

Chapter 6. Conclusions

Equity in health care is an important national goal, both because it fulfills our commitment to equality of opportunity for all and because it can improve the overall health of all Americans. Although the United States spends more on health care per capita than any industrialized nation, some health indicators remain lower than we would like. Multiple studies conducted over the past two decades have documented that differences in health care related to race, ethnicity, and socioeconomic status exist in the United States. This report assesses the extent of these differences from a national perspective and examines the capacity of current datasets to measure and monitor differences across the country.

Key Findings

The NHDR presents seven key findings to policymakers, clinicians, health system administrators, and community leaders who seek to use this information to improve health care services for all populations:

- 1) Inequality in quality exists
- 2) Disparities come at a personal and societal price
- 3) Differential access may lead to disparities in quality
- 4) Opportunities to provide preventive care are frequently missed
- 5) Knowledge of why disparities exist is limited
- 6) Improvement is possible
- 7) Data limitations hinder targeted improvement efforts

Inequality in quality exists

This report presents the most comprehensive national picture confirms that there is significant inequality in quality in the United States. Although selected research studies have documented disparities in health care services, these examinations were often limited to specific populations with specific conditions. By using nationally available data sets, a national view on health care disparities is provided.

This first report clearly demonstrates that racial, ethnic, and socioeconomic disparities are national problems that affect health care at all points in the process, at all sites of care, and for all medical conditions—in fact, disparities in the health care system are pervasive. Our conclusions bring us closer to understanding why, where, and how disparities occur—essential knowledge for devising and targeting programs to eliminate these inequities.

While disparities in health care potentially affect all Americans and individuals of any population group, they are not uniformly distributed across populations. We are only

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beginning to understand the magnitude of differential burden of illness in populations with special health care needs, such as minority children and poor patients with disabling chronic illnesses. Geography can play an important mitigating role in health care disparities. Remote rural populations, for example, are clearly at risk for having worse access and receiving poorer quality care.

Examples from the NHDR:

- Minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer compared with whites.
- Patients of lower socioeconomic position are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications.
- When hospitalized for acute myocardial infarction, Hispanics are less likely to receive optimal care.
- Many racial and ethnic minorities and persons of lower socioeconomic position are more likely to die from HIV disease. Minorities also account for a disproportionate share of new AIDS cases.
- The use of physical restraints in nursing homes is higher among Hispanics and Asian/Pacific Islanders than among non-Hispanic whites.
- Blacks and poorer patients have higher rates of avoidable admissions.

Disparities come at a personal and societal price

Health care disparities are costly. Poorly managed care or missed diagnoses result in expensive and avoidable complications. As discussed in *Unequal Treatment*: “to the extent that minority beneficiaries of publicly funded health programs are less likely to receive high quality care, these beneficiaries—as well as the taxpayers that support public health care programs—may face higher future health care costs.”¹ The personal cost of disparities can lead to significant morbidity, disability, and lost productivity at the individual level. At the societal level, distal costs follow from proximal opportunities that were missed to intervene and reduce burden of illness. For example, end-stage renal disease may result from longstanding, poorly controlled diabetes. The highly morbid and highly costly condition could potentially be avoided with access to indicated services and effective management of diabetes.

Examples from the NHDR:

- Without screening, cancers may not be detected until they grow large or metastasize to distant sites and cause symptoms. Such late-stage cancers are usually associated with more limited treatment options and poorer survival. Minorities and persons of lower socioeconomic status are less likely to receive cancer screening services and more likely to have late-stage cancer when the disease is diagnosed.

- Persons of lower socioeconomic position who have diabetes are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications.
- Many racial and ethnic minorities and persons of lower socioeconomic position are less likely to receive recommended immunizations for influenza and pneumococcus. Once hospitalized, some ethnic and racial minorities, as well as lower income patients, suffer worse quality of care for pneumonia. These differential rates of vaccination and hospitalization present opportunities for provider-based and community-based interventions to reduce disparities.

Differential access may lead to disparities in quality

Access to health care is an important prerequisite to obtaining quality care. Some access barriers, whether perceived or actual, can result in adverse health outcomes. Patients may perceive barriers to delay seeking needed care, resulting in presentation of illness at a later, less treatable stage of illness. For example, a usual source of care can serve as a navigator to the health care system and an advocate to obtain needed evidence-based preventive and health care services. Of the major measures of access, the lack of health insurance has significant consequences. Avoidable hospitalizations are a good example of the link between access and disparities in quality of care. These hospitalizations may reflect, in part, the adequacy of primary care. When health care needs are not met by the primary health care system, rates of avoidable admissions may rise. In contrast, perceived problems with specialty referral do not have clear clinical consequences.

Examples from the NHDR:

- Many racial and ethnic minorities and individuals of lower socioeconomic status are less likely to have a usual source of care.
- Hispanics and people of lower socioeconomic status are more likely to report unmet health care needs
- While most of the population has health insurance, racial and ethnic minorities are less likely to report health insurance compared with whites. Lower income persons are also less likely to report insurance compared with higher income persons.
- Higher rates of avoidable admissions by blacks and persons of lower socioeconomic position may be explained, in part, by lower receipt of routine care by these populations.

Opportunities to provide preventive care are frequently missed

Our health care system continues to emphasize care that occurs after an illness occurs, rather than preventive services that could potentially prevent the illness or reduce the burden of disease. The NHQR documents that this is a pervasive issue for all Americans; the NHDR illustrates that there are significant disparities in the use of evidence-based preventive services for certain populations. For example, while smoking remains the

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single most preventable cause of mortality, rates of smoking cessation counseling during hospitalization are only 40%. For blacks, this rate of smoking cessation counseling is only 29%. Given the significant impact on morbidity, mortality, outcomes, and costs of care, efforts to target preventive services to populations most at risk would be a critical aspect of an improvement strategy to decrease disparities.

Examples from the NHDR:

- Blacks and persons of lower socioeconomic status tend to have higher rates of death from cancer. Although cancer death rates may reflect a variety of factors not associated with health care (such as genetic disposition, diet, and lifestyle), screening and early treatment of cancers can lead to reductions in mortality.
- Many racial and ethnic minorities and persons of lower socioeconomic position are less likely to receive screening and treatment for cardiac risk factors. The combination of lower screening and effective treatment of risk factors, such as smoking among the uninsured, lend themselves to quality improvement initiatives that can potentially reduce heart disease disparities among populations at risk.
- Many racial and ethnic minorities and persons of lower socioeconomic position are less likely to receive childhood immunizations.
- Many racial and ethnic minorities and individuals of lower socioeconomic status are less likely to receive recommended immunizations for influenza and pneumococcal disease.

Knowledge of why disparities exist is limited

There are complicated interrelationships between race, ethnicity, and socioeconomic status that may result in health care disparities. Although we may have sufficient data about disparities by race and ethnicity, it is difficult to tease out the individual contributions of race, income, or education to these differences. For example, we found significantly lower rates of smoking cessation offered to minority patients. However, we cannot determine how much these differences are affected by different levels of patient income, education, or types of insurance. While the relationships between these factors may seem theoretical, a better understanding of the underlying factors that result in disparities could better target improvement efforts aimed at reducing disparities. Further research may help to sort out these issues for future reports.

The NHDR cannot tell us what factors are causally related to health care disparities, although it does identify factors that may be related to disparities.

Examples from the NHDR:

- Many racial and ethnic groups, as well as poor and less educated patients, are more likely to have report poor communication with their physicians.

- Many racial and ethnic minorities and poor patients report more problems with some aspects of the patient-provider relationships.
- Asians, Hispanics, and those of lower socioeconomic status have greater difficulty accessing health care information, including information on prescription drugs.

Improvement is possible

Although this report offers a sobering view of health care disparities, there are some positive findings which suggest that targeted improvement efforts could significantly reduce health care disparities. The following notable exceptions demonstrate what is *possible* to achieve.

Examples from the NHDR:

- While blacks and poor patients are more likely to present with later stage cancers with higher death rates, black women have higher screening rates for cervical cancer and no evidence of later stage cervical cancer presentation. Although it is not possible to demonstrate a causal link, the significant investment in community-based cancer screening and outreach programs for cervical cancer may be responsible for the lack of disparity.
- Quality improvement efforts have resulted in demonstrable reductions in black-white differences in hemodialysis. A targeted intervention within a quality improvement culture may offer important lessons in disparity reduction.
- Black patients are more likely to receive blood pressure monitoring without any disparity in blood pressure management. A greater perceived risk for significant cardiovascular disease among blacks may result in appropriately increased screening rates and treatment for risk factors. Directed public education campaigns about cardiac risk factors and the importance of an actively involved patient may play an important role in the lower observed rate of cardiac disparities among blacks.

When detailed data are available at the most actionable level, such as population subgroups, the efficiency of quality improvement efforts can be enhanced. For example, the subpopulation data from the California Health Interview Survey would allow more targeted prevention efforts directed at Asians over age 50 in need of colorectal cancer screening. The information on language spoken at home provides a far more precise target population—Asians who do not speak English were 20% less likely to undergo colorectal cancer screening than their English-speaking Asian counterparts. The NHDR can also serve to identify the best “performers,” help others learn from their experiences, and disseminate the lessons learned to other communities. Community-based

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participatory research has numerous examples of communities working to improve quality overall, while reducing health care disparities for vulnerable populations.

Data limitations hinder targeted improvement efforts

Gaps in national data exist. National data currently being collected are useful for examining many racial, ethnic and socioeconomic disparities in U.S. health care. However, large gaps in the data required for a complete study of disparities were noted. For analyses of disparities related to racial/ethnic groups, data limitations were found to usually related to sample sizes.

Examples from the NHDR:

- Data are often adequate to assess the health care of whites, blacks, Hispanics, and Asians but are rarely adequate for the study of American Indians or Alaska Natives (AI/AN) and almost never adequate for the study of Native Hawaiians or Other Pacific Islanders (NHOP). The majority of smaller racial/ethnic priority populations cannot be assessed, especially with regard to the care received for specific health conditions.
- These disparities in data are exacerbated when the general population is subdivided to examine disparities among priority populations and become severe for many studies of children, the elderly, and rural populations.
- Data limitations for the study of socioeconomic groups usually relate to the lack of relevant information included in many health care provider databases.

Current Efforts To Improve Data Quality

More data would improve understanding of disparities

Much is still unknown about disparities in U.S. health care. As noted above, because of data limitations, relatively little is known about disparities among many populations such as AI/ANs and NHOPs. Studies have just begun to explore disparities among individuals with special health care needs—such as the disabled, persons receiving chronic care, and persons at the end of life. In addition, possible disparities in the care provided for many medical conditions have yet to be addressed.

As Federal data continue to improve, the ability to study different aspects of disparity will increase. For example, the expansion of questions related to barriers to health care and delays in care and the addition of questions related to cultural competency in the Medical Expenditure Panel Survey starting in 2002 are expected to greatly improve the ability to study disparities in these areas. The increase in sample size of over 50% between 2000 and 2002 and the addition of oversamples of Asians and of low income populations in 2002 will also greatly facilitate disparities research using MEPS.

In addition, new Federal data collections will help fill some data gaps. For example, the recently completed National Survey of Children with Special Health Care Needs will provide a unique opportunity to examine disparities in health care among this otherwise difficult-to-study population.

Although health care disparities are a national problem, they vary from place to place; and solutions will likely be developed at the local as well as the national level. Currently, however, relatively little information is available about disparities in health care in many States and localities. The measurement tools developed for the first NHDR (as well as in future iterations of the report) will be made widely available in hopes that it can help States and localities measure and understand disparities at the local level.

Better methods would improve understanding of disparities

A variety of methodological issues also limit understanding of disparities in health care. For example, this first NHDR focuses on measures that have been developed for, and used to study, access and quality of health care in the general U.S. population. However, priority subpopulations—i.e., women, children, the elderly, each racial and ethnic minority, low income persons, rural populations, and individuals with special health care needs—often have different health care priorities and different needs for services. Measures that capture the unique needs of specific priority populations are required for a fuller understanding of disparities faced by each group.

In this first NHDR, income and education level were used in this study as primary measures of socioeconomic position. It is unknown if other dimensions of socioeconomic position might be more relevant to disparities in health care, especially in terms of access and quality of services. Are different dimensions relevant for different aspects of health care? If so, can they be measured? And should they be measured individually or as a composite measure?

Data and measurement issues also limit the examination of disparities in health care as they relate to the urban-rural continuum. Most Federal data collections are able to distinguish MSA from non-MSA counties, and these two categories form the basis for the geographic analyses presented in this report. However, it is well known that these two categories do not capture well the heterogeneity that exists along the urban-rural continuum. As a result, disparities being experienced by residents of inner cities and very rural areas could not be adequately addressed.

It is hoped that future NHDRs will benefit from continuing methodological innovation in each of these areas. Such innovations will help to focus investigation of the most pressing disparities issues and allow a better understanding of disparities with reduced data collection needs.

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Knowledge of why disparities exist and how they can be eliminated is limited

Perhaps the most important limitation of this first NHDR is the scarcity of information about why disparities in health care exist. Causes of disparities are likely to be multifactorial, complex, and specific to each priority population and type of health care. While DHHS continues to support research aimed at identifying the root causes of disparities, much remains to be known. Optimal interventions to eliminate disparities cannot be developed without knowledge of the causal factors.

How such interventions should relate to quality improvement activities is also relatively unstudied. With some notable exceptions such as the HRSA Health Disparity Collaboratives, interventions to reduce disparities and to improve quality are often conducted separately. Additional research is needed to understand how efforts to reduce disparities and improve quality can best be coordinated.

Future NHDRs

This report, the first NHDR, could not address all the issues important to the elimination of health care disparities. Future reports will build upon this initial effort and will seek to fill in gaps as they are identified.

Progress will be tracked

The first NHDR is cross-sectional and provides a snapshot of disparities in the United States at a point in time. While some longitudinal data were gathered, these generally were insufficient to examine trends over time. Future NHDRs will build upon this baseline to identify trends and mark the progress of the Nation towards the elimination of health care disparities. In addition, future NHDRs will seek to communicate innovations in measuring, understanding, and intervening to eliminate disparities as these are developed.

Measures of disparity will be refined

The first set of NHDR measurement tools has limitations. The measure set on the first NHDR is long, and similar concepts are sometimes duplicated by different data sources. In addition, it is generally restricted to common measures that were developed to assess access to care and quality of care in the general population. Many health care needs and services specific to particular populations are not addressed.

Future NHDRs will build upon the first NHDR measurement tools. Data assembled for the first NHDR, which encompass a broad range of measures, will enable an informed review of these measures. It is anticipated that the number of measures that are useful for tracking disparities in the general population will be reduced significantly. In addition, measures specific to particular priority populations will be developed and incorporated into the measure set.

Methods for assessing disparities will be improved

Identified methodological limitations for studying disparities include problems measuring socioeconomic position and rurality. Future NHDRs will incorporate refined measures of socioeconomic position and rurality as these are developed.

Knowledge of why disparities exist and how they can be eliminated will be emphasized

Using this report as a baseline, future NHDRs will be able to report on best practices and innovations for reducing disparities in health care. In addition, effective ways of coordinating efforts to eliminate disparity and to improve quality will be presented. The continuing simultaneous release of the NHDR and the NHQR should serve to reinforce the important linkages between disparities and quality and facilitate the study of solutions that effectively address both issues.

The journey to high quality and equitable health care will be long and challenging. It will be marked by small but continuous improvements. At its end lies the promise of better health and well being for all Americans. The first NHDR and the first NHQR are small but significant steps on this journey. Future reports will mark the progress of the Nation towards a better health care system for all.

Reference

¹ Institute of Medicine, Board of Health Sciences Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal treatment: Confronting racial and ethnic disparities in Health Care*. Washington DC: Institute of Medicine; 2003.