Student National Medical Association

Health Policy Fact Sheets

Healthcare Disparities

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Overview

Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income are controlled. The 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, healthcare professionals, and patients.

Inequality in quality persists

There is significant inequality in the quality of healthcare in the United States. While disparities in health care potentially affect all Americans and individuals from of any group, they are not uniformly distributed across populations.

- Minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer compared with whites.
- Patients of lower socioeconomic position are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications.
- When hospitalized for acute myocardial infarction, Hispanics are less likely to receive optimal care.
- Many racial and ethnic minorities and persons of lower socioeconomic position are more likely to die from HIV. Minorities also account for a disproportionate share of new AIDS cases.
- The use of physical restraints in nursing homes is higher among Hispanics and Asian/Pacific Islanders compared with non-Hispanic whites.
- Blacks and poorer patients have higher rates of avoidable hospital admissions (i.e., hospitalizations for health conditions that, in the presence of comprehensive primary care, rarely require hospitalization).

Disparities come at a personal and societal price

Health care disparities are costly. Poorly managed care or missed diagnoses result in expensive and avoidable complications. The personal cost of disparities can lead to significant morbidity, disability, and lost productivity at the individual level. At the societal level, distal costs follow from proximal opportunities that were missed to intervene and reduce burden of illness.

- Minorities and persons of lower socioeconomic status are less likely to receive cancer screening services and more likely to have late stage cancer when the disease is diagnosed.
- Persons with diabetes of lower socioeconomic position are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications.

- Many racial and ethnic minorities and persons of lower socioeconomic position are less likely to receive recommended immunizations for influenza and pneumococcal pneumonia. Once hospitalized, some ethnic and racial minorities, as well as lower income patients, suffer worse quality of care for pneumonia.

Differential access may lead to disparities in quality

Access to healthcare is an important prerequisite to obtaining quality care. Some access barriers, whether perceived or actual, can result in adverse health outcomes. Patients may perceive barriers to delay seeking needed care, resulting in presentation of illness at a later, less treatable stage of illness.

- Many racial and ethnic minorities and individuals of lower socioeconomic status are less

likely to have a usual source of care.

- Hispanics and people of lower socioeconomic status are more likely to report unmet health care needs
- While most of the population has health insurance, racial and ethnic minorities are less likely to report health insurance compared with whites. Lower income persons are also less likely to report insurance compared with higher income persons.
- Higher rates of avoidable admissions by blacks and lower socioeconomic position persons may be explained, in part, by lower receipt of routine care by these populations.

Opportunities to provide preventive care are frequently missed

Our healthcare system continues to emphasize care that occurs after an illness occurs, rather than preventive services that could potentially prevent the illness or reduce the burden of disease. While the National Healthcare Quality Report documented that this is a pervasive issue for all Americans, there are significant disparities in the use of evidence-based preventive services for certain populations.

- Blacks and persons of lower socioeconomic status tend to have higher rates of death from cancer. While rates of cancer death may reflect a variety of factors not associated with health care such as genetic disposition, diet, and lifestyle, screening and early treatment of cancers can lead to reductions in mortality.
- Many racial and ethnic minorities and persons of lower socioeconomic position are less likely to receive screening and treatment for cardiac risk factors. The combination of lower screening and effective treatment of risk factors, such as smoking among the uninsured, lend themselves to quality improvement initiatives that can potentially reduce heart disease disparities among populations at risk.
- Many racial and ethnic minorities and persons of lower socioeconomic position are less likely to receive childhood immunizations.
- Many racial and ethnic minorities and individuals of lower socioeconomic status are less likely to receive recommended immunizations for influenza and pneumococcal disease.

Knowledge of why disparities exist is limited

There are complicated interrelationships between race, ethnicity, and socioeconomic status that may result in healthcare disparities. While we may have sufficient data about racial disparities by race and ethnicity, it is difficult to tease out the individual contributions of race, income or education to these differences.

- Many racial and ethnic groups, as well as poor and less educated patients, are more likely to have report poor communication with their physicians.
- Many racial and ethnic minorities and poor patients report more problems with some aspects of the patient-provider relationships.
- Many racial and ethnic minorities and lower income patients report more difficult patient-provider relationships.
- Asians, Hispanics, and those of lower socioeconomic status have greater difficulty accessing health care information, including information on prescription drugs.

Improvement is possible

While the report offers a sobering view of healthcare disparities, there are some positive findings that suggest that targeted improvement efforts could significantly reduce healthcare disparities. There are some notable exceptions that demonstrate *what is possible*.

- While blacks and poor patients are more likely to present with later stage cancers with higher death rates, black women have higher screening rates for cervical cancer and no evidence of later stage cervical cancer presentation.
- Quality improvement efforts have resulted in demonstrable reductions in black-white differences in hemodialysis.
- Black patients are more likely to receive blood pressure monitoring without any disparity in blood pressure management. A greater perceived risk for significant cardiovascular disease among blacks may result in appropriately increased screening rates and treatment for risk factors.

Overall, disparities in quality and access for minority groups and poor populations have not been reduced since the first National Healthcare Disparities Report in 2003. In 2007, the number of measures on which disparities have gotten significantly worse or have remained unchanged since the first NHDR is higher than the number of measures on which they have gotten significantly better for Blacks, Hispanics, American Indians and Alaska Natives, Asians, and poor populations.

2007 UPDATE

Disparities in Disease Prevention, Treatment, and Management

Cancer

- Poor women were less likely than high income women to have had a mammogram within the past 2 years, regardless of race or ethnicity. Women with less than a high school education were less likely than women with some college to have had a mammogram, regardless of race or ethnicity.
- In 2003, the proportion of adults age 50 and over who had received recommended colorectal cancer screening was significantly lower among Blacks and Asians compared with Whites; among Hispanics compared with non-Hispanic Whites; among poor, near poor, and middle income persons than among high income persons; and among persons with a high school education or less compared with persons with any college education.
- After controlling for income and education, significant differences between Blacks and Whites are eliminated.

Diabetes

- In 2004 there were no significant differences between Blacks and Whites in the proportion of adults age 40 and over with diabetes who received three recommended services (HbA1c testing, eye examination, and foot examination).
- In 2004, the proportion of adults age 40 and over with diabetes who received three recommended services was significantly lower for Hispanics than for non-Hispanic Whites (38.8% compared with 49.2%). Additionally, this proportion was significantly lower for poor (38.4%), near poor (37.6%), and middle income people (41.9%) than for high income people (58.4%).
- In 2004, the proportion of adults age 40 and over with diabetes who received three recommended services was lower for people with less than a high school education and high school graduates than for people with at least some college (35.2% and 45.7% compared with 55.9%).
- In 1999-2004, only 48.7% of adults with diagnosed diabetes had their HbA1c under optimal control. The rate was significantly lower for Blacks and Mexican Americans than Whites (36.6% and 33.9% respectively compared with 55.7%). There were no statistical differences between income groups for this measure.
- In 1999-2004, only 56.6% of adults with diagnosed diabetes had their blood pressure under control. The rate was significantly lower for Blacks than Whites (45.0% compared with 63.4%). There was no statistical difference between Mexican Americans and Whites for this measure. The rate was significantly lower for poor (53.6%), near poor (50.7%), and middle income (51.3%) than high income people (70.4%).

End-Stage Renal Disease

- Kidney transplantation often allows persons with ESRD to continue a lifestyle similar to that which they had before their kidney failure. It is important that persons with ESRD be registered on the waiting list for kidney transplantation to increase the likelihood of transplantation. In 2003, Blacks and AI/AN were less likely to be registered for transplantation than Whites (10.5% and 9.6% respectively compared with 16.9%). From 1998 to 2003, none of the groups achieved the Healthy People 2010 target of 66%.

Heart Disease

- Over 32% of adults age 20 and over in the United States are obese, putting them at increased risk for many chronic, deadly conditions, such as hypertension, cancer, diabetes, and coronary heart disease. Reducing obesity is a major objective in preventing heart disease and stroke. The proportion of obese adults told that they were overweight was significantly lower for Blacks (61.1%) and Mexican Americans (56.5%) compared with Whites (68.8%); for middle income people compared with high income people (64.2% compared with 69.8%); and for adults with less than a high school education compared with adults with any college education (62.7% compared with 70.7%).

HIV/AIDS

- From 1998 to 2005, the overall rate of new AIDS cases remained about 18 cases per 100,000 persons. However, in this time period, the gap between Blacks and Whites remained the same. In 2003, the rate of new AIDS cases was 10 times higher (75.0 per 100,000 compared with 7.5 per 100,000) for Blacks than for Whites. Additionally, in 2003, the rate of new AIDS cases was over 3 times higher for Hispanics than for Whites (26.4 per 100,000 compared with 7.5 per 100,000).
- No group has reached the Healthy People 2010 target of 1.0 new AIDS case per 100,000 population.

Mental Health and Substance Abuse

- Poverty is a risk factor for poor mental health. Poor people are more likely to be exposed to stressful social environments (e.g., violence and unemployment) and less likely to have social and material resources. Poverty disproportionately affects racial and ethnic minorities.
- Culturally appropriate treatment has the potential to decrease the prevalence, incidence, severity, and duration of certain mental disorders, such as depression and substance abuse. However, cost of care, societal stigma, fragmented organization of services, shame, discrimination, racism, and mistrust represent significant barriers to treatment for depression and substance abuse. One way to help meet the needs of racial and ethnic populations is to engage representatives from the community being served in the design, planning, and implementation of services.

Respiratory Diseases

- From 1999 to 2005, the overall proportion of adults age 65 and over who had received pneumococcal vaccine improved significantly, from 49.9% to 56.3%. Improvements were observed for Whites, Blacks, and non-Hispanic Whites. However, the gap between Blacks and Whites remained the same. as the proportion who ever had pneumococcal vaccine was significantly lower for Blacks than for Whites (40.4% compared with 58.4%).
- Even worse, in 2005 the proportion of Hispanic adults age 65 and over who had ever had pneumococcal vaccine was about half that of non-Hispanic Whites (29.0% compared with 60.5%).
- The gap between poor and high income people remained the same. In 2005, the proportion was significantly lower for poor elderly people than for high income elderly (45.8% versus 57.3%). There were no statistically significant Black-White differences in pneumococcal vaccination in the poor and high income groups
- Blacks and Hispanics at all education levels were less likely than Whites to have ever had a pneumococcal vaccination
- In 2005, as in 2004, no group achieved the Healthy People 2010 target of 90% of adults age 65 and over having received pneumococcal vaccination.

Reference:
AHRQ National Healthcare Disparities Report (2003, 2007)