

HEALTH CARE DISPARITIES

Our country prides itself on having the most advanced medical care in world. However, it is very expensive, which raises concerns about who has access to this care. Various studies have shown that people with lower incomes have considerably less access to healthcare than wealthier individuals (Fiscella and Williams 2004). Disparities in healthcare insurance coverage is only part of the problem (Doty and Holmgren 2004). Other reasons include age, education, cultural background (Hayward, Shapiro et al. 1988; Schneider, Zaslavsky et al. 2002) and the bias of the healthcare giver (Hayward, Shapiro et al. 1988; Lee, Gehlbach et al. 1997; Schneider, Zaslavsky et al. 2002; O'Connell and Brown 2003). Treatment by physicians of the same cultural background appear to ameliorate some of these disparities (LaVeist and Carroll 2002; LaVeist, Nuru-Jeter et al. 2003).

For our meeting on June 28th please read the abstracts to the cited articles and the full article by (Weisfeld and Perlman 2005) and come to the meeting prepared discuss how healthcare disparities affects your own community.

References:

- Doty, M. M. and A. L. Holmgren (2004). "Unequal access: insurance instability among low-income workers and minorities." Issue Brief (Commonw Fund)(729): 1-6.
- Fiscella, K. and D. R. Williams (2004). "Health disparities based on socioeconomic inequities: implications for urban health care." Acad Med **79**(12): 1139-47.
- Hayward, R. A., M. F. Shapiro, et al. (1988). "Inequities in health services among insured Americans. Do working-age adults have less access to medical care than the elderly?" N Engl J Med **318**(23): 1507-12.
- LaVeist, T. A. and T. Carroll (2002). "Race of physician and satisfaction with care among African-American patients." J Natl Med Assoc **94**(11): 937-43.
- LaVeist, T. A., A. Nuru-Jeter, et al. (2003). "The association of doctor-patient race concordance with health services utilization." J Public Health Policy **24**(3-4): 312-23.
- Lee, A. J., S. Gehlbach, et al. (1997). "Medicare treatment differences for blacks and whites." Med Care **35**(12): 1173-89.
- O'Connell, L. and S. L. Brown (2003). "Do nonprofit HMOs eliminate racial disparities in cardiac care?" J Health Care Finance **30**(2): 84-94.
- Schneider, E. C., A. M. Zaslavsky, et al. (2002). "Racial disparities in the quality of care for enrollees in medicare managed care." Jama **287**(10): 1288-94.
- Weisfeld, A. and R. L. Perlman (2005). "Disparities and discrimination in health care: an introduction." Perspect Biol Med **48**(1 Suppl): S1-9.

Abstracts:

- Doty, M. M. and A. L. Holmgren (2004). "Unequal access: insurance instability among low-income workers and minorities." Issue Brief (Commonw Fund)(729): 1-6.
- Analysis of health insurance coverage and employment patterns from 1996 through 1999 reveals even higher uninsured rates and greater insurance instability among low-income adults and minorities than had been previously documented. Most low-income adults worked during the four years, but many had no or only intermittent job-based coverage. Low-income Hispanic adults were particularly hard hit: more than one-third (37%) of this group were never insured with private coverage, even though they

worked all four years. Policies that expand coverage to low-income families could help reduce racial and ethnic disparities in access to care.

Fiscella, K. and D. R. Williams (2004). "Health disparities based on socioeconomic inequities: implications for urban health care." Acad Med **79**(12): 1139-47.

Health is unevenly distributed across socioeconomic status. Persons of lower income, education, or occupational status experience worse health and die earlier than do their better-off counterparts. This article discusses these disparities in the context of urban medical practice. The article begins with a discussion of the complex relationship among socioeconomic status, race, and health in the United States. It highlights the effects of institutional, individual, and internalized racism on the health of African Americans, including the insidious consequences of residential segregation and concentrated poverty. Next, the article reviews health disparities based on socioeconomic status across the life cycle, beginning in fetal health and ending with disparities among the elderly. Potential explanations for these socioeconomic-based disparities are addressed, including reverse causality (e.g., being poor causes lower socioeconomic status) and confounding by genetic factors. The article underscores social causation as the primary explanation for health disparities and highlights the cumulative effects of social disadvantage across stages of the life cycle and across environments (e.g., fetal, family, educational, occupational, and neighborhood). The article concludes with a discussion of the implications of health disparities for the practice of urban medicine, including the role that concentration of disadvantage plays among patients and practice sites and the need for quality improvement to mitigate these disparities.

Hayward, R. A., M. F. Shapiro, et al. (1988). "Inequities in health services among insured Americans. Do working-age adults have less access to medical care than the elderly?" N Engl J Med **318**(23): 1507-12.

To determine whether groups other than the elderly and the uninsured have difficulty obtaining access to medical care, we studied 7633 adults nationwide. As we expected, the insured had much greater access than the uninsured, but among the insured there were substantial disparities in access to care. Insured adults of working age were 3.5 times as likely (95 percent confidence interval, 2.7 to 4.4) as the elderly to have needed supportive medical services (including medications and supplies) but not to have received them, and 3.4 times (2.3 to 4.4) as likely to have had major financial difficulties because of illness. Among insured, working-age adults, the poor were 4.4 times (3.5 to 5.3) as likely as those who were not poor to have needed supportive services but not to have received them, and 5.2 times (3.6 to 6.8) as likely to have had major financial problems because of illness. Apart from insurance status and income, blacks were 1.7 times (1.1 to 2.2) as likely as whites to have needed supportive services but not to have received them. Hispanics with a medical illness were 2.2 times (1.3 to 3.2) as likely as whites not to have seen a physician within the past year. We conclude that insured, working-age adults have less access to medical care than the elderly, and that poor, black, or Hispanic persons in this group are at risk for even greater problems with access to care. Current policy strategies are unlikely to improve the ability of these groups to obtain care.

LaVeist, T. A. and T. Carroll (2002). "Race of physician and satisfaction with care among African-American patients." J Natl Med Assoc **94**(11): 937-43.

The purpose of this study is to examine predictors of physician-patient race concordance and the effect of race concordance on patients' satisfaction with their primary physicians among African American patients. The specific research question is, do African American patients express greater satisfaction with their care when they have an African American physician? Using the Commonwealth Fund, Minority Health Survey, we conduct multivariate analysis of African American respondents who have a usual source of care (n = 745). More than 21% of African American patients reported having an African American physician. Patient income and having a choice in the selection of the physician were significant predictors of race concordance. And, patients who were race concordant reported higher levels of satisfaction with care compared with African American patients that were not race concordant.

LaVeist, T. A., A. Nuru-Jeter, et al. (2003). "The association of doctor-patient race concordance with health services utilization." J Public Health Policy **24**(3-4): 312-23.

We examined a national sample of African-American, white, Hispanic, and Asian-American respondents to test the hypothesis that when patients are race concordant with their physicians, they are more likely to utilize health services. The analysis used the 1994 Commonwealth Fund Minority Health Survey to construct a series of multivariate models. Using three dimensions of health services utilization, we found support for the hypothesis. Compared to patients whose regular doctors are of a different race, patients who are of the same racial or ethnic group as their physicians were more likely to use needed health services (OR=.62; 95% CI .46, .81); were less likely to postpone or delay seeking care (OR=.78; 95% CI .65, .94); and reported a higher volume of use of health services (OR=2.68; 95% CI 2.07, 3.45). Analysis within race-specific sub-samples found this pattern to be most consistent among white and African-Americans and less prevalent among Hispanic and Asian-Americans. Adjusting the models for health status and a variety of other known predictors of health care utilization did not substantially affect the relationship between doctor-patient race concordance and health services use.

Lee, A. J., S. Gehlbach, et al. (1997). "Medicare treatment differences for blacks and whites." Med Care **35**(12): 1173-89.

OBJECTIVES: This study investigated racial differences in procedure use among elderly Medicare beneficiaries. It is hypothesized that providers do not discriminate inappropriately in treating black and white patients and that the apparent differences in black-white treatment could be attributed to other differences between the two populations. **METHODS:** Rates of use for selected procedures were examined among two patient groups: (1) the universe of Medicare beneficiaries in 10 states and the District of Columbia and (2) a subset of this sample created by matching beneficiaries on the basis of zip code of residence to neutralize the effects of black-white differences in provider access and regional practice patterns. Because all Medicare beneficiaries have a common core of standard benefits, the importance of financial access differences in accounting for black/white utilization differences is diminished. **RESULTS:** Three major findings were indicated from this study: (1) area-controlled comparisons find even larger black-white disparities than those shown from uncontrolled comparisons, (2) the disparities are larger

in southern states, and (3) the disparities vary substantially with procedure cost.
CONCLUSIONS: Although no clinical data were analyzed, providers appeared to be giving less intensive treatment to otherwise similar black Medicare beneficiaries.

O'Connell, L. and S. L. Brown (2003). "Do nonprofit HMOs eliminate racial disparities in cardiac care?" *J Health Care Finance* **30**(2): 84-94.

African-Americans have far less access to treatment for heart disease than similar white Americans. In this article, we explore the sector difference theory hypothesis that treatment provided by a nonprofit Medicaid managed care plan can reduce or even eliminate the race gap. Specifically, we compare the treatment offered to patients in for-profit Medicaid managed care programs to the treatment offered to similar patients in nonprofit Medicaid managed care programs. Data are from the Maryland Health Services Cost Review Commission and cover all patients discharged from hospitals in Maryland during calendar year 1998 with principal diagnoses indicating diseases of the circulatory system (ICD-9-CM codes 390 through 459) or chest pain (ICD-9-CM codes 786.50 through 786.52 and code 786.59). African-Americans were significantly less likely to receive the three treatments of interest, even after controlling for principal diagnosis, blood pressure, co-morbidities, and age. In regard to African-American access to treatment, there were no significant differences between the sectors.

Schneider, E. C., A. M. Zaslavsky, et al. (2002). "Racial disparities in the quality of care for enrollees in medicare managed care." *Jama* **287**(10): 1288-94.

CONTEXT: Substantial racial disparities in the use of some health services exist; however, much less is known about racial disparities in the quality of care. OBJECTIVE: To assess racial disparities in the quality of care for enrollees in Medicare managed care health plans. DESIGN AND SETTING: Observational study, using the 1998 Health Plan Employer Data and Information Set (HEDIS), which summarized performance in calendar year 1997 for 4 measures of quality of care (breast cancer screening, eye examinations for patients with diabetes, beta-blocker use after myocardial infarction, and follow-up after hospitalization for mental illness). PARTICIPANTS: A total of 305 574 (7.7%) beneficiaries who were enrolled in Medicare managed care health plans had data for at least 1 of the 4 HEDIS measures and were aged 65 years or older. MAIN OUTCOME MEASURES: Rates of breast cancer screening, eye examinations for patients with diabetes, beta-blocker use after myocardial infarction, and follow-up after hospitalization for mental illness. RESULTS: Blacks were less likely than whites to receive breast cancer screening (62.9% vs 70.9%; $P < .001$), eye examinations for patients with diabetes (43.6% vs 50.4%; $P = .02$), beta-blocker medication after myocardial infarction (64.1% vs 73.8%; $P < .005$), and follow-up after hospitalization for mental illness (33.2 vs 54.0%; $P < .001$). After adjustment for potential confounding factors, racial disparities were still statistically significant for eye examinations for patients with diabetes, beta-blocker use after myocardial infarction, and follow-up after hospitalization for mental illness. CONCLUSION: Among Medicare beneficiaries enrolled in managed care health plans, blacks received poorer quality of care than whites.