data from enrollees on a voluntary basis, often offering a limited number of them. As a result, the data are often incomplete.[20]

At the hospital level, research suggests that there are gaps in the collection and standardization of race and ethnicity data across hospitals.[21] Congress may well consider ways to improve the collection of race and ethnicity data as a first step in solving the problem of disparities.

Health information technology may be one avenue for improving the standardization of data on race, ethnicity and language data. Standardized use of electronic health records systems to capture patient data related to race, ethnicity and language could dramatically enhance the ability to identify and

Variations by Race and Place

The Robert Wood Johnson Foundation's Aligning Forces for Quality program recently commissioned a special report by the Dartmouth Atlas Project (DAP) looking at racial disparities. DAP draws on Medicare data to look at patterns of use for specific health care services. DAP research is famous for documenting wide regional variations in use of services, highlighting issues of efficiency and effectiveness in our health care system.[1]

DAP's Aligning Forces for Quality research illustrates how where a person lives has an impact on the quality of care received. For many measures, there was greater variation by region than by race. And on some measures, blacks received care that was equal to or better than whites received.

But the data showed significant differences by race in addition to region in whether patients lost a leg to amputation, a complication of peripheral vascular disease and diabetes. African Americans lost legs to amputations at a rate nearly five times that of whites - 4.17 per 1,000 African-American Medicare beneficiaries, compared to 0.88 per 1,000 white Medicare beneficiaries. In Louisiana, the state with the highest rate of amputations, 1.66 of every 1,000 beneficiaries lost a leg to amputation in 2003-2005, compared to the national average of 1.14. Utah fared best - 0.50 per 1,000 beneficiaries.[2]

The DAP researchers speculate that factors outside the health care system such as poverty, limited health literacy and poor housing may account for the dramatic racial disparity in amputations.[3] So while where you get care is one significant cause of disparities, who you are and the environment you live in also affects the type of care you receive.

1 The Dartmouth Atlas of Health Care. (http://www.dartmouthatlas.org/).
2 Robert Wood Johnson (2008). Robert Wood Johnson Foundation Announces $300 million Commitment to Dramatically Improve Quality of U.S. Health Care. Press Release. (http://www.rwjf.org/files/research/nationalpressrelease.pdf).
3 Dartmouth Atlas Project on Health Care. "Frequently Asked Questions." (http://www.dartmouthatlas.org/af4q/AF4Q_FAQ.pdf).

monitor care disparities.

The American Recovery and Reinvestment Act signed into law by President Obama in February 2009 includes language to ensure that data are collected on race, ethnicity and primary language.[22] There are also actions that the Health and Human Services Department's Office of Civil Rights can take to create incentives for voluntary collection of race and ethnicity data to clarify that these data may be collected by private parties without running afoul of civil rights laws.[23]

MEDICARE PROVIDER PAYMENTS

Congress may consider moving Medicare provider payment increasingly from volume-based to value-based payment. While such a payment change is likely critical in order to promote sustainable high quality care, some researchers think these kinds of payment reforms could inadvertently aggravate disparities by reducing income to providers in minority communities.[24]

This problem might be addressed by implementing payment strategies that reward physicians both for improvement over time as well as for their absolute quality scores. Provider payments could take into account poorer health status in minority communities and reward providers for reduction of disparities.[25]

OTHER LEGISLATIVE APPROACHES

Congress may also choose to address the issue of disparities directly through comprehensive legislation. A number of such bills were introduced in the 110th Congress. Among them, the Minority Health Improvement and Health Disparity Elimination Act (S. 1576) introduced by Sen. Edward Kennedy (D-MA) would fund grants to increase the number of minority health professionals, support demonstration projects designed to improve health care of racial minorities, and fund research to improve the health of racial and ethnic minorities.

H.R. 3014, supported by the Congressional Black Caucus, had provisions similar to the Senate bill, and would also ensure Medicaid coverage for the children of low-income legal immigrants.

Of course, the congressional legislative agenda will undoubtedly be influenced by the priorities of President Obama, who campaigned on a number of general quality issues that could affect racial and ethnic disparities, such as improved health IT systems that may allow for better collection of disparities data and improved chronic disease management programs. Directly or indirectly, the issue of health disparities will surely be touched on in some fashion in the coming year.

HISPANIC EPIDEMIOLOGICAL PARADOX

One notable exception to the positive relationship between health status and socioeconomic status is the so-called "Hispanic Paradox." Despite higher poverty rates, less education, and less access to health care, the health and mortality outcomes of many Hispanics presently living in the United States are equal to, or better than, those of non-Hispanic whites.[1,2] For example, Hispanics have lower cardiovascular mortality despite increased prevalence of diabetes and obesity.[3] Theories to explain this phenomenon include: (1) new immigrants retain healthier habits from their native country [4] (for example, smoking, obesity and excessive alcohol consumption in Mexico are more prevalent among higher-income people than lower-income);[5] (2) Latinos may return to their country of birth after temporary employment, retirement, or becoming seriously ill, showing the desire to die in one's birthplace and removing them from U.S. statistics; [6] or (3) individuals who have the health, motivation, and resources to migrate for work are in better general health than non-migrant counterparts.[7] There isn't sufficient evidence to validate these theories at this time. Despite the label, the "Hispanic Paradox" may occur with non-Hispanic immigrants as well.[8]

[1] Franzini, L., Ribble, J., Keddie, A. (2001). "Understanding the Hispanic Paradox." Ethnic Disparities. 11(3): 496-518.

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TIPS FOR REPORTERS

- Look at state health care reform efforts to see whether and how they are addressing the issue of disparities.
- Don't overlook private sector activities around the issues of disparities. What are health plans doing to collect and analyze data on race and ethnicity, and how are they using these data to reduce disparities? What are private hospital systems and physician groups doing to address the issue of disparities?
- Monitor how racial and ethnic groups are categorized as the population becomes increasingly more diverse and as intermarriage between racial groups become more common. Are federal programs, state administered programs, health plans, hospitals and physicians adapting to demographic changes appropriately in their approach to disparities?
- Consider whether successful quality improvement strategies are being adopted by providers that serve minority populations? Are community health centers and public hospitals able to adopt IT systems that enable better quality improvement and care coordination?
- If you'd like to write stories about health disparities but your editor is less than enthusiastic, point him or her to a March 2009 survey by the Kaiser Family Foundation and the Association of Health Care Journalists (AHCJ). Among AHCJ members responding, 69 percent said U.S. news media in general give too little coverage to health disparities. In contrast, 52 percent said there's too much coverage of consumer/lifestyle health. You can see the survey and a webcast of its release at www.healthjournalism.org/blog/2009/03/report-survey-look-at-health-care-journalism.

STORY IDEAS

- How do health care reform proposals aim to reduce disparities? What kind of access and quality measures do they contain?
- Disparities and immigration - what are the effects of federal immigration reforms? Will tighter restrictions increase disparities? Would

loosening restrictions on access to federal health programs for children decrease disparities?

- Disparities and the economic downturn - how will minorities fare in the face of an economic downturn? What happens to the safety net providers (e.g., public hospitals and community health centers) where minorities often receive care? What happens to those who gain insurance in a downturn as they become poor enough to qualify for Medicaid?

- Take a look at the annual National Healthcare Disparities Report put out by the Agency for Healthcare Research and Quality (www.ahrq.gov) and see how the data compare with those of previous years. The report usually comes out in February or March.

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Websites

Agency for Healthcare Research and Quality
www.ahrq.gov/research/mentalix.htm

Alliance for Health Reform
www.allhealth.org

Alliance of Community Health Plans
www.achp.org

American Academy of Pediatrics
www.aap.org

American College of Physicians
www.acponline.org

American Medical Association
www.ama-assn.org

America's Health Insurance Plans
www.ahip.org

Asian and Pacific Islander American Health Forum
www.apiahf.org

Asian Health Services
www.ahschc.org

Black Women's Health Imperative
www.blackwomenshealth.org

Catholic Health Association
www.chausa.org

Center for Health Care Strategies
www.chcs.org

Center on Budget and Policy Priorities
www.cbpp.org

Centers for Medicare and Medicaid Services
www.cms.hhs.gov

Congressional Black Caucus Foundation
www.cbcfinc.org

Cross Cultural Training, White Memorial Medical Center
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Dartmouth College Dept. of Economics
www.dartmouth.edu/~economic

DHHS Office of Minority Health
www.omhrc.gov

Federation of American Hospitals
www.fah.org

George Washington University Department of Health Policy
www.gwhealthpolicy.org

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www.law.georgetown.edu

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www.son.jhmi.edu

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The Commonwealth Fund
www.commonwealthfund.org

UnitedHealth Group
www.unitedhealthgroup.com

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www.sph.uth.tmc.edu

University of Maryland Dept. of Women's Studies
www.womensstudies.umd.edu

University of Maryland School of Medicine Dept. of Epidemiology and Preventive Medicine
www.medschool.umaryland.edu/Epidemiology/

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www.wellpoint.com

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ENDNOTES

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c Kimbro, Rachel Tolbert; Bzostek, Sharon; Goldman, Noreen; Rodríguez, Germán (2008). "Race, Ethnicity, and the Education Gradient in Health." Health Affairs, March/April, p. 361. (www.healthaffairs.org).

d The Commonwealth Fund, Racial and Ethnic Disparities in U.S. Health Care: A Chartbook, charts 2-3, 2_4 and 2-6.

e Federal Register Notice, October 30 1997 Office of Management and Budget and Office of Management and Budget Directive No. 15.

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2 U.S. Census Bureau (2008). "An Older and More Diverse Nation by Midcentury." News release, Aug. 14. (www.census.gov/Press-Release/www/releases/archives/population/012496.html).

3 There is no apparent consensus about the appropriate use of the term "Latino" vs. "Hispanic." The U.S. Census Bureau uses questions on Hispanic origin that ask correspondents if they are "Spanish, Hispanic or Latino." The terms are used interchangeably in this chapter.

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