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Addressing Racial and Ethnic Disparities in Health Care Delivery: The Purchaser's Role

Throughout the past century, the overall health of and life expectancy for many Americans has vastly improved. However, many studies indicate that racial and ethnic minorities experience less than adequate access to care, lower quality care, and poorer health outcomes than the rest of the nation. Reducing or eliminating racial and ethnic health care disparities is a priority for the Pennsylvania Department of Health and federal health care agencies, and is one of the most significant goals under Healthy People 2010, a comprehensive national health promotion and disease prevention initiative of the federal government and the public health community.

Why should purchasers be concerned? Minorities account for an increasing portion of the working population. According to the U.S. Bureau of Labor Workforce Statistics, approximately 25% of all people in the workforce in 2000 were from minority groups: 11% were African Americans; 10% were Hispanics, and 4% were Asian Americans. In addition, members of minority groups are expected to comprise about 41% of all people entering the U.S. workforce in the decade between 1998 and 2008, according to the Bureau of Labor Statistics.

Factors Contributing to Disparities in Health Care Delivery

Many factors contribute to the poorer health status of minorities. These include socioeconomic, cultural, and environmental factors, as well as health behaviors. In addition, minorities are more likely to face access-related problems. For example, in 2001, almost one in three Hispanics and one in five African Americans lacked health insurance, compared with one in ten whites. Furthermore, in 2001, only 55% of Hispanics and 64% of African Americans had a regular provider, compared to 75% of whites, according to the Center for Studying Health System Change Tracking Report (June 2002).

Even when insurance status, patient income and other access-related factors are comparable, minorities are less likely than whites to receive needed health services, including clinically necessary procedures, according to an Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (March 2002).

For example, African Americans are less likely to receive diagnostic procedures and life-saving therapies for heart attack. They are less likely to receive major diagnostic tests and therapeutic interventions for stroke, despite the fact that they suffer strokes at a rate as much as 35% higher than whites. Minorities are less likely to receive appropriate cancer diagnostic tests and treatments; to be placed on waiting lists for kidney transplants or to receive kidney dialysis or transplants; to receive certain therapies and state-of-the-art treatments for HIV; and to receive appropriate medications to manage asthma.

These disparities in appropriate diagnosis and treatment of an illness may result in worse outcomes. For example, in the U.S., the death rate is 30% higher for heart disease, 38% higher for stroke, and 27% higher for cancer for African Americans than for whites. Another disease with a higher death rate for minorities is diabetes; the death rate for diabetes is more than twice as high for African Americans as for whites.

The IOM report identified several factors within the health care system that may contribute to differences in the delivery of care. These include: cultural or linguistic barriers between providers and patients; limits on health care services for those with lower-cost health plans;

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incentives to limit services and contain costs; and the settings where minorities receive care (e.g. minorities are less likely to receive care in a private physician's office).

Another factor involves the clinical encounter between the provider and the patient, the IOM report suggests. If there is clinical uncertainty about a patient's condition, physicians' decisions may be influenced in subtle ways by their attitudes toward minorities or stereotypes about their minority patients' behaviors or health. Minority patients' attitudes toward health care, preferences for treatment, and patient refusal of treatment were not found to be major reasons for health care disparities in the IOM study.

Measuring Disparities Will Support Quality Improvements

Those working to better understand disparities and to measure progress toward their elimination realize that the collection of reliable race and ethnicity data is essential. This information, as well as a patient's language preference, can be used to understand the health needs of specific populations, to assist program planning and development, and to target quality improvement efforts. In addition, it can be used to develop culturally and linguistically appropriate services, to develop appropriate interventions and to evaluate and monitor their effectiveness.

The collection of this data, however, is neither universally practiced nor accepted. While some health care provider organizations and commercial health plans ask their patients/members to self-report information on their race, ethnicity and language preference, many do not. Some of the barriers to universal data collection include legal concerns, confidentiality and privacy concerns, cost, and the potential for misuse.

A Purchaser's Role

With increasing numbers of minorities in the workforce, health care purchasers have a vested interest in efforts to eliminate racial and ethnic disparities in health care delivery. There are several ways purchasers can support efforts to close the health care gap.

One central strategy often suggested, and strongly supported by Pennsylvania Secretary of Health Calvin Johnson, M.D., M.P.H., is increasing the "cultural competence" of the health care workforce. Cultural competence, as defined by Betancourt, et al., is "the ability of the health care delivery system to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs." When negotiating with health plans and providers, purchasers can ask questions about the measures that are in place to increase cultural competence.

In addition, purchasers can insist that providers and health plans develop and implement strategies to reduce racial and ethnic disparities in health care delivery. Contract negotiations with insurers and providers could be an opportunity for purchasers to address racial and ethnic disparities.

Workplace health education programs, specifically tailored to reflect the cultural and linguistic needs of employees, can produce significant savings in health care and disability costs, and may result in earlier returns to work after an illness, increased productivity, decreased absenteeism and an overall healthier workforce.

Purchasers can encourage further research on racial disparities in health care delivery. This includes identifying and measuring racial and ethnic disparities within populations, identifying practical approaches that providers and health plans can use to reduce disparities, and encouraging the development of more comprehensive, timely data regarding utilization of health care services.

A comprehensive multi-level strategy is needed to reduce racial and ethnic disparities in health care delivery. This will take a concerted effort from stakeholders, providers, training programs, insurers, researchers, government, community organizations, and purchasers. Health care purchasers and their employees can benefit from collaborative efforts to meet the social, cultural and linguistic needs of all persons seeking health care. Recognizing and focusing on racial and ethnic disparities will lead to a healthier, more productive workforce. And, because better quality outcomes typically cost less than poor quality outcomes, it is reasonable to expect that reducing racial and ethnic disparities could also reduce purchasers' costs.

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