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Overview of Health Disparities: Maryland Considerations

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Introduction

Despite improvements in health and life expectancy over the past 100 years, advances in medicine and public health have not benefitted all communities. Lack of translation of advances in prevention and disease management for some communities contributes to lags in health status and life expectancy. Differences, compared to a reference population, in disease rates and burden of illness are referred to as "health disparities."[1] The focus on population and individual disparities in health status and health care demonstrates the need to ensure equity and equality in access to quality health care, health care delivery and health outcomes.

The term "health disparities," which is widely used in the United States, is defined as follows: "…..differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[2] Although the United States has increased the use of additional terminology, the terms "health inequity" and "health inequality" are more commonly used outside the United States. Health inequity (lack of fairness) and health inequality (not being equal) are "… differences in health which are not only unnecessary and avoidable, but are considered unfair and unjust."[1] These two terms incorporate the concept of "social justice," whereas the term "health disparities" emphasizes differences in disease rates, health-related data and other measures.

Health disparity populations are defined as populations where there are significant differences in disease prevalence, incidence, mortality and survival when compared to the general population.[2] This includes African Americans, American Indian and Alaska Natives, Asians, Hispanics, Native Hawaiian and other Pacific Islander, low socioeconomic groups and rural communities.

Note: CME questions for this article are posted at www.mdafp.org; CME Quiz tab, Spring, 2013.

The paper briefly discusses health disparities, some of Maryland's efforts to address them, and family physicians' roles in reducing and eliminating them.

As research on the causes of health disparities and inequities has progressed, a national and global focus has defined associated factors, called "social determinants of health," which emphasize the social, economic, and other characteristics related to health disparities. The World Health Organization Commission on Social Determinants of Health states that health inequities are "…the unfair and avoidable differences in health status…."[3]

Socioeconomic status influences insurance status, tobacco and alcohol use, whether individuals have a usual source of care and other factors associated with health disparities. Determinants include transportation; housing or place of residence; access and availability of services; educational level; income and material goods, such as home ownership; diet; discrimination by social grouping (e.g., race, gender, and class); and social and environmental stressors.[4] Less-educated and poorer communities are at the highest risk of being uninsured, not having a usual source of health care and delays in seeking diagnosis or treatment.

Descriptions of disparity populations have historically focused on health indicator differences between racial/ethnic groups; thus, these data are the most readily available. Disparities are also associated with geography, such as rural versus urban communities, age, gender, and a host of other factors. The changing demographics in the United States and in Maryland show an increase in racial/ethnic minority populations. The estimated population for 2009 was, over 40% of Maryland's population was minorities.[5] These demographics emphasize the need for clinical care delivery that incorporates cultural influences on health behaviors and compliance with treatment and cultural competence in health care delivery to meet the needs of an increasingly diverse population.

Selected Examples of Maryland's Health Disparities

Data on health disparities in Maryland are available from state and national data collection and monitoring systems.[5,6] The state Office of Minority Health and Health Disparities (MHHD) Chartbook[5] contains detailed data on racial, ethnic, gender and geographic disparities for a number of diseases and disorders. Selected examples of Maryland's disparities in diseases, disorders and related factors are listed on the next page.

Lack of Health Insurance

From 2004 to 2008, the proportions of Maryland adults in various populations who reported having no health insurance were as follows (compared with the non-Hispanic white population):

- Over 2 times higher for non-Hispanic Blacks or African Americans,
- Approximately 4.7 times higher for Hispanic/Latinos, and
- Approximately 1.7 times higher for other minorities combined (Asian and Pacific Islander, American Indian, and other).[5] Source: Maryland Behavioral Risk Factor Surveillance System Data, 2004 to 2008

Late or No Prenatal Care

From 2004 to 2008, the proportions of pregnant minority women who received late or no prenatal care were as follows (compared to pregnant white females):

- Nearly 3 times higher for Black or African American women,
- Approximately 3.5 times higher for Hispanic/Latino women,
- Approximately 1.3 times higher for Asian/Pacific Islander women, and
- Approximately 1.1 times higher for American Indian women.[5] Source: Maryland Vital Statistics Annual Reports 2004 to 2008

End-Stage Renal Disease

For pooled data from 1991 through 2001, compared to whites, the rates of new cases of end-stage renal disease in Maryland have been approximately

- Three times higher for Blacks or African Americans,
- Three times higher for American Indians, and
- 1.2 times higher for Asians and Pacific Islanders over 64 years of age.[5]

Infant Mortality Rate

In Maryland for the years 2004-2008, the infant mortality rates for minority populations were: (compared to the white population):

- 2.6 times higher for Blacks or African Americans,
- 1.8 times higher for American Indians,
- Similar to whites for Asians and Pacific Islanders, and
- Similar to whites for Hispanics/Latinos.[5] Source: Maryland Vital Statistics Annual Reports 2004 to 2008

Mortality Disparities for Leading Causes of Death

The Chartbook also indicates that the death rates are higher among African Americans than among whites in 20 of the 23 Maryland jurisdictions where the age-adjusted rates could be calculated.

Nine of the top 14 causes of death show a mortality disparity between Blacks or African Americans and Whites.

- Black or African American age-adjusted cardiovascular disease mortality exceeds that of Whites by 52.1 deaths per 100,000 population.
- Blacks or African Americans are 16 times more likely to die from HIV/AIDS than Whites.

Health disparities exist in Maryland’s rural regions for a number of chronic diseases, including certain cancers, cardiovascular disease, and metabolic syndrome. In addition, high

rates of no health insurance, aging populations, shortages of primary and specialty health care resources and lack of public transportation contribute to rural disparities.[7]

Contributing Factors

The factors that contribute to health disparities are complex, may interact with each other and are multi-factorial. Some factors are modifiable, and others are not. However, it is evident that many disparities are avoidable. Risk factors and exposures, including tobacco use, alcohol intake, environmental exposures, and family history, may contribute to disparities. Lack of quality health care includes racial differences in treatment of disease; poor health-seeking behaviors, such as delays in seeking diagnosis or treatment or overuse of emergency departments; and lack of health care resources. Furthermore, social determinants of health play considerable roles in health disparities and focuses more on multidisciplinary approaches rather than a single disease focus. The failure to translate to all populations research-generated evidence and clinical best practices is referred to by Freeman and others as the “discovery-delivery disconnect” which can lead to higher mortality and poorer survival rates from diseases such as cancer.[8]

Another factor that is closely related to health disparities is health care access. Access is complex and extends beyond simply having health insurance. Access is critically important, especially in view of the passage of the Affordable Care Act (Health Insurance Reform 2010) and its planned implementation in 2014. Access is defined as “the ability of a person to receive health care services,” which is a function of both the availability of health care personnel and supplies and the ability to pay for those services. The following five dimensions of access are important: availability, accessibility, accommodation, affordability and acceptability.[9] The concept of access and the relationship to patient satisfaction has also been recognized as important. Patient perceptions are critical for understanding barriers to health care delivery and potential modulators of treatment adherence. For example, a gay man may be reluctant to discuss certain risk factors for sexually transmitted diseases with his doctor if he does not feel comfortable disclosing his sexual orientation because of suspected prejudice. (See Dr. Hersh’s article, p. 16)

Disparities in access to care occur for many groups, including racial/ethnic minorities and low income and rural patients. Access disparities may relate to health insurance coverage and having a usual source of health care. Disparities exist in the receipt of quality health care, as documented by the Institute Of Medicine (IOM) and a number of landmark studies of African American patients and women.[10] The IOM landmark Report brought national attention to racial/ethnic disparities in health care. Findings from this study and others showed that disparities were consistent across a wide range of disease areas and clinical services:

- Disparities are found even when clinical factors, such as the stage of disease presentation, co-morbidities, age, and disease severity, are taken into account.
- Disparities are found across a range of clinical settings, including public and private hospitals and teaching and non-teaching hospitals.
- Disparities in care are associated with higher mortality among minorities.[11]

- Prolonged lack of health insurance has significant, serious health consequences. People who are uninsured delay seeking medical care and are reported to have greater difficulty obtaining health care when they do seek it. Prolonged periods without insurance can have a serious impact on a person's health and stability.

Whether an individual has a usual source of health care has an important influence on disparities. Patients with a usual source of care (a provider or facility where he or she regularly receives care) are reported to have better health outcomes and reduced disparities, such as smaller differences between population groups[12] and reduced health care costs.[13] Researchers suggest that the combination of having a usual source of care and health insurance has an additive effect on an individual's health care quality.[14] In addition, having a usual source of health care increases the receipt preventive services.[15] Patients who are uninsured, have less education and are poor are less likely to have a usual source of care.

Addressing Health Disparities and Inequities

Long-term, multilevel strategies are needed to reduce and eliminate health disparities. Patient, family, community and health care system changes are required to address differences in health and health care. Programs such as the Maryland Special Populations Network[7] and Regional Community Network[17] and the Maryland National Best Practice Award for rural cancer clinical trials[16] are just some of a variety of solution-oriented programs to address disparities in health. Each incorporates bidirectional partnerships with local communities and health professionals.

Maryland has led the nation in policy solutions to identify and address health disparities. A variety of creative strategies have incorporated policy research and research-guided policy efforts. Many of these efforts have included valuable input from community-based physicians, nurses and nurse practitioners, pharmacists, social workers, oral health care professionals and others.

Maryland Health Disparities Policy and Access Initiatives

The discussion below presents several key policy and legislative activities in the state that are related to health disparities.

Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234)—The law, signed April 10, 2012, establishes a $4 million pilot project to reduce health disparities in the state; improve health care access and outcomes, such as infant mortality, obesity and cancer; and lower health care costs and hospital readmissions. The law also contains a number of permanent provisions aimed at reducing health disparities. This law creates Health Enterprise Zones (HEZs) where health outreach will be targeted, with grants for community nonprofits and government agencies and tax breaks for health care providers who locate in HEZs. The five Maryland HEZs were awarded and announced the week of January 30, 2013.

Other provisions of this law are as follows:

- It establishes a standardized method to collect data on race and ethnicity in health care (both public and private providers) and ensures that carriers are working to track and reduce disparities
- It requires hospitals to describe their efforts to track and reduce health care disparities
- It establishes a process to set criteria for health care providers on cultural competency and health literacy training and continuing education.

Maryland Office of Minority Health and Health Disparities (HB 86)—In 2004, House Bill 86 and Senate Bill 177 officially established Maryland's Office of Minority Health and Health Disparities (MHHD) in the state's Department of Health and Mental Hygiene, effective Oct. 1, 2004. The Office aims to eliminate health disparities by assessing the health status of all populations, engaging local communities and partnering with the public and private sector. Health equity among African Americans, Hispanic/Latino Americans, Asian Americans, Native Americans, and all other groups experiencing health disparities is promoted (http://dhmh.maryland.gov/mhhd/). The Office reports and monitors health disparity data in the state.

Maryland State Office of Primary Care and Rural Health

This Office addresses health needs in primary health care and rural health. It provides coordination and technical assistance to stakeholders in underserved regions of the state and tracks state and federal designations for health professions shortage areas and medically underserved areas. http://fha.dhmh.maryland.gov/ohpp

Maryland Health Benefit Exchange

In preparation for the federal requirements for state implementation of the ACA, a number of activities have been completed in the state, including planning the state health exchanges discussed in the legislation. The Maryland Health Benefit Exchange (MHBE), working in partnership with the Department of Health and Mental Hygiene, the Maryland Insurance Administration, the Department of Human Resources and statewide stake-holders, is establishing Maryland's state-based health insurance exchange, scheduled to open in October 2013.

The goal of the exchanges is to make health insurance affordable and accessible for all Maryland residents, including the approximately 730,000 (or 14 percent) of Maryland's 5.8 million residents who are currently uninsured. To incorporate the needs of the marketplace, stakeholder insight and involvement throughout the state is necessary as the process continues to engage consumers and small employers to facilitate their understanding and use of the state-based exchange and ensure their access to health benefits. Additional information can be found at http://marylandhbe.com/.

Health Care Reform Coordinating Council

The Maryland Health Benefit Exchange Act of 2012 mentioned above delegated the task of selecting the state's health benefit benchmark plan to the Health Care Reform Coordinating

Council. The Council made its initial selection of the state's benchmark on September 27, 2012, after conducting an expert analysis comparing the ten plan options and obtaining the input of an Essential Health Benefits Advisory Committee composed of a broad range of diverse stakeholders. For more information on the EHB, see http://www.governor.maryland.gov/ltgovernor/pressreleases.

What can one family doctor do?

It would be easy to observe the pervasiveness of health care disparities in our state, throw up your hands and think, "I am already doing a lot." We urge you to look critically at your own community and consider seeking additional opportunities to serve. You may save a life or change an individual's world by doing so. As difficult as it is to run a cost-efficient family practice, we must recognize that many of our neighbors are suffering more than we are.

What more can you do? Consider pursuing evidence-based advocacy with your local or state elected officials. Legislators are receptive to hearing from doctors who are on the front lines of providing care to underserved members of the community. Ask your county health officer or Area Health Education Center director how you may partner together to improve your community's health. Keep abreast of the medical issues that are presented before the General Assembly each year. Look for calls for action by Med-Chi's leadership on health care disparity issues. You may find that serving others outside of the traditional office visit provides you with a great sense of fulfillment and personal satisfaction. Whatever level of involvement you choose, we hope this article and MFD edition has encouraged you to reflect on the health care disparities that exist not only in our state, but also in our neighborhoods. Each of us can do more to brighten the life of someone who is less fortunate.

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Biography

REFERENCES

1. Carter-Pokras, Olivia; Baquet, Claudia. “What is a” health disparity“?.”. Public health reports. 2002; 117.5:426–434. PMCID: PMC1497467. [PubMed: 12500958]
2. NIH Health Disparities Strategic Plan and Budget 2009-2013 and NCI/Center to Reduce Cancer Health Disparities (CRCHD). website http://crchd.cancer.gov/about/defined.html
3. CDC Health Disparities and Inequalities Report — United States, 2011. MMWR. Jan.2011 (Supplement 60)
4. CSDH. Final Report of the Commission on Social Determinants of Health. World Health Organization; Geneva: 2008. Closing the gap in a generation: health equity through action on the social determinants of health.
5. Maryland Chartbook of Minority Health And Minority Health Disparities Data. Second Edition. Department of Health and Mental Hygiene; Dec. 2009 p. 82http://dhmh.maryland.gov/mhhd/SitePages/Homeaspx
6. National Healthcare Disparities Report. AHRQ, HHS; 2011.
7. Baquet CR, Mack KM, Mishra SI, et al. Maryland’s Special Populations Network. A model for cancer disparities research, education, and training. Cancer. Oct; 2006 107(8 Suppl):2061–70. 15. [PubMed: 16944470]
8. Freeman HP. Poverty, culture, and social injustice: determinants of cancer disparities. CA Cancer J Clin. 2004; 54(2):72–77. [PubMed: 15061597]
9. Penchansky R, Thomas JW. Med Care. Feb; 1981 19(2):127–140. [PubMed: 7206846]
10. Smedley, Brian D.; Stith, Adrienne Y. Unequal treatment: Confronting racial and ethnic disparities in health care. Vol. Vol. 1. National Academy Press; 2003.
11. Bach, Peter B.; Cramer, Laura D.; Warren, Joan L.; Begg, Colin B. Racial Differences in the Treatment of Early-Stage Lung Cancer N Engl J Med. Oct 14.1999 341:1198–1205. M.D. Sc.M. Ph.D. Ph.D. 1999. DOI: 10.1056/NEJM199910143411606. [PubMed: 10519898]
12. Starfield, Shi. Milbank Quarterly. Contribution of Primary Care to Health Systems and Health. Sep; 2005 Volume 83(Issue 3):457–502. 2004.
13. De Maeseneer, et al. Quality of care: the need for medical, contextual and policy evidence in primary care. Journal of Evaluation in Clinical Practice. Oct; 2005 Volume 11(Issue 5):417–429. 2003. [PubMed: 16164582]
14. Haas, Jennifer S.; Phillips, Kathryn A.; Sonneborn, Dean; McCulloch, Charles E.; Baker, Laurence C.; Kaplan, Celia P., Dr; Pérez-Stable, Eliseo J.; Liang, Su-Ying. Variation in Access to Health Care for Different Racial/Ethnic Groups by the Racial/Ethnic Composition of an Individual’s County of Residence. Medical Care. Jul; 2004 Volume 42(Issue 7):707–714. MD, MSPH*†. PhD‡§. MA‡. PhDII. PhD*¶. PH††. MD††. PhD§. [PubMed: 15213496]
15. Ettner, Susan L. The Relationship Between Continuity of Care and the Health Behaviors of Patients: Does Having a Usual Physician Make a Difference? Medical Care. Jun; 1999 Volume 37(Issue 6):547–555. [PubMed: 10386567]
16. US HHS National Best Practice Award for increasing cancer clinical trial participation and availability on the rural Eastern Shore: Award recipients: CBaquet, MD, MPH and MDeShields, MD.
17. Baquet, C. A Model for Bidirectional Community-Academic Engagement (CAE): Overview of Partnered Research, Capacity Enhancement, Systems Transformation, and Public Trust in Research. Journal of Health Care for Poor and Underserved. published November 2012: PMCID: PMC Journal - In Process