CLOSING THE GAP: RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE

Alliance for Health Reform
Washington, DC

Do all Americans receive the same quality of healthcare? According to recent polls, most Americans think so. They believe that the "average" African American receives the same or better quality of healthcare as the "average" white patient. Similarly, about 70% of physicians believe that minorities are "rarely" or "never" treated unfairly in healthcare systems.

But a large body of published research demonstrates that racial and ethnic minority patients—even when insured at the same levels as white patients—receive lesser amounts of care, and a lower quality of care, for the same illnesses.

How could this pattern exist, given that healthcare professionals work hard and are dedicated to providing a high quality of healthcare for all patients? This brief explores this question and offers some possible remedies. It draws upon existing research, as well as the findings of a congressionally mandated report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, issued in 2002 by the Institute of Medicine.

Race/Ethnicity and Insurance Status

More than any other factor, whether or not a person has health coverage determines how soon the person will get healthcare and whether he or she gets the best care available. Individuals who are uninsured or underinsured are less likely to receive appropriate healthcare, if they receive any care at all. For some conditions, people without insurance live sicker and die sooner. These facts especially affect racial and ethnic minorities. Latinos, for example, are almost three times as likely as whites to be uninsured, and African Americans have almost twice the uninsurance rates of whites.

Minorities who do have insurance are almost three times as likely as whites to be covered by publicly funded programs, such as Medicaid, and are less likely to have employment-based coverage. Although Medicaid coverage has made an enormous difference in expanding access to care for low-income Americans, its often-low reimbursement rates mean that many providers consider it a less-attractive source of health coverage for their patients than private insurance. Some practitioners refuse to see Medicaid patients outright; others restrict the number of Medicaid patients they will see.

Racial/Ethnic Disparities Among the Insured

Being uninsured disproportionately harms access to appropriate care for racial and ethnic minority groups. But a large body of scientific research conducted over the past three decades has established that even when minority patients are insured at levels comparable to white patients, they tend to receive a lower quality of healthcare for the same health conditions.

This conclusion is consistent across studies comparing African-American and white patients. Increasingly, studies are demonstrating the same disparities between Hispanic and white patients. (More research must be done to determine whether other minorities face the same disparities.) Existing research shows that:

- African Americans and Hispanics tend to receive lower-quality healthcare than whites across a range of diseases (including cancer, cardiovascular disease, HIV/AIDS, diabetes, mental health, and other chronic and infectious diseases) and clinical services.
- African Americans are more likely than whites

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to receive certain less-desirable treatments, such as amputation of all or part of a limb.
- Disparities are found even when clinical factors are taken into account, such as severity of disease when the patient seeks care, coexisting medical problems, and age.
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and nonteaching hospitals, etc.

Potential Sources of Racial/Ethnic Disparities

Aspects of health systems—such as how they are organized and financed, and the range of services they offer—sometimes work to the disadvantage of minorities.

Geography. Where minorities live and work can pose barriers to care. Racial and ethnic minorities are more likely than whites to live in medically underserved communities and have fewer choices with regard to where they seek care. In some cases, sources of healthcare are limited or nonexistent in minority communities.

Twenty-eight percent of African Americans and 30% of Hispanics report having little or no choice in where to seek care, while only 16% of whites report this difficulty. Even among the insured, African-American and Hispanic patients are nearly twice as likely as whites to report having a "nonmainstream" usual source of care (e.g., a hospital-based provider, rather than a private physician.). Geographic disparities also affect the availability of prescription medicines. A study of the availability of prescription pain killers, for example, revealed that only one in four pharmacies located in predominantly nonwhite neighborhoods carried adequate supplies, compared to 72% of pharmacies in predominantly white neighborhoods.

Managed Care. According to the Institute of Medicine report, the gatekeeper rules of managed care plans "may pose greater barriers to care for minority patients." One study, for instance, found that African Americans were nearly one-and-a-half times more likely than whites to be denied authorization for care after an emergency department visit for the same severity of problems. Other analysts are less certain about the impact of managed care arrangements on racial and ethnic minorities.

Unfortunately, most private health systems do not monitor racial and ethnic differences in access to health services and use of those services among their enrollees—even though such data collection and monitoring is legal. And the federal government does not require states to report evidence of disparities in care among Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries, or promote data collection and monitoring of disparities among other publicly funded health systems. As a result, policymakers, researchers, and consumers lack knowledge of when and under what circumstances these disparities occur, and whether trends are improving over time.

Within the Medicaid program, some 56% of patients were enrolled in managed care in 2000—up from just 9.5% in 1991. This may have disrupted ties with community-based providers who are not in the patients' managed care plan but who are familiar with the language, culture, and values of ethnic minorities. A recent study indicates that minorities required to enroll in publicly funded HMO plans are less likely to use services than either white Medicaid recipients in the same plans, or minority Medicaid enrollees who are not in managed care plans.

Cost-Containment Pressures. Clinical encounters (such as office visits) afford doctors and other healthcare providers the opportunity to better understand patients' concerns and jointly develop a treatment plan with the patient. Increasingly, however, these encounters are short, with patients having only a few minutes to meet with their provider face to face to discuss their concerns. While both the patient and provider might wish it otherwise, in many set-

Fast Facts

In 2002, 20.2% of African Americans and 32.4% of Hispanics/latinos were uninsured, compared to 11.7% of whites.

By 2050, nearly half of the U.S. population will be comprised of minority groups.

In 2001, more than half of Hispanics/latinos, African Americans, and Native Americans were considered poor or near poor (household income less than $28,256 for a family of three). Only one-fourth of whites were below this income level.

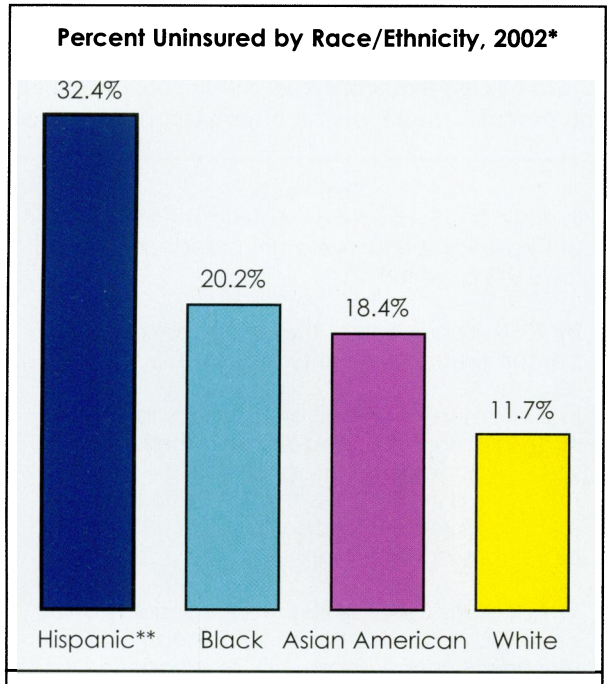
While nearly 8% of whites were considered to be in fair or poor health in 2000, nearly 13% of Hispanics/latinos, nearly 14% of African Americans, and more than 17% of Native Americans were in fair or poor health.

tings these time constraints are caused by high patient caseloads and pressures to contain costs.

Cost-containment efforts may also limit the provider's ability to order diagnostic tests or to be able to prescribe more expensive—yet potentially more effective—treatments.

Stereotyping. Faced with the pressure to cut costs by spending less time with each patient, even well-intentioned providers may resort to generalizations or stereotypes about patients who are members of racial and ethnic minority groups. We need to better understand how this affects the clinical encounter. But research to date indicates that healthcare providers' diagnostic and treatment decisions, as well as their feelings about patients, are sometimes unfairly influenced by patients' race or ethnicity. For example:

- Researchers found that doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients' income, education, and personality characteristics were taken into account.
- Cardiologists involved in one study were significantly less likely to refer African-American female patients for catheterization than they were to refer white male, African-American male, and white female patients.



* Uninsured for all of 2002; **Hispanics may be of any race; Source: U.S. Census Bureau, 2003

Communication Barriers. Even if a provider is able to devote an ample amount of time to patient care, communication between the two can sometimes be a problem. Many racial and ethnic minority patients in the United States experience difficulties with the English language, affecting the timeliness and quality of their care. Almost 12 million people in the United States live in "linguistically isolated" households (those in which no one over age 14 speaks English "very well.")

Minority patients may have a harder time finding a healthcare provider who shares their cultural and linguistic background. African Americans, Hispanics, and American Indians are under-represented among physicians, nurses, dentists, pharmacists, and other healthcare professionals. As a consequence, one-fifth of Spanish-speaking latinos recently reported not seeking medical treatment due to language barriers.

A host of problems can result when patients and their providers don't speak the same language, and when translators are lacking. These problems include lower patient satisfaction with care, lower rates of appropriate follow-up, less access to specialty care, and poorer adherence to treatment plans.

Additionally, researchers have speculated that some racial and ethnic minority patients may receive a lower quality of care because they fail to seek care when their problem could be dealt with effectively. Mistrust of healthcare providers could be a reason for delay, as could the stigma associated with seeking care for certain problems, such as HIV/AIDS. Some cultures tend to place a high value on home or "folk" remedies, which could also delay seeking care from mainstream providers. While these are concerns, they do not appear to be nearly as important in explaining disparities as the factors already cited.

What Can Be Done?

The Institute of Medicine *Unequal Treatment* report argues for a comprehensive, multi-level strategy to eliminate healthcare disparities by addressing healthcare systems, the legal and regulatory contexts in which they operate, healthcare providers, and their patients.

Educational Strategies. The *Unequal Treat-*

ment report concludes that a significant barrier to eliminating healthcare disparities is a lack of awareness of the problem among key stakeholders. Therefore, an important first step is to raise awareness of the healthcare gap among healthcare providers, their patients, purchasers of care (such as employers), and society at large.

Moreover, both patients and providers can benefit from tailored training and educational programs. Patients can benefit from culturally appropriate education programs to improve their knowledge of how to gain access to care and their ability to participate in clinical decision-making.

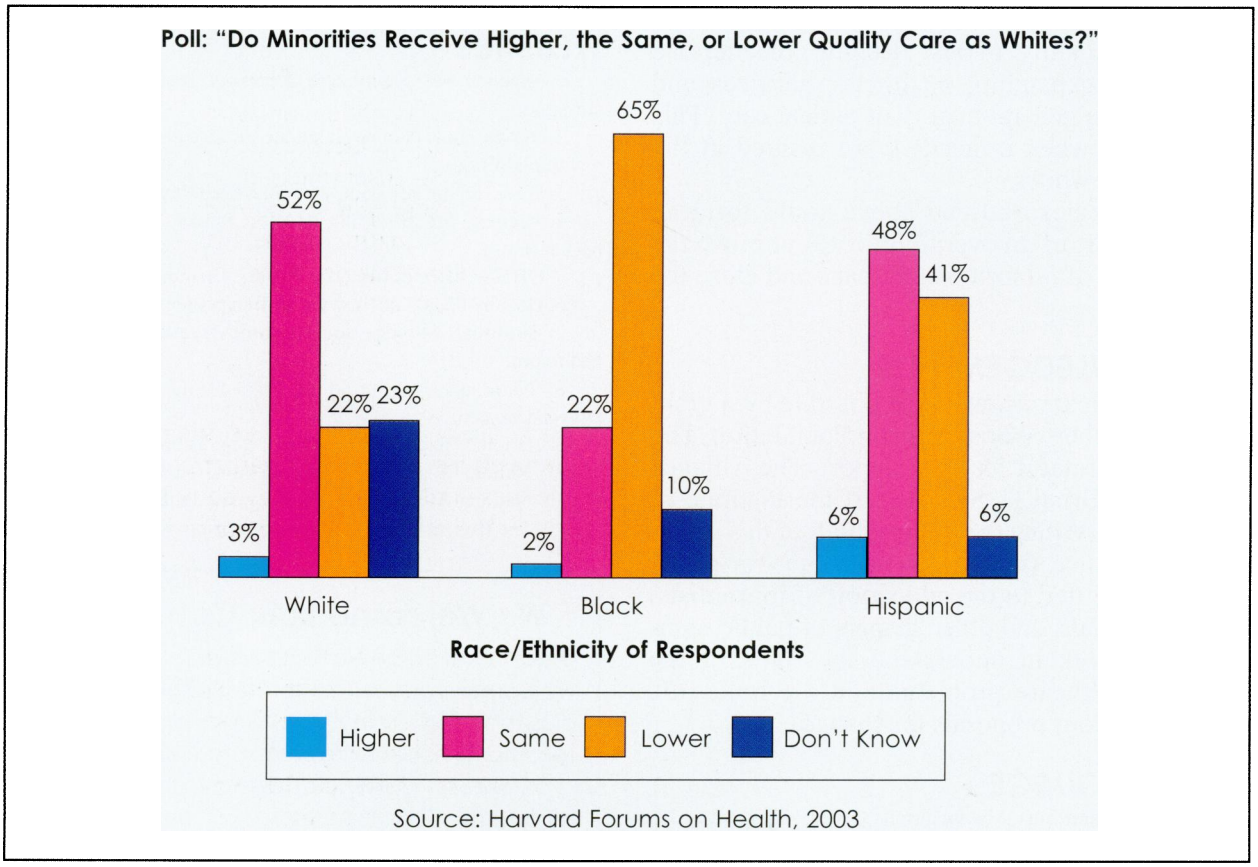
More importantly, healthcare professionals need tools to understand and manage the cultural and linguistic diversity of patients seen in today's health systems and to avoid allowing unconscious biases and stereotypes to affect their interactions with patients. Cultural sensitivity training should be integrated early into the education of future healthcare providers; and practical, case-based, rigorously evaluated training should persist through continuing education programs.

Health Systems Interventions. Health systems can take several steps to equalize and promote high-quality care for all patients, including:

- Basing decisions about resource allocation (e.g., which patients should receive particular treatments for specific health conditions) on published clinical guidelines.
- Removing barriers to care by taking steps such as providing translators, where they are needed.
- Insure that physician financial incentives do not overly burden or restrict minority patients' access to care.
- Supporting the use of community health workers and multidisciplinary treatment and preventive care teams.
- Collecting and monitoring data on patients' access and utilization of healthcare services by race, ethnicity, and primary language.

Governmental Actions. The IOM report calls for several steps to be taken by state and federal health policymakers:

- State programs that mandate the enrollment of Medicaid beneficiaries in managed care plans



should pay plans at rates that give enrollees access to the same health plans that serve substantial proportions of privately insured patients.
- Publicly funded health systems should improve the stability of patient–provider relationships by establishing guidelines for patient caseloads, allowing time flexibility in clinical encounters, and enhancing the stability of patients' assignments to primary care providers.
- Federal, state, and private stakeholders should continue efforts to substantially increase the proportion of under-represented U.S. racial and ethnic minorities among health professionals, to improve access to care among minority patients, and to reduce cultural and linguistic barriers to care.
- The U.S. Department of Health and Human Services should encourage health plans and federal and state payors to collect, monitor, and report patient care data by ethnic and racial group. This would permit the assessment of progress in eliminating disparities, to evaluate intervention efforts, and to assess potential civil rights violations.

CONCLUSION

Racial and ethnic disparities in healthcare access and quality persist despite considerable progress in expanding healthcare services and improving the general quality of patient care. This is true even when minorities are insured at the same level as whites.

The strategies outlined above could form an important part of an overall effort to improve the health status of minority Americans and close the health gap.

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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 healthcare problems and the trade-offs posed by various proposals for change.

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