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CHAPTER FOUR

**RACIAL AND ETHNIC DISPARITIES IN
HEALTH CARE**

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Learning Objectives

- Understand the definition of disparity in health care
- Learn how patient-, provider-, and system-level factors contribute to disparities
- Understand the role of historical context causing disparities in health care
- Learn about efforts to reduce and eliminate disparities
- Understand how the ACA addresses disparities

Racial and ethnic disparities in health care pervade the American health care system. In 1999, the U.S. Congress commissioned a report on the health care quality and experiences of racial and ethnic minorities in the United States, which resulted in the Institute of Medicine's (IOM's) seminal report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (IOM, 2003). An earlier report on the quality of health care in the United States identified six aims for improving performance of the

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health care system: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (IOM, 2001). *Equity*, as defined by the IOM, is the delivery of health services of equal quality to all individuals, regardless of such personal characteristics as gender, socioeconomic status, geographic location, and race or ethnicity. Despite the increasing awareness of health care disparities facing various racial and ethnic groups in the United States, several reviews of the scientific literature document the existence of racial and ethnic disparities in the processes and outcomes of care for a variety of diseases and clinical conditions, including cancer, HIV/AIDS, and chronic conditions such as cardiovascular disease and diabetes, as well as in the delivery of preventive care services (Department of Health and Human Services [DHHS], 2010). For example, the National Healthcare Disparities report published by the AHRQ since 2003 has consistently found that blacks, Latinos/Hispanics, Asians, and American Indians and Native Alaskans were more likely than whites to receive lower-quality care across a range of quality-of-care indicators (DHHS, 2010). Thus, the existence of disparities in health care represents a failure of the American health care system and signals the need for attention and reform.

Addressing racial and ethnic disparities in health care is of growing importance because the population of the United States is more diverse than ever. Between 2010 and 2050, the Latino population is expected to increase from 16 to 30 percent as a percentage of the U.S. population, the Asian and Pacific Islander population is expected to grow from 4 to 9 percent, while the black population is expected to remain at 12 percent of the U.S. population (U.S. Census Bureau, 2009; Ortman & Guarneri, 2009). Over the same period, the non-Latino white population is expected to decrease from 65 percent to 46 percent as a percentage of the U.S. population. If racial and ethnic minorities continue to receive lower-quality care, then in the coming years a substantial portion of the U.S. population will have suboptimal health status, which will in turn lower labor market productivity and increase national health care spending (Bound, Waidmann, Schoenbaum, & Bingenheimer, 2003).

We begin this chapter by defining our view of disparities in care. Next, we review some of the historical factors specific to racial and ethnic groups that have contributed to the patterns of disparities we observe today. In the following sections, we summarize some of the evidence documenting health care disparities by racial and ethnic groups. In the final sections of the chapter, we summarize a number of ongoing initiatives to reduce disparities in care.

Definition of Disparity in Health Care

A distinction can be made between disparity in health and *disparity in health care*. The former refers to racial and ethnic differences in morbidity and mortality and is influenced by a variety of factors (social, environmental, behavioral, and biological), only one of which is health care. With recent advances in human genomics, much more attention is being given to the genetic basis for racial and ethnic disparities in health (Fine, Ibrahim, & Thomas, 2005). Disparities in health are discussed in Chapter Three. In this chapter, we focus on disparities in health care.

Researchers have adopted various perspectives on disparities in health care over time (Carter-Pokras & Baquet, 2002; Braveman, 2006; Adler & Rehkopf, 2008; Vargas Bustamante, & Chen, 2011). Some have viewed all the differences in health care between racial and ethnic groups as constituting disparities. From this point of view, differences in the use of services are viewed as disparities regardless of coexistent differences in access to care, insurance coverage, personal preferences, clinical need, or clinical appropriateness. It has been suggested that in some cases lower use of services may constitute an advantage, in particular where overuse is thought to lead to excess morbidity or mortality.

Others have taken a narrower perspective, defining disparity as a difference in care that is not accounted for by a difference in access to care, personal preference, clinical need, or clinical appropriateness (see Figure 4.1). In this narrower view, two groups of factors are identified as being responsible for disparities in care. The first is the group of system-level factors such as the structure of health care systems and the legal and regulatory environment in which those systems operate. These may also include structural factors such as underfunding of hospitals that predominantly serve minority patients or organizational characteristics such as inadequate workforce diversity or the absence of policy and procedures that promote culturally competent care. The second group of factors is discrimination at the patient-provider level, whether it takes the form of prejudice or unconscious stereotyping.

Few datasets include information on quality of care, race and ethnicity, and patient needs. Moreover, few of these sources differentiate between the effects of structural or legal and regulatory factors on the one hand and discrimination on the other. Hence, most of the existing literature tends to support the view that disparities in health care are a result of a myriad of

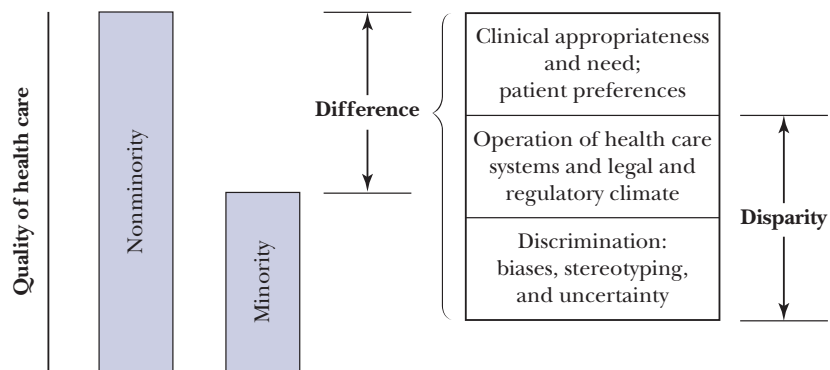
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factors including patient preferences and behaviors, provider constraints and practices, and system or institutional policies (see Figure 4.2).

Patient Factors

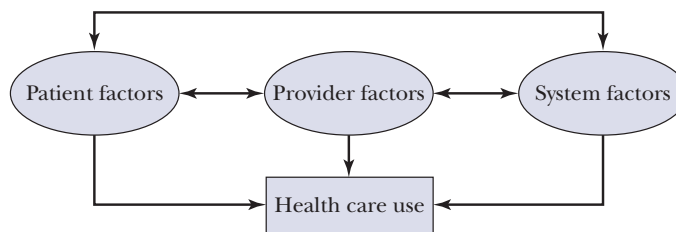
Many patient-related factors are associated with access to and utilization of health care. Some of these factors are more salient to minority patients. Patient perception of health status, views of specific diseases and the patient's ability to accept and cope with illness are all associated with health care use. These points of view on health may be shaped by

FIGURE 4.1. Institute of Medicine model of disparities in health care



Source: Institute of Medicine, 2003.

FIGURE 4.2. Factors related to health care use and their synergies



individual's cultural or traditional beliefs and practices. In addition, psychosocial constructs such as readiness for change, perceived self-efficacy, self-reliance, and fatalism are all related to individual decision making (Ortega & Alegría, 2002; Lorig & Holman, 2003; Wolff et al., 2003; Green et al., 2008). These attitudes in turn determine whether a patient will seek care, adhere to providers' recommendations, and successfully achieve desired outcomes. Patient trust, level of comfort with medical providers, and satisfaction with care are important factors for entry into the health care system as well for its continued use (Sheppard, Zambrana, & O'Malley, 2004; Shi & Stevens, 2005). Individuals' previous experiences with care providers as well as the broader minority communities' history with the health care system also influence patients' attitudes toward providers and the health care system.

Provider Factors

A number of racial and ethnic minorities in the United States come from socioeconomically disadvantaged communities and households with lower education and income levels. On the other hand, White males from affluent socioeconomic backgrounds are overrepresented in the medical establishment. Accordingly, discordance between patient and provider demographics prevails (Vargas Bustamante & Chen, 2011). It is reasonable to believe that most providers feel more comfortable communicating with patients who share similar socioeconomic backgrounds. Researchers have asserted that how providers communicate and understand their patients is likely to influence the effectiveness and continuity of care. Stereotyping or misunderstanding patients due to such differences may lead to inaccurate or inappropriate clinical decision making. For instance, Schulman and colleagues—using a sample survey of more than seven hundred physicians in videotaped, scripted interviews on their recommendations for chest pain management—found that black women were less likely to be referred for cardiac catheterization than white men (Schulman et al., 1999). They also suggest that race and gender play significant and synergistic roles in how providers manage their patients.

Recently, researchers have explored the role of unconscious bias among physicians. Social psychologists posit a dual process theory in which individuals hold attitudes and beliefs on two levels of consciousness: explicit attitudes and beliefs, which are readily available for recall and can be reported, and implicit or unconscious, automatic attitudes and beliefs that exist outside of conscious awareness (Greenwald, Poehlman, et al.,

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2009). Unconscious bias refers to social attitudes and stereotypes about certain demographics or groups of people that are formed outside of their own conscious awareness and are thus “hidden” attitudes and beliefs (Dovidio, Kawakami, & Gaertner, 2002). An individual can hold egalitarian beliefs and unconscious biases simultaneously. Implicit or unconscious preferences and stereotypes are pervasive across populations and topics (Nosek et al., 2007). Implicit race attitudes are related to perceptions of a persons’ trustworthiness (Stanley, Sokol-Hessner, Banaji, & Phelps, 2011). In sensitive areas such as interracial attitudes and beliefs, implicit attitudes are better predictors of the behaviors of discrimination than self-reported attitudes (Greenwald, Poehlman, Uhlman, & Banaji, 2009). In response to racial and ethnic disparities in health care, researchers have been studying implicit and explicit racial bias among physicians and have found that physicians hold implicit racial biases similar to others in society. One exploratory study found that African American physicians showed no unconscious racial bias for either white or African Americans, while physicians of other races and ethnicities showed a strong implicit pro-white preference (Sabin, Nosek, Greenwald, & Rivara, 2009).

Provider communication is associated with patient satisfaction, adherence to recommendations, and health outcomes, which may have consequential effects on the type of service sought (emergency versus primary care) (Murray-García, Selby, Schmittiel, Grumbach, & Quesenberry, 2000; Betancourt & Maina, 2004; Johnson, Roter, Powe, & Cooper, 2004; Betancourt, Green, Carrillo, & Park, 2005). Providers who communicate effectively with their patients and are sensitive to the process tend to have patients who are satisfied and informed of their health issues; more important, such patients are more likely to follow through with treatment and continue to seek primary care services (Johnson et al., 2004; Saha, Komaromy, Koepsell, & Bindman, 1999). Hence, it is important to examine the role of providers in the process, particularly as patient-provider communications become more diverse, with the increasing participation of nonphysician medical providers such as nurses, physician assistants, pharmacists, community health workers, and office staff.

Finally, some argue that racial disparities in medical treatment are rooted in discrimination on the part of providers and health care systems, while others disagree and posit that there is insufficient empirical evidence to show that the disparities are due to conscious or subconscious discrimination (Epstein & Ayanian, 2001). Nonetheless, abundant evidence shows that disparities in health care are persistent, are deep-seated, and exist

across many medical disciplines, practices, and populations, including children, adults, and the elderly.

System Factors

System factors have also been implicated in health care disparities. Lack of health insurance coverage among Latinos has been associated with uncertainty over family health care expenditures, potentially ruinous out-of-pocket payments, and lower health care access and utilization (Monheit & Vistnes, 2000; Waidmann & Rajan, 2000; Hadley, 2003; Hargraves & Hadley, 2003; Zuvekas & Taliaferro, 2003). Difficulties in navigating through a complex health care system and understanding bureaucratic procedures have been cited as major barriers to receiving quality health care for both low-income and racial and ethnic minorities (Betancourt, 2006). For example, patients who are without knowledge or tools required to access primary health care may delay seeking care or may resort to using urgent care or emergency room services. This problem is exacerbated in individuals with more serious conditions requiring secondary or tertiary care, where they would have to access complex systems of specialty care and follow-up (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006).

Structural and environmental conditions within clinical care settings and health care sites that serve racial and ethnic minorities may also contribute to health care disparities. The decline in funding for public clinics and community hospitals that predominantly serve racial and ethnic minorities leads to increased wait times for appointments, crowded facilities, and understaffing and negatively affects the quality of care (Hsiao, Knight, Kappel, & Done, 2011; Vargas Bustamante & Chen, 2011).

Historical Overview of Disparities in Medical Care

The historical and contemporary causes of health care disparities differ for each racial and ethnic group, given their unique experiences in the United States. While there may be overlapping reasons or commonalities among the groups, the histories of African Americans, Latinos, Asian and Pacific Islanders, and Native Americans have distinct paths and trajectories leading to the health care disparities they face. Defining and distinguishing the major forces that have influenced the emergence of health care disparities for these groups would allow health professionals and policymakers to identify appropriate policy and practice solutions specific to these groups.

Factors Related to Disparities among African Americans

The Tuskegee Syphilis Study, a forty-year study of untreated syphilis in black men from Alabama conducted by the U.S. Public Health Service, is typically cited as the central reason for nonparticipation of many African Americans in medical studies and for their reluctance to seek needed health care. However, the legacy of distrust of and mistreatment by the medical establishment among minorities predates the Tuskegee study (Gamble, 1997). Minorities, particularly African Americans, have a long history of segregation in medical care and of receiving poor-quality care (Smith, 1999). Inequity in medical care began with racial segregation and slavery in American history. Slaves were able to obtain care only in slave hospitals, which were typically staffed by other slaves, slave owners, and their family members (Gamble, 1997; Smith, 1999). After emancipation, the federal government set up more than ninety hospitals for the emancipated slaves, but only one (Howard University Medical Center) remained open until the end of the 1800s (Smith, 1999). In segregated America, no one took responsibility for the delivery of care for African Americans. In the late 1800s, African American physicians led efforts to establish black hospitals, starting with the Provident Medical Center in Chicago (Gamble, 1991).

However, in the early 1900s African Americans were excluded from mainstream professional medical societies as well as from most medical schools. In fact, in 1900 only seven medical schools were training physicians of color. Moreover, public health departments and medical societies did not begin taking responsibility for the health of African Americans until they were deemed a threat to the health of whites; thus, the type of care delivered was generally in the form of hygiene control and treatment of infectious diseases.

In addition to these historic factors that contribute to health care disparities faced by African Americans, researchers have identified a variety of other contemporary risk factors (recall Chapter Three). For example, African Americans in the United States are disproportionately represented among the poor and people who live in inner-city neighborhoods. Socioeconomic status and race are associated with a slew of disease risk factors, among them access to primary health care, behaviors (diet, smoking, and physical activity), access to resources and social capital, and environmental and psychosocial stressors. Minority and low-income populations are also less likely to receive effective public health and prevention messages that could help increase their awareness.

Studies have found that African Americans are less likely to have private insurance and more likely than whites to be publicly insured, underinsured,

or uninsured (Kaiser Commission on Medicaid and the Uninsured, 2004). This is an important risk factor, because private insurance coverage is associated with better access to primary care, continuity of care, site of care, and the type and quality of care received, whereas publicly and uninsured patients often receive inadequate and poor-quality care.

Factors Related to Disparities among Latinos

Latinos make up a diverse group of people who trace their roots to several countries of origin that have distinct histories and political ties to the United States. Much like other ethnic groups in the United States, Latinos have a range of immigration and migration patterns. For instance, many Latinos in the Southwest have a family history that can be traced in the region to the time following the Treaty of Guadalupe Hildalgo, well before the colonization of the American Southwest. Puerto Ricans have a history in the United States that dates back to the Jones Act in 1917 (almost twenty years after the Treaty of Paris ended the Spanish-American War), stipulating that Puerto Rico was a U.S. territory whose inhabitants were entitled to U.S. citizenship. Other Latino groups from the Americas and the Caribbean have immigration histories that arise from refugee status, as with the Cubans who sought refuge in the United States after the Bay of Pigs fiasco in the 1960s.

Given the changing demographics of the United States, the significance of issues related to Latinos' health care access and use can be expected to rise. According to recent census data, Latinos make up approximately 16 percent of the total population (U.S. Census Bureau, 2009). Within the Latino population, those of Mexican and Puerto Rican descent make up the two largest groups, accounting for 65.5 percent and 9.1 percent respectively of the entire U.S. Latino population (not including the 3.9 million U.S. citizens in Puerto Rico). Latinos also make up the largest minority group of children and adolescents. Census data show Latinos constituting 22 percent (or sixteen million) of the U.S. population under the age of eighteen.

Studies document that compared to non-Latino Whites, Latinos tend to have worse access to health care, worse morbidity as a result of lack of medical care or treatment, and poorer quality of care. Many factors have been implicated in disparities in access to and quality of care for Latinos. Some studies have reported that Latinos, compared to non-Latino whites, have low rates of insurance coverage, usually as a result of noncitizen status or low-wage employment that does not provide employer-based health insurance; have worse geographic access to care, usually



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because of migration or living on farms or in rural areas; and receive low-quality care, usually because of language discordance between them and their medical providers (Vargas Bustamante & Chen, 2012). Disparities in insurance and access differ, however, within Latino subgroups. For instance, Puerto Ricans born on the island are citizens by birth, facilitating circular migration and qualifying them for certain federal and state health programs (Medicaid, SCHIP, and Medicare).

Latinos have a high presence in public insurance programs, mainly in Medicaid (IOM, 2003). Medicaid is characterized by higher per capita resource constraints and stricter limits on covered services, which are the indicators of poor access and lower quality of care. Low Medicaid capitation payments have been linked to restricted provider networks, limiting the pool of available providers for its beneficiaries, including minorities (Tai-Seale, Freund, & LoSasso, 2001).

Spanish-speaking populations in the United States face a language barrier that can affect the quality of care through poor communication with physicians and other medical care providers. As a result, there can be deficient or inaccurate transfer of important information such as details of disease symptoms, consequences of treatment or lack of treatment, and medication regimens, all of which can lead to ineffective disease management or prevention. Many Latinos delay seeking care until their condition is severe. Such delays, coupled with the need for effective medical interpreters and culturally and linguistically competent providers, make Latinos more vulnerable, potentially more expensive to treat, and more complicated to manage than other ethnic groups who are more fluent English speakers (IOM, 2003).

Factors Related to Disparities among Asians, Pacific Islanders, and Native Hawaiians

Similar to the Latino population, the Asian, Pacific Islander, and Native Hawaiian population is a heterogeneous population from different countries with diverse cultures, histories, and health statuses. While Native Hawaiians became part of the United States through the colonization of Hawaii, Asian and Pacific Islanders have a long history of immigration to the United States dating back to the late 1800s. The first large-scale immigration occurred in 1848, during the Gold Rush in California with the migration of large groups of Chinese. Subsequently, Chinese immigrants continued to fill labor demands by working on sugarcane farms in Hawaii, in various other service occupations, and also as laborers for the

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transcontinental railroad. Similarly, other ethnic groups such as Japanese and Filipinos experienced their own waves of migration. The passage of the Immigration and Nationality Act of 1965 eliminated the national origins quota system and opened up immigration to previously excluded South Asian and Southeast Asian groups. More recently, the United States has seen a growth in refugee migrant populations of Laotians, Hmong, and Cambodians.

Since 2000, the Asian American and Pacific Islander (AAPI) population in the United States has increased by 45 percent, surpassing the growth rate of other racial and ethnic groups (API Health Forum, 2012). The largest subgroups within the Asian population are Chinese, Indian, Filipino, and Vietnamese. Hawaiians, Samoans, and Guamanians represent the largest subgroups of the Pacific Islander population. While many AAPI subgroups have achieved high rates of education, income, homeownership, and social capital relative to non-Latino whites, substantial disparities still exist within this community. For example, while 60 percent of Asians aged twenty-five to twenty-nine reported having a college degree, after disaggregating the data only 18 percent of Native Hawaiians and Pacific Islanders and 7 percent of Hmongs had attained a college education (National Center for Education Statistics, 2012). In addition, although Asians, Pacific Islanders, and Hawaiians have high rates of employment, Asian Americans with a college degree were more likely to be unemployed in comparison to non-Latino whites (Austin, 2010). Finally, the Hmong, Laotian, and Cambodian communities continue to face high rates of poverty, ranging from 35 to 65 percent, in comparison to the national average of 17 percent (National Commission on Asian American and Pacific Islander Research in Education, 2008).

These socioeconomic variations within the AAPI population dispel the “model minority” myth that has been popularized by mainstream American society and by many policymakers (Chen & Hawks, 1995). This myth holds that AAPI groups have successfully acculturated to the U.S. lifestyle and achieved the “American dream,” which masks many AAPIs’ experiences of discrimination, prejudice, and limited access to resources, which in turn affect their access to health care. The heterogeneity of the Asian, Pacific Islander, and Hawaiian population poses several complexities that influence the health care disparities experienced by this community. According to U.S. Census data, 38 percent of AAPIs do not speak English fluently, and many subgroups have lower rates of English proficiency compared to other groups (Ponce et al., 2009; U.S. Census, 2003). Language barriers, along with the lack of bilingual service providers and translated health materials, have been cited as major barriers to care



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(Ngo-Metzger, Sorkin, & Phillips, 2009). Equally important is the need to provide culturally competent care to diverse groups of Asians, Pacific Islanders, and Hawaiians, who have unique beliefs regarding health behaviors, outcomes, and treatment. In addition, although rates of health care insurance are high for the overall Asian population, specific subgroups (such as the recently arrived Hmong, Laotian, and Cambodian subgroups) with lower education levels, higher rates of poverty, and unemployment rely on public insurance or remain uninsured, which negatively affects their access to and receipt of health care services (OMH, 2012).

Factors Related to Disparities among American Indians and Alaska Natives

While comprising of only 2 percent of the entire U.S. population, American Indians and Alaska Natives have the longest history in the United States of any racial and ethnic group. At the time of the arrival of European settlers, scholars estimate the population of these groups to have been approximately thirty-four million, but warfare and colonization, foreign diseases, and cultural dislocation have reduced this community to roughly five million people (U.S. Census Bureau, 2009). The American Indian and Native Alaskan population is also culturally diverse; the U.S. federal government officially recognizes 566 tribes as sovereign nations (Bureau of Indian Affairs, 2012). In addition, there is a high level of geographic dispersion, with only 22 percent living on federal reservations. The states with the largest native populations include California, Oklahoma, and Arizona.

Social disparities and economic disadvantage have long been major factors in the health care disparities facing American Indians and Alaska Natives. Lower rates of education have translated into high rates of unemployment and poverty for this community. In terms of educational attainment, 77 percent have earned a high school diploma by the age of twenty-five, compared to 99 percent of non-Latino whites, and 13 percent have earned college degrees, compared to 31 percent of non-Latino whites (OMH, 2012). Twenty-eight percent of American Indians and Alaska Natives live at or below the federal poverty line, in comparison to 9.9 percent of non-Latino whites (OMH, 2012). As has been shown with other racial and ethnic groups, living in poverty contributes to poor health behaviors and limited access to social resources that promote health. Loss of cultural traditions, language, and native lands has also been attributed to the decline in health and escalation in health care disparities.

The Indian Health Service, the only federal health care system specifically established for a racial or ethnic group, has faced challenges in



providing quality and accessible health care (Families USA, 2010). As a part of the treaties established in 1787, members of federally recognized tribes were guaranteed health care by the U.S. government, and the Indian Health Service (IHS) was established in 1955 to fulfill this commitment. However, only 57 percent of American Indians and Alaska Natives are serviced directly by the IHS, and members face significant restrictions on where they can access services and the extent of care they can receive (US Commission on Civil Rights, 2004). Moreover, direct services from IHS are mostly provided on or near reservations, leaving the 66 percent of natives who do not live on reservations to access care through limited Urban Indian Health programs. However, due to underfunding and structural barriers, 37 percent of all Native Americans receive no services from the IHS (Urban Indian Health Institute, 2004).

Traditional insurance access is also a major barrier for American Indians and Alaska Natives. According to a report by the Kaiser Commission on Medicaid and the Uninsured, 43 percent of American Indians have employer-sponsored health insurance, in comparison to 73 percent of non-Latino whites, while 27 percent rely on public insurance programs such as Medicaid and Medicare, with nearly a quarter of the American Indian population remaining uninsured. As discussed previously, the IHS provides care for all qualified American Indians, but barriers to access place these uninsured individuals at risk of delaying care and not receiving services. Moreover, the complexity of both IHS and public insurance programs and lack of awareness are major barriers to receiving requisite care, even for qualified American Indians and Native Alaskans (US Commission on Civil Rights, 2004).

Scientific Evidence of Disparities in Health Care

In this section we review some of the evidence supporting the existence of disparities in health care. Because the literature on disparities in care is extensive, spanning several decades, we have selected several condition-specific areas of research for our review: cardiovascular disease, cancer, renal disease and transplantation, HIV/AIDS, obesity, diabetes, asthma, and mental health. These areas were selected for a variety of reasons. Cardiovascular disease, cancer, renal disease and transplantation, and HIV/AIDS were selected because they are among the most studied areas of racial and ethnic disparities in care. Asthma, obesity, and diabetes were selected because various racial and ethnic subgroups are disproportionately affected by these conditions. Finally, because the other areas included

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in this review focus on physical domains of health status, we elected to include mental health.

Cardiovascular Disease

Coronary artery disease (CAD) and acute myocardial infarction (AMI) are the most analyzed topics among studies of racial and ethnic disparities in care. Due to data limitations and elevated risk, the most frequently studied groups are African Americans, Latinos, and whites. Although blood pressure and cholesterol screening are common among both African Americans and whites, one study using seven federal datasets found that hospitalization rates for hypertension, angina, and congestive heart failure were higher for African Americans compared to whites across almost all age groups, suggesting that screening and preventive care are insufficient to prevent heart disease in African Americans (Holmes, Arispe, & Moy, 2005). Similar findings in congestive heart failure hospitalization rates have also been found for Latinos and Native Americans in comparison to non-Latino whites (Mensah, Mokdad, Ford, Greenlund, & Croft, 2005). In addition, from 1999 to 2006 blood pressure control and cholesterol levels have improved in the United States; however, disparities persist among African Americans and Latinos compared to non-Latino whites (McWilliams, Meara, Zaslavsky, & Ayanian, 2009).

Studies of racial and ethnic disparities in cardiovascular disease have become increasingly sophisticated in their control and adjustment for confounders (Geiger, 2003). African Americans are less likely than whites to be catheterized; when it is done, they are 20 to 50 percent less likely to undergo a revascularization procedure. They are also less likely to receive beta-blockers, thrombolytic drugs, or aspirin when these interventions are indicated. There are similar findings for Latinos, as studies have found that they receive less blood pressure control, aspirin, beta-blockers, and assessments of left ventricular function (Correa-de-Araujo et al., 2006; Hicks et al., 2004).

In addition, racial and ethnic minorities are less likely to receive advanced and expensive treatments and therapies for cardiovascular disease conditions. African Americans are less likely than whites to undergo cardiac catheterization and revascularization, less likely to be given newer antiplatelet agents during hospitalization, and less likely to receive lipid-lowering agents and smoking cessation counseling at time of hospital discharge (Sonel et al., 2005). In addition, African Americans and Latinos were less likely to receive cardiac resynchronization therapy with

defibrillation, even when they met clinical guidelines for receiving that treatment (Farmer et al., 2009).

The role of race in clinical decision making regarding cardiovascular disease has also been investigated. In one study where a committee of cardiologists and cardiothoracic surgeons made decisions about coronary artery bypass grafting (CABG) versus angioplasty for 938 patients after catheterization—decisions based only on a presentation by a cardiology fellow, and thus effectively blinded to the patient's race—the rate of revascularization was similar for African Americans and whites, though African Americans were more likely to receive angioplasty and whites more likely to receive CABG (Okelo et al., 2001). A study that included Medicare patients treated for myocardial infarction in 4,609 hospitals found that on average African Americans were treated at “hospitals with lower-quality medical treatment but higher-quality surgical treatment.” Nevertheless, “African Americans received fewer surgical treatments than whites admitted to the same hospital” (Barnato, Lucas, Staiger, Wennberg, & Chandra, 2005). In a similar study conducted in New York state, African Americans and AAPIs who underwent CABG received treatment from lower-quality hospitals and surgeons compared to whites (Rothenberg, Pearson, Zwanziger, & Mukamel, 2004).

Cancer

Studies of racial and ethnic disparities in cancer incidence and prevalence, screening, stage at diagnosis, as well as treatment and survival have been attributed to a range of factors, among them differences in tumor biology, genetics, cultural differences and folk beliefs, socioeconomic status, problems of access to continuity of care, physician practice style and communication with patients, and interaction among all of these factors (Geiger, 2003).

For several types of cancers, racial and ethnic minorities are less likely to receive screenings and early diagnosis, which is essential for effective treatment and survivorship. One study that analyzed national cancer data found that only 52 percent of Native American women, 57 percent of Asian women, 62.6 percent of Latina women, and 68.2 percent of African American women had received a mammogram in the past two years, compared to 72 percent among non-Latino white women (Ward et al., 2004). The same study found that rates of Pap smears were similar among African American women (83.9 percent) and non-Latino white women (85.5 percent); however, rates were lower for Latinas (77.9 percent),

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American Indians and Alaska Natives (78.4 percent), and Asians (68.2 percent). As a result, non-Latino white women are more likely to receive a breast cancer diagnosis when the cancer is in the localized stage as opposed to African American, Latina, and American Indian women, who have high rates of diagnoses in the regional stage. The same is true for cervical cancer, where Asian women are more likely to be diagnosed with invasive cervical cancer, followed by African American and Latina women.

Variation in cancer treatment has also been found in several reports and studies. Shavers and Brown found that, after controlling for clinical factors, African American women are less likely than white women to receive breast-conserving surgery (BCS) and radiation. After undergoing BCS, African American women and women from other racial and ethnic minority groups are less likely than whites to have radiation therapy (Shavers & Brown, 2002). In addition, Latina women were less likely to receive reconstructive surgery, and they report being less satisfied with their breast cancer treatment in comparison to African American and non-Latino white women (Katz et al., 2005). Similar patterns according to race and ethnicity were found for men and women with colorectal cancer. Both Latinos and African Americans have been shown to be treated less aggressively than non-Latino whites with similar disease, even after adjusting for insurance coverage, hospital type, and comorbidities (Elston Lafata, Cole Johnson, Ben-Menachem, & Morlock, 2001; Roetzheim et al., 2000).

Diabetes

Diabetes disproportionately affects racial ethnic minorities, including Latinos, African Americans, and Native Americans; however, the literature highlights several gaps in care facing these groups. Successful treatment and management of diabetes includes healthy eating and nutrition education, eye exams, foot inspections, prescription drug and/or insulin therapies, cholesterol and blood pressure monitoring, and glucose control.

In one review of seventy-eight articles relating to diabetes treatment and management, findings suggested that glycemic and blood pressure control was worse for racial and ethnic minorities in comparison to non-Latino whites (Kirk et al., 2006). Patient adherence and behaviors, provider practices, and health care systems all contribute to disparities in diabetes treatment faced by minority patients. For example, African American patients were found to be less adherent to medication and in turn to have less metabolic control, although the effect of race was still independent of adherence (Schechtman, Nadkarni, & Voss, 2002). Similarly, a meta-analysis

of several articles found that A1C levels were found to be higher among Latinos in comparison to non-Latino whites, but the causes of elevated levels were unknown (Kirk et al., 2008).

In addition, racial and ethnic minorities face more complications from diabetes when compared to non-Latino whites, which highlights failures in treatment and management. Common complications cited in the literature include glaucoma, cataract, neuropathy, cardiovascular disease, kidney disease, and mental health disease. One study examining insured patients found that Latinos, Asians, and African Americans had a higher likelihood of end-stage renal disease in comparison to non-Latino whites in the sample (Karter et al., 2002). In addition, diabetic African Americans have experienced higher rates of blindness, amputations, and amputation-related mortality, while Latinos have higher prevalence of retinopathy. Finally, Latinos, African Americans, and Native Americans have higher risks of diabetes-associated mortality compared to non-Latino whites (Peek, Cargill, & Huang, 2007).

Renal Disease and Transplantation

African Americans and Native Americans have the highest incidence of risk of illness and death from end-stage renal disease (ESRD) among racial and ethnic minorities. Among Native Americans, for example, the rate is four times that for whites. This is due to more hypertension, diabetes, and sickle cell disease among African Americans, diabetes among Native Americans, and less access to or use of early primary care interventions among both groups. The two main treatments for ESRD are dialysis and renal transplantation. Although Medicare specifically supports ESRD treatment, kidney transplantation rates vary by race (Eggers, 1995). Studies have shown that Asians, Latinos, and women initiate dialysis treatment later.

Reasons for differences in transplant rates involve numerous factors, including race. One study found that Latinos and Asians on a transplant list were less likely to receive a kidney in comparison to non-Latino whites and African Americans, after controlling for severity of the disease (Mathur, Schaubel, Gong, Guidinger, & Merion, 2010). In addition, many studies show that patient preferences, including refusal of and disinterest in transplantation, is an important contributing factor (Geiger, 2003). A study that examined physicians' beliefs about racial differences in referral for renal transplantation related that whereas physicians did not view patient-physician communication and trust as important reasons for racial differences in care, African American patients were less likely than

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white patients to report receiving some or a lot of information about transplantation (55 percent versus 74 percent; Ayanian et al., 2004).

HIV/AIDS

Over the past two decades, infections with HIV and progression to AIDS have disproportionately affected African Americans and Latinos. For example, in 2002 HIV/AIDS was the sixth leading cause of death among African Americans and tenth leading cause of death among Latino males, whereas it was not among the ten leading causes of death for non-Latino white males (Hoyert and Xu, 2012). Evidence from various studies indicate that racial and ethnic minorities are less likely than whites to receive various medications or to undergo some diagnostic procedures, though they vary by source of care (Geiger, 2003).

African American and Latina women have been shown to receive highly active antiretroviral therapy (HAART) less often than non-Latino white women after controlling for potential confounders (Lillie-Blanton et al., 2010). Similarly, a review of the literature found mixed effects in relation to the influence of race on the use of antiretrovirals and prophylaxis for opportunistic infection (Palacio, Kahn, Richards, & Morin, 2002). Possible reasons for the differences include misconceptions about HIV/AIDS among racial and ethnic minorities, distrust of health authorities, and “prescribing habits” of providers.

Additionally, many studies have found difficulties in physician-patient communication in HIV/AIDS cases, particularly in discussing decisions about end-of-life care and resuscitation (Haas et al. 1993) and when there was racial or ethnic discordance between patient and physician. One study found that African Americans with white physicians were less likely to receive protease inhibitors when compared to racially concordant physician-patient pairs (King, Wong, Shapiro, Landon, & Cunningham, 2004).

Finally, patient practices and beliefs are important factors in explaining disparities in HIV treatment. Appointment nonadherence was found to be an important factor in virologic failure, and it partially explained disparities in virologic failure between African American and white patients (Mugavero et al., 2009). Patient mistrust and conspiracy beliefs are also a factor. A study found that 27 percent of 520 African American adults in ten randomly selected census tracts agreed with the statement “HIV/AIDS is a man-made virus that the federal government made to kill and wipe out black people,” and an additional 23 percent were undecided (Klonoff & Landrine, 1999).

Asthma

Asthma is a major health problem across many socioeconomic and racial and ethnic categories. However, African Americans and Latinos, especially Puerto Ricans, share a disproportionate burden. Asthma is the most common chronic condition afflicting children in the United States. Among children, African Americans and Latinos have worse morbidity and African Americans have higher mortality due to asthma than all other racial or ethnic groups of children (Akinbami, Moorman, & Liu, 2011). The asthma death rate among African Americans is approximately three times more compared to whites (Akinbami, Moorman, & Liu, 2011). Between the ages of five and thirty-four (when asthma is easier to distinguish from other causes of ventilatory impairment), African Americans experience an asthma mortality rate approximately three to five times higher than that of whites (Akinbami, Moorman, & Liu, 2011). Multiple risk factors have been implicated for asthma morbidity and mortality for racial and ethnic minorities: tobacco smoke exposure, obesity, air pollution, house dust mite allergens, cockroaches, and cat hair (Luder, Melnik, & DiMaio, 1998; Gilliland, et al., 2000).

An elevated level of severe asthma and related hospitalization among inner-city minority children is associated with features of health care and treatment, such as inadequate use of long-term controller steroid medications and overuse of quick-acting reliever drugs such as albuterol (Ortega & Calderon, 2000). Researchers have observed that poor asthma management and control among racial and ethnic minorities is associated with a variety of factors, including poor provider-patient communication, deficient access to and use of high-quality and effective primary care, poor perceived patient and family efficacy to manage asthma, and perceived inadequate treatment efficacy by patients and their families (Ortega & Calderon, 2000).

Mental Health

Improving the access and utilization of mental health services has been a top health policy priority in the United States. The attention to mental health care comes from increasing awareness that many people who meet diagnostic criteria for mental illness do not seek or obtain needed care. Several studies have demonstrated that minorities, particularly African Americans and Latinos, are less likely to use mental health services than whites. In the U.S. Surgeon General's (2001) supplement "Mental Health: Culture, Race, and Ethnicity," it is noted that ethnic and racial minorities have less access to mental health care than whites, and that they are less likely to

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receive needed care and stay in care. The reasons for minorities' underuse of mental health services are multifactorial. Considerable attention in mental health services research has focused on the role of payment and insurance. Many people in the United States lack sufficient insurance coverage to cover mental health; many health plans also limit the number of visits people may have over a period of time. Further, some plans require costly copayments or do not allow people to go out of plan networks to find suitable providers. Other barriers include lack of access to providers who speak the same language, especially for low-aculturated Latinos. There are also accessibility factors, such as location and awareness of available services.

A growing body of literature indicates that other factors in addition to payment mechanisms for mental health disparity may also be in play. For example, researchers are focusing on factors such as health beliefs, knowledge of mental health problems, and coping mechanisms such as self-reliance and social networks (Ortega & Alegría, 2002). For example, two reports of island Puerto Ricans demonstrated a high level of psychiatric disorder but also high denial and self-reliance (Ortega & Alegría, 2002; Ortega & Alegría, 2005). Denial can be a maladaptive coping strategy, especially if it results in little or no usage of needed mental health care. The extent to which denial is more or less prevalent in minority populations relative to nonminority populations is unknown. For Latinos, some researchers have focused on the role of families and social networks in protecting members from morbidity (Pescosolido, Wright, Alegría, & Vera, 1998). Other factors that have been examined as potential determinants of mental health care disparities for all minorities include stigma, discrimination, and racism.

Due to these factors, racial and ethnic minorities face multiple disparities in mental health treatment, including limited access to care and lower quality of care. Among both nondepressed and depressed individuals, Asians, Latinos, and African Americans were less likely to access mental health services in comparison to non-Latino whites (Alegría et al., 2008). In addition, Asians and African Americans received lower-quality care when compared to non-Latino whites.

Future Directions

In response to the ever-growing body of literature documenting the existence of racial and ethnic disparities in care, there have been and continue to be numerous efforts to address those disparities. Examples of these efforts exist in the public and private sectors of U.S. society.

For the past thirty years, Healthy People, an initiative developed by the U.S. Department of Health and Human Services, has been outlining the national priorities for improving Americans' health. Healthy People 2000 included "reducing health disparities" as one of its major goals. Ten years later, Healthy People 2010 went one step further, with a goal of "eliminating health disparities" (DHHS, 2000). More specifically, the objectives target improving access to care and increasing immunizations as major objectives. Despite the declaration of these public efforts, studies that reviewed the progress toward Healthy People 2010 goals found mixed results in terms of improving health care access and immunizations for racial and ethnic minorities (Sonik, Stein-Wexler, Rogers, Coulter, & Wootton-Gorges, 2010). With the recognition that health care disparities continue to be a major issue, Healthy People 2020 has expanded this goal to "achieve health equity, eliminate disparities, and improve the health of all groups" according to the Office of Minority Health (OMH, 2012).

The Department of Health and Human Services has similarly called for the reduction in health disparities facing racial and ethnic minority groups and has integrated Offices of Minority Health in federal agencies under its leadership. In addition, the department organizes the Federal Interagency Health Equity Team that assembles leaders across DHHS and eleven other federal agencies to coordinate and maximize the effectiveness of the many federal efforts to eliminate disparities and to identify and evaluate new opportunities for eliminating disparities. Finally, the DHHS Disparities Action Plan, developed in 2011, provides strategic objectives over the next five years aimed at guiding agencies under DHHS to reduce health care disparities for racial and ethnic minorities (minority-health.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf).

Also, directed by Congress, the Agency for Healthcare Quality and Research has produced a yearly National Healthcare Disparities Report since 2003 documenting variations in quality of care by racial and ethnic groups. This report draws on data from numerous national surveys, including the Medical Expenditure Panel Survey, the National Health Interview Survey, the National Immunization Survey, the National Ambulatory Care Survey, and many others. The purpose of this report is to highlight areas of greatest need and track reduction in disparities over time.

In addition to monitoring efforts and goal-setting strategies, various government and private agencies have attempted to address health and health care disparities through expansion of health access and provision of care to racial and ethnic minorities. The Health Resources and Services Administration (HRSA)-supported health centers provide infrastructure support and often funding to various safety-net providers

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such as community clinics that provide care to the uninsured, low-income, and disadvantaged individuals. In 2010, these health centers served 19.5 million patients across the United States, where 92 percent were below 200 percent of the federal poverty guideline and 62.3 percent were racial and ethnic minorities (OMH, 2012).

Diversifying the health care workforce and promoting cultural competency have also been major initiatives of the last twenty years. Established in 1972, the National Health Service Corps places physicians, nurses, dentists, and health personnel in Health Professional Shortage Areas in exchange for scholarship and loan repayment programs (DHHS, n.d.). Also, various public and private efforts have aimed to provide more opportunities for minority students to pursue careers in medicine, nursing, dentistry, and public health. For example, Title VII of the Public Health Services Act supports the training of over ten thousand underrepresented graduates, residents, and faculty in various health professional fields (American Public Health Association, 2009). In addition, the Office of Minority Health has established national standards on Culturally and Linguistically Appropriate Services (CLAS), which guide health care organizations and providers in offering care to racial and ethnic minorities and other underserved communities (OMH, n.d.).

Finally, the Patient Protection and Affordable Healthcare Act (ACA), which passed in 2010, includes several provisions directly and indirectly intended to improve racial and ethnic disparities in health care through data collection and reporting, insurance coverage, cultural competence, access to health care, quality improvement, and research (Andrulis, Siddiqui, Purtle, & Duchon, 2010). While the full impact of these efforts is still unclear as health care reform is still being implemented, various initiatives already set into motion are projected to significantly reduce racial and ethnic health disparities.

First, the expansion of insurance and health care coverage will address significant barriers to care faced by racial and ethnic minorities. As previously discussed, compared to non-Latino whites, African Americans, Latinos, some subgroups of Asian and Pacific Islanders, and Native Americans are more likely to be uninsured. Through Medicaid expansion included in ACA, the creation of state-based health insurance exchanges, and employer-based health insurance reforms, an estimated thirty-two million individuals will gain access to health insurance (Kaiser Family Foundation, 2011). The ACA also sets out to improve access to care by providing funding and improving the infrastructure of health care systems that serve racial and ethnic minorities. For example, community

health centers, which predominantly serve racial and ethnic minority and low-income patients, will receive \$11 billion starting in 2011 to support expansion of operational capacity and capital improvements (National Association of Community Health Centers, 2010).

Strengthening and establishing centers to coordinate efforts to improve health and care for racial and ethnic minorities is also a priority of the ACA. In 2010, the National Center for Minority Health and Health Disparities (NCMHD) was transitioned to the National Institute on Minority Health and Health Disparities (NIMHD), which gives the institute discretion to develop research priorities and funding allocations for research focused on minorities and health disparities. In addition, federal agencies under the Department of Health and Human Services; the Agency for Healthcare Research and Quality (AHRQ); the Centers for Disease Control and Prevention (CDC); the Centers for Medicare and Medicaid Services (CMS); the Food and Drug Administration (FDA); the Health Resources and Services Administration (HRSA); and the Substance Abuse and Mental Health Services Administration (SAMHSA), in the Department of Health and Human Services, are mandated to create Offices of Minority Health to coordinate their efforts and initiatives regarding racial and ethnic minorities (OMH, n.d.).

Finally, much is still not understood about the nature and causes of health care disparities facing racial and ethnic minorities and effective solutions, therefore the ACA includes several provisions to improve research and develop effective interventions. One of the major efforts implemented in the law is the requirement to collect and utilize race, ethnicity, language, sex, and disability data in research studies and in monitoring efforts so that policymakers, practitioners, and researchers have a more holistic picture of the needs of various populations and subgroups (DHHS, 2010). To improve the quality of care for racial ethnic minorities, the law also establishes a Patient-Centered Outcomes Research Institute (PCORI) to independently investigate clinical effectiveness of medical interventions and programs for diseases, disorders, and health conditions, with a focus on what works for racial and ethnic minorities (Washington & Lipstein, 2011).

SUMMARY

According to the medical and public health literature, disparities in health care system are prevalent, with racial and ethnic minorities receiving lower-quality care in a variety of health care settings and across a range of

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medical conditions. A number of factors account for disparities in care, ranging from legal and structural factors to patient and provider factors. From a historical perspective, these findings are not surprising; racial and ethnic minorities have experienced discrimination and segregation in health care settings since the founding of the United States. Although efforts to address racial and ethnic disparities in care are multiple and ongoing, minority patients continue to have suboptimal health status, which will in turn affect labor market productivity and national health care spending. With the growing size of minority populations in the United States, addressing disparities in care is a paramount health policy issue.

KEY TERMS

Disparity in health care According to the Institute of Medicine (IOM), “disparity is any difference not due to clinical need or preferences for health care services” (IOM, 2003).

Equity According to the IOM, equity or equal treatment can be defined as the “delivery of health services of equal quality to all individuals regardless of personal characteristics as gender, socioeconomic status, geographic location, race or ethnicity” (IOM, 2003).

DISCUSSION QUESTIONS

1. Discuss what is meant by disparities in health care, both in terms of the relationship of disparities in health care and disparities in health, and in terms of what constitutes a disparity in health care.
2. Discuss the role that personal preference and medical appropriateness play in causing disparities in health care.
3. Discuss the role of patient provider communications in causing and also in alleviating disparities in health care.
4. Discuss the history of segregation in medical care of African American patients, physicians, and nurses and how this history might affect current racial and ethnic disparities in the delivery and receipt of medical care.
5. Discuss some of the efforts currently underway to address disparities in care, including the ACA.

6. Discuss what might be done in your community to address disparities in health care.

FURTHER READING

Aguirre-Molina, M., Molina, C. W., & Zambrana, R. E. (2001). *Health issues in the Latino community*. San Francisco: Jossey-Bass.

This book summarizes health issues among Latino populations in the United States. It includes causes of and statistics on health care disparities affecting Latinos.

Fadiman, A. (1997). *The spirit catches you and you fall down*. New York: Farrar, Straus & Giroux.

Well-written book by a journalist that describes the interactions between a Hmong family with an epileptic daughter and the health care system. This book illustrates how poor doctor-patient communication due to divergent cultural beliefs can result in poor health outcomes.

Gamble, V. N. (1995). *Making a place for ourselves: The black hospital movement*. New York: Oxford University Press.

This book examines the roles of black physicians and nurses, black community organizations, local and federal governments, and major health care organizations in the creation and demise of black hospitals from 1920 to 1945.

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press.

This report summarizes the literature on health care disparities and makes recommendations for addressing them. This is a landmark report issued by the National Research Council.

Institute of Medicine. (2012). *How far have we come in reducing health disparities? Progress since 2000: Workshop summary*. Washington, DC: National Academies Press.

Building upon previous IOM reports on health care quality and unequal treatment, the IOM held a workshop on April 8, 2010, that discussed progress toward addressing health disparities and focused on the success of various federal initiatives to reduce health disparities. This report summarizes the IOM workshop and explains the progress in the field since 2000.

LaVeist, T. A. (2005). *Minority populations and health: An introduction to health disparities in the United States*. San Francisco: Jossey-Bass.

This book describes racial and ethnic disparities in health and its causes, including disparities in health care. This book's main strength is that it includes a lot of descriptive statistics on minority health drawn from various sources.

Smith, D. B. (1999). *Health care divided: Race and healing a nation*. Ann Arbor: University of Michigan Press.

This book is a chronicle from 1920 to the present of racial segregation and discrimination in health care in the United States.

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U.S. Department of Health and Human Services. (2012). *2011 National healthcare disparities report*. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality.

National report of health care disparities issued yearly by the Agency for Healthcare Research and Quality. This report uses indicators of quality of care drawn from various sources and reported by race and ethnicity.

White, A. A., III, & Chanoff, D. (2011). *Seeing patients: Unconscious bias in health care*. Boston: Harvard University Press.

This book uses the story of one of the authors, Gus White, as a way to talk about unconscious biases and their consequences in the medical profession and beyond. White is an orthopedic surgeon who grew up in Tennessee under Jim Crow, went to Ivy League schools, and was the only and first black medical student in most of those places. He was the first black chief resident at Yale, the only black surgeon in Vietnam, and the first black chief of service in a Harvard teaching hospital. The authors use an autobiographical approach, showing how Dr. White's life spans an enormous change in American race relations. They also show how great the disparities still are and make the case for "culturally competent" medical training.

Williams, R. A. (Ed.). (2011). *Healthcare disparities at the crossroads with the healthcare reform*. New York: Springer Science + Business Media.

This volume addresses how the Affordable Care Act addresses the problem of health care disparity and analyzes the benefits and shortcomings of the law as it relates to disparities.

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