
An Overview: Eliminating Racial, Ethnic, and SES Disparities in Health Care

Nancy De Lew, M.A., M.A.P.A., and Robin M. Weinick, Ph.D.

The papers featured in this issue of the Health Care Financing Review were presented at “Eliminating Racial, Ethnic, and SES Disparities in Health Care: A Research Agenda for the New Millennium.” This conference was held on October 15, 1999, in the Washington, DC., area and was co-sponsored by the Health Care Financing Administration (HCFA), the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research), and the Henry J. Kaiser Family Foundation. The conference was undertaken in response to the challenge posed by President Clinton’s national goal of eliminating racial and ethnic disparities in six health domains by the year 2010.

BACKGROUND

Since the 1985 landmark report of the Department of Health and Human Services Secretary’s Task Force on Black and Minority Health (United States Task Force on Black and Minority Health, 1985) that focused attention on excess mortality rates among many minority groups, there has been a proliferation of studies and reports on racial and ethnic differences in access to and use of health services (Mayberry et al., 1999). The evidence is clear—race makes a difference. Race and ethnicity are associated with consistent patterns of health services use and health outcomes, with minority groups frequently experiencing a substantial disadvantage.

Noting the substantial economic differences between various racial and ethnic groups, income and health insurance coverage are frequently cited as potential explanations for these disparities. However, a growing body of research has demonstrated that these racial and ethnic differences persist even when differences in income and health insurance are held constant. For example, among the nearly 70 million Americans whose health care services are financed by Medicare and Medicaid, there are persistent racial and ethnic disparities in access to care, health care utilization, and health outcomes (Ayanian, et al., 1999a; Ayanian et al., 1999b; McBean and Gornick 1994; Gornick, et al., 1996; Mustard et al., 1996; Fielding, Cumberland, and Pettitt, 1994; Schoendorf et al., 1992; Kotelchuck, 1994). There are also racial differences in utilization within the Veterans Administration health system (Whittle et al., 1993). Other research has demonstrated that disparities in access to care and the use of health care services remain substantial after controlling for health insurance status, and that health insurance coverage and income explain only a comparatively small proportion of these disparities (Weinick, Zuvekas, and Cohen, 2000; Zuvekas and Weinick, 1999; Cornelius, 1993; Wood et al., 1990).

Given the consistency of these findings regarding income and health insurance coverage, researchers have begun to explore other potential explanations for racial and ethnic disparities in health. The case of cardiovascular disease is illustrative. Over the

Nancy De Lew is with the Office of Strategic Planning, HCFA. Robin Weinick is with AHRQ. The views expressed in this article are those of the authors and do not necessarily reflect the views of HCFA and AHRQ.

past 30 years, heart disease mortality rates have been decreasing across all racial and ethnic groups, but the decline has been much greater for white Americans (National Center for Health Statistics, 1998). Black Americans continue to have the highest mortality rates for heart disease—about 50 percent higher than that of white Americans (National Center for Health Statistics, 1998). Research has shown that one reason behind these differences may be the fact that black Americans are less likely to undergo medical procedures and surgery known to increase life expectancy (Peterson et al., 1994; Sedlis et al., 1997). Although the gap between black and white patients in diagnostic cardiac catheterization rates has narrowed over time, large racial disparities in the treatment of heart disease with angioplasty and coronary bypass graft surgery persist (Whittle et al., 1993). Even after controlling for factors such as clinical characteristics (Maynard et al., 1986), and insurance status (Wenneker and Epstein, 1989), racial differences in the use of cardiac procedures remain.

Despite the knowledge gained from such research, racial and ethnic disparities in health and health care persist. For example, Hispanic Americans are substantially more likely than white Americans to be uninsured, with about 1 in 3 Hispanic Americans being uninsured in 1997 (Vistnes and Zuvekas, 1999). Hispanic Americans were also far more likely to lack a usual source of health care than any other group in 1996, and families headed by Hispanic Americans were the most likely to report barriers to receiving needed care (Weinick, Zuvekas, and Drilea, 1997). Even when admitted to the hospital for the same condition, Hispanic Americans were often significantly less likely to receive major therapeutic procedures than white Americans (Andrews and Elixhauser, 1998). In addition, research has found that

as some immigrant families, many of whom are Hispanic, assimilate into the United States, their health status sometimes deteriorates over subsequent generations (Hernandez and Charney, 1998), potentially increasing the magnitude of racial and ethnic disparities in health status.

The fact that such disparities remain large and significant more than 15 years after the initial Task Force report raises troubling questions about ongoing differentials in the access to and use of health care in this country. A variety of factors beyond socioeconomic status and health insurance coverage have been implicated as reasons for these disparities, including health providers' behaviors and biases (Schulman et al., 1999); differences in patient's expectations, preferences, and health care seeking behavior; differing perceptions about the availability and effectiveness of care (The Henry J. Kaiser Family Foundation, 1999); residential segregation; and differential satisfaction overall with the health system. Nonetheless, our accumulated research to date has not resulted in measurable declines in most previously observed racial and ethnic disparities in health.

PURPOSE OF CONFERENCE

The goal of the conference was to respond to the challenge to eliminate racial and ethnic disparities in health care over the next decade by moving beyond simply describing racial and ethnic disparities to discuss:

- Why these racial and ethnic disparities in health exist.
- What we know about ways to reduce these disparities.
- What knowledge and research are still needed in order to eliminate these disparities.

By focusing on these issues, the conference was intended to inform the policy-making and research communities about disparities and to help develop agendas to inform future research and funding priorities. In addition, there was an emphasis on assisting the Medicare peer review organizations in developing effective strategies to improve care for racial and ethnic minorities and work effectively with local providers to reduce disparities. The conference brought together participants from the peer review organizations, foundation, advocacy, policy, and research communities in order to develop strategies to reduce those disparities.

AGENDA FOR THE CONFERENCE

Opening Remarks and Charge to the Group
Moderator: W. David Helms, Ph.D.,
Association for Health Services Research

Speakers: Michael M. Hash, Health Care Financing Administration, John M. Eisenberg, M.D., Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), and Diane Rowland, Sc.D., Henry J. Kaiser Family Foundation

Session 1: OMB Directive 15: Implications for Data Collection, Data Analysis, and Policy Development

Panelists: Clyde Tucker, Ph.D., M.S., Bureau of Labor Statistics and Nicole Lurie, M.D., M.S.P.H., Department of Health and Human Services

Session 2: What Disparities and Causes Still Need Additional Study? What do we still not know about the role of socioeconomic status and other factors which play a role in these disparities? What research methods are most needed at this point to increase our understanding?

Authors: Beverly Coleman-Miller, M.D., Harvard University, Thomas A. LaVeist, Ph.D., Johns Hopkins University, and Marian Gornick, M.A., Georgetown Public Policy Institute

Working Luncheon

Speaker: Reed V. Tuckson, M.D., American Medical Association

Session 3: HCFA's New Scope of Work for Medicare Peer Review Organizations

Speaker: Stephen F. Jencks, M.D., M.P.H., Health Care Financing Administration

Session 4: What Do We Know about Interventions to Decrease Disparities? Have interventions been adequately evaluated? What are the challenges in evaluating demonstrations and interventions designed to eliminate disparities?

Speaker: Carol Horowitz, M.D., M.P.H., Mount Sinai Medical Center

Discussants: Irwin A. Goldzweig, M.S., Mid-South Foundation for Medical Care, Inc. Holmes Peacher-Ryan, Ph.D., Mid-South Foundation for Medical Care, Inc.

Session 5: Conceptual Framework Organizing the Research Agenda

Author: David R. Williams, Ph.D., M.P.H., University of Michigan

Closing Remarks

Speakers: Nathan Stinson, Jr., M.D., Ph.D., M.P.H., Department of Health and Human Services Daniel R. Waldo, M.A., Health Care Financing Administration

PAPERS

Five papers were commissioned for the conference, and are presented in this issue of the **Review**. The first three describe racial and ethnic disparities. These papers draw upon a wide range of sources, including

previously published literature, re-examining existing data, and personal experience. By focusing on different populations, and viewing these problems from a variety of angles, this group of papers adds depth to our base of knowledge on racial and ethnic disparities. The fourth paper provides an overview of issues associated with programs designed to eliminate these disparities, emphasizing the importance of learning about the successes and failures that result from such efforts. Finally, the last paper places racial and ethnic disparities in health and health care in the larger context of American society, focusing on the roles of racism and discrimination.

LaVeist and Bowie begin by addressing minority health status among adults ages 21- 64. As they point out, children and the elderly have received a considerable amount of attention among researchers working on minority health issues. While non-elderly adults likely have received less attention due to their relatively good health, many racial and ethnic disparities may result from differentials in the premature onset of chronic disease in this age group.

They describe excess deaths among different racial/ethnic groups, as well as their causes. In addition, they discuss issues which specifically relate to Hispanic health, preventive health practices, and the roles that socioeconomic status and culture play in these disparities. The paper concludes with a recommendation that health research focus on social variables as the reasons underlying racial and ethnic disparities in health, and briefly considers the role that race variables have played in health services research.

Gornick focuses on potential explanations for racial/ethnic disparities in the use of Medicare services. Since all Medicare enrollees have the same core health insurance coverage, one crucial aspect of access to care—the ability to pay for services—is

largely equalized among racial/ethnic groups, although there may be differences in supplemental coverage. Starting from this perspective, the paper provides information on racial variation in health status and then explores variation in the use of a number of health care services, including specific procedures such as coronary artery bypass graft, mammograms, influenza immunization, and cataract removal, as well as rates of physician visits, emergency room encounters, and hospitalizations.

Gornick explores the reasons why elderly black Americans and the least affluent Medicare beneficiaries have lower rates of preventive and health promotion service use and have lower rates of certain tests and elective services. She also examines reasons behind observed differential rates of non-elective procedures which are associated with poor chronic condition outcomes, such as lower limb amputation. The explanations she considers include individual characteristics of Medicare beneficiaries, characteristics of the health care system, and more broadly, the “culture of advantage and disadvantage” whereby individuals’ general socioeconomic status may affect their expectations, demands, and experiences with the health care system. The paper concludes with two sets of recommendations for research on eliminating disparities: the first targeted toward beneficiaries, and the second targeted toward the health care service delivery system.

Coleman-Miller’s personal essay is based on her 35 years of experience as a nurse and physician providing health care services to minority populations in a variety of settings (e.g., ambulance bureau, medical examiner’s office, hospitals, clinics, and nursing homes). She reviews a number of problems, many of which have a particularly disparate impact on young peo-

ple living in urban areas, and makes recommendations for research and changes in the delivery of health care. In particular, this paper emphasizes the role of history, patient care and communications, cultural issues, and patient options and choices.

From her perspective of day-to-day involvement in direct patient care, Coleman-Miller urges that researchers and health care providers view racial and ethnic disparities as a problem requiring a sense of urgency that has been lacking to this point. At the conference, she called for a rapid response to this problem, analogous to the response to an airplane crash, immediately after which a team of government investigators examines the wreckage and determines the cause of the crash. The paper also introduces a new term, "cultural disregard," to describe "a lack of insight into the intricacies of the minority population to the degree that it appears to exclude, ignore, or, at best, minimize the role of the social dynamics and the unique struggle of that population."

Horowitz, Davis, Palermo, and Vladeck focus on programs which have been developed to reduce or eliminate sociocultural disparities in health and health care, providing overviews of three types of programs. First, they describe efforts targeted at providers, such as formal training in cultural and linguistic competency. Next, they discuss programs focused on the patient and community, including creating culturally-appropriate health care settings. The final type of effort they describe centers around health system approaches, including Federal initiatives to eliminate disparities, and the monitoring and enforcement of civil rights.

Horowitz and colleagues then turn to questions of implementing and evaluating these interventions, asking how we know the extent to which these programs have been effective. They focus on the infra-

structure needed to foster program implementation and evaluation, and the need to clearly identify the aims and targets of the intervention. They discuss general barriers to evaluating these programs, including a lack of appreciation of the importance of evaluation, a lack of technical expertise and a lack of resources and data. Finally, they make specific suggestions on areas which should be targeted for further research, such as evaluating commonly used but poorly evaluated programs like interpreter services, cultural competency training and community health worker programs, and work that needs to be done with program personnel to encourage effective program development and evaluation.

In the last paper, Williams and Rucker turn to a conceptual framework for understanding racial and ethnic disparities in health care. They provide a brief overview of issues relating to racism and discrimination in the United States, including how attitudes have changed over time. They then discuss the lessons learned for addressing disparities in health care, concluding that "racism appears to be a technological hazard in the practice of medicine." While noting the need to recognize that "discrimination is routine and commonplace in society and likely to be similarly prevalent in medicine," they point out that much of the discrimination experienced today is likely the result of unintentional action, and that institutional racism needs to be considered above and beyond any personal attitudes.

Williams and Rucker then suggest some directions for future research and policy. They focus on improving equity in access beyond the elimination of financial barriers and on the need for improved data systems and quality monitoring—including the need to routinely link information on race/ethnicity to data on medical encounters and to then routinely analyze and pub-

lish this information. They discuss a proposal for "report cards," similar to those used in the banking industry, so that disparities in health plans, health care institutions and communities could be publicly monitored. They recommend increased regulatory vigilance, including the potential role of the Joint Commission on Accreditation of Health Care Organizations, the potential use of civil rights laws, and the need to focus monitoring specifically on managed care plans. Finally, they turn to issues related to education and training such as the recruitment and retention of minority health professionals. They close by calling for a "national priority to build on the cultural support for egalitarian principles and develop strategies to eradicate racial inequities in medical care."

CONCLUSION

Each of the papers presented at the conference provides a unique perspective on the issue of racial and ethnic disparities in health care. It is our hope that this issue of the **Health Care Financing Review** will enable the conference materials to reach a broader audience and make an ongoing contribution to both research on racial and ethnic disparities and, ultimately, to progress toward eliminating them.

In closing, the words of President Clinton when he announced his goal to eliminate disparities by 2010: "We do not know all the reasons for these disturbing gaps. Perhaps inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences are all contributing factors. But we do know this: no matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for

all. And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities."

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Reprint Requests: Nancy De Lew, Health Care Financing Administration, 200 Independence Avenue, SW., Room 317H, Washington, DC 20201. E-mail: ndelew@hcfa.gov