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PRESENTS



AN INFORMATIONAL BRIEFING

EMERGING HEALTH CARE DISPARITIES and its **IMPACT** on The **HEALTH CARE SAFETY NET SYSTEM**



Emerging Health Care Disparities and Its Impact on the Health Care Safety Net System

Briefing Overview: 10 years later, where are we now?

It has been over a decade since Congress first officially acknowledged that this country has a problem with race and health. In 1999, the Federal Government asked the Institute of Medicine—an independent nonprofit whose reports are the gold standard for health-care policymakers—to investigate disparities in health and health care among racial and ethnic minorities. The results of their findings were released on March 20, 2002 and it was damning. The ensuing study, called *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, found that minorities had poorer health and received consistently lower-quality care even when factors such as insurance status and income were not involved.

The congressionally mandated report stated that a large body of research underscores the existence of disparities. For example, minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery, and are less likely to receive kidney dialysis or transplants. In addition, several studies show significant racial differences in who receives appropriate cancer diagnostic tests and treatments. Minorities also are less likely to receive the most sophisticated treatments for HIV infection, which could forestall the onset of AIDS. By contrast, they are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions.

The committee's first recommendation for reducing racial and ethnic disparities in health care was to increase awareness about them among the general public, health care providers, insurance companies, and policy-makers. Consistency and equity of care should also be promoted through the use of "evidence-based" guidelines to help providers and health plans make decisions about which procedures to order or pay for based on the best available science. Other specific steps to reduce and eliminate disparities appear in the report.

In the 10 years since the release of

the report, many more have followed, and several agencies—including the National Center on Minority Health—have examined the problem and suggested solutions. However, studies continue to turn up disturbing disparities. For instance, in 2010, a paper from the Fred Hutchinson Cancer Research Center found that between 1992 and 2004, black women were up to 90 percent more likely to be diagnosed with advanced breast cancer than white women were, even though rates of mammogram screening were similar for the two groups. Another recent study put the health data in financial terms and found that race-related differences in health care cost the country \$229 billion between 2003 and 2006, a result that could not be ignored by anyone in the health care industry.

So why, now that it is a decade since the IOM report was released and we are aware there is a problem, do we still have one? The California Legislative Black Caucus (CLBC) intends to address this question during its briefing and look at workable solutions that have been implemented at both the Federal and State levels to address health disparities, and evaluate whether or not these solutions are working adequately in California and identify any challenges that might exist.

For example, a common argument to the difficulty of addressing race and health is the simple issue of how to classify people in order to study health disparities. Take the case of Hispanics, "They're a group that is linked only by being from countries that were under Spanish rule," says Thomas A. LaVeist, Director of the Hopkins Center for Health Disparities Solutions. "To combine Cubans and Mexicans and everyone else into one category doesn't make a lot of sense. The populations are so different. You have a tremendous amount of variation [in health, lifestyle, and genetic heritage] that's being masked." Or take the fact that studies often put Africans living in the U.S. in the same category as African-Americans who were born and raised here. If you want to study, say, HIV rates, that catchall category becomes meaningless, says

LaVeist, because the virus is so much more prevalent in Africa.

These complications make it extremely difficult to implement good policies around race and health. Even though, says Sequist, "about three or four years ago, there was a huge push to move into the phase of actually doing something about this." Cultural competency training has now become standard in many medical centers, and once the Affordable Health Care Act is implemented "over three dozen provisions that offer promise" for addressing inequities, says Dennis P. Andrulis, director of the Center for Health Equality at Drexel University.

Health-care reform probably will not be enough to change the fact that minorities are more likely to be in poor health. For that, "we will need even more sweeping social policies," says Brian Smedley, one of the authors of the Institute of Medicine report. "There's a growing recognition that we need to address environmental health hazards; that we need to improve the food options in neighborhoods and schools, to improve the availability of parks and recreation facilities in communities that are overrun with liquor stores and fast-food restaurants," he says.

The CLBC agrees with this assessment and as a result will look at the Safety Net Systems in California to determine their role in eliminating health disparities, as well as their impact on these already "budget strapped" programs. In this preliminary briefing, the health care safety net system will be examined. Other State programs will be subsequently looked at during the CLBC conference series scheduled from June to November 2012. The results of these briefings and conferences will be submitted to the Legislature and public through a report that will be released in March of 2013.

CLBC INFORMATIONAL BRIEFING

Emerging Health Care Disparities
and Its Impact on the Health Care Safety Net System
**Wednesday, March 28, 2012 | Upon Adjournment of Senate Health
State Capitol, Room 4203**

I. Welcome and Opening Statement

- **Senator Curren D. Price, Jr.**

II. Overview

Where are we now? 10 years after the Institute of Medicine (IOM) released its report: Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care in 2002.

- **Dr. Gary Puckrein**, Executive Director, National Minority Quality Forum

III. Panel Discussion: *Emerging Disparities in the African American Community*

How have the numbers changed for African Americans suffering with chronic diseases 10 years after the IOM report was released?

1. Chronic Kidney Disease & Other Emerging Chronic Diseases

- **Dr. Keith Norris**, Vice President, Charles Drew University

2. Stroke & Diabetes

- **Dr. Gary Puckrein**, Executive Director, National Minority Quality Forum

IV. Agencies/Health Care Providers

What measures were implemented in CA after the Institute of Medicine (IOM) report was released to ensure that these disparities did not continue? How has the Safety Net System been impacted by these growing disparities?

1. Department of Health Care Services

- **Dr. Neal Kohatsu**, Medical Director

2. Kaiser Permanente

- **Angela Jenkins**, Community Benefit Manager

V. Community Testimonies

How has the Safety Net System assisted or made it more difficult to address the needs of minority patients suffering with chronic diseases?

1. American Heart Association

- **Dr. Barbara Nash**, Family Practice

VI. Closing Statement

INSTITUTE OF MEDICINE

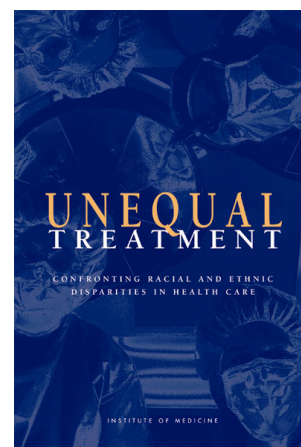
Shaping the Future for Health

UNEQUAL TREATMENT: WHAT HEALTH CARE SYSTEM ADMINISTRATORS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE

If you are a health system administrator or manager, yours may be among the most difficult jobs in the nation: on a daily basis, you contend with multiple challenges, including rapidly escalating health care costs, concerns about patient safety, and negative public perceptions of health insurers. At the same time, you work hard to provide high-quality health care products and services to an increasingly diverse patient population—including a growing number of racial and ethnic minorities and individuals who primarily speak a language other than English.

To compound these concerns, minorities and non-English speakers have greater difficulty accessing needed health care services. Minorities are disproportionately more likely than the general population to be uninsured, and are overrepresented among those in publicly-funded health systems (e.g., Medicaid, see Figure 1). Even when these individuals have the same health insurance and similar access to a health care provider as non-minorities, recent research indicates that racial and ethnic minorities tend to receive a lower quality of healthcare than whites. How can these disparities exist, when health systems and health care professionals have dedicated themselves and work hard to provide the highest possible quality of care to all patients?

The Institute of Medicine (IOM) addressed this and other questions regarding disparities in the quality of care for different racial and ethnic groups in a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. This report concluded that “[t]he sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, health care professionals, and patients.” In other words, many actors may contribute—wittingly or unwittingly, in ways both large and small—to create a pattern of inequitable care. This brief summary of the IOM *Unequal Treatment* report describes how these disparities may emerge, and summarizes relevant findings and recommendations to help healthcare managers and professionals meet the objective of providing high-quality care for all patients.



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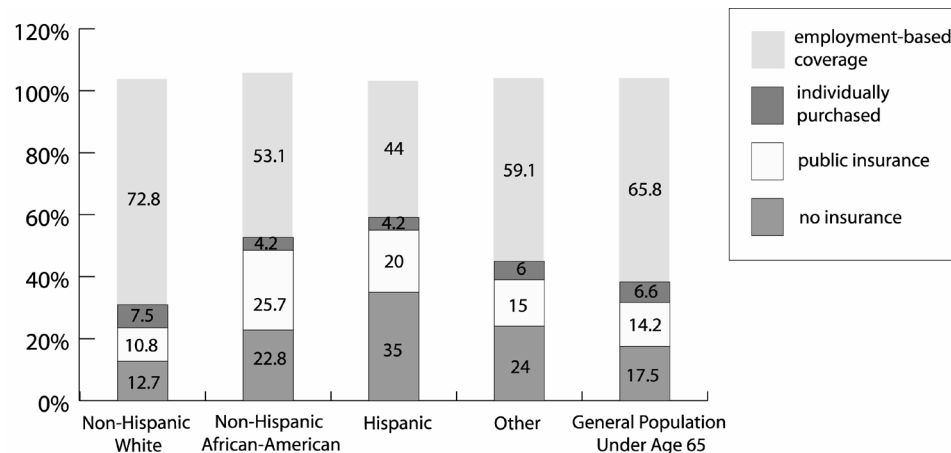


Figure 1. Sources of health insurance for population under age 65, by race and ethnicity, 1999. NOTE: Numbers may not add to 100 percent due to respondents reporting more than one source of coverage and due to rounding. SOURCE: Fronstin, 2000

WHAT IS THE EVIDENCE REGARDING HEALTH CARE DISPARITIES?

In 1999, Congress requested that the IOM: 1) assess the extent of racial and ethnic disparities in healthcare, assuming that access-related factors such as insurance status and the ability to pay for care are the same; 2) identify potential sources of these disparities; and 3) suggest intervention strategies. To fulfill this request, an IOM study committee reviewed well over 100 studies that assessed the quality of healthcare for various racial and ethnic minority groups, while holding constant variations in insurance status, patient income, and other access-related factors. Many of these studies also controlled for other potential confounding factors, such as racial differences in the severity or stage of disease progression, the presence of co-morbid illnesses, where care is received (e.g., public or private hospitals and health systems) and other patient demographic variables, such as age and gender. Some studies that employed more rigorous research designs followed patients prospectively, using clinical data abstracted from patients' charts, rather than administrative data used for insurance claims.

The study committee was struck by what it found. Even among the better-controlled studies, the vast majority of published research indicates that minorities are less likely than whites to receive needed services, including clinically necessary procedures, even after correcting for access-related factors, such as insurance status. In general, this research shows that:

- African Americans and Hispanics tend to receive a lower quality of healthcare across a range of disease areas (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 to receive less desirable services, such as amputation of all or part of a limb;
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account;
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.; and

...research indicates that minorities are less likely than whites to receive needed services, including clinically necessary procedures, even after correcting for access-related factors, such as insurance status.

- Disparities in care are associated with higher mortality among minorities who do not receive the same services as whites (e.g., surgical treatment for small-cell lung cancer).

WHAT ARE POTENTIAL SOURCES OF RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE?

The IOM report notes that many sources—including those related to characteristics of patients, of health systems, and the clinical encounter—may contribute to racial and ethnic disparities in care:

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Minority Patients and Health Care Disparities

Some researchers speculate that minority patients may receive a lower quality of healthcare as a result of differences in health care seeking behaviors. Minority patients, for example, may be more likely than whites to refuse recommended services and delay seeking healthcare. These behaviors and attitudes can develop as a result of a poor cultural match between minority patients and their providers, mistrust, misunderstanding of provider instructions, poor prior interactions with health care systems, inadequate access to private physician offices and clinics, or simply from a lack of knowledge of how to best use health care services.

Racial and ethnic differences in patient preferences and care-seeking behaviors and attitudes, however, are unlikely to be major sources of health care disparities. For example, while minority patients have been found to refuse recommended treatment more often than whites, differences in refusal rates are small and have not fully accounted for racial and ethnic disparities in the utilization of health care services. In addition, it remains unclear why these patients are more likely to reject treatment recommendations. Are they refusing treatment because of a general mistrust of health care providers? Or do some decline treatment because of negative experiences in the clinical encounter or a perception that their doctor is not invested in their care? More research is needed to fully understand treatment refusal because the reasons for refusal may lead to different strategies to help patients make informed treatment decisions.

The Clinical Encounter and Health Care Disparities

To understand how aspects of the clinical encounter may contribute to health care disparities, it's important to understand how doctors make decisions about patient care. Many of the decisions that doctors must make are made with a degree of uncertainty. This uncertainty may be related to the patient's diagnosis, how the patient may respond to treatment, whether treatment might lead to potential complications, or even the patient's long-term outlook. To make matters worse, in many health care settings doctors may face significant time pressures, resource constraints, and on occasion, complex medical problems that are not easily understood or solved.

Uncertainty can therefore make finding the right diagnosis and treatment plan a challenge for any doctor. But when faced with patients who are from different racial or ethnic backgrounds, doctors may find that their uncertainty about the patient's condition and best course of treatment is even greater. This uncertainty can "open the door" for physicians' stereotypes and biases to affect their judgment of patients and interpretation of their presenting concerns.

A large body of research in social psychology has demonstrated that stereotyping is an almost universal human cognitive function.

A large body of research in social psychology has demonstrated that stereotyping is an almost universal human cognitive function. Stereotyping is a process by which people use social groups (such as sex and race) to gather, process, and recall information about other people. Stereotyping helps people to organize a very complex world, and can give us more confidence in our abilities to understand a situation and respond to it, particularly when we lack information. There is, however, a downside to stereotyping, in that it is the nature of stereotypes to be biased or unfair.

Over four decades of research in cognitive and social psychology reveals that stereotypes:

- Are automatically activated (that is, they are generated without conscious effort);
- Are held even by people who truly believe that they do not judge others based on social categories, but have been unconsciously influenced by the implicitly biased stereotypes in American society;
- Affect how we process and recall information about others (people are more likely to recall information about others that is consistent with widely-held social stereotypes about minorities, women, etc.); and,
- Guide our expectations and perceptions and shape our personal interactions, producing “self-fulfilling prophecies” (that is, our own beliefs about how a situation should or will unfold can actually influence the interaction so that it meets our expectations).

While more research must be done to better understand how stereotypes and biases affect the clinical encounter, research to date has demonstrated that health care providers’ diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients’ race or ethnicity and stereotypes associated with them.

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A study of cardiologists, for example, found that these physicians referred white male, black male, and white female hypothetical “patients” (actually videotaped actors who displayed the same symptoms of cardiac disease) for cardiac catheterization at the same rates (approximately 90 percent for each group), but were significantly less likely to recommend catheterization procedures for black female patients exhibiting the same symptoms. Another experiment found that when mental health professionals were briefly shown African American stereotype-laden words (for example, “basketball,” “lazy,” and “jazz”) before reading a description of a hypothetical patient, they evaluated the patient (whose race was not identified) more negatively than when they were shown neutral words prior to reading the patient description. In a study based on actual clinical encounters, 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.

HEALTH SYSTEMS ATTRIBUTES AND HEALTH CARE DISPARITIES

Aspects of health systems—such as the ways in which systems are organized and financed, and the availability of services—may exert different effects on patient care, particularly for racial and ethnic minorities. Language barriers, for example, pose a problem for many patients where health systems lack the resources, knowledge, or institutional priority to provide interpretation and translation services. Nearly 14 million Americans

are not proficient in English (see Figure 2), and as many as one in five Spanish-speaking Latinos reports not seeking medical care due to language barriers. Similarly, time pressures on physicians may hamper their ability to accurately assess presenting symptoms of minority patients, especially where cultural or linguistic barriers are present. Further, the geographic availability of health care institutions—while largely influenced by economic factors—may have a differential impact on racial and ethnic minorities, independently of insurance status. A study of the availability of opioid supplies, for example, revealed that only one in four pharmacies located in predominantly non-white neighborhoods carried adequate supplies, compared to 72 percent of pharmacies in predominantly white neighborhoods.

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Changes in the financing and delivery of health care services—such as the shifts brought by cost-control efforts and the movement to managed care—may also pose greater barriers to care for racial and ethnic minorities than for non-minorities. Increasing efforts by states to enroll Medicaid patients in managed care systems, for example, may disrupt traditional community-based care and displace providers who are familiar with the language, culture, and values of ethnic minority communities. For example, a recent study indicates that minorities enrolled in publicly-funded managed care plans are less likely to access services after mandatory enrollment in an HMO, compared to whites enrolled in the same health systems and other minorities enrolled in Medicaid non-managed care plans.

Some disparities may also emerge from the fact that health systems are becoming increasingly fragmented based on resource constraints. Fragmentation occurs when patients—even those enrolled in private health plans—receive different types and qualities of treatment as a result of different levels of plan coverage, differing benefit packages and different degrees of provider choice. Individuals in lower tier health plans commonly face higher per-patient resource constraints and have fewer choices with regard to health products and services, which may result in a poorer quality of care. To the extent that racial and ethnic minorities are more likely, for economic reasons, to enroll in lower tiered plans, fragmentation may contribute to disparities in healthcare.

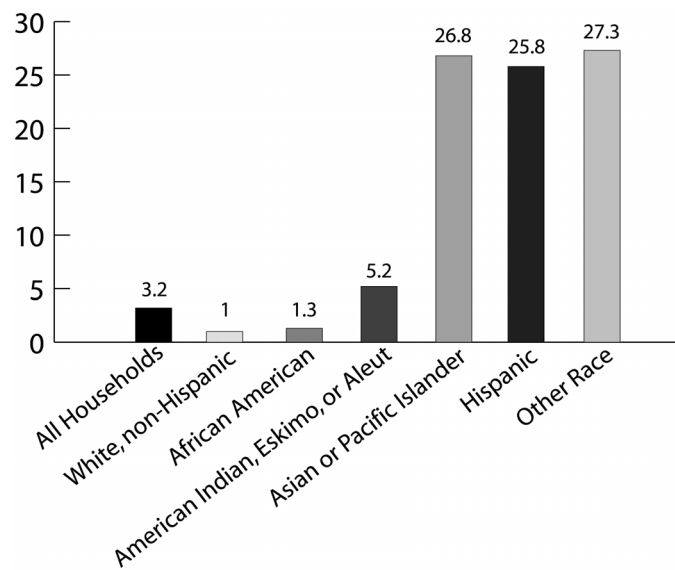


Figure 2. Percentage Linguistically Isolated Households, by Race and Ethnicity, United States, 1990. SOURCE: U.S. Bureau of the Census, 1993.

WHAT CAN BE DONE TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE?

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

Raising Public and Health Care Professionals' Awareness of the Problem. The report's authors conclude that a significant barrier to eliminating health care disparities is a lack of awareness of the problem on the part of key stakeholders. Therefore, an impor-

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tant first step is to raise awareness of the health care gap among broad sectors, including health care providers, their patients, payors, health plan purchasers, and society at large.

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

- Base decisions about resource allocation (e.g., which patients should receive particular treatments for specific health conditions) on published clinical guidelines;
- Take steps to improve access to care—including the provision of interpretation and translation services, where community need exists;
- To the extent possible, equalize access to the same health care products and services, to avoid fragmentation of health plans;
- Insure that physician financial incentives do not disproportionately burden or restrict minority patients' access to care;
- Support the use of community health workers and multidisciplinary treatment and preventive care teams; and
- Collect and monitor data on patients' access and utilization of health care services by race, ethnicity, and primary language.

Legal, Policy, and Regulatory Strategies. 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 plan products serving substantial proportions of privately-insured patients;
- Publicly-funded health systems should take steps to improve the stability of patient-provider relationships by establishing guidelines for minimum 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 underrepresented 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; and,
- The U.S. Department of Health and Human Services should encourage collection, reporting, and monitoring of patient care by health plans and federal and state payors as a means to assess progress in eliminating disparities, to evaluate intervention efforts, and to assess potential civil rights violations.

Educational Strategies. Both patients and providers can benefit from education. Patients can benefit from culturally appropriate education programs to improve their knowledge of how to access care and their ability to participate in clinical-decision making. More importantly, health care professionals need tools to understand and manage the cultural and linguistic diversity of patients seen in today's health systems and avoid allowing unconscious biases and stereotypes to affect their interactions with patients. Cross-cultural curricula should be integrated early into the training of future health care providers, and practical, case-based, rigorously evaluated training should persist through practitioner continuing education programs.

CONCLUSION

Racial and ethnic disparities in healthcare persist despite considerable progress in expanding health care services and improving the quality of patient care. Many factors contribute to these disparities in complex ways, but the quality of healthcare can be improved for all patients with a comprehensive strategy that includes attending to the needs of health care providers and their patients, to the conditions of health care settings in which care takes place, to the broader policies and practices of health systems, and to state and federal policies that govern the operation of health systems. These strategies are likely not only to reduce health care disparities, but also to improve the efficiency and equity of care for all patients.

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For More Information...

Copies of *Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care* are available for sale from the National Academy Press; call (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area), or visit the NAP home page at www.nap.edu. The full text of this report is available at <http://www.nap.edu/catalog/10260.html>

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Racial and Ethnic Disparities in Health Care

November 2006



ALLIANCE FOR
HEALTH REFORM

The Agency for Healthcare 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.

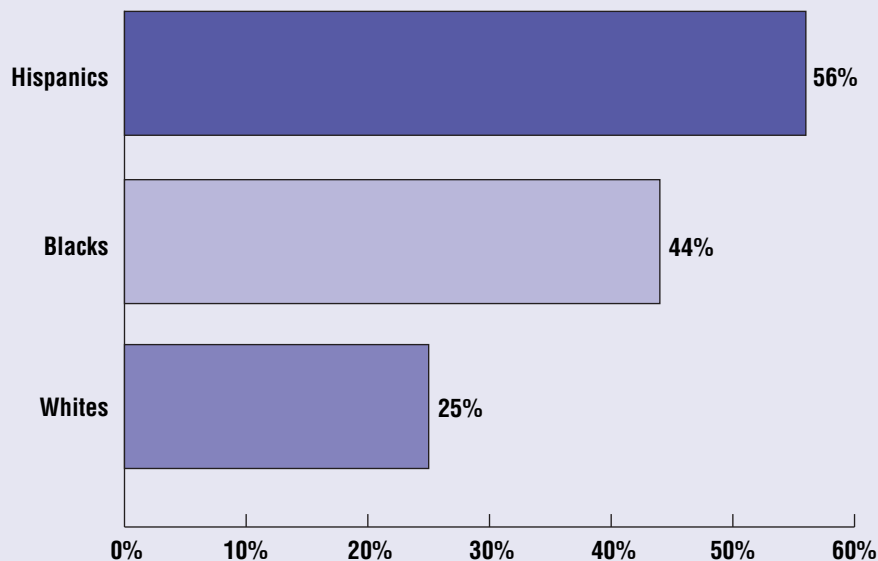
Other possible explanations for disparities include health practices among minor-

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



ALLIANCE FOR HEALTH REFORM

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

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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

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- ▲ **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
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Websites

- ▲ **Agency for Healthcare Research and Quality** www.ahrq.gov
- ▲ **Asian and Pacific Islander American Health Forum** www.apiahf.org
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- ▲ **Black Women's Health Imperative** www.blackwomenshealth.org
- ▲ **DHHS Office of Minority Health** www.omhrc.gov
- ▲ **National Center on Minority Health and Health Disparities** http://ncmhd.nih.gov/
- ▲ **National Hispanic Medical Association** www.nhmamd.org
- ▲ **National Minority Health Month Foundation** www.nmhmf.org
- ▲ **Robert Wood Johnson Foundation** www.rwjf.org

For additional experts and websites on this and other subjects, go to www.allhealth.org.

Tables Showing Changes in Expenditure for Social Services from 2002 to 2012 by the State of California:

DSS Overall	General Fund	Special Fund	Federal Funds	TOTAL	Percent change
2001-02	\$7,570,324,000	\$3,201,000	\$5,853,153,000	\$13,426,678,000	
2006-07	\$9,131,831,000	\$27,080,000	\$5,929,027,000	\$15,087,938,000	12.4%
2011-12	\$6,300,341,000	\$29,209,000	\$6,977,199,000	\$13,306,749,000	-11.8%

CalWORKs	General Fund	Special Fund	Federal Funds	TOTAL	Percent change
2001-02	\$2,016,406,000		\$3,228,698,000	\$5,245,104,000	
2006-07	\$2,017,840,000		\$2,908,899,000	\$4,926,739,000	-6.1%
2011-12	\$1,059,402,000		\$3,200,189,000	\$4,259,591,000	-13.5%

SSI/SSP	General Fund	Special Fund	Federal Funds	TOTAL	Percent change
2001-02	\$2,793,176,000			\$2,793,176,000	
2006-07	\$3,533,580,000			\$3,533,580,000	26.5%
2011-12	\$2,737,249,000			\$2,737,249,000	-22.5%

Sources: January Governor's Budget Summaries from 2003-04, 2008-09 and 2012-13 for actual 2001-02 and 2006-07 figures and estimated 2011-12 figures, respectively.

CAUSES OF DEATH IN THE STATE OF CALIFORNIA BY RACE AND ETHNIC GROUP FOR 2009

TABLE 5-8¹

Tables Showing the Percentage of Deaths in each Disease Group

Listing them in order of Highest to Lowest Percentage

No. 1 Cause of Death in California

Deaths Caused by Diseases of the Heart (2009)

NH= Non-Hispanic

Rank	Race/Ethnic Group	No. of Deaths	% of Pop	Population	
				Amount	% of Deaths
1	White	40,996	40.1%	14,938,836	0.2744%
2	NH Black	4,637	6.1%	2,272,491	0.2040%
3	NH Pacific Islander	204	0.4%	149,016	0.1369%
4	NH Asian	4,424	13.0%	4,843,014	0.0913%
5	Hispanic	7,933	34.5%	12,852,615	0.0617%
6	NH American Indian	187	1.0%	372,540	0.0502%
7	NH 2 or more races	420	4.9%	1,825,444	0.0230%
Total		58,801	100.0%	37,253,956	

No. 2 Cause of Death in California

Deaths Caused by Malignant Neoplasms (Cancers) (2009)

NH= Non-Hispanic

Rank	Race/Ethnic Group	No. of Deaths	% of Pop	Population	
				Amount	% of Deaths
1	White	37,095	40.1%	14,938,836	0.2483%
2	NH Black	4,227	6.1%	2,272,491	0.1860%
3	NH Pacific Islander	165	0.4%	149,016	0.1107%
4	NH Asian	5,220	13.0%	4,843,014	0.1078%
5	Hispanic	8,445	34.5%	12,852,615	0.0657%
6	NH American Indian	185	1.0%	372,540	0.0497%
7	NH 2 or more races	416	4.9%	1,825,444	0.0228%
Total		55,753	100.0%	37,253,956	

CAUSES OF DEATH IN THE STATE OF CALIFORNIA BY RACE AND ETHNIC GROUP FOR 2009

TABLE 5-8¹

Continued

No. 3 Cause of Death in California

Deaths Caused by Cerebrovascular Diseases (2009)

NH= Non-Hispanic

Rank	Race/Ethnic Group	No. of Deaths	% of Pop	Population	
				Amount	% of Deaths
1	White	8,564	40.1%	14,938,836	0.0573%
2	NH Black	1,032	6.1%	2,272,491	0.0454%
3	NH Pacific Islander	49	0.4%	149,016	0.0329%
4	NH Asian	1,531	13.0%	4,843,014	0.0316%
5	Hispanic	2,110	34.5%	12,852,615	0.0164%
6	NH American Indian	45	1.0%	372,540	0.0121%
7	NH 2 or more races	79	4.9%	1,825,444	0.0043%
Total		13,410	100.0%	37,253,956	

No. 4 Cause of Death in California

Deaths Caused by Chronic Lower Respiratory Disease (2009)

NH= Non-Hispanic

Rank	Race/Ethnic Group	No. of Deaths	% of Pop	Population	
				Amount	% of Deaths
1	White	10,201	40.1%	14,938,836	0.0683%
2	NH Black	760	6.1%	2,272,491	0.0334%
3	NH Asian	719	13.0%	4,843,014	0.0148%
4	NH Pacific Islander	22	0.4%	149,016	0.0148%
5	Hispanic	1,079	34.5%	12,852,615	0.0084%
6	NH American Indian	30	1.0%	372,540	0.0081%
7	NH 2 or more races	94	4.9%	1,825,444	0.0051%
Total		12,905	100.0%	37,253,956	

No. 6 Cause of Death in California

Deaths Caused by Alzheimer's Disease (2009)

NH= Non-Hispanic

Rank	Race/Ethnic Group	No. of Deaths	% of Pop	Population	
				Amount	% of Deaths
1	White	7,927	40.1%	14,938,836	0.0531%
2	NH Black	460	6.1%	2,272,491	0.0202%
3	NH Asian	487	13.0%	4,843,014	0.0101%
4	Hispanic	933	34.5%	12,852,615	0.0073%
5	NH Pacific Islander	10	0.4%	149,016	0.0067%
6	NH American Indian	15	1.0%	372,540	0.0040%
7	NH 2 or more races	50	4.9%	1,825,444	0.0027%
Total		9,882	100.0%	37,253,956	

CAUSES OF DEATH IN THE STATE OF CALIFORNIA BY RACE AND ETHNIC GROUP FOR 2009

TABLE 5-8¹

Continued

No. 7 Cause of Death in California Deaths Caused by Diabetes Mellitus (2009)

NH= Non-Hispanic

Rank	Race/Ethnic Group	No. of Deaths	% of Pop	Population	
				Amount	% of Deaths
1	NH Black	784	6.1%	2,272,491	0.0345%
2	NH Pacific Islander	50	0.4%	149,016	0.0336%
3	White	3,444	40.1%	14,938,836	0.0231%
4	NH Asian	722	13.0%	4,843,014	0.0149%
5	Hispanic	1,865	34.5%	12,852,615	0.0145%
6	NH American Indian	41	1.0%	372,540	0.0110%
7	NH 2 or more races	55	4.9%	1,825,444	0.0030%
Total		6,961	100.0%	37,253,956	

TABLE 4-7²

Infant Mortality Rate among California Resident Births, 2009

NH= Non-Hispanic

Rank	Race/Ethnic Group	No. of Deaths*	% of Pop	Population	
				Amount	
1	NH 2 or more races	13.5	4.9%	1,825,444	
2	NH Black	10.6	6.1%	2,272,491	
3	NH Pacific Islander	7.5	0.4%	149,016	
4	NH American Indian	5.5	1.0%	372,540	
5	Hispanic	5.0	34.5%	12,852,615	
6	White	4.1	40.1%	14,938,836	
7	NH Asian	3.1	13.0%	4,843,014	
Total			100.0%	37,253,956	

Total Infant Mortality Rate: 4.9

*Rate per 1,000 live births

1 - TABLE 5-8: THIRTEEN LEADING CAUSES OF DEATH BY RACE/ETHNIC GROUP AND SEX CALIFORNIA, 2009 (By Place of Residence) **Source:** State of California, Department of Public Health, Death Records. <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2009-0508.pdf>

2 - TABLE 4-7: INFANT, NEONATAL, AND POSTNEONATAL DEATHS AND INFANT MORTALITY RATES BY SEX, AND RACE/ETHNIC GROUP¹ OF CHILD, CALIFORNIA, 2009 (By Place of Residence) (Rates are per 1,000 live births in specified group.) <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2009-0508.pdf>

