

Eliminating Racial and Ethnic Disparities in Access to Healthcare: The Challenge of the American Healthcare System

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Abstract

Historically, ethnic minority groups tend to fare much worse on national indicators and typically have higher rates of morbidity and mortality from most diseases. Due to the steady increase of the racial and ethnic minority populations in the US it is becoming more and more apparent that one of the major goals of the United States healthcare system should be to eliminate racial and ethnic healthcare disparities. Current strategies suggest that the most promising outcomes have included culturally-based and multi-component interventions. However, finding a definite strategy that works to ameliorate these disparities cannot be completely evaluated until a universally acceptable definition and standardized measurement of disparity is developed which will allow for a better evaluation of healthcare disparities.

Eliminating Racial and Ethnic Disparities in Access to Healthcare: The Challenge of the American Healthcare System

Disparities in health care have been a major problem for members of ethnic minority groups for several years. Ethnic minority groups tend to fare much worse on national indicators and typically have higher rates of morbidity and mortality from almost any disease that can be named (Ramirez, Ford, Stewart, & Teresi, 2005; Egede & Bosworth, 2008; Syme, 2008). The disparities that have been found encompass a wide spectrum of healthcare issues ranging from issues dealing with quality of care to clinician biases (Straker, 2008). Even though previous research has been done to acknowledge that health care disparities do exist, modern research is still grappling with defining the construct of “disparity”—that is, should mere differences between racial and ethnic groups dictate disparity or how much of a discrepancy needs to be seen before a difference between minority groups becomes a disparity? (Herbert, Sisk, & Howell, 2008). Having a clearly defined measure of disparity is important because it would give a direction as to how to work to ameliorate the differences between races. This paper will discuss the challenges involved with defining the construct of disparity as well as, take a look at what research has already been found with regard to racial and ethnic disparities. After looking at what has been found, implications for practice in both the Public Health and Physician Assistant professions will be discussed.

Defining Disparity

Before one can talk about the disparities that exist in the US healthcare system, it is important to note the challenges that arise when it comes to providing an acceptable definition

of the terms “disparity” or “health disparity”. Throughout the literature there is a wealth of information that supports the idea that health disparities exist between racial and ethnic populations (Ramirez, Ford, Stewart, & Teresi, 2005; Egede & Bosworth, 2008; Syme, 2008); however, equally as prevalent is the discrepancy in what researchers say constitutes an acceptable definition of the terms. When it comes to defining these terms one will find that there is also a myriad of definitions that exist (Carter-Pokras & Baquet, 2002). Despite the differing of opinions, there is one concept of the definitions that is widely agreed upon within the research and that is that the construct of disparity is implicit of some type of inequity or injustice (Carter-Pokras & Baquet, 2002; Herbert, et al., 2008). Herbert, et al., goes on further to explain how difficult it is to define this concept because of the gray area that remains after several confounding factors have been statistically controlled for. This gray area leads to a lack of consensus which makes it difficult to decipher when a mere difference between groups can be officially classified as a disparity. This is why a universally acceptable definition of disparity is needed. In its 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, the Institute of Medicine (IOM) defines healthcare disparities as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.”(Carter-Pokras & Baquet, 2002; Egede, 2006; Herbert, et al., 2008). Conversely, the Agency for Healthcare Research and Quality (AHRQ) uses the following definition for its annual *National Healthcare Disparities Report* “...any difference among populations that are statistically significant and differ from the reference group by at least 10 percent.”(Herbert, et al., 2008), while the National Institutes of Health (NIH) defines health disparity as a “...difference in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exists among specific population

groups in the United States...” (Carter-Pokras & Baquet, 2002; Jones & Crump, 2005). In examining the definitions presented above it is evident that there are varying interpretations as to what research says a disparity is. Varying definitions of this construct makes it more difficult to measure, which in-turn affects the possibility of data-linkage and cross-over among research studies. If there is no universal definition or standardized measure of health disparity, then how can one truly measure whether outcomes are improving or getting worse? This presents yet another reason why a universally acceptable definition of disparity is needed. For the purposes of this paper health disparities will be discussed as a general difference among healthcare status indicators, particularly as it relates to access to care for racial and ethnic minority populations in the US.

Disparities in Healthcare

In the United States, racial and ethnic minorities are consistently at the bottom of the list when it comes to national indicators of health and well-being. African Americans have a heart attack death rate that is 29% higher than whites and a stroke death rate that is 40% higher than whites. The rate of diabetes is 1.9 times higher among Hispanics, 2 times higher among African Americans, and 2.6 times higher among Native Americans when compared to whites. African American women are twice as likely as white women to die from cervical cancer, and have the highest rate of breast cancer deaths among all women of racial or ethnic minority backgrounds. For the past twenty years the African American to white ratio of infant mortality rates has been on a steady increase and is now at 2.5 to 1 (Gunderman, 2007). In a country where the per capita spending is twice as much as it is than in any other industrialized county these types of health disparities should not exist (Lavizzo-Mourey, 2008). According the AHRQ (2008), roughly 30% of the US population identifies themselves as a member of a racial or ethnic minority group. It is

estimated that by the year 2050, members of ethnic minority groups will account for half of the United States' population (AHRQ, 2008). Taking this information into account, it is easy to see why the elimination of health care disparities has become a “hot topic” amongst researchers. The growth rate of the racial and ethnic populations in the US and the quality of care received by these individuals are growing at rates inversely proportionate to one another—as the population of racial and ethnic minorities increase, the quality of care received by these populations is decreasing. If things continue to trend in this direction, the overall health of the US will begin to suffer as a result; therefore there needs to be a reduction in healthcare disparities amongst the ethnic minority populations as this would help to optimize health outcomes for not only those minority groups involved, but also for the general health of the US. According to Franks (2008), optimization of health and healthcare should be the primary goal of the healthcare industry. In order to affect change, there needs to be a call to action involving all facets of the healthcare industry.

Disparities in Access to Care

The AHRQ (2006 & 2008) defines access to care as the “the timely use of personal health services to achieve the best health outcomes.” It posits that good access to care requires all of the following: 1) gaining entry into the health system, 2) getting access to sites where patients can receive needed services, and 3) finding providers who can meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust. In order to adequately reduce health care disparities one must address the barriers to care that prevent the individual from achieving the above goals. Barriers to care may involve any combination of the following: lack of insurance, lack of transportation, cultural barriers, language barriers, perception of need, etc. African Americans are 15% more likely to have worse

access to care than whites, while Hispanics are 88% more likely to have worse access to care than non-Hispanic whites (AHRQ, 2006). Sixteen percent of whites report having no usual source of medical care compared with 20% of African American and 30% of Hispanics. Sixty-six percent of African American adults identify a doctor's office as their regular source of care compared to 80% of whites (National Health Plan Collaborative, 2007). These statistics can go on and on; however they only serve to show that something needs to be done to close the gaps in access to care between the racial majority and the racial minorities in the US.

Promising Intervention Strategies

Multi-component Interventions

When designing interventions that are geared toward reducing racial and ethnic disparities, it is important to take a look at the whole picture. This is where multi-component interventions step in. Chin and colleagues (2007) found that interventions that targeted a wide range of patients, providers, and multiple health care organizations and healthcare systems frequently improved processes of care and outcomes. They explored the REACH 2010 project which included a multi-component, multi-targeted system of care that consisted of a coalition of health care and academic institutions, community-based and faith-based organizations, civic groups, libraries, professional associations, government and business organizations and local media. With the help of all of these organizations several components of health were addressed with the use of community health worker, education, patient registries for continuity of care, community-based case management, advocacy, provider feedback and audit, to name a few. With all of these components in place this intervention actually produced a reduction in racial disparities. Achieving such a good outcome would lend to the idea that a multidisciplinary and

multifaceted approach needs to be taken when designing interventions to reduce racial disparities.

Culturally-tailored Interventions

Chin and colleagues (2007) also found that tailoring an intervention to a specific culture could improve care by providing a mechanism for individualizing care. This concept was also noted by Dreaschlin and Hobby (2008) who also gave credence to the idea that culturally driven interventions need to have race and ethnicity concordance because it may make it easier for the patient to relate to healthcare providers who “look-like” them. This implies that individuals are more comfortable in dealing with health care providers who share the same cultural background and experiences as them. This would allow the patient to form a rapport with the provider which ties into the AHRQs third premise of “finding providers who can meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust” to increase access to care.

Implications for the Future

The Role of the Public Health Profession

There is a great need for policy intervention when dealing with health care disparities as a result of the varying definitions of the terms disparity and health disparity. The first step in eliminating the healthcare disparities of this country would be to develop a universally acceptable definition of the construct of disparity. Once this is developed it would aid Public Health researcher in developing a standardized measure of the construct which would ultimately make the future of disparities research more reliable. Having a standardized measure will also make it easier to evaluate the progress in eliminating racial and ethnic disparities.

The Role of the Physician Assistant Profession

Physician assistants (PA) can begin working to eliminate disparities by educating themselves on the disparities that exist within their area of practice (Straker, 2008). This is important because it keeps the PA abreast of the current disparities in their specialty area which should make them more aware as a practitioner. Another way PAs can work to eliminate health disparities is to recruit racial and ethnic minorities into the profession (Straker, 2008). Doing so would enhance the idea of race and ethnicity concordance in the field. Patients like to see practitioners who look like them because it provides them with a sense of ease and comfort. Lastly Straker (2008) suggests that PAs should work to provide better quality of care by always providing patient-centered care to all of their patients. Each patient that presents to the clinic has a unique situation and need to be treated within that context.

Conclusion

Racial and ethnic disparities in health care have existed for many years; however it is important to note that to affect change in these disparities a clearly defined constructs needs to be developed. Until this happens, the health disparities research community is left with data that cannot adequately be evaluated. It is also important to note that the ethnic and racial disparities that exist encompass several factors. New interventions need to be developed that address all of these factors together involving all aspects of the health care continuum. Just as the African proverb states “it takes a village to raise a child” it is going to “take a village” to eliminate the present health care disparities of the United States.

References

- Agency for Healthcare Research and Quality (2006). National healthcare disparities report, 2006. (AHRQ Publication No. 07-0012). Rockville, MD: United States Department of Health and Human Services. Retrieved July 9, 2008 from <http://www.ahrq.gov/qual/nhdr06/nhdr06report.pdf>
- Agency for Healthcare Research and Quality (2008). National healthcare disparities report, 2007. (AHRQ Publication No. 08-0041). Rockville, MD: United States Department of Health and Human Services. Retrieved July 9, 2008 from <http://www.ahrq.gov/qual/nhdr07/nhdr07.pdf>
- Carter-Pokras, O., & Baquet, C. (2002). What is a “health disparity”? *Public Health Reports*, 117(5), 426-434.
- Chin, M.H., Walters, A.E., Cook, S.C., & Huang, E.S. (2007). Interventions to reduce racial and ethnic disparities in health care. *Medical Care Research and Review*, 64(Suppl. 5), 7S-28S.
- Dreaschlin, J.L., & Hobby, F. (2008). Racial and ethnic disparities: Why diversity leadership matters. *Journal of Healthcare Management*, 53(1), 8-13.
- Egede, L.E. (2006). Race, ethnicity, culture and disparities in healthcare. *Journal of General Internal Medicine*, 21(6), 667-669.
- Egede, L.E., & Bosworth, H. (2008). The future of health disparities research: 2008 and beyond. *Journal of General Internal Medicine*, 23(5), 706-708.
- Franks, P., Fiscella, K. (2008). Reducing disparities downstream: Prospects and Challenges. *Journal of General Internal Medicine*, 23(5), 672-677.

- Gunderman, R.B. (2007). Addressing racial and ethnic disparities in health care. *Radiology*, 244(1), 28-30.
- Herbert, P.L., Sisk, J.E., & Howell, E.A. (2008). When does a difference become a disparity? Conceptualizing racial and ethnic disparities in health. *Health Affairs*, 27(2), 374-382.
- Jones, D.J., & Crump, A.D. (2005). Methodological challenges in conducting health disparities research. *Journal of Urban Health*, 82(Suppl. 3), 1-4.
- Lavizzo-Mourey, R. (2008). Racial disparities in health: Quality should mean equality. *Healthcare Financial Management*, 62(1), 102-104.
- National Health Plan Collaborative (2007). Facts on disparities in healthcare. Center for Healthcare Strategies. Retrieved July 9, 2008 from http://www.chcs.org/NationalHealthPlanCollaborative/400_disparities.html
- Ramirez, M., Ford, M.E., Stewart, A.L., & Teresi, J.A. (2005). Measurement issues in health disparities research. *Health Service Research*, 40(5 Pt 2), 1640-1657.
- Straker, H. (2008). Reducing health disparities: Every PA's obligation. *Journal of the American Academy of Physician Assistants*, 21(2), 13.
- Syme, S.L. (2008). Reducing racial and social-class inequalities in health: The need for a new approach. *Health Affairs*, 27(2), 456-459.