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Health Policy Brief

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Achieving Equity in Health. Racial and ethnic minorities face worse health and health care disparities—but some interventions have made a difference.

WHAT'S THE ISSUE?

America's racial and ethnic minorities have worse health than whites do, and they often receive a lesser standard of health care. People who have limited education or income or who live in poor neighborhoods have worse health and health care compared to those who are better educated or financially better off. People with disabilities are also in worse health, and receive worse health care, compared to people without disabilities.

Narrowing these disparities in health and health care has been the goal of many public and private efforts since the early 1990s. Although some progress has been made—particularly in closing the quality gap in the care that minorities and whites receive—much more remains to be done.

The multiple causes of health and health care disparities are complex, and some are only beginning to be explored deeply. This policy brief summarizes what is known about health and health care disparities, discusses recent efforts to close the gaps, and enumerates some policy recommendations for making further progress.

WHAT'S THE BACKGROUND?

Racial and ethnic minorities represent about one-third of the US population and, according to the latest Census Bureau projections,

will become the majority of the population by 2042. It has long been known that these minorities face *health disparities*, in that their health is worse overall than the health of white Americans. A separate but related issue is that they also experience *disparities in the health care* they receive.

HIGHER MORTALITY RATES: As an example of *health disparities*, according to the National Center for Health Statistics, the age-adjusted death rate for blacks has been sharply higher than for whites for decades and was almost 29 percent higher in 2007. What's more, infant mortality among black infants has been more than twice that of white infants and was 130 percent higher in 2006.

Minorities as a whole have a higher prevalence of diabetes, stroke, and other largely preventable diseases and conditions than their white counterparts. And in 2007, the age-adjusted death rate from breast cancer was 31.4 deaths per every 100,000 black women, versus 22.2 breast cancer deaths for every 100,000 for white women—a 41 percent higher rate.

Health care disparities have proved persistent as well. African Americans, for example, are three times more likely to die from heart disease compared to whites. A recent US government report showed that since 2007, inpatient care for people with heart failure has actually grown worse for Hispanics or Latinos, Native Americans, and Alaska Natives. These

minorities with heart failure are younger than their white counterparts. They also encounter socioeconomic, language, and cultural barriers to care that lead to higher rates of readmission to hospitals and to poorer outcomes.

What's more, with respect to health insurance and the effect on having access to health care—blacks and Hispanics have long had lower coverage rates as a whole than whites.

LANDMARK STUDIES: In 2001 and 2003 the Institute of Medicine (IOM), an arm of the National Academies, published two reports drawing further attention to the issue of disparities in health care. In *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM highlighted equity as one of the six key pillars to providing high-quality care and pointed to the lack of equity as one of the major deficiencies of the US health care system.

In 2003 the institute published another landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. This second report defined *health care disparities* as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.”

This second report cited a “consistent body of research” showing that racial and ethnic minorities were less likely to receive even routine medical procedures and were far more likely to experience lower-quality health services than whites. Minorities, for example, were less likely than whites to be given appropriate cardiac medications or to receive kidney dialysis or transplants, and were more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes. The report also cited evidence that health care providers frequently stereotyped minorities, held biases against treating them, or displayed uncertainty in how to treat them effectively.

To address these issues, the IOM recommended increasing awareness about disparities among the general public, health care providers, insurance companies, and policy makers. It also recommended better adherence to evidence-based quality guidelines for all patients, as well as expansion of the ranks of health care providers who were minorities themselves and therefore more likely to serve in minority communities.

Following these two IOM reports, various national initiatives and educational campaigns were undertaken to draw attention to health disparities. By 2010, 59 percent of Americans nationwide knew that African Americans and Hispanics or Latinos had poorer health outcomes than whites—a statistic that represented a modest increase in awareness compared to the 55 percent who reported this knowledge in a 1999 national survey conducted by the Kaiser Family Foundation. (See “Awareness of Racial and Ethnic Health Disparities Has Improved Only Modestly Over a Decade,” *Health Affairs*, October 2011.)

THE COST OF DISPARITIES: Disparities are costly. Among African Americans and Hispanics, the cost burden of three preventable conditions—high blood pressure, diabetes, and stroke—was about \$23.9 billion in 2009, according to a study by the Urban Institute. Health inequities were estimated to contribute \$1.2 trillion in lost wages and productivity between 2003 and 2006. In arriving at this number, the Joint Center for Political and Economic studies considered the direct costs associated with providing care to a sicker and more disadvantaged population as well as the indirect costs of health inequities, such as a lost productivity, lost wages, absenteeism, family leave, and premature death.

The Agency for Healthcare Research and Quality, a federal agency that seeks to improve the quality, safety, efficiency, and effectiveness of health care in the United States, began issuing annual reports on health care disparities in 2003. In its annual disparities report for 2010 (issued in February 2011), the agency said that blacks, American Indians, and Alaska Natives received worse care than whites for about 40 percent of the agency's list of core measures (which include such criteria as whether women receive timely mammography screenings and whether heart attack patients receive recommended hospital care).

Hispanics or Latinos, meanwhile, received worse care than non-Hispanic whites for about 60 percent of core measures. The agency said the situation was improving, but very slowly. And as for minorities' access to health care—defined as the ability to obtain care when and where they needed it—about 60 percent of the agency's core measures did not show any improvement, and 40 percent were getting worse, the agency reported.

59%

Americans with knowledge

By 2010, only 59 percent of Americans nationwide knew that African Americans and Hispanics or Latinos had poorer health outcomes than whites.

“Minorities as a whole have a higher prevalence of diabetes, stroke, and other largely preventable diseases and conditions than whites.”

\$1.5 billion

Recruitment funds

The Affordable Care Act authorizes \$1.5 billion to recruit minority health care workers to enroll in an expanded National Health Service Corps.

In April 2011 the Department of Health and Human Services (HHS) released the first federal strategic Action Plan to Reduce Racial and Ethnic Health Disparities. The plan's goals include moving forward under the 2010 Affordable Care Act to expand health insurance coverage; continue efforts to diversify the health care workforce; and continue efforts to improve population health. (See "Reducing Racial and Ethnic Disparities: The Action Plan from the Department of Health and Human Services," *Health Affairs*, October 2011, for more information on the plan.) HHS also released the National Stakeholder Strategy for Achieving Health Equity, a set of goals and objectives for public and private sector initiatives and partnerships "to help racial and ethnic minorities and other underserved groups reach their full health potential."

SOURCES OF DISPARITIES

The causes of health and health care disparities are complex and interrelated. A person's health status in life is determined by a number of factors, including one's behavior (such as smoking); genetics; social circumstances; the environment in which one lives, even as an unborn child; and one's access to health care. Health disparities can be driven by so-called social and economic determinants, such as income level, education, and living conditions in homes and neighborhoods.

- **Economic determinants.** US adults living at or below the federal poverty level (\$22,350 for a family of four in 2011) are more than five times as likely to say they are in poor or fair health compared to those whose incomes are four times the federal poverty level. Without a decent financial foundation, the ability to live in a good neighborhood is less likely—meaning limited access to healthy foods, safe playgrounds, and schools with cafeterias that serve wholesome lunches.

- **Education.** Adults without a high school diploma or equivalent are three times more likely to die before age 65 than those with a college degree (Exhibit 1). Studies have also found that a white man with a bachelor's degree will live 17 years longer than a black man who didn't finish high school. And the reverse is also true: Blacks who finished more than 16 years of school live more than six years longer than whites without a high school diploma, but they die earlier than their equally educated white counterparts.

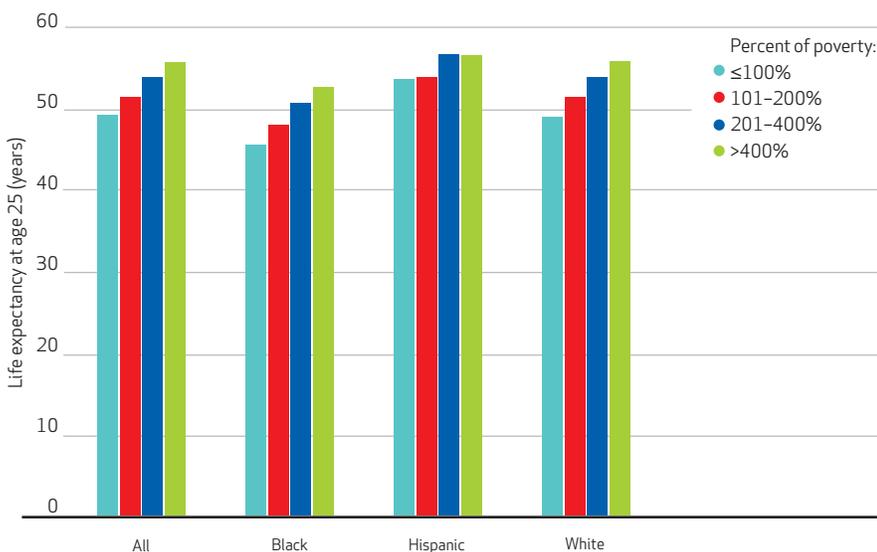
- **Geography and neighborhood.** Conditions unique to particular neighborhoods can exacerbate health disparities. Compared to white neighborhoods, many black urban neighborhoods have more fast-food outlets, have fewer grocery stores and recreational facilities, and are in closer proximity to sources of industrial pollution, such as older factories and dump sites. Health disparities also show up among those living in rural areas compared to those in urban areas. Whites, blacks, and Hispanic adults living in rural areas are at a higher risk of death than their urban counterparts. But after social and economic factors such as education, health insurance, and income are equalized, the health disparities are found to be reduced or even eliminated. (See "Higher Risk of Death in Rural Blacks and Whites than Urbanites Is Related to Lower Incomes, Education, and Health Coverage," *Health Affairs*, October 2011.)

- **Environment.** The damaging effects of pollution and other environmental contaminants are well documented. Blacks and others living in or near low-income or distressed neighborhoods are exposed to greater levels of lead and allergens in their homes as well as to harmful emissions from nearby bus depots, factories, and dumps.

- **Stress.** There is growing evidence that some health disparities may result from the fact that specific social environments might "get under the skin" to cause disease. Chronic stress related to poverty or hardship

EXHIBIT 1

Disparities in US Life Expectancy at Age 25, By Income and Race or Ethnicity



SOURCE Analysis by the Robert Wood Johnson Commission to Build a Healthier America's research staff of data from the National Longitudinal Mortality Study, 1988-98. **NOTE** Life expectancy is the number of years an average 25-year-old could expect to live, based on family income relative to the federal poverty level.

35%

Higher breast cancer mortality

In 2000–04, black women experienced 8.8 more deaths from breast cancer per 100,000 people than white women—a 35 percent higher rate.

translates into high levels of the stress-related hormones cortisol and epinephrine, which may in turn influence other body processes such as inflammation or the performance of the immune system.

Researchers are exploring whether such a connection may help explain higher rates of breast cancer in black women than in white women (see “People and Places,” *Health Affairs*, October 2011). Other research suggests that the combination of stress and exposure even to very low levels of lead may be responsible for the higher rates of high blood pressure in black men compared to white men. (See “How Cumulative Risks Warrant a Shift in Our Approach to Racial Health Disparities: The Case of Lead, Stress, and Hypertension,” *Health Affairs*, October 2011.)

Many of these same factors, such as poverty, can, and do, contribute to health care disparities. But there are also discrete reasons why the care minorities receive is often inferior to the care received by whites.

- **Lower-quality care.** Research has shown racial and ethnic minorities often receive health care in hospitals and other facilities that offer lower-quality care than other institutions. Ashish Jha and coauthors examined the cost and quality characteristics of US hospitals to find which facilities most cared

for elderly, black, or Medicaid patients. They found that the nation’s “worst” hospitals—defined as institutions that provided high-cost, low-quality care, and primarily small or public hospitals located in the South—cared for twice the proportion of elderly black and Medicaid patients than the nations’ “best” hospitals—those providing low-cost, high-quality care, and primarily urban, large, nonprofit teaching hospitals in the Northeast (Exhibit 2).

- **Inadequate access to care.** Access is a broad term that includes everything from patients’ ability to find providers who meet their needs, to whether they have health insurance coverage that helps them pay for care, and whether they possess the ability to pay any out-of-pocket costs. Racial and ethnic minorities and people of low socioeconomic status are disproportionately represented among those with access problems.

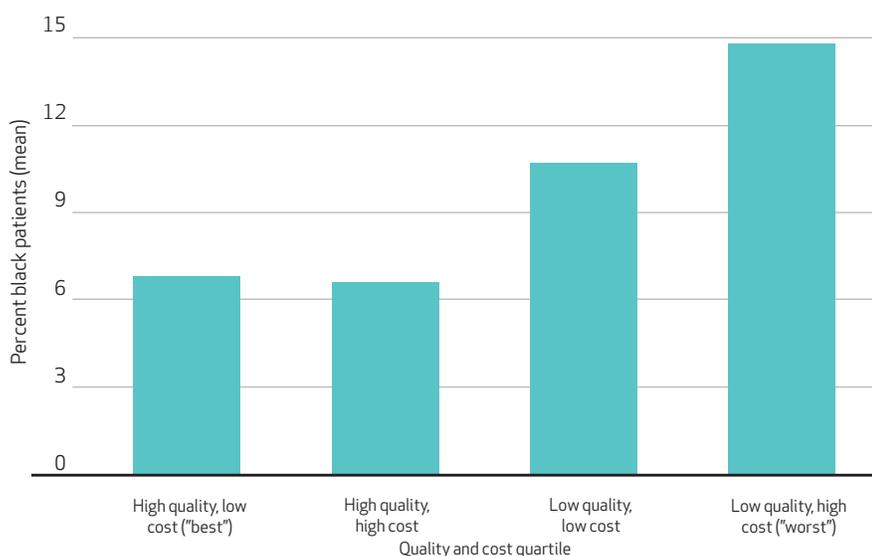
Lack of health insurance has been shown to be the most significant contributing factor to poor quality of care for some of the core measures captured by the Agency for Healthcare Research and Quality. Uninsured people are less likely to get recommended care for disease prevention, such as cancer screening, and for disease management, such as diabetes care management.

- **Inability to navigate the system.** Getting health care in the United States can be complicated, and navigating the system requires some degree of knowledge, confidence, and skill. Among recent Hispanic/Latino immigrants, ignorance of this country’s health system and cultural unfamiliarity are obstacles to seeking high-quality health care. These populations exhibit relatively low rates of “patient activation”—they are somewhat passive about their health and are more likely than others to be deterred by barriers to care. As a result, they are less likely to get preventive services, to adhere to prescribed treatment regimens, or to seek out health information or ask questions during a medical encounter. They are also more likely to have their medical needs go unmet. (See “Raising Low ‘Patient Activation’ Rates Among Hispanic Immigrants May Equal Expanded Coverage in Reducing Access Disparities,” *Health Affairs*, October 2011.)

- **Provider ignorance or bias.** Some evidence suggests that providers don’t give adequate care to certain groups, such as people with disabilities, out of ignorance or because of stigmas associated with these groups.

EXHIBIT 2

Percentage of Elderly Black Patients in Hospitals, By Quality and Cost Quartile



SOURCE Ashish K. Jha, E. John Orav, and Arnold M. Epstein, “Low-Quality, High-Cost Hospitals, Mainly in South, Care for Sharply Higher Shares of Elderly Black, Hispanic, and Medicaid Patients,” *Health Affairs* 30, no. 10 (2011):1904-11. Analysis of 2007 data from the Hospital Compare database and Medicare Impact File; and 2005 data from the Medicare Provider Analysis and Review database. **NOTE** Differences across all four groups were significant ($p < 0.01$).

1 million

Fewer heart attacks

The “Million Hearts” campaign aims to prevent 1 million heart attacks and strokes over the next five years.

“Racial and ethnic minorities often receive health care in hospitals and other facilities that offer lower-quality care than other institutions.”

People with disabilities generally report being in fair or poor health to begin with; they then experience lower rates of prevention and health promotion services, such as mammography screening.

- **Other barriers.** Analyzing data from a 2008 survey of physicians, Arturo Vargas Bustamante and Jie Chen found that many physicians treating Hispanic/Latino patients, and especially non-Latino physicians, doubted that they could provide high-quality care for these patients. The doctors cited such problems as difficulty communicating with patients, not having enough time to spend with them, and patient nonadherence to recommended treatment.

WHAT'S HELPING NARROW DISPARITIES?

Efforts to reduce disparities take two main forms: first, a focus on improving the overall health of the population and targeted efforts to improve the health of underserved populations in particular; and second, a focus on improving the overall quality of health care and closing the care gaps for underserved groups, such as racial and ethnic minorities.

Improving population health and, in particular, the health of minority populations is a major national challenge and is being addressed across a broad array of interventions. Examples include the “Million Hearts” campaign launched by the Department of Health and Human Services in September 2011. The initiative aims to prevent 1 million heart attacks and strokes over the next five years—a reduction of approximately 50 percent—in part by increasing the proportion of Americans whose blood pressure is under control from 46 percent at present to 65 percent by 2017. This is an example of an initiative that will particularly benefit minority health, because three in five blacks has hypertension, the leading cause of cardiovascular disease, versus one in three whites.

Health care disparities, meanwhile, are being addressed as some health care systems have taken steps to improve the quality of care they provide everybody, with particular attention to closing gaps that affect minorities. An example is the Veterans Health Administration, which has undergone substantial improvements in quality of care and now sees minimal racial disparities in most process-of-care measures, such as rates of screenings for cholesterol or colorectal cancer. Similarly, the

Indian Health Service has taken steps to increase screenings for alcohol misuse and obesity and has seen improvements in measures such as blood glucose control.

HEALTH REFORM ACTIVITIES: An important thrust of the Affordable Care Act is to reduce disparities further by several means. One avenue is expansion of health insurance coverage for an estimated 32 million Americans, through both Medicaid and private coverage purchased through new state health insurance exchanges with the assistance of federal subsidies starting in 2014. Another objective is expanding care that can be delivered through community health centers, which now serve about 20 million people annually and are scheduled to double their capacity with the aid of \$11 billion in dedicated funding over five years.

Diversifying the health care workforce and creating a larger pool of “culturally competent” providers to treat racial and ethnic minorities is yet another goal of health reform. Research has shown that patients may be more adherent to treatment if their provider speaks the same language. The Affordable Care Act authorizes \$1.5 billion to recruit minority health care workers to enroll in an expanded National Health Service Corps. This effort will complement others currently under way in the private sector to increase diversity in hospital and health system leadership and to increase cultural competency training in medical schools, hospitals, and other institutions.

To further understanding of target interventions and record progress made in reducing disparities, the law also mandates that all federally associated programs collect and report information on race, ethnicity, and language of patients and enrollees.

POLICY RECOMMENDATIONS

To make further progress on disparities, experts generally agree that the following will be needed:

- Improvements in quality of care across the board in the US health care system, with particular attention to places where minority patients are likely to receive most of their care. (For more discussion of these issues, see the Health Policy Brief, “Improving Quality and Safety,” published April 15, 2011.) To make certain that quality standards are raised across the board, and not just in better-off institutions serving more white patients, the

\$11 billion

Health center funding

Community health centers are to receive \$11 billion in dedicated funding over five years.

federal government could carry out a “disparities impact assessment” to measure the situation before and after implementation of quality improvement initiatives.

- More attention to lessening or eliminating the drivers of poor health, including poverty, low levels of education, and the health and safety of neighborhoods. In particular, some experts caution against current and pending budget reductions at the federal and state levels that could threaten the continuity of government programs aimed at helping people get an education, find a job, and obtain healthy food and stable housing. (See “Where Health Disparities Begin: The Role of Social and Economic Determinants—And Why Current Policies May Make Matters Worse,” *Health Affairs*, October 2011.)

- More attention to making certain that health care safety-net facilities remain viable amid changes driven by the Affordable Care

Act. Once millions more Americans have coverage, they will be able to seek care from a broad range of health care providers and institutions. It will be important to ensure that institutions that have traditionally served racial and ethnic minorities remain economically viable. (See “Health Reform Holds Both Risks and Rewards for Safety-Net Providers and Racially and Ethnically Diverse Patients,” *Health Affairs*, October 2011.)

- More research to further understand health disparities. Research to date has shown that even when care disparities are eliminated, stubborn differences may still persist in health outcomes. Despite care improvements at the Veterans Health Administration that have closed gaps in disease screening, for example, black veterans still have higher rates of high blood pressure, “bad” cholesterol, and blood sugar compared to whites. More research is needed to understand why these disparities persist even when care is more equal. ■

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