

Issue Brief: Racial and Ethnic Health Disparities

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Why is this Issue Relevant to Policymakers?

Efforts to reduce the disturbing levels of racial and ethnic disparities in health and health care in the United States will continue to fall short unless the complex interplay of social, physical, and organizational influences is better understood and addressed through collaborative, interdisciplinary actions.

What are Health Disparities?

No universally accepted definition of health disparities or health inequities exists. To some, disparities are simply differences in health processes or outcomes between population groups. However, more precise descriptions focus on differences where one group is “losing” or where differences are seen as avoidable and unjust. For example, some differences between groups (such as men and women) are based on different physiology and are not “unjust,” and do not fall within the purview of health disparities. Other differences – such as average life span for racial or socioeconomic groups – are connected to issues of social advantage and are thus viewed as health disparities or inequities. In the United States, much work has focused on racial and ethnic health disparities, while many other countries focus more on socioeconomic differences.

What are the Key Findings?

Complex factors operating at the levels of individuals, interpersonal networks, organizations, communities, and society influence disparities in health and health care. Both race and socioeconomic status play important roles. Action in four major arenas is likely to have the most impact:

- 1) Individual socioeconomic circumstances
- 2) Physical and cultural community environment
- 3) Personal management of health
- 4) Health care financing and delivery

Strong evidence exists in the medical literature connecting each of these arenas to individual health. Although their interrelationships are complex, that should not be allowed to result in paralysis and inaction in the policy community.

What are the Implications?

The four arenas for policy action are a useful starting point, but disparities will not be eliminated by addressing these arenas one at a time. Instead, solutions will require multidisciplinary actors and cross-sector collaboration. While some actors may have natural strengths in addressing one arena over another, all types of actors can play roles in each of the four arenas. For example, health care systems will have a logical role in improving the equity of health care delivery, but they also have roles as employers and community members that affect the other three arenas.

Discussion of Major Findings

A voluminous literature, including the landmark 2003 Institute of Medicine report, “Unequal Treatment,”¹ documents the existence of disparities between whites and non-whites in many different measures of health status and health care access and quality. Despite this attention, consensus is lacking on the definition, existence, or extent of the problem, let alone the causes and potential solutions.

Defining the Problem

Health disparities are generally described as differences in health care processes or health outcomes between population groups, but more specific criteria sometimes include whether those differences are avoidable or unjust.² Population groups are often defined by race and ethnicity, but can also be based on socioeconomic status (SES), gender, age, language preference, country of origin, or other characteristics. Some researchers describe SES (usually characterized by education, income, occupation, and/or wealth) as the most important determinant of racial and ethnic health disparities. Some have found that health differences between socioeconomic groups are often greater than differences between racial groups. At the same time, the majority of studies find that measured disparities between races are reduced but not eliminated after controlling for SES. Whether disparities are an issue of race or of socioeconomic status is a false choice – there are disparities by race, there are disparities by SES, and these factors are intertwined but also likely play distinct, independent roles.

Different perspectives also distinguish between disparities in overall health status versus disparities in health care – meaning access to or quality of services. This distinction has bearing on policy opportunities, including which actors hold primary responsibility for making change. While the issues are sometimes considered separately, their influences are overlapping, and both issues must be addressed for maximum effect.

Another source of debate is whether racial and ethnic health disparities should be approached as a civil rights/social justice issue³ or as a health care quality issue.⁴ The social justice aspects of disparities can serve as an effective call to action, and they underscore the importance of upstream determinants of health. At the same time, racial disparities in health care quality indicators are part of the overall deficiencies of the health care system and can be addressed using some existing tools. Understanding the factors that influence disparities in a given population or setting will help determine when

solutions might primarily emphasize one or the other of these perspectives.

While the term “disparities” is frequently used in the United States, many European countries refer to “inequities,” a term that places greater emphasis on issues of morality and fairness. Though debate over the use of the term continues, this policy brief uses “disparities” for consistency with the bulk of work in the United States.

Reducing Disparities: Influences and Opportunities

Disparities in health status and health care have been well documented, but solutions for reducing them are less clear. One reason is that the landscape of influences on health disparities is complex. Consider the adapted version of the “ecological model”⁵ presented here, which shows how individuals exist within, influence, and are influenced by their interpersonal networks, organizations in their communities, the physical and cultural environment, and larger societal and policy circumstances (Figure 1, p. 6). The model conveys the multifaceted causality of health disparities, and it makes clear that policies addressing one or more of these “levels” in isolation will be insufficient. It highlights the following key arenas for policy action, all with ample research connecting them to health:

- 1) Individual socioeconomic circumstances
- 2) Physical and cultural community environment
- 3) Personal management of health
- 4) Health care financing and delivery

Arena 1: Individual Socioeconomic Circumstances

Although the causal relationship is not completely understood, the existence of differences in health status and health care access and quality by income and education is well documented,⁶ with higher SES associated with better health status and vice versa.^{7,8} In addition to this “wealth-health gradient,” unequal distribution of income (in contrast to absolute income level) has also been linked to differences in mortality.⁹

Given the association between education, income, and health, policies promoting better education may well have health benefits. Similarly, changes in income distribution may affect health status and outcomes, but little research has been done on this question in the United States.¹⁰ Studies seeking to identify the relative influence or weight of individual SES factors (i.e., education, income, occupation, wealth) on different health outcomes have had varying results. Despite these limitations, a

comprehensive approach to disparities must consider opportunities to address such factors because of their strong connection to health.

Arena 2: Physical and Cultural Community Environment

Community factors and neighborhood of residence affect health status or mortality, even when individual socioeconomic, demographic, and/or behavioral characteristics are taken into account.¹¹ However, which specific neighborhood factors have the greatest impact – and thus where the greatest policy opportunities lie – is not clear.

Physical aspects of communities affect the health of residents directly through:

- pollution, toxins, or other harmful substances in air, water, and housing (such as lead paint, cockroaches, or dust mites);
- natural disasters and extreme weather;
- injuries due to violent crime;
- stress due to deterioration of the built environment, such as graffiti and dilapidated or abandoned buildings; and
- stress due to neighborhood crime/public safety issues.

For example, black Americans are 79% more likely than whites to live in neighborhoods with the highest risk scores for industrial pollution, which are linked to asthma, bronchitis, and cancer.¹²

The physical environment can also indirectly influence health behaviors and resources of residents. Examples include:

- availability of safe and clean exercise and play areas (such as bicycle paths, sidewalks and walking trails, parks, and playgrounds);
- availability of affordable, healthy foods; and
- access to other services that support health.

Cultural and economic characteristics of communities can also influence individual health. Though causality is not completely understood, numerous studies have associated concentration of poverty and residential racial segregation with health status (even when controlling for other individual-level factors that influence health).¹³ In addition, relationships within communities and connections to broader resources that enable communities to thrive and advocate for themselves are important influences on individual health.¹⁴

Arena 3: Personal Management of Health

Individuals' health behaviors, resources, and beliefs can impact their health and may contribute to disparities. Physical, cultural, and economic aspects of communities impact personal management of health. For example, adolescents from socioeconomically disadvantaged neighborhoods are more likely to smoke, eat high-fat diets, and be overweight, with most differences persisting even after controlling for race and ethnicity.¹⁵ Overall, the relative influence of race, income, education, health status, other cultural attributes, or combinations of these characteristics on health behaviors is not well understood. However, the connection between behavior and health is clear, making supports for healthy behavior a prime area for policy action.

Health-related resources and beliefs impact whether or not individuals engage in preventive or curative health behaviors, what they do when a health need arises, and whether they can optimally engage with the health care system if necessary. These resources and beliefs include:

- self-efficacy – belief in one's ability to influence events that affect one's life;¹⁶
- "personal health ecology" – norms and beliefs about health, source and meaning of illness, when to seek care and from whom;¹⁷
- knowledge of benefits of specific behaviors and options for managing health needs;
- willingness to take responsibility to manage those needs;
- consistent connection to a care source, with ability to access and pay for services;
- ability to access information or services in preferred language;
- trust in care source; and
- agreement with rationale for health behaviors and treatments.

Arena 4: Health Care Financing and Delivery

Despite the importance of socioeconomic and community factors, much of the national dialogue and research on racial and ethnic health disparities in the United States has centered on the role of the health care system. While this emphasis is probably disproportionate, several important health system or health policy factors influence care access and quality, and thus merit analysis. The relationships between these factors are not always "neat" or fully understood; this complexity reinforces the need for multifaceted approaches.

Geographic Location – Numerous studies have documented geographic variations in health care practices and quality and in the extent and types of

racial disparities. However, areas of the country with large disparities on one clinical indicator are not consistently more likely to have disparities on other indicators.¹⁸ Racial disparities are not clustered in just a few geographic areas of the country – they are observed across regions.¹⁹ What this tells us is that variation in care practices may contribute to, but do not fully explain, disparities.

Insurance Status and Type – Having insurance is a key determinant of timely, reliable access to health care services, but studies of countries with universal coverage or populations with similar insurance (such as Medicare) have demonstrated persistent health care disparities by race and/or income. Insurance alone does not eliminate care disparities. To the extent that insurance plays a role, racial differences in coverage may influence health disparities. People of color are disproportionately uninsured or on Medicaid, influencing access to different types of care facilities and patients' decisions to seek medical care.

Provider Payment Rates – Insurers' provider payment rates influence which physicians and hospitals accept which patients, and create incentives for how those patients are treated. Low payment rates lead many providers to refuse Medicaid patients, resulting in many Medicaid (and uninsured) patients receiving care in different settings than people with private insurance or Medicare. While safety net providers such as community health centers often have excellent quality results and lower disparities than other care settings, they are typically under-resourced and may not have ready access to specialty care or necessary diagnostic tests and treatments.

Linguistic and Cultural Competency – Much of the emphasis on reducing disparities in health care has centered on creating “a health care system and workforce...capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency.”²⁰ The principal tool used to improve cultural competency has been training of providers and staff on tools and approaches to meet the needs of patients from diverse backgrounds and cultures. While there is good evidence that such training can improve clinician knowledge, attitudes, skills, and patient satisfaction, the impact on patient adherence or health outcomes is unclear.²¹ Stronger evidence supports an association between linguistic competency and patient satisfaction, access, communication, quality of care, and outcomes.²²

Representation of Racial and Ethnic Groups among Health Professionals – African Americans, Hispanics, and Native Americans make up over 25% of the U.S. population but represent only 9% of nurses, 6% of physicians, and 5% of dentists.²³ Many observers therefore recommend increasing the proportion of underrepresented clinicians in health systems and medical education to increase linguistic and cultural competency of the health care workforce. Proponents of increased diversity cite the potential for greater understanding of cultures, increased linguistic competence, better opportunities for building trust between providers and patients, and provision of role models in the care-giving fields.²³ Some studies have found an association between patient/physician racial concordance and patient reports of greater participation in medical decisions and higher levels of satisfaction,²⁴ but little is known about the impact on health care quality or outcomes. Proponents also cite evidence that underrepresented minority providers are more likely to practice in underserved communities and in Medicaid,^{23,24} supporting the need to increase their numbers.

Implicit or Explicit Provider Bias or Use of Stereotypes – The IOM's “Unequal Treatment” report examined how biases among physicians and other care providers may result in differences in care decisions, and how stereotyping may impact clinicians' beliefs about and actions with their patients.¹ Additional research directly examining the influence of racism, prejudice, and stereotyping on health disparities is needed – bias among health care providers is just one way these factors can impact health. Bias and racism in other facets of life, including housing, education, employment, and daily social interactions, also warrant close examination.

Adherence to Known Care Standards – The movement towards evidence-based medicine, where care protocols based on critical syntheses of medical data inform clinician behavior, holds promise for reducing racial variation in quality measures. More evidence is needed to support this theory – one review found strong evidence supporting the use of tracking/reminder systems to improve health care quality among minority patients, but insufficient evidence on whether provider interventions could specifically reduce health disparities.²⁵ Despite the potential for evidence-based clinical practice guidelines to reduce variation, improvement in care processes does not automatically translate into improvement in outcomes.

Distribution of Health Information Technology – The promise of electronic medical records with decision-support capabilities, registries, and computerized physician order entry to improve quality of care has been demonstrated within the U.S. Veterans Affairs (VA) medical system. Since its improvement processes began, the VA system has significantly improved on quality indicators and has outperformed Medicare in most cases.²⁶ The VA has also demonstrated better performance than usual care outside the VA: a landmark RAND study examining quality of care for people living in 12 communities found that study participants received about 55% of recommended care for chronic and acute conditions and disease prevention, while a follow-up study found VA medical system participants received 67% of recommended care.²⁷

Several studies of VA patients have demonstrated equal (if not better) outcomes for blacks compared with whites, and while these results cannot be solely attributed to the system's use of information technology, they support the potential usefulness of such tools to reduce disparities. Clearly, the cost and implementation challenges of information technology are barriers, especially for care providers serving a disproportionate share of Medicaid or uninsured patients and for providers in solo or very small group practices.

Roles for Policy Actors

Ample evidence connects each of the four policy arenas to health and health disparities, but far less is known about potential solutions to the challenges in each arena, and consensus is lacking on the role of different actors to address those challenges. Dialogue across sectors is needed to move towards greater consensus and action. To support such dialogue, this paper presents a framework to guide policy actors (Figure 2, p. 7). This classification of policy actors' roles in impacting each of the four policy arenas is not intended to be comprehensive – to contain scope, actors specializing in education, employment, urban planning, transportation, and other relevant policy fields are not included.

For each group of actors, we hypothesize their potential impact and note some sample activities they might pursue. These examples are not necessarily the highest impact or most feasible opportunities, and they do not represent a comprehensive set of policy options. Rather, the hypotheses are intended to spur thinking and discussion about what groups are best positioned to take action in particular arenas, where opportunities for

collaboration may exist, and to encourage actors to think beyond the status quo about their roles in addressing health disparities. Organizations committed to eliminating disparities in health and health care can use Figure 2 as a starting point in discussions about the unique role they can play, and to strategize about potential opportunities for collaboration among different sectors and disciplines to achieve common goals.

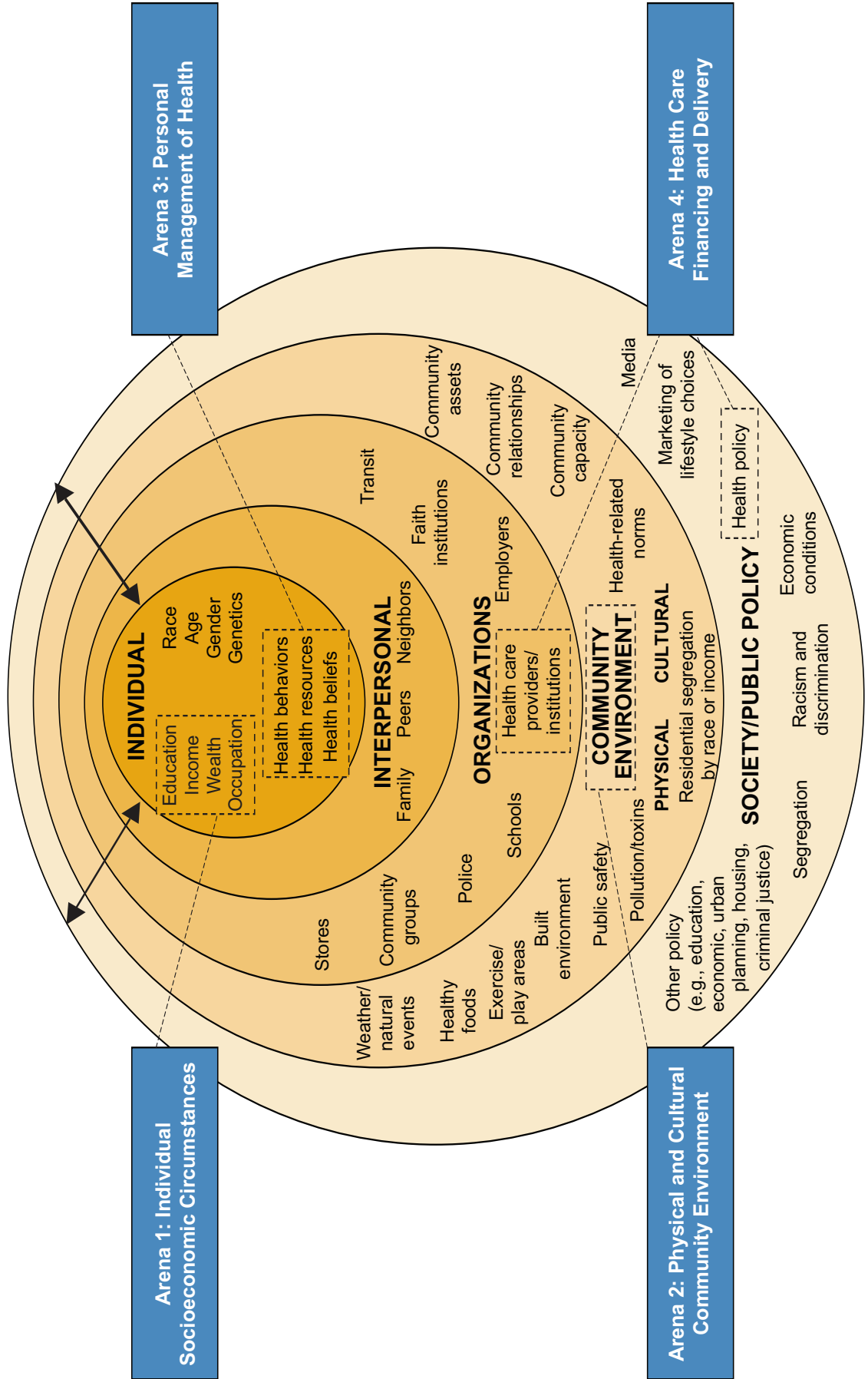
Take-Aways

The persistence of racial and ethnic disparities in health and health care is a continual reminder of how far we still have to go to achieve equal opportunity for health and well-being. While progress has been made in some instances, disparities appear to be worsening in other areas and for some groups. This issue has attracted a substantial amount of attention in the medical and lay press, yet many opportunities remain to engage a broader national dialogue and a cohesive, integrated, interdisciplinary strategy for action.

The complex nature of disparities means that paying attention to only one policy arena is insufficient. Long-term solutions demand action to address factors in all of these arenas. The policy actors who could impact these arenas represent a broad swath of organizations and individuals, many of whom are already committed to working to address disparities – but who may have greater opportunities to address arenas currently seen as peripheral or beyond their scope.

Continued progress in the elimination of racial and ethnic disparities in health and health care will require integrated, interdisciplinary action from the affected communities and from the vast variety of actors whose policies impact their health and well-being. As potential actors examine their current or future strategies, consideration of the broad landscape of influences on disparities and of others who may be positioned to act in collaborative or complementary ways are essential to accomplish sustained, significant change.

Figure 1: Landscape of Influences on Health Disparities and Arenas for Policy Action



Selected Resources

Kaiser Permanente Institute for Health Policy: <http://kpihp.org/publications/docs/disparities.pdf>

Kaiser Family Foundation: <http://www.kff.org/minorityhealth/disparities.cfm>

The Commonwealth Fund: http://www.cmwf.org/topics/topics.htm?attrib_id=12024

Joint Center Health Policy Institute: http://www.jointcenter.org/new_site/index.htm

RAND Center for Population Health and Health Disparities: <http://www.rand.org/health/centers/pophealth/index.html>

PolicyLink: <http://www.policylink.org/HealthAndPlace/default.html>

Prevention Institute: <http://www.preventioninstitute.org/healthdis.html>

Grantmakers in Health: http://www.gih.org/topics3985/topics_list.htm?attrib_id=8495

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