Racial and Ethnic Health Care Disparities

Educational Briefing for Health Care Industry Stakeholders

What are racial and ethnic health care disparities?

Certain population groups experience poorer health outcomes and health care services relative to other groups, even after accounting for variations in health care needs, patient preferences, and recommended treatments. These differences are typically classified as ‘health disparities’ or ‘health care disparities.’ For simplicity, we use the term ‘health disparities’ in this resource to refer to both health disparities and health care disparities. Disparities often refer to differences across racial and ethnic groups, but can also occur across many other dimensions (such as socioeconomic status, gender, and sexual orientation).

<table>
<thead>
<tr>
<th>Health Disparity</th>
<th>Health Care Disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differences in illness, injury, disability, or mortality rates across population groups</td>
<td>Differences in health insurance coverage, access to care, use of care, and quality of care across population groups</td>
</tr>
</tbody>
</table>

What causes health disparities?

Race-based disparities are driven by complex interactions between a number of factors relating to individuals, clinicians, health systems, environments, communities, and society. The chart below provides an overview of the various elements contributing to disparities.

Kaiser Family Foundation’s Framework of the Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Provider availability</td>
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<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Support systems</td>
<td>Provider bias</td>
<td></td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Community engagement</td>
<td>Provider cultural and linguistic competency</td>
<td></td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Discrimination</td>
<td>Quality of care</td>
<td></td>
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<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
</tr>
<tr>
<td>Morbidity</td>
</tr>
<tr>
<td>Life Expectancy</td>
</tr>
<tr>
<td>Health Care Expenditures</td>
</tr>
<tr>
<td>Health Status</td>
</tr>
<tr>
<td>Functional Limitations</td>
</tr>
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</table>

Is there evidence demonstrating these disparities?

A large body of research identifies consistent racial and ethnic disparities that exist in health care. Notably, the Institute of Medicine’s report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care catalogues the significant variation that exists in care across racial groups—even when accounting for insurance status, income, age, and condition severity. The examples below highlight differences in care quality and access.

**Demonstrated Race-Based Health Care Disparities**

**RECEIPT OF EVIDENCE-BASED CARE**

- **Early Non-Small Cell Lung Cancer**
  - 64% of black patients received curative surgery, compared to 76.7% of white patients (n=10,984)

- **Diabetes Management**
  - 52% of black men were given a low density lipoprotein cholesterol test, compared to 66% of white men (n=14,527)

- **End-Stage Renal Disease**
  - 35.3% of black men were placed on a waiting list for renal transplantation, compared to 60.6% of white men (n=654)

**TIMELINESS OF CARE**

- **ED Wait Times**
  - 14.5% increase in emergency department wait times experienced by Hispanic patients compared to white patients, 1997-2004

- **Time to Surgery**
  - 64% increase in likelihood to undergo a delay to DCIS\(^1\) surgery (>50 days) for black women compared to white women

Why are these disparities important for providers now?

While race-based disparities have been documented for decades, addressing these gaps will become paramount in the changing health care landscape. Minority populations are growing in size, and their access to care is expanding. Simultaneously, provider revenues increasingly depend on high-quality care and reduced costs. Health systems must ensure effective, efficient care for all groups in their market to remain successful.

**Key Developments Requiring Shifts in Provider Business Strategies**

- **Changing Population Composition**
  - 43.6% of U.S. population projected to be non-Hispanic whites in 2060, down from 62.2% in 2015

- **Medicaid Expansion**
  - 63% of newly eligible uninsured individuals are minorities, compared to 39% overall\(^2\)

- **Marketplace Subsidies**
  - 28% of black adults shopped on ACA marketplaces in 2015, compared to 24% of white adults\(^3\)

- **Population Health Contracts**
  - 744 public and private ACO contracts in 2015, up from 64 in 2011

- **Pay for Value**
  - 90% of Medicare payments to be tied to quality or value by 2018

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1) Ductal carcinoma in situ
2) Uninsured nonelderly individuals at ≤138% of the federal poverty level, compared to all nonelderly individuals.
3) Percentage of adults ages 19-64.

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How do disparities specifically impact providers?

Race-based health care disparities can have far-reaching consequences for hospital business priorities. The examples below demonstrate the potential impacts of disparities on health system performance, finances, and compliance. Additionally, as payment models increasingly incorporate patient experience and quality of care, disparities will have multiplicative effects on hospital bottom lines.

Example Impacts of Racial and Ethnic Health Disparities on Health System Priorities

<table>
<thead>
<tr>
<th>Safety &amp; Liability</th>
<th>Quality of Care</th>
<th>Costs &amp; Revenues</th>
<th>Accreditation &amp; Standards</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minority patients face greater communication barriers</td>
<td>Minority patients receive evidence-based care at lower rates</td>
<td>Minority patients have longer lengths of stay, more readmissions</td>
<td>Language barriers inconsistently documented</td>
<td>Minority patients report less overall satisfaction with care</td>
</tr>
<tr>
<td>Legal risk due to inadequate consent, medical errors</td>
<td>Reduced quality scores</td>
<td>Increased care costs</td>
<td>Failure to meet TJC¹ standards</td>
<td>Lower HCAHPS scores</td>
</tr>
</tbody>
</table>

What can providers do to address disparities?

Addressing health care disparities is extremely difficult because they are caused by many factors outside of health systems’ control, and because health systems already strive to provide equally high-quality care to all patients. However, health systems are often unaware of differences in the health outcomes and care experiences of their minority patients, and often do not account for the different patient needs that may be driving those differences. The framework below, adapted from the Disparities Solutions Center at Massachusetts General Hospital, provides guidance on how health systems can develop a strategy for detecting and addressing disparities among their patients.

Initial Framework to Guide Providers in Addressing Health Disparities

Adapted from the Disparities Solutions Center at Massachusetts General Hospital

1. Educate Leadership
   - Educate leadership about the prevalence and impacts of health disparities
   - Get leadership buy-in for focus on disparities

2. Assess Current Disparities
   - Develop data collection strategy with ability to stratify metrics by race and ethnicity

3. Analyze Impacts
   - Detect major patterns of disparities in care
   - Analyze impact of disparities on organizational goals

4. Identify Potential Causes
   - Investigate high-impact disparities to identify underlying root causes and drivers

5. Target Interventions
   - Develop interventions aimed at addressing the specific drivers of major disparities

6. Monitor Performance
   - Establish formal method for evaluating interventions’ success
   - Assign program improvement responsibilities

Further reading on health disparities:

**Improving Quality and Achieving Equity: A Guide for Hospital Leaders**
Disparities Solutions Center, Massachusetts General Hospital
- Overview of hospital rationales for addressing disparities
- Model hospital practices
- Next steps for hospital leaders

**Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care**
The Institute of Medicine
- Summary of evidence of health care disparities
- Assessment of sources of disparities
- Recommendations for addressing disparities

**HHS Action Plan to Reduce Racial and Ethnic Health Disparities**
HHS Office of Minority Health
- Overview of disparities and new opportunities to reduce racial and ethnic health disparities
- Department-wide action plan for reducing racial and ethnic health disparities

**Disparities in Health and Health Care: Five Key Questions and Answers**
Kaiser Family Foundation
- Definition of health and health care disparities
- Current status and importance of disparities
- Key initiatives in place to address disparities
- Impact of the ACA on disparities

**2014 National Healthcare Quality and Disparities Report**
Agency for Healthcare Research and Quality
- Overview of the quality of health care received by the general U.S. population
- Overview of disparities in care experienced by different racial, ethnic, and socioeconomic groups
- Based on more than 250 measures of quality and disparities

**HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity and Primary Language from Patients**
Health Research and Educational Trust
- Web-based tool to assist health care organizations in systematically collecting race, ethnicity, and primary language data from patients
- Resources for educating and informing staff about the importance of data collection
- Instructions for using data to improve quality of care for all populations

Sources from page 2: