Five Things You Need to Know About **Racial and Ethnic Disparities** in U.S. Health Care

1 Access ≠ equality.

Having access to coverage, providers, and hospitals does not ensure high-quality care. Research has shown that racial and ethnic minorities often receive health care in hospitals and other facilities that offer lower-quality care than other institutions. The five percent of hospitals with the highest volume of Black patients care for nearly half of *all* older Black patients, and the 25 percent of hospitals that are the most crowded care for nearly 90 percent of older Black patients. Similar trends exist for older Hispanic patients.[1]

There are also large disparities in preventable hospitalizations, with Blacks hospitalized at a rate nearly twice that of Whites. Eliminating these disparities would prevent approximately one million hospitalizations and save $6.7 billion in health care costs each year. [2]

2 Equitable care ≠ treating every patient the same.

Equitable care does not mean treating every patient exactly the same. Instead, equitable care ensures optimal outcomes for all patients regardless of their background or circumstances. Quality improvement that focuses on the overall population without addressing racial and ethnic differences can result in unequal quality. In fact, even when outcomes appear to improve across the entire patient population, disparities between racial/ethnic groups can remain or even worsen. For instance, mortality rates for breast cancer declined in Chicago between 1990 and 2005, but the disparity between White and Black patients grew significantly, from 20 percent to 99 percent.[3]

3 Disease and mortality rates ≠ equal.

The age-adjusted death rate for Blacks has been sharply higher than for whites for decades[4] and infant mortality has been more than twice that of White infants.[5]

Minorities as a whole have a higher prevalence of diabetes, stroke and other largely preventable diseases and conditions than their White counterparts.[6] Minority patients assume a greater proportion of the burden of asthma, with higher rates of emergency department visits (350 percent), hospitalizations (240 percent) and mortality (200 percent) than Whites. Within ethnic populations, the Puerto Rican community has a higher prevalence of asthma than any other racial or ethnic group.[7]

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Ethnic minorities are disproportionately impacted by cancer. In 2007, the age-adjusted death rate from breast cancer was 41 percent higher for Black women than for White women.[8] Black men have the highest incidence of cancer,[9]and are more than twice as likely to die from prostate cancer as White men.[10] Black, Latina and Vietnamese-American women have significantly higher incidences of cervical cancer than the average for U.S. women.[11]

4 Care for specific conditions ≠ equal.

Even when access to care is equal, racial and ethnic minorities tend to receive a lower quality of health care than Whites.[12] In recent years, inpatient care for people with heart failure has actually grown worse for Hispanics and American Indians. These minorities with heart failure are younger than their White counterparts.[13] Blacks and Hispanics are less likely than Whites to receive recommended services for diabetes.[14] Black people are more than four times as likely as Whites to undergo a leg amputation (a devastating complication of diabetes).[15]

5 Eliminating disparities = possible.

While disparities remain, recent evidence of their narrowing suggests that eliminating them is possible. Cardiovascular care, for instance, has improved dramatically in only a few years. The overall inpatient mortality rate for hospital admissions with heart attack decreased significantly for all racial and ethnic groups from 2001 to 2008. In all years, Blacks had lower inpatient mortality rates than Whites, and were more likely to receive the proper medications when discharged from the hospital.[16] At current rates of improvement, all racial and ethnic groups could receive the same care by 2015.[17]

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Office of Minority Health. "Diabetes Data/Statistics." U.S. Department of Health and Human Services. http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=62 (accessed September 2012).

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9 *National Vital Statistics Reports*, May 2010

10 U.S. Cancer Statistics Working Group. "United States Cancer Statistics: 2008 Cancer Types Grouped by Race and Ethnicity". *United States Cancer Statistics: 1999–2008 Incidence and Mortality Web-based Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. *apps.nccd.cdc.gov/uscs/cancersbyraceandethnicity.aspx* (accessed September 2012).

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11 Ibid.

12 Ibid.

13 Ibid.

14 Ibid.

15 Goodman DC, Brownlee S, Chang CH, et al. 2010. *Regional and Racial Variations in Primary Care among Medicare Beneficiaries*. Lebanon, N.H.: The Dartmouth Institute for Health Policy and Clinical Practice.

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17 Ibid.