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Racial and ethnic disparities in access to and quality of health care

By Sarah Goodell and José J. Escarce, M.D., Ph.D., based on a Research Synthesis by Escarce

SUMMARY OF KEY FINDINGS

> Racial and ethnic disparities in access to and quality of care are pervasive although not universal. The largest access disparities are for Spanish-speaking Hispanics.

> Insurance coverage, income and other factors explain a portion of disparities, but gaps remain after accounting for these measures.

> After adjusting for other factors, disparities in recommended processes of care—the appropriate use of screening tests, medications and laboratory tests—tend to be small or nonexistent.

> Disparities are larger for intermediate outcomes—newer therapies and invasive procedures—even after adjusting for other factors.

Why is this issue important to policy-makers?

- **Eliminating racial and ethnic disparities in health is a major national objective,** one of two overall goals for *Healthy People 2010* (Reference 1). Efforts to eliminate *health* disparities must incorporate strategies to reduce racial and ethnic disparities in health care as well. These strategies are also a critical component of overall efforts to improve health care quality.

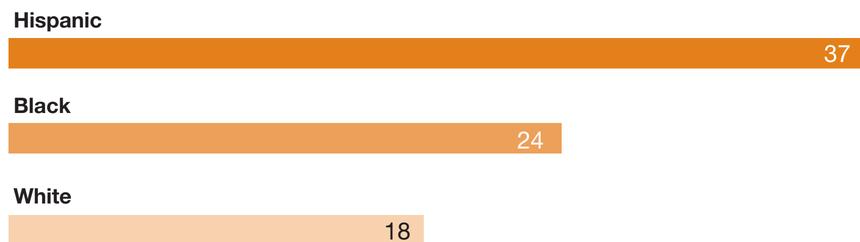
- **There is a pressing need for policy-makers to understand the degree to which race and ethnicity or other factors (e.g., insurance coverage, income, etc.) contribute to health care disparities.** This knowledge will help shape interventions to eliminate disparities.

This policy brief will present the findings on racial and ethnic disparities in access to care–in particular, having a usual source of care and having an ambulatory visit in the past year–followed by findings on disparities in quality of care.

What are the disparities in *access* to health care?

- **Studies consistently find that blacks and Hispanics are more likely than whites to report not having a usual source of care** (Figure 1). A usual source of care is a provider that people usually go to when they are sick or need advice on their health.

Figure 1. Percent of white, black and Hispanic adults lacking a usual source of care



Source: Kirby, et al, 2006.

- **Adjusting for other factors nearly eliminates the black-white gap in usual source of care in some studies, but an appreciable gap remains in others.** After adjustments, the gap ranges from 0.1 percent to nearly seven percent (References 2, 3, 4).

  The size of the Hispanic-white gap that remains depends on whether language is included in the adjustment. A gap of seven to 11 percentage points remains in studies that do not take language into account (References 2, 5). Additionally adjusting for language further reduces the disparity but does not eliminate it. Studies show a disparity of two to seven percent even after adjusting for language (References 3, 6).

The largest access disparities are for Spanish-speaking Hispanics.

WHAT IS THE ROLE OF LANGUAGE IN DISPARITIES?

Across key measures of access to health care—having a usual source of care, type of usual source, and having an ambulatory visit—Hispanics have a large gap relative to whites. One reason is the language barrier Hispanic patients may experience communicating with health care providers.

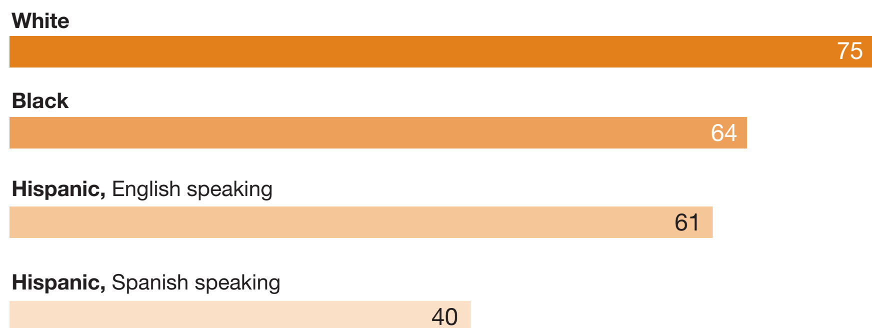
Studies attempt to understand the role this barrier plays by statistically adjusting for language or by obtaining separate estimates for English-speaking and Spanish-speaking Hispanics. Some studies have found a greater contribution of language to disparities than others, but all studies agree that Spanish speakers have the least access.

Very few studies of quality of care assess the role of language. Those that do, find that Spanish-speaking Hispanics have lower rates of influenza and pneumococcal vaccination and cancer screening than their English-speaking counterparts.

- **Spanish-speaking Hispanics are the most likely to lack a usual source of care even after adjusting for other factors.** One study found a gap of 20 percentage points between whites and Spanish-speaking Hispanics even after all other factors were considered (Reference 4).

- **Blacks and Hispanics are less likely than whites to have a physician's office as their usual source of care (Figure 2)** (References 7, 8). These differences are not explained by insurance status, income or other factors. Having a physician's office as a usual source of care is associated with continuity of care and, consequently, with a number of favorable outcomes (Reference 7).

Figure 2. Percent of adults whose usual source of care is a physician's office



Source: Doescher, et al., 2001

- **Blacks are less likely than whites to have an ambulatory visit during the year.** Adjusting for insurance status, income and other factors reduces the disparity between whites and blacks, but a sizeable gap–ranging from seven to 13 percentage points–remains (References 2, 3, 5, 9).

- **The disparity between whites and Hispanics in ambulatory visits ranges from six to nine percentage points** after adjusting for insurance status, income and other factors excluding language (References 2, 5, 9). One study finds that once language and neighborhood composition is adjusted for, however, the gap between whites and Hispanics is eliminated (Reference 3).

- **The gap in ambulatory visits is greater for Spanish-speaking Hispanics than for English-speaking Hispanics even after adjusting for other factors.** One study found the gap for English speakers was seven percent compared to ten percent for Spanish speakers (Reference 10).

Racial and ethnic disparities in the quality of care are pervasive, although not universal.

What are the disparities in the *quality* of health care received?

Racial and ethnic disparities in the quality of care are pervasive, although not universal. Disparities in quality tend to be small or nonexistent for measures that reflect the appropriate use of screening tests, medications and laboratory tests. Disparities are larger for intermediate outcomes (measures that reflect the adequate control of risk factors and physiologic abnormalities), use of newer therapies and use of invasive procedures, even after adjusting for other factors that influence quality.

- **Studies consistently find that blacks and Hispanics are less likely than whites to receive the influenza vaccine.** The differences are reduced–particularly for Hispanics–after taking insurance, income and other factors into account, but a sizeable gap between whites and blacks remains (References 11, 12).

- **Studies of breast cancer screening in Medicare managed care plans find that the gap between white women and their black peers has declined over time to only two percentage points** (References 13, 14).

- **A landmark study of quality of care found that black and Hispanic adults are *as likely or more likely* than whites to receive recommended processes of care** (Reference 15). The findings, however, are based on a review of medical records and are therefore only applicable to patients who have access to care and receive treatment. As indicated earlier, blacks and Hispanics are less likely than whites to have access to care.

- **There are several important racial and ethnic disparities in the quality of care for heart disease.** In general, disparities in the quality of care for heart disease are sizable for the recommended use of newer therapies and for invasive procedures. Disparities tend to be small or nonexistent for the recommended use of medications.
  - Blacks and Hispanics with acute coronary syndrome or myocardial infarction are less likely than whites to receive acute reperfusion, invasive procedures and coronary artery bypass surgery (References 16, 17, 18).
  - The average time between hospitalization and acute reperfusion is longer for blacks and Hispanics than whites (Reference 19).
  - By contrast, the gap in the receipt of recommended medications within the first 24 hours after hospitalization or at discharge is small (References 16, 17).

- **Black Medicare beneficiaries with cancer are less likely than whites to receive recommended adjuvant therapy as well as invasive procedures for staging and treatment** (References 20, 21, 22).

WHAT ARE THE BEST MEASURES OF QUALITY OF CARE?

What measures should be used?

Quality of care can be evaluated in many ways. This policy brief measures quality based on process measures and intermediate outcome measures.

Process measures refer to the appropriateness of the services provided and the skill with which the services are performed.

Outcome measures refer to the effects on patients' health. Intermediate outcomes include the degree of control of risk factors while distal outcomes include functional status and mortality. Distal outcomes are influenced by many factors and may be only loosely linked to quality of care.

What methodological adjustments should be made?

Most studies adjust for factors such as age, sex, income, education, insurance coverage and health status to determine the degree to which disparities are explained by factors other than race. Studies that also adjust for access measures (e.g., having a usual source of care, doctor visits), however, may mask real disparities in quality because blacks and Hispanics have worse access than whites.

Studies based on reviewing medical records may similarly understate disparities because they are limited to persons who receive care. As described earlier, blacks and Hispanics are less likely than whites to receive care.

Policy Implications

Strategies to diminish and eventually eliminate racial and ethnic disparities in access to and quality of care are a crucial component of efforts to reduce health disparities. Any approach should be accompanied by rigorous evaluation to determine its effectiveness. The existing evidence provides the following insights for developing strategies to reduce disparities:

> **Expansions in insurance coverage** would reduce, but not eliminate, racial and ethnic disparities in access to care.

> **Initiatives by health plans and health care providers to provide culturally and linguistically appropriate services** might reduce the access barriers experienced by Spanish-speaking Hispanics.

> **Systemic strategies to foster continuity of care** might contribute to reducing disparities as well. Such strategies might focus on promoting use of physicians' offices by black and Hispanic patients.

> **Increased adherence by providers to evidence-based guidelines** is likely to promote better care for all patients and could reduce disparities in quality of care.

THE SYNTHESIS PROJECT (Synthesis) is an initiative of the Robert Wood Johnson Foundation to produce relevant, concise, and thought-provoking briefs and reports on today's important health policy issues.

PROJECT CONTACTS

David C. Colby, Ph.D., the Robert Wood Johnson Foundation

Brian C. Quinn, Ph.D., the Robert Wood Johnson Foundation

Claudia H. Williams, Synthesis Project

Sarah Goodell, Synthesis Project

SYNTHESIS ADVISORY GROUP

Linda T. Bilheimer, Ph.D., National Center for Health Statistics

Jon B. Christianson, Ph.D., University of Minnesota

Elizabeth Fowler, J.D., Ph.D., WellPoint, Inc.

Paul B. Ginsburg, Ph.D., Center for Studying Health System Change

Jack Hoadley, Ph.D., Georgetown University Health Policy Institute

Haiden A. Huskamp, Ph.D., Harvard Medical School

Julia A. James, Independent Consultant

Judith D. Moore, National Health Policy Forum

William J. Scanlon, Ph.D., Health Policy R&D

Michael S. Sparer, Ph.D., Columbia University

Joseph W. Thompson, M.D., M.P.H., Arkansas Center for Health Improvement

The Synthesis Project
The Robert Wood Johnson Foundation
Route 1 & College Road East
P.O. Box 2316
Princeton, NJ 08543-2316
E-mail: synthesisproject@rwjf.org
Phone: 888-719-1909
www.policysynthesis.org

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The Robert Wood Johnson Foundation
Route 1 & College Road East
P.O. Box 2316
Princeton, NJ 08543-2316
E-Mail: synthesisproject@rwjf.org
Phone: 888-719-1909

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