16e Racial and Ethnic Disparities in Health Care

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Over the course of its history, the United States has experienced dramatic improvements in overall health and life expectancy, largely as a result of initiatives in public health, health promotion, disease prevention, and chronic care management. Our ability to prevent, detect, and treat diseases in their early stages has allowed us to target and reduce rates of morbidity and mortality. Despite interventions that have improved the overall health of the majority of Americans, racial and ethnic minorities (blacks, Hispanics/Latinos, Native Americans/Alaskan Natives, Asian/Pacific Islanders) have benefited less from these advances than whites and have suffered poorer health outcomes from many major diseases, including cardiovascular disease, cancer, and diabetes. Research has revealed that minorities may receive less care and lower-quality care than whites, even when confounders such as stage of presentation, comorbidities, and health insurance are controlled. These differences in quality are called *racial and ethnic disparities in health care*. Addressing these disparities has taken on greater importance with the significant transformation of the U.S. health care system and the implementation of health care reform and value-based purchasing. The shift toward creating financial incentives and disincentives to achieve quality goals makes focusing on those who receive lower-quality care more important than ever before. This chapter will provide an overview of racial and ethnic disparities in health and health care, identify root causes, and provide key recommendations to address these disparities at both the clinical and health system levels.

NATURE AND EXTENT OF DISPARITIES

Minority Americans have poorer health outcomes than whites from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, cancer, and HIV/AIDS (Fig. 16e-1). Multiple factors contribute to these racial and ethnic disparities in health. First and foremost, social determinants—such as lower socioeconomic status (SES; e.g., lower income, less wealth, and lower educational attainment), inadequate and unsafe housing, and racism—are strongly linked to poor health outcomes. These factors disproportionately impact minority populations. In fact, SES has consistently been found to be one of the strongest predictors of health outcomes. While the mechanisms are complex (i.e., does poverty cause poor health, or does poor health cause poverty?), it is clear that low-SES populations experience disparities in health and that low SES is a major factor in racial/ethnic disparities.

Racial/ethnic disparities are documented globally, although their assessment has centered more on the comparison of individuals by SES in other countries than in the United States. Similar to the U.S. pattern, low-SES residents of other nations tend to have poorer health outcomes. It is noteworthy that results are mixed when the health status of nations is compared by SES. High-SES nations such as the United States do not necessarily have health outcomes that correlate with their high expenditures for health care. For example, as of 2011, the United States ranks 34th in the world—just behind Cuba—on basic public health measures such as infant mortality. This ranking may be due in part to the correlation between wealth distribution and SES rather than just absolute SES. This area of active research is outside the scope of this chapter.

Racism has more recently been shown to predict poorer health outcomes. The physiologic impact of the stress imposed by racism (and poverty), including increased cortisol levels, can lead to chronic adverse effects on health. Lack of access to care also takes a significant toll. Uninsured individuals are less likely to have a regular source of care and are more likely to delay seeking care and to go without needed care; this limited access results in avoidable hospitalizations, emergency hospital care, and adverse health outcomes.

In addition to racial and ethnic disparities in *health*, there are racial and ethnic disparities in the *quality of care* for persons with access to the health care system. For instance, disparities have been found in the treatment of pneumonia (Fig. 16e-2) and congestive heart failure, with blacks receiving less optimal care than whites when hospitalized for these conditions. Moreover, blacks with end-stage renal disease are referred less often to the transplant list than are their white counterparts (Fig. 16e-3). Disparities have been found, for example, in the use of cardiac diagnostic and therapeutic procedures (with blacks being referred less often than whites for cardiac catheterization and bypass grafting), prescription of analgesia for pain control (with blacks and Latinos receiving less pain medication than whites for long-bone fractures and cancer), and surgical treatment of lung cancer (with blacks receiving less curative surgery than whites for non-small-cell lung cancer). Again, many of these disparities have occurred even when variations in factors such as insurance status, income, age, comorbid conditions, and symptom expression are taken into account. However, one additional factor—disparities in the quality of care provided at the sites where minorities tend to receive care—has been shown to be an important contributor to overall disparities.

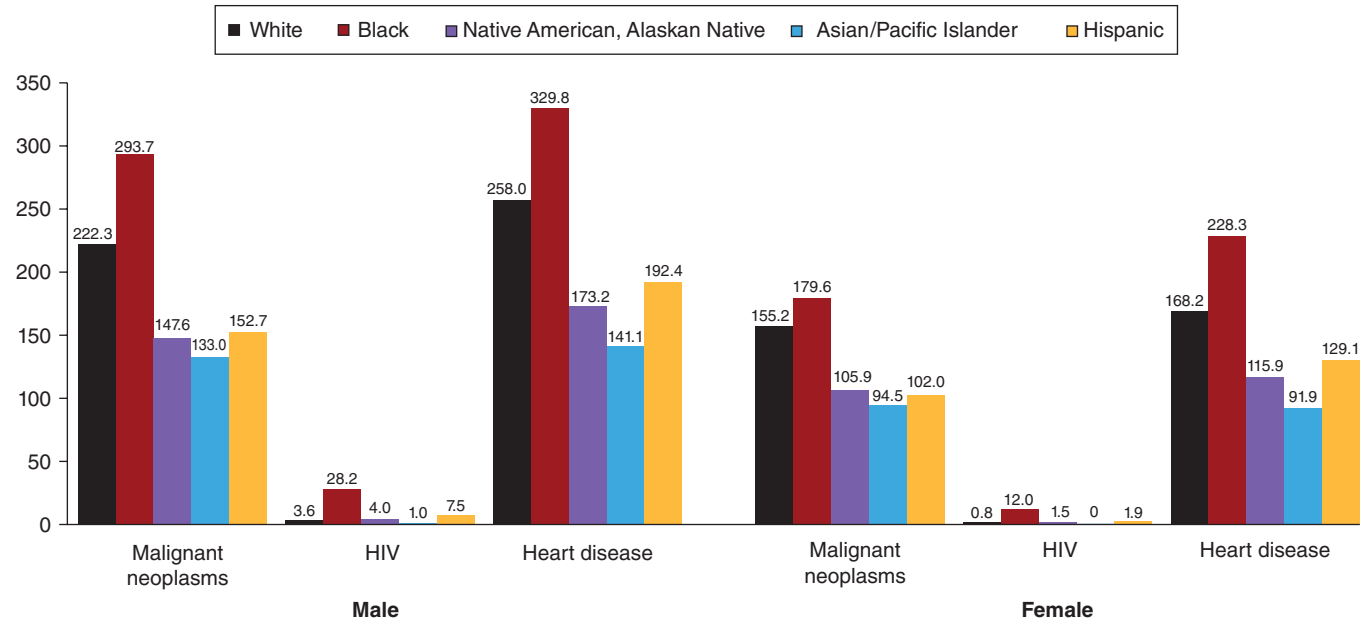

FIGURE 16e-1 **Age-adjusted death rates for selected causes by race and Hispanic origin, 2005.** *(From the U.S. Census Bureau, 2009.)*