

Racial and Ethnic Disparities in Health Care

November 2006



ALLIANCE FOR
HEALTH REFORM

The Agency for Health Care Research and Quality will soon release its annual report on racial and ethnic disparities in health care. In the three years since that report first appeared, there has been some slow improvement in some areas for some ethnic groups. But there is still troubling evidence that racial and ethnic disparities still pervade health care in the U.S. despite many efforts to reduce them—by government bodies, private foundations and grassroots organizations. (See chart, “Percent of Americans Who Believe Minorities Receive Worse Care.”)

Where We've Been

Health care in the U.S. may be the best in the world for many Americans, but certainly not for all.

African-Americans, Latinos and other racial and ethnic minorities in the U.S. often receive a lower quality of care than do their white counterparts, especially for more complicated procedures. This is true even when minorities have health insurance and are of the same social class as whites.

Disparities are apparent for many clinical conditions and in many settings. For example, African-Americans with heart problems are referred less frequently than whites for catheterization and bypass grafting. In cases of bone fractures and cancer, African-Americans and Latinos get prescriptions for pain control less often than whites.

Surgery for lung cancer is performed less frequently for African-Americans than for whites. African-Americans with end-stage renal (kidney) disease receive fewer referrals for transplant than whites. The medical literature suggests that African-Americans receive lower quality care than whites when hospitalized for pneumonia and congestive heart failure. The literature also shows lower use by African-Americans of services covered by

Medicare, including immunizations and mammograms than for whites.

In analyzing this evidence, a 2002 report by the federally chartered Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care*, concluded that racial and ethnic disparities in health care don't occur in isolation. They are part of the broader social and economic inequality experienced by minorities in many sectors of American life.

Many parts of the system—including health plans, health care providers and patients—may contribute to racial and ethnic disparities in health care.

Some examples include:

- ▲ **Lack of Health Coverage**
Minorities are far more likely to be uninsured than whites.
- ▲ **Too few minority providers**
Minorities are underrepresented in health care professions.
- ▲ **Inadequate provider qualifications and clinical resources**
Physicians who treat black patients are less likely to be board certified than are physicians who treat white patients. In addition, physicians treating black patients report greater difficulties in securing access for them to high-quality subspecialists, high-quality diagnostic imaging and nonemergency hospital admissions.
- ▲ **Communication difficulties**
Many minority patients experience difficulties in communicating with their health care providers.
- ▲ **Geography**
Minority communities often have fewer sources of health care than white communities, or none at all.

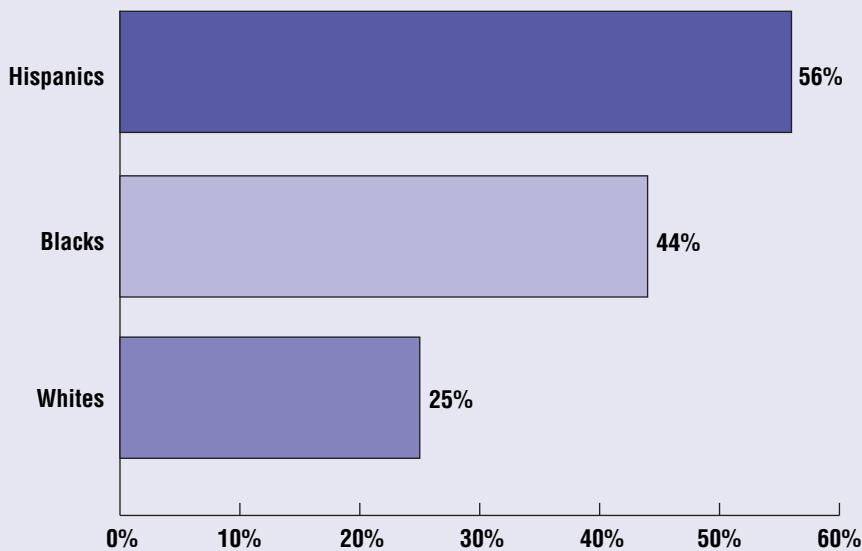
Other possible explanations for disparities include health practices among minor-

Fast Facts

- ▲ By the year 2050, people from minority populations are expected to represent nearly half of the U.S. population.
- ▲ Even when they have insurance and are of the same social class, minorities often receive a lower quality of care than do their white counterparts.
- ▲ A Robert Wood Johnson Foundation survey found that 54 percent of health plans now either ask members to provide their race voluntarily on enrollment, or use indirect methods to obtain aggregate data on race.
- ▲ While some progress has been made in eliminating disparities in primary care, according to recent studies, little progress has been made in addressing racial and ethnic disparities in cardiovascular procedures and other serious surgical procedures.
- ▲ The 2005 National Healthcare Disparities Report found that over time, more of the types of disparities in quality of care experienced by African Americans were narrowing than widening. The converse is true for Latinos.
- ▲ A majority of Americans are unaware that racial and ethnic minorities receive poorer care than whites do.

The Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, held a briefing to explore the latest information on racial and ethnic disparities in health and health care. This issue brief is largely derived from information presented at that briefing.

Percent of Americans Who Believe Minorities Receive Worse Care



SOURCE: Robert Wood Johnson Foundation (2005). "Americans' Views of Disparities in Health Care." December 9, p.1 and Table 1. (www.rwjf.org/files/research/Disparities_Survey_Report.pdf)

ity communities (such as a preference for home remedies or folk medicine), psychosocial stress and risk-increasing environmental exposures.

Where We Are

The latest data on health care disparities facing minorities come from the 2005 *National Healthcare Disparities Report*, released by the Agency for Healthcare Research and Quality (AHRQ) in January 2006.

Examining numerous health care indicators—ones that measure both process and treatment outcomes—the report found that the overall disparity picture looks somewhat better for African-Americans, but somewhat worse for Latinos. For the types of disparities faced by African-Americans, 58 percent of the measures showed signs of improvement, while 42 percent were widening compared with whites. For disparities experienced by Latinos, however, 41 percent had improved compared with whites, while 59 percent worsened.

It's important to note that the types of disparities measured in the report are still fairly limited, improvements were modest and in none of the areas measured were disparities eliminated. Also, the report doesn't mention by *how much* disparities are getting better or worse. In sum, while the jury is still out, several points are clear:

- ▲ Disparities still exist.
- ▲ Some disparities are diminishing.
- ▲ Opportunities for improvement remain.
- ▲ Information about disparities is improving

Three 2005 reports in the *New England Journal of Medicine* offer a more pessimistic view. In contrast to the 2005 AHRQ report, these reports indicate that little progress has been made in addressing racial/ethnic disparities in the care of patients needing major treatment.

In the first study, researchers analyzed data from 1994 to 2002 and concluded that racial differences between African-Americans and whites had persisted in several heart-related conditions.

The second study examined data for men and women enrolled in Medicare, and measured rates at which common surgical procedures—such as coronary artery bypass surgery and total hip replacement—were performed on different groups.

The investigators found that between 1992 and 2001 the difference between the rates for whites and African-Americans increased significantly for five of the nine procedures, remained unchanged for three procedures and improved significantly for only one procedure. The authors conclude that there had been no meaningful or consistent reductions in the gaps in care between black and white Medicare enrollees.

But some modest progress has been made in addressing disparities in primary care. A third study using data from enrollees in Medicare managed care plans found a narrowing in racial disparities from 1997 to 2003 for several preventive care measures, including mammography, glucose testing and cholesterol testing. However, the same study found that racial disparities for other key areas such as glucose control among diabetics, and cholesterol levels in patients after a heart attack, actually widened.

A March 2006 RAND study seemingly contradicts the findings of studies that find minorities receive lower quality care. The study reviewed the medical records of 13,000 study participants to see if they received clinically appropriate care. The researchers calculated an overall quality-of-care score, and found that it was 3.5 percentage points *higher* for African-Americans than for whites and 3.4 percentage points *higher* for Hispanics than for whites. However, when the RAND researchers looked only at those indicators used in previous studies showing less favorable treatment for African-Americans and Hispanics, minority participants did score lower than whites, although not by much.

Most important, according to lead researcher Steven Asch of RAND Health, is that all racial and ethnic groups received recommended care far too infrequently—an average of only 54.9 percent of the time. Says Asch, "We are all in the same boat, and it's a leaky one."

As the desire to monitor and address disparities gains greater public attention, there have been some positive developments in the area of data gathering and measurement, especially among health plans. A growing number of health insurance plans are beginning to collect data on the race and ethnicity of their members.

A Robert Wood Johnson Foundation survey conducted in 2003–2004 found that 54 percent of health plans now either ask members to provide information about their race voluntarily on enrollment and other forms, or use other indirect methods to obtain aggregate data on race. Other plans lag, fearing that critics will accuse them of racial profiling.

But only four states—Maryland, New Jersey, New Hampshire and California—have legal barriers against the collection and use of racial information in health care. Already, the information gathered has led many plans to consider developing new, targeted strategies to address disparities in care, such as in the management of diabetes.

Where We Are Going

Unequal Treatment provides a blueprint for addressing disparities. Ideas have come as well from both sides of the political aisle.

Senate Majority Leader William H. Frist, M.D.(R- Tenn.), notes that “Disparities in U.S. health care are largely subsets of our overall quality problems.” Accordingly, Senator Frist calls for improving the quality of care across the nation through better data collection, greater use of health information technology, provider incentives and encouraging patients to take a greater role in their care.

The senator also recommends:

- ▲ Engaging “the entire federal health apparatus” to “systematically address disparities whenever and wherever they may occur,” across a range of federal agencies and departments.
- ▲ Expanding training for health care providers in cultural understanding, so they can better serve minority communities.
- ▲ Taking racial and ethnic disparities into account in clinical research, and speeding the translation of clinical findings into bedside practice.

Sen. Edward Kennedy (D-Mass.) says expanded health insurance coverage “would dramatically reduce racial and ethnic disparities in health care and improve minority health.”

Among Sen. Kennedy’s other recommendations:

- ▲ Improving the cultural competence and foreign language skills of health care providers,

and also non-physician “patient navigators” and community health workers.

- ▲ Encouraging more racial and ethnic diversity among the health professions.
- ▲ Standardizing racial and ethnic health data collection
- ▲ Supporting disease prevention efforts through increased funding for public health activities.

Several challenges, however, await those seeking to build policy solutions from the IOM blueprint or on the basis of recommendations from opinion leaders such as Sens. Frist and Kennedy, according to Dr. Joseph Betancourt of the Harvard School of Public Health. Among them:

▲ Absence of an action-oriented health care disparities research agenda

Neither private nor public funders of health disparities research have developed a coherent, consistent agenda that paves the way for health care practice and policy change.

▲ Lack of leadership to address disparities

High-profile leaders and advocacy organizations generate a steady drumbeat for change for many pressing issues in American health care—such as those relating to the uninsured, patient safety, medical technology, pharmaceutical treatment and quality improvement. Reducing racial and ethnic disparities doesn’t attract the same intensity of interest.

▲ Many in the U.S. are not aware of health care disparities

A 2005 study supported by the Robert Wood Johnson Foundation (RWJF) found that only 25 percent of whites believe that health care is worse for racial and ethnic minorities than for whites. In contrast, 44 percent of African-Americans and 56 percent of Hispanics said minorities receive worse care than whites.

On the positive side of the ledger:

▲ Racial and ethnic data collection is getting more attention

Health plans and hospitals, for example, have begun to consider the importance of stratifying their quality data by race and ethnicity to more readily identify and address disparities.

▲ Reducing disparities is increasingly seen as part of improving quality overall

The strategy of tackling disparities as part of quality improvement programs has gained significant traction nationally. Another IOM report, *Crossing the Quality Chasm*, highlighted the concept of *equity*—the principle that health outcomes should not vary based on personal

Acknowledgements

This publication was made possible by a grant from The Robert Wood Johnson Foundation. The Alliance is grateful for that support.

The Alliance also thanks Joseph Betancourt and Nisha Dogra for writing the original draft of this paper.

The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

Design by Yael Konowe of Yael Design, Reston, Va.

Printed on recycled paper. © 2006



Alliance for Health Reform
1444 I Street, NW, Ste 910
Washington, D.C. 20005
Phone 202/789-2300
Fax 202/789-2233
www.allhealth.org

characteristics such as race, ethnicity or gender. Many leading health plans and top hospitals are now viewing the issue of reducing disparities as part of their broader efforts to improve the quality of health care.

- ▲ **Private sector efforts are alive and well**
In 2005, the Robert Wood Johnson Foundation launched two new national initiatives, *Finding Answers* and *Leading Change*, to test and disseminate solutions for well documented racial and ethnic disparities.

National program offices at the University of Chicago and the Massachusetts General Hospital are working together to identify and implement practical solutions for eliminating disparities in care within health care systems. (Contacts: Marshall Chin, Director, Finding Answers (773)702-4769, mchin@medicine.bsd.uchicago.edu; Joseph Betancourt,

Director, Leading Change (617) 724-7658, jbetancourt@partners.org)

A third RWJF initiative, *Expecting Success*, housed at George Washington University, is designed to test the rigorous use of clinical guidelines, uniform performance measures and improved data collection in hospitals to improve care for minority Americans with cardiovascular disease. (Contact: Bruce Siegel, Director, Expecting Success (202)530-2399, siegelmd@gwu.edu)

Conclusion

Racial disparities are a persistent problem with our health care system. National leadership is needed to push for innovations in quality improvement, and to take actions that reduce disparities in clinical practice, health professional education, and research.

(For the sources used in this publication, contact info@allhealth.org.)

Expert Sources

- ▲ **Paul Akio Kawata**, *Executive Director*, National Minority AIDS Council 202/483-6622
- ▲ **Steven Asch**, RAND Corporation 310/393-0411 x.6516
- ▲ **Peter Bach**, *Senior Advisor*, Office of the Administrator, Centers for Medicare and Medicaid Services 202/690-6726
- ▲ **Joseph Betancourt**, Director of the Disparities Solution Center, Massachusetts General Hospital 617/724-9713
- ▲ **Gem Daus**, *Policy Director*, Asian and Pacific Islander American Health Forum 202/466-7772
- ▲ **John C. Goodman**, *President and CEO*, National Center for Policy Analysis 202/220-3082
- ▲ **Garth Graham**, *Deputy Assistant Secretary*, Office of Minority Health, Department of Health and Human Services 240/453-2882
- ▲ **Ashish Jha**, *Assistant Professor of Health Policy and Management*, School of Public Health, Harvard University 617/432-5551
- ▲ **Risa Lavizzo-Mourey**, *President & CEO*, Robert Wood Johnson Foundation 888/631-9989
- ▲ **Lucy Perez**, *National Health Director*, NAACP Division of Health Advocacy 410/580-5672
- ▲ **Gary Puckrein**, *Executive Director*, National Minority Health Month Foundation 202/223-7560
- ▲ **Evelyn Moore**, *President*, National Black Child Development Institute 202/833-2220
- ▲ **William Robinson**, *Director*, HRSA Office of Minority Health and Health Disparities, Department of Health and Human Services 301/443-2964
- ▲ **John Ruffin**, *Director*, National Center on Minority Health and Health Disparities, National Institutes of Health 301/402-1366
- ▲ **Sally Satel**, *Resident Scholar*, American Enterprise Institute 202/862-7154

Websites

- ▲ **Asian and Pacific Islander American Health Forum** www.apiahf.org
 - ▲ **Asian Health Services** www.ahschc.org
 - ▲ **Black Women's Health Imperative** www.blackwomenshealth.org
 - ▲ **DHHS Office of Minority Health** www.omhrc.gov
 - ▲ **National Center for Cultural Competence** <http://gucchd.georgetown.edu/nccc/>
 - ▲ **National Center on Minority Health and Health Disparities** <http://ncmhd.nih.gov/>
 - ▲ **National Hispanic Medical Association** www.nhmamd.org
 - ▲ **National Minority AIDS Council** www.nmac.org
 - ▲ **National Minority Health Month Foundation** www.nmhmf.org
- For additional experts and websites on this and other subjects, go to www.allhealth.org.