Race, Ethnicity and Health Care

Issue

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. 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] These disparities exist even when comparing individuals of similar income and insurance. 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 geographic areas were of major concern.[3] The decision for the U.S. 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 the nation's health and thus, health care system.

Policy Challenges 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 early 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.[4] 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 from circumstances or interactions at the level of the patient, provider, and health care system. The recommendations point to four broad areas of policy challenges:

- Raising public and provider awareness of racial/ethnic disparities in care;
- Expanding health insurance coverage;
- Improving the capacity and number of providers in underserved communities; 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.[5] Not surprisingly, some of the misperceptions of the public are also found among physicians. The vast majority (69%) of physicians say that the health care system "rarely or never" treats people unfairly based on an individual's racial/ethnic background.[6]

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 misunderstands 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. 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. 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

Access to a racially and ethnically diverse mix of high-quality sources of medical care also affects disparities in care. 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 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.[7] 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.[8]

When health providers are geographically accessible, language and cultural barriers are sometimes a problem. 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.[9] 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.[10]

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 we know so little about patterns of health care use of American Indians/Alaska Natives, Asian /Pacific Islanders, and Latinos is that we have not collected the data or have insufficient sample sizes in available data sources. Baseline and follow-up data across racial/ethnic groups is essential for monitoring purposes.

Assessing Candidate Positions

Attracting the votes of people of color has been a goal of both candidates in the closely contested 2004 election. Recent surveys show that communities of color place considerable importance on health care issues when casting their votes. African Americans are about twice as likely as whites to say that health care issues are important in deciding their vote, and about half of registered Latinos say that the cost of heath care and insurance will be extremely important to their vote.[11] Views also differ by race on government's role in eliminating health care disparities. The vast majority (90%) of 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." [12] Such contrasting views contribute to the lack of consensus on how to address disparities in care.

The following questions will help you evaluate the candidates' proposals for addressing racial/ethnic health care disparities:

- What is the candidate's general approach to reducing racial/ethnic disparities in health care?
- What is the candidate's plan to raise awareness about racial/ethnic disparities in health care?
- What is the candidate's proposal to expand sources of insurance coverage? What segments of the population does the proposal target?
- Does the candidate have a plan to increase prevention efforts for diseases that disproportionately impact communities of color?
- What is the candidate's stance on directing funds specifically for training health care professionals of color to increase diversity in the healthcare workforce?
- What is the candidate's plan to ensure cultural and linguistic competence in health care?
- How does the candidate plan to hold government agencies accountable for monitoring and addressing racial/ ethnic disparities within the health care system?

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

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

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

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

[7] The Commonwealth Fund Health Care Quality Survey, 2001

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

[9] Kaiser Family Foundation/Pew Hispanic Center, Health Care Experiences, *Survey Brief,* 2004.

[10] 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.

[11] Talylor-Clark, K. et al. African Americans' Views on Health Policy: Implications for The 2004 Elections. *Health Affairs*, 2003; Kaiser Family Foundation/Pew Hispanic Center, Health Care Experiences, *Survey Brief,* 2004.

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

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