RACE, ETHNICITY & HEALTH CARE

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Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care

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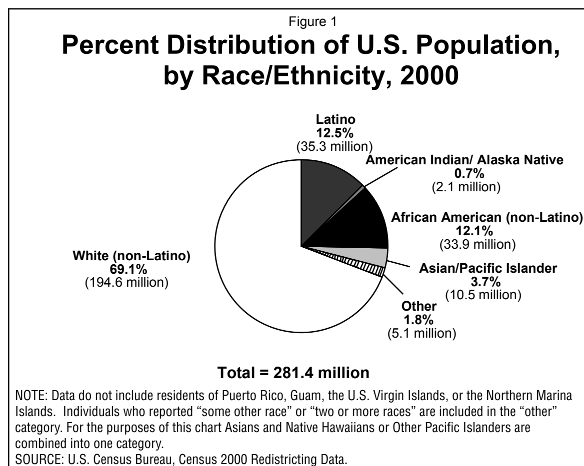
Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care

Racial and ethnic disparities in health care – whether in insurance coverage, access, or quality of care – are one of many factors producing inequalities in health status in the United States.[1] Eliminating these disparities is politically sensitive and challenging in part because their causes are intertwined with a contentious history of race relations in America. Nonetheless, assuring greater equity and accountability of the health care system is important to a growing constituency base, including health plan purchasers, payers, and providers of care. To the extent that inequities in the health care system result in lost productivity or use of services at a later stage of illness, there are health and social costs beyond the individual or specific population group.

Background

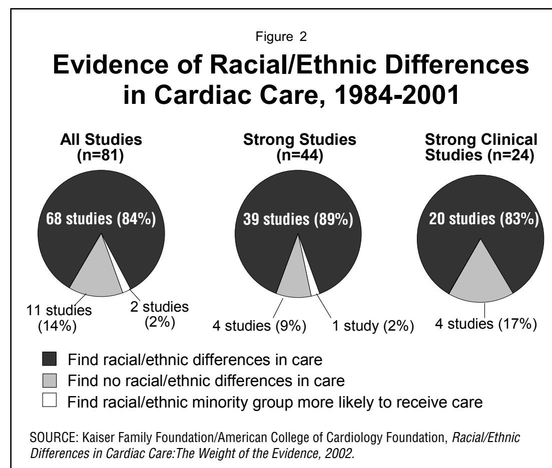
About 1 in 3 residents of the United States self-identify as either African American, American Indian/Alaska Native, Asian/Pacific American, or Latino. (Figure 1) By the year 2050, persons of color are expected to represent nearly half of the U.S. population. (see Appendix 1)



Few would disagree that for most of this nation's history, race was a major factor in determining if you got care, where that care was obtained, and the quality of medical care. However, the influence of race today is more subtle. Public policy efforts, most notably the enactment of Medicaid and Medicare in 1965, along with enforcement of the 1964 Civil Rights Act, have made an enormous difference in reducing the health care divides in the U.S. So much progress has been achieved that many think that the disparities that remain are inconsequential, but they are not.

The Institute of Medicine (IOM) landmark report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care* provides compelling evidence that racial/ethnic disparities persist in medical care for a number of health conditions and services.[2] Disparities in care exist even when comparing individuals of similar income and insurance.

For example, a review of studies from 1984 to 2001 investigating racial/ethnic differences in cardiac care provides credible evidence of lower rates of diagnostic and revascularization procedures for at least one of the minority groups under study.[3] (Figure 2) This finding held true whether reviewing all studies meeting criteria for the review, the subset of studies defined methodologically, as the strongest, or the subset of those studies that analyzed clinical data. Evidence of racial/ethnic disparities among patients with comparable insurance and the same illness has been the most troubling since health insurance coverage is widely considered the "great equalizer" in the health system.



The momentum to address health care disparities has grown largely in response to the step taken by the U.S. Department of Health and Human Services (DHHS) in 1999, establishing a national goal of eliminating health disparities by the end of this decade. Disparities between racial/ethnic groups and those between geographic areas were of major concern.[4] The decision to have one set of goals for all Americans, rather than separate goals for the health of whites and minority populations, has helped to focus public and private sector attention on racial/ethnic disparities in health and thus, in the health care system.

Challenges and Opportunities in Addressing Health Care Disparities

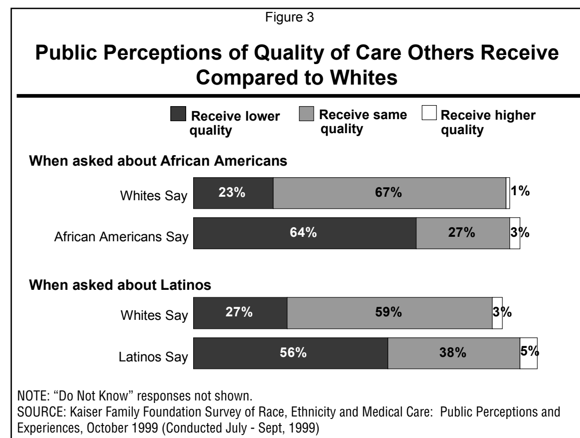
Although attention to racial/ethnic disparities in care has increased among policymakers, there is little consensus on what can or should be done to reduce these disparities. The U.S. Congress provided leadership on the issue by legislatively mandating the IOM study on health care disparities and creating in statute, the National Center on Minority Health and Health Disparities at the National Institutes of Health. Congress also required DHHS to produce an annual report, starting in 2003, on the nation's progress in reducing health care disparities.[5] These efforts have provided an important foundation for addressing health and health care disparities.

The IOM study committee for *Unequal Treatment* recommended the use of a comprehensive, multi-level strategy to address potential causes of racial/ethnic disparities in care that arise at the level of the patient, provider, and health care system.
The recommendations point to five broad areas of policy challenges:

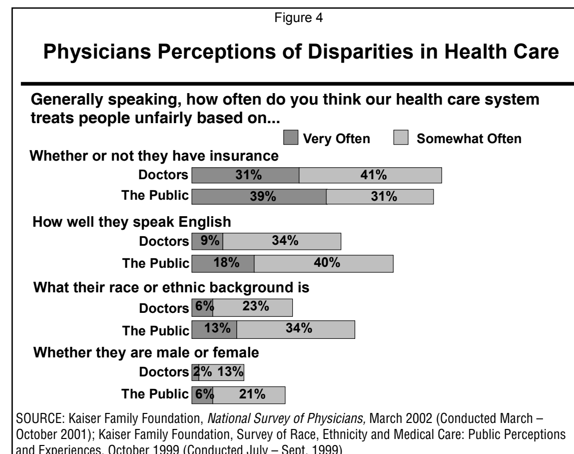
- Raising public and provider awareness of racial/ethnic disparities in care;
- Expanding health insurance coverage;
- Improving the number and capacity of providers in underserved communities;
- Improving the quality of care; and
- Increasing the knowledge base on causes and interventions to reduce disparities.

Raising Public and Provider Awareness

Misperceptions about the nature and extent of racial/ethnic disparities in care add a level of complexity to efforts to address the problem. The public has a marginal, at best, awareness of racial/ethnic disparities in the U.S. health system. Over two-thirds (67%) of whites say they believe African Americans get the same quality of care as they do, and over half (59%) of whites say they believe Latinos get the same quality of care as they do.[6] (Figure 3)



Not surprisingly, some of the misperceptions of the public are also found among physicians. Less than a third (29%) of physicians say the health care system "very or somewhat often" treats people unfairly based on their racial/ethnic background.[7] (Figure 4)



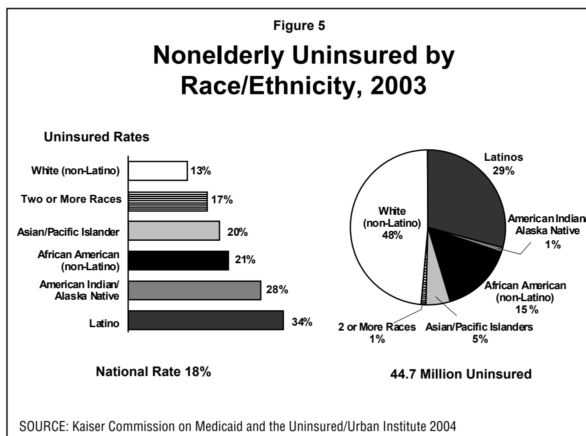
Among those who believe disparities exist, the most common perception is that they are largely a result of differences in patient characteristics – especially insurance, education, and personal preferences. This perception persists despite an abundance of

studies that control for these patient level characteristics.

Perceptions of a problem often influence the actions taken (or not taken) to change policy and practices. If the public or providers are unaware that a problem exist or misunderstand the nature of the problem, it is difficult to direct resources to address that problem.

Expanding Health Coverage

Race clearly matters in the U.S. health system, but so do many other factors – especially insurance coverage. Racial/ethnic minority Americans make up about a third of the U.S. population, but disproportionately comprise 52% of the uninsured – 23 million of the 45 million uninsured in 2003. (Figure 5) When compared with the insured, the uninsured are less likely to have a regular doctor or to get timely and routine care, and are more likely to be hospitalized for preventable conditions.



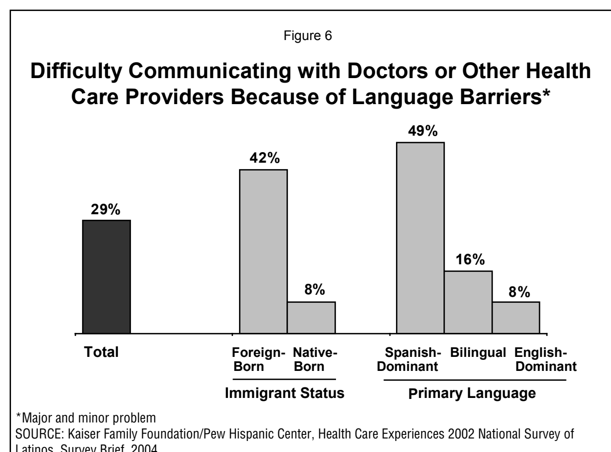
Differences in health insurance coverage across racial/ethnic groups are partially explained by differences in types of employment and eligibility for public programs. They are also a result of geographic variations in health insurance coverage rates. (see Appendix 2)

Like the general population under age 65, employers are a major source of coverage for racial/ethnic minority groups. However, Medicaid, a source of coverage for many of the nation's poor and disabled, is an important safety net for about 1 in 5 nonelderly African Americans, American Indians/Alaska Natives, and Latinos and about 1 in 10 Asian/Pacific Americans and whites. Efforts are needed, therefore, to assure that existing sources of coverage, such as Medicaid, are not undermined while also working to expand sources of coverage for those who are uninsured.

Improving the Number and Capacity of Providers in Underserved Communities

The availability and mix of medical providers in a community also affect the care that is obtained. Despite efforts to increase the number of health professionals in medically underserved areas, people of color are still more likely than whites to live in neighborhoods that lack adequate health care resources. For example, 28% of Latinos and 22% of African Americans report having little or no choice in where to seek care, while only 15% of whites report this difficulty.[8] Even among the insured, African Americans and Latinos are twice as likely as whites to rely upon a hospital clinic or outpatient department as their regular source of care, rather than on a private physician or other office-based provider.[9]

Among geographically accessible health providers, language and cultural barriers are sometimes a problem.[10] About three in ten Latinos say they have had a problem communicating with health providers over the past year, and half of Latinos whose primary language is Spanish report language barriers. (Figure 6) Medical interpretation services are among the strategies recommended by the IOM to reduce these barriers.



To strengthen patient-provider communication and relationships, the IOM committee also recommended expanding the racial/ethnic diversity of the health professions workforce and developing provider training programs and tools in cross-cultural education. These recommendations are rooted in evidence that minority providers are more likely than whites to practice in minority and medically underserved areas, and that when patient and providers are of the same race there is greater satisfaction and adherence to treatment.[11]

The efforts underway to improve cross-cultural education and cultural competence fill a critical void in medical education and clinical practice. However, reducing disparities in care will require an emphasis on assuring access to culturally competent care as well as care that is technically competent.

Improving Health Care Quality

An IOM report, *To Err is Human*, estimated that hundreds of thousands of medical errors (e.g., errors in medication dosage or clinical procedures) occur each year, a finding that brought to the nation's attention issues of patient safety and more broadly gaps in the quality of care in the U.S. health system.[12]

Since disparities in care sometimes reflect "inequality in the quality of care," the National Healthcare Disparities Report (NHDR) uses the IOM dimensions of quality to examine racial/ethnic differences in patterns of care. The NHDR examined five aspects of quality - whether services are safe, effective, patient-centered, timely and equitable.[13]

For example, the NHDR found that hospitalized Hispanic and Non-Hispanic black Medicare beneficiaries, as compared to their white counterparts, obtained lower quality care for pneumonia. The report examined several quality indicators, including the percent of patients receiving an initial antibiotic dose within eight hours of arrival to the hospital.[14]

Racial/ethnic disparities in quality of care are a concern among the privately as well as publicly insured. However, the potential consequences of poorer quality care for the publicly insured extend beyond the individual to society if more costly care is obtained at a later stage of the illness.

The federal government as a payer of medical care -- through Medicaid, Medicare, the Indian Health Service and the military is responsible for assuring that quality medical care is provided in the services it operates and/or finances. Current estimates indicate that approximately 12 million African Americans, 10 million Latinos, and 2.2 million American Indians/Alaska Natives obtain care financed by a public sector program. (see Appendix 3) These programs will require data information systems that can be used to monitor and provide feedback to practitioners about racial/ethnic differences in the quality of care.

Increasing the Knowledge Base

Although evidence of racial/ethnic health care disparities is substantial, the evidence-base for developing interventions to eliminate these disparities is limited. For example, one of the most controversial conclusions of the IOM report *Unequal Treatment* was that provider bias and stereotypical beliefs may play a role in clinical decisionmaking. More precise information about the role of bias and other potential causes of disparities will help when making decisions about how to allocate resources to eliminate disparities.

Increasing the knowledge base will require routinely collecting and analyzing data on health care use across racial/ethnic groups. Data from national surveys, health insurers, and different health settings is needed to better understand the problems and impact of interventions. The lack of data on racial/ethnic minority groups other than African Americans is a major cause for concern. One reason so little is known about patterns of health care use of Latinos, American Indians/Alaska Natives, and Asian /Pacific Islanders is that national data sources rarely have sufficient sample sizes of subpopulation groups for reliable analysis. Baseline and follow-up data across racial/ ethnic groups is essential for monitoring purposes.

Next Steps in Closing the Gap

While there is increasing agreement that a comprehensive, multi-level strategy is needed

to eliminate racial/ethnic disparities in health care; views continue to differ on the specific strategies, the financing of the strategies, and the federal role.

Since the mid 1950s, the federal government -- through the Congress and the Courts -- has been a leading force in efforts to remedy racial inequalities in society (e.g., in education, employment, housing). However, current views on the federal role in addressing racial disparities in health care differ by race.[15] Most (90%) African Americans, as compared to 55% of whites, say the "federal government should be responsible for ensuring that minorities have equality with whites in health care services, even if it means raising taxes." Such contrasting views contribute to the lack of consensus on how to address disparities in care.

Government's role in reducing health disparities has emerged as an issue on the policy agenda. Congressional leaders from both political parties introduced legislation in the 108th Congress to address health care disparities.[16] Both parties say they plan to reintroduce legislation in the current Congress.[17]

The increasing racial/ethnic diversity of the U.S. gives reason for government to be a major partner in efforts to eliminate disparities in care. However, issues of national security, the federal deficit, and rising health care costs appear to be deferring prospects for a major federal role on this issue.

Nonetheless, the federal government is engaged in a number of initiatives explicitly focused on reducing racial/ethnic disparities in health care, as are many state and private sector agencies.[18] Many of the activities address challenges identified in this issue brief. Some efforts are specific to communities of color (e.g., improving patient-provider communication); others are broader in reach (e.g., expanding health coverage). Some efforts are new (e.g., quality improvement activities to help narrow gaps in treatment); while others have a longer history (e.g., programs to increase providers in medically underserved areas). And some efforts are public education initiatives designed to increase awareness of medical care options and encourage greater personal responsibility for health. Monitoring the outcomes of these initiatives will be important in developing a roadmap for the next steps in addressing health care disparities.

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[1] Disparities in "health care" and in "health" are often discussed as if they are one in the same. A health care disparity refers to differences in, for example, coverage, access, or quality of care that is not due to health needs. A health disparity refers to a higher burden of illness, injury, disability, or mortality experienced by one population group in relation to another. The two concepts are related in that disparities in health care can contribute to health disparities, and the goal of the use of health services is to maintain and improve a population's health. However, other factors (e.g., genetics, personal behavior, and socio-economic factors) also are major determinants of a population's health.

[2] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* 2002.

[3] Kaiser Family Foundation/American College of Cardiology Foundation, *Racial/Ethnic Differences in Cardiac Care; The Weight of the Evidence, 2002.*

[4] U.S. Department of Health and Human Services, *Healthy People 2010*. pp:11-16.

[5] U.S. Department of Health and Human Services, *2003 National Healthcare Disparities Report, 2003*.

[6] Kaiser Family Foundation, Race Ethnicity & Medical Care: Survey of Public Perceptions and Expectations, 1999.

[7] Kaiser Family Foundation, National Survey of Physicians, Part 1: Doctors on Disparities in Medical Care, 2002;

[8] The Commonwealth Fund Health Care Quality Survey, 2001.

[9] Lillie-Blanton et al. Site of Medical Care: Do Racial and Ethnic Differences Persist? *Yale Journal of Health Policy, Law, and Ethics*, 2001.

[10] Kaiser Family Foundation/Pew Hispanic Center, Health Care Experiences 2002 National Survey of Latinos, *Survey Brief,* 2004.

[11] Komaromy et al. The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. *NEJM*. 1996; Cooper-Patrick et al. Race, Gender, and Partnership in the Patient -Physician Relationship. *JAMA*. 1999.

[12] Institute of Medicine. *To Err is Human*: *Building a Safer Health System.* 2000.

[13]U.S. Department of Health and Human Services, *National Healthcare Disparities Report (NHDP), 2003.*

[14] US DHHS *NHDP*, Table 14 , pg 93.

[15] Taylor-Clark, K. et al. African Americans' Views on Health Policy: Implications for the 2004 Elections. *Health Affairs*, 2003.

[16] Closing the Health Care Gap Act of 2004 (S.2091) and Healthcare Equality and Accountability Act (S.1833; H.R. 3459).

[17] Healthcare Disparities Report. Washington Watch, pg 1. February 2005.

[18] McDonough et al. A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities. The Commonwealth Fund, 2004.; Kaiser Family Foundation. Compendium of Cultural Competence Initiatives in Health Care, 2003. ; The Sullivan Commission Report. Missing Persons: Minorities in the Health Professions, 2004. DHHS *NHDP* Prepublication copy, pgs 12-14, 2003.

Appendices

Appendix 1: Distribution of U.S. Population by Race/Ethnicity, 2000 and 2050

	Percent		Number (in millions)	
	2000	**2050**	**2000**	**2050**
U.S. Total	100%	100%	281.4	403.7
White (non-Latino)	69.1%	52.8%	194.6	213.0
Latino	12.5%	24.3%	35.3	98.2
African American (non-Latino)	12.1%	13.2%	33.9	53.5
Asian/Pacific Islander	3.7%	8.9%	10.5	35.8
American Indian/Alaska Native	0.7%	0.8%	2.1	3.2
Other[1]	1.8%	-	5.1	-

NOTE: Data do not include residents of Puerto Rico, Guam, U.S. Virgin Islands or Northern Marina Islands.
[1] "Other" category includes Non-Latino individuals who reported "Some other race" and "Two or more races." 2050 data do not include estimates for people identified in the "Other" category.

SOURCE: U.S. Census Bureau, Census 2000 Redistricting Data (PHC-T-1) and Population Projections Program Population Division www.census.gov/ipc/www/usinterimproj/.

Appendix 2: Nonelderly Uninsured Rates, by Region and Race/Ethnicity, 2002-2003

	U.S Total Nonelderly	Northeast	South	Midwest	West
White (non-Latino)	12.7%	11.2%	14.6%	11.2%	13.2%
Latino	34.2%	28.0%	40.5%	29.3%	32.1%
African American (non-Latino)	21.3%	21.6%	22.1%	18.8%	18.8%
Asian/Pacific Islander	20.1%	23.7%	24.0%	15.2%	18.3%
American Indian/Alaska Native	28.3%	11.5%	27.0%	25.6%	31.7%

NOTE: **Northeast includes:** Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; **South includes:** Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; **Midwest includes**: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; **West includes:** Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2002 and 2003 CPS.

Appendix 3: Government's Role in Health Coverage of People of Color

	Estimated Number (in millions)				
	U.S. Total	Medicaid[a]	Medicare[b]	Military (VA & DOD)[c]	Indian Health Service
Latino	~10.2[†]	~7.0	~2.7	~0.5	n/a
African American (non-Latino)	~11.7[‡]	~7.5	~3.2	~1.0	n/a
American Indian/Alaska Native	~2.2[§]	~0.7	*	*	1.5

NOTE: n/a means not applicable; * means data not available to produce estimate. [†] This estimate represents 35% of U.S. African Americans in 2000; [‡] This estimate represents 33% of U.S. Latinos in 2000; § This estimate includes a duplicate count of the AI/AN population since some Medicaid beneficiaries also obtain care from the I.H.S.

SOURCES: [a]2001 data derived from Kaiser Family Foundation Key Facts: Race/Ethnicity and Medical Care, 2003; [b]1999 data derived from Gaskin/Briesacher analysis of MCBS, see (http://www.kff.org/content/2003/6098/); [c]2001data derived from KCMU 2001 Health Coverage Update.

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