Understanding Health Disparities

“Health is the place where all the social forces converge.”

Reed Tuckson, M.D., Vice President, American Medical Association

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Research suggests that health disparities in the United States are often associated with an individual’s race and ethnicity, gender, income level, sexual orientation, or geographic location. Of these factors, the literature primarily focuses on racial and ethnic differences. It is well documented that minority populations—generally classified as African Americans, Native Americans, Asian/Pacific Islanders, and Hispanics—have more chronic diseases, higher mortality, and poorer health outcomes than individuals classified as white.

Nationally, the commitment to understanding and eliminating racial and ethnic health disparities is strong. The Healthy People 2010 initiative, a set of health promotion and disease prevention objectives for the nation, aims to eliminate health disparities by the year 2010. Healthy People 2010 has led to a number of federal programs designed to support this goal through data collection and research. The U.S. Department of Health and Human Services (HHS) and its agencies spearhead these efforts. HHS agencies with prominent roles include the Centers for Disease Control and Prevention (CDC), the Office for Civil Rights, the Centers for Medicare & Medicaid Services (CMS), the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA). In 1999, as part of the Healthcare Research and Quality Act, Congress directed the Agency for Healthcare Research and Quality, a division of HHS, to develop an annual National Healthcare Disparities Report to track “prevailing disparities in health care delivery as they relate to racial factors and socioeconomic factors in priority populations.”

Thirty-four states, including Ohio, have a designated governmental entity addressing minority health. Ohio’s Commission on Minority Health, established in 1987, was the first entity of its kind in the nation. Recently, the commission won a federal contract to create the National Association of State Offices of Minority Health.

The purpose of this background paper is to create a common understanding on the issue of health disparities. The paper will define and describe current health disparities among racial and ethnic groups as well as present a framework for examining the intricate web of factors that can contribute to disparities. It will then offer potential policy solutions for addressing the issue of health disparities, as well as the challenges associated with each.

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* The terms African American and black are used interchangeably throughout this paper. Similarly, the terms Hispanic and Latino are also used interchangeably.
What Is Meant by “Disparities”?

Healthy People 2010 defines disparities in health as the “unequal burden in disease morbidity and mortality rates experienced by ethnic/racial groups as compared to the dominant group.”¹ The Institute of Medicine’s 2002 report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (“the IOM Report”) defines disparities in health care as “differences in the quality of health care that are not due to access-related factors or clinical needs, preferences or appropriateness of intervention.”² The Health Resources and Services Administration, a key player in the national effort to eliminate disparities in health, defines health disparities as “population-specific differences in the presence of disease, health outcomes, or access to health care.”

What causes health disparities? Why are minority populations overburdened with disease and poor health outcomes? Are there promising solutions to this complex problem? A review of the research literature suggests that a multitude of complex factors contributes to health disparities, but little is known about the relative importance of these factors. In the 1985 Health and Human Services’ “Report of the Secretary’s Task Force on Black and Minority Health,” health is said to be “influenced by the interaction of physiological, cultural, psychological, and societal factors that are poorly understood for the general population and even less so for minorities.”³ In short, it is challenging for social scientists to find ways to determine if, how, and to what extent each of these factors is related to health disparities experienced by minorities.

Why is there such a strong national commitment to eliminate health disparities? With an increasingly diverse population, the health of our nation depends on our ability to keep minority populations healthy. According to Census 2000 results, minorities represent approximately 25 percent of the nation’s population. Hispanics—now the nation’s largest minority group—represent 12.5 percent of the total population, with 11 percent of the United States population citing Spanish as their primary language.⁴ Hispanics and Asians account for more than 50 percent of the nation’s population growth; between 2000 and 2050, the Hispanic⁵ and Asian populations will more than triple, with Hispanics representing nearly a quarter of the total population and Asians representing 8 percent.⁵

In Ohio, whites represent about 85 percent of the population and minorities represent about 15 percent [African American (11.5 percent), two or more races (1.4 percent), Asian (1.2 percent), other (0.8 percent), and Native American (0.2 percent)].⁶ The Hispanic population in Ohio grew 36 percent between 1990 and 2000, and now accounts for 1.9 percent of the state’s total population.⁷

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¹ According to the U.S. Census Bureau, “Race and Hispanic origin are two separate concepts in the federal statistical system. People who are Hispanic may be of any race. People in each race group may be either Hispanic or Not Hispanic. Each person has two attributes, their race (or races) and whether or not they are Hispanic.” U.S. Census Bureau, “U.S. Census Bureau Guidance on the Presentation and Comparison of Race and Hispanic Origin Data” (2003). http://www.census.gov/population/www/socdemo/comraces.html (accessed 8/23/04).
Examples of Disparities

The literature often refers to disease-specific racial and ethnic disparities and defines or describes them in terms of incidence, treatment, or mortality. Examples of these include the following:

**Cancer**

- The cancer incidence rate among African Americans is 10 percent higher than among whites.\(^9\)
- The cancer death rate for African Americans is 35 percent higher than the rate for whites.\(^9\)
- Hispanics have higher rates of cervical, gallbladder, and stomach cancer than whites.\(^10\)
- Minority representation in cancer treatment trials in the United States is declining. Between 1996 and 2002, black representation dropped from 11 percent of all cancer trial participants to 7.9 percent, while Hispanic representation dropped from 3.7 percent to 3 percent.\(^11\)
- Women of racial and ethnic minorities are less likely to have mammograms and Pap tests than white women.\(^12\)
- For the years 1996–99, the incidence of cancer among Ohio blacks was 6 percent higher than among whites; Ohio blacks were 32 percent more likely to die from the disease.\(^13\)

**Cardiovascular Disease**

- Coronary heart disease is more prevalent among blacks compared with whites and the prevalence among blacks is rising while the prevalence among whites is falling. In addition, coronary heart disease mortality is higher among blacks than whites.\(^14\)
- Heart disease is the leading cause of death for all racial and ethnic groups in the United States. In 1999, the rate of death from cardiovascular disease for African Americans was about 30 percent higher than for whites.\(^15\)
- African Americans are less likely to undergo diagnostic procedures (e.g., catheterization or angiography), revascularization procedures, and thrombolytic therapy for heart disease.\(^16\)
- When hospitalized with acute myocardial infarction, Hispanics are less likely to receive aspirin and beta-blockers than whites.\(^17\)

**Diabetes/Kidney Disease**

- Nationally, African Americans age 20 and older are twice as likely as whites to have diabetes, while Hispanics are 1.9 times more likely to have diabetes.\(^18\)
- The incidence of diabetes among American Indians and Alaska Natives is more than twice that of the total population.\(^19\)
- The death rate is 27 percent higher for African Americans with diabetes, and 40 percent higher for Hispanics, than for whites.\(^20\)
• African Americans have higher rates of diabetes-related complications; they are four times more likely to develop kidney failure\textsuperscript{21} and three times more likely to develop glaucoma\textsuperscript{22} than whites.

• In Ohio, the death rate among African Americans with diabetes is 2.5 times greater than for whites.\textsuperscript{23}

**HIV/AIDS**

• Nationally, the death rate from AIDS for African Americans is eight times that for whites and three times that for Hispanics.\textsuperscript{24}

• African Americans and Hispanics account for over 50 percent of the newly reported AIDS cases in the United States.\textsuperscript{25}

• African American youths are three to four times more likely to contract the AIDS virus than whites of the same age.\textsuperscript{26}

• In Ohio, African Americans and Hispanics account for just under 50 percent of newly reported AIDS cases. The AIDS prevalence rate for black Ohioans is six times higher than for whites, and the prevalence rate for Hispanic Ohioans is four times higher than for whites.\textsuperscript{27}

**Infant Mortality**

• African American infant mortality rates are twice as high as for white infants, and the rates are rising.\textsuperscript{28}

• The rate of death due to low birth weight/prematurity among African American infants is almost four times that for white infants.\textsuperscript{29}

• In Ohio, access to prenatal care among African American women is 15 percent less than for whites.\textsuperscript{30}
A Health Disparities Framework

To better understand the complex causes of health disparities among racial and ethnic groups, it is useful to rely on a conceptual model, or framework. The health disparities framework presented in this paper draws from similar models proposed by the Institute of Medicine and the Office of Technology Assessment. Our framework is comprised of three distinct dimensions: 1) Health—Before Care; 2) Access to Health Care; and 3) Health Care Delivery. Each of these dimensions contains variables that are considered as possible causes of disparities among racial and ethnic groups. These dimensions are summarized below and presented in Table 1 (opposite page).

Health—Before Care

Disparities in health can arise from personal, socioeconomic, and environmental characteristics—variables that are external to the health care system and exist prior to the individual entering the system. Disparities in health status are known to correlate with income levels, adequacy and safety of housing, employment status, education level, lifestyle choices (e.g., tobacco use, alcohol use, diet, exercise), environmental conditions (e.g., air and water quality, pesticides, green space), and social conditions (e.g., crime rates, employment opportunities).

Access to Health Care

Disparities in health care access are most often associated with barriers of entry into the health care delivery system. Factors impeding access to health care include a lack of financial resources, a cultural preference that discourages health-seeking behavior, low health literacy levels, language barriers, lack of diversity in the health care workforce, and a mistrust of the health care system due to a prior negative experience. Additional impediments to access include systemic barriers such as the lack of available and proximate providers, the lack of transportation, the lack of or poor health insurance coverage, the lack of access to a regular source of care, and legal or bureaucratic barriers to receiving public aid.

Health Care Delivery

Once entry to the health care delivery system is gained, disparities can arise in the quality of care received. Studies show that diagnoses, treatments, and quality of care all vary according to insurance coverage and type, provider cultural competency, patient-provider communications, provider bias and discrimination, differential treatments based on population group, patient preferences and adherence to treatment plans, language barriers, diversity of the health care workforce, appropriateness of care, and effectiveness of care.
### TABLE 1: Health Disparities Framework

<table>
<thead>
<tr>
<th>Health — Before Care</th>
<th>Access to Care</th>
<th>Health Care Delivery</th>
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<tbody>
<tr>
<td>Income-levels, poverty, and other social conditions</td>
<td>Financial resources</td>
<td>Insurance coverage and type</td>
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<tr>
<td>Safety and adequacy of housing</td>
<td>Availability and proximity of providers</td>
<td>Cultural competency levels</td>
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<tr>
<td>Employment status and type of employment</td>
<td>Access to transportation</td>
<td>Patient-provider communications</td>
</tr>
<tr>
<td>Education levels</td>
<td>Insurance coverage</td>
<td>Provider discrimination or bias</td>
</tr>
<tr>
<td>Lifestyle choices—diet, exercise, tobacco and alcohol use</td>
<td>Regular source of care</td>
<td>Differential propensities for certain diseases by racial / ethnic populations</td>
</tr>
<tr>
<td>Environmental conditions—air and water quality, pesticide exposure, green space</td>
<td>Language barriers</td>
<td>Patient preferences and adherence to treatment plans</td>
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<td></td>
<td>Legal barriers (e.g., eligibility restrictions, illegal immigrants)</td>
<td>Diversity of the health care workforce</td>
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<tr>
<td></td>
<td>Prior experience with the health care system</td>
<td>Appropriateness of care</td>
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<tr>
<td></td>
<td>Cultural preferences—care-seeking behaviors</td>
<td>Effectiveness of care</td>
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<tr>
<td>Health literacy levels</td>
<td></td>
<td>Language barriers</td>
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<tr>
<td>Diversity of the health care workforce</td>
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Racial and ethnic disparities in health status and health outcomes are partly the result of differences in access to medical care among groups. The reasons for disparities in access are many; some of these are examined below.

**Lack of Insurance Coverage**

Health insurance coverage directly affects access to medical care, regardless of race. Without it, patients are more likely to postpone seeking medical care, more likely to go without needed medical care, and more likely to go without prescription medicines. As shown in Figure 1 (opposite page), over half of the non-elderly, uninsured population is composed of minorities—yet minorities account for only a third of the total non-elderly population.

According to a September 2003 U.S. Census Bureau report, 10.7 percent of non-Hispanic whites were uninsured, compared to 20.1 percent of African Americans, 32.4 percent of Hispanics, and 18.4 percent of Asians. Ohio’s distribution of the uninsured was similar, with 11 percent of whites uninsured versus 16 percent of blacks and 24 percent of Hispanics.

Some of the disparity in coverage is related to differences in income level and type of employment. Low-income working adults face the highest risk of being uninsured because they are often ineligible for Medicaid coverage, work in low-wage jobs that do not offer insurance, cannot afford their share of the premiums, or cannot afford the high cost of private insurance. The hurdle for low-income, working minorities appears to be even higher:

- Forty-seven percent of working adult Hispanics and 44 percent of working adult blacks are below 200 percent of poverty level versus 17 percent of whites.
- A 2004 survey revealed that 35 percent of employed Hispanics do not have insurance versus 18 percent of African Americans and 11 percent of whites.
- Between 1996 and 1999, over a third of low-income Hispanics had never been insured by private insurance despite having the most stable employment of any group.

**Lack of a Regular Source of Care**

A second important barrier to access to medical care is the lack of a usual source of care. Without access to a regular source of care, patients have more difficulties obtaining care, make fewer doctor visits, and have more difficulty accessing prescription drugs. Adults with a regular source of care have higher rates of receiving preventive services than those without, and children with a regular source of care have higher rates of immunization than those without. Lacking a regular source of care, particularly a primary care physician, can also limit a patient’s access to referrals for specialty care.

Several surveys confirm the disparities that exist in access to a regular source of care among whites and minorities:
Compared to whites, minority groups are less likely to have a regular doctor: 80 percent for whites, 70 percent for blacks, 57 percent for Hispanics, and 68 percent for Asian Americans.

Minority groups are more likely to list hospital emergency rooms, clinics, or “nowhere” as their regular source of care: 13 percent for blacks, 14 percent for Hispanics, 8 percent for Asian Americans, and 6 percent for whites.\(^{41}\)

A 1999 Commonwealth Fund survey found that 22 percent of Hispanics and 16 percent of African Americans reported a “major problem accessing specialty care” compared to 8 percent of whites.\(^{42}\)

**Lack of Financial Resources**

Although the lack of financial resources is a barrier to health care access for many Americans, particularly those who are uninsured and low-income, the impact on access appears to be greater for minority populations. Nearly half (45 percent) of Hispanic adults, more than two fifths (41 percent) of Asian American adults, and more than one third (35 percent) of black adults report difficulty paying for medical care, compared to approximately one quarter (26 percent) of white adults.\(^{43}\) A recent national survey found that 30 percent of blacks and 25 percent of Latinos with chronic health conditions had to forgo prescription drug purchases due to the high cost; this compares to 17 percent of whites.\(^{44}\)
Legal Barriers

Access to medical care by low-income immigrant minorities can be hindered by legal barriers to getting coverage through public insurance programs. A 1996 federal law bars states from providing Medicaid and State Children’s Health Insurance Program (SCHIP) coverage to most immigrants who have been in the country for less than five years. According to a report by the General Accounting Office (GAO), in 1999, about 38 percent of nonimmigrants from families earning less than the federal poverty level were covered by Medicaid, compared to just 20 percent of immigrants from families earning similar amounts. The GAO reported that some immigrants who are eligible for Medicaid or SCHIP remain outside of the system because they cannot understand complex eligibility rules and enrollment processes. This might explain why one in three poor Latino children eligible for Medicaid and SCHIP are not insured.

With the exception of emergency treatment, illegal aliens are ineligible for coverage under Medicaid and SCHIP, regardless of entry date. Although their citizen children are eligible for these programs, few illegal immigrants enroll them for fear of being deported. Similarly, illegal immigrants may be reluctant to seek emergency treatment for themselves or their children for fear that they will be turned over to the immigration authorities. In Ohio, where an estimated 40,000 illegal aliens reside as of 2000 (an increase of 220 percent over the estimate for 1990), this implies a significant number of vulnerable minorities.

The Health Financing System

The IOM Report cites fragmentation of the health care delivery and financing system as a structural barrier to accessing care. Racial and ethnic minorities are more likely to be enrolled in “lower end” health plans that have greater limits on covered services and a limited choice of providers. The IOM Report authors argue that the lower payment rates associated with lower end plans further limits access to services for minority populations by discouraging provider participation.

Structural Barriers

According to the “National Healthcare Disparities Report,” “Structural barriers—poor transportation, inability to get care (e.g., schedule appointments quickly or during convenient hours), and excessive time spent in the waiting room—affect a person’s ability and willingness to obtain... needed care.” Missed appointments due to transportation difficulties, for instance, can reduce a patient’s access to care in many ways. First, the patient may be less willing to seek care in the future because of the exhausting effort to get to the provider, the fees assessed for the missed appointment, or the hours required to take off from work. Second, providers might refuse to treat a patient who regularly misses appointments or may treat the patient with such disrespect that the patient hesitates to return. In many cases, patients are forced to use the emergency room simply because it is the only medical facility open during nonwork hours.
Recent research confirms that such structural barriers contribute to disparities in access to care:

- In a study of emergency departments done in conjunction with the National Hospital Ambulatory Medical Care Survey (1999–2000), blacks were more likely than whites to report waiting times of more than an hour for semi-urgent/non-urgent care and to report leaving the emergency department without being seen.50

- In a nationwide study of migrant farm workers, the majority of whom are Mexican, 57 percent listed clinic hours as the main barrier to receiving dental care.51

- When minorities in New Hampshire’s Hillsborough County were asked to identify the greatest barriers to accessing care, clinic hours and transportation ranked second and third, respectively, behind cost.52

- In a similar study conducted by the North Carolina Center for Public Policy Research, 55.2 percent of Hispanics named transportation as one of the top three barriers to health care.53

- In predominantly black southeast Washington, D.C., where it could take as many as three bus rides and two hours to get to a health care provider, patients are likely to miss appointments.54

**Scarcity of Providers**

Access to medical care is further limited by the scarcity of primary care practitioners, medical specialists, and diagnostic facilities in inner cities and rural areas—communities with high concentrations of minority populations. Thus, minority groups are more likely to report that they have little or no choice in where they obtain care compared to whites.55 In a recent study linking Medicare records with a survey of primary care physicians, it was found that physicians caring most often for black patients were less likely to be able to “always or nearly always” provide patients with access to specialists, high-quality diagnostic services, and nonemergency admission to hospitals, mainly because of the limited choice of quality providers and resources in the geographic area.56 Only 77 percent of doctors treating mostly black patients were board certified in their primary care specialty versus 86 percent of those treating mainly whites; traditionally, those without board certification are less likely to perform diagnostic screening procedures, and more apt to just treat symptoms.57

Without regular care, patients rely on emergency rooms for treatment when symptoms become acute. Since hospitals are required under the Emergency Medical Treatment and Labor Act to treat and stabilize all patients needing emergency care, regardless of their ability to pay or citizenship status, hospital budgets become strained, forcing hospitals to close and further restricting health care access in the community.

In addition, minorities have difficulty filling prescriptions in areas with inadequate pharmacy services. In New York City, for instance, a study found that 75 percent of pharmacies in nonwhite neighborhoods do not stock or have adequate supplies of prescription opioids (painkillers) compared to 28 percent of pharmacies in white neighborhoods.58
Disparities in Access to Care (continued)

Linguistic Barriers

Language differences can restrict access to medical care for minorities who are non-English proficient (NEP) or limited-English proficient (LEP). According to the IOM Report, one in five Spanish-speaking Latinos has forgone seeking medical advice due to language barriers. Non-English-speaking patients are less likely to use preventive care services and more likely to rely on the emergency room for care. In a survey of non-English-speaking women, those who did not see a doctor for cervical cancer screening cited the inadequacy of the translated materials as a contributing factor. In some cases, NEP and LEP individuals may not be aware of certain medical services and how to access them due to language differences. They also may encounter language problems in simply trying to set up an appointment with a doctor. Furthermore, dissatisfaction with a prior cross-language encounter in a physician’s office or other health care facility may limit a patient’s willingness to access care in the future.

In Ohio, where 2.2 percent of the population speaks little or no English, hospitals are required to inform low-income, uninsured residents that they are entitled to nonemergency, medically necessary treatment free of charge under the Hospital Care Assurance Program. Unfortunately, some of the posted signs and notices on patient bills are only in English.

Health Literacy

Health literacy is another potential barrier to access to care. Healthy People 2010 defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Problems with health literacy can make it difficult to complete intake forms, enroll in insurance programs, read appointment slips, and understand how to navigate the health care system. Patients with a poor understanding of good health may not know when it is necessary to seek care for certain symptoms. A recent survey revealed that between 20 and 25 percent of minorities believe that staying healthy is a matter of luck (versus 12 percent for whites), indicating that these groups may not be educated about the benefits of preventive care.

To be sure, health literacy is not a problem restricted to minority racial and ethnic groups. However, health literacy and literacy problems in general are more pronounced among these groups than among English-speaking whites. According to the Institute for Healthcare Advancement, 50 percent of Hispanics, 40 percent of blacks, and 33 percent of Asians have problems with health literacy. Although the Institute for Healthcare Advancement reports that native-born whites account for the largest number of low-literate Americans, it does not provide the percentage of whites in this category.

Lack of Diversity in the Health Care Workforce

Disparities in access to care are partially explained by cultural and linguistic differences between predominantly white health care providers and minority patients. Thus, increasing the diversity of the health care workforce to include more minorities may reduce some of the disparity in access and ultimately improve the health of minority populations. A study using data from the Commonwealth
Fund 1994 National Comparative Survey of Minority Health Care found that African Americans and Hispanics, if given a choice, sought care from physicians of their own race. The study found that 25 percent of African Americans and 23 percent of Hispanics saw either an African American or Hispanic physician, even though African American and Hispanic physicians represented just 4 percent and 5 percent, respectively, of physicians nationwide. Although geographic proximity played a role in physician choice, personal preference for seeing a doctor of a similar race and language was more important. In addition, a recent study by the Commonwealth Fund found that when a physician and patient are of the same race, levels of patient satisfaction with care are higher, based on ratings of physicians’ participatory styles.

The underrepresentation of minority physicians further restricts access because minority physicians are more likely than other physicians to practice in underserved communities, particularly those consisting of residents from their own racial and ethnic groups. Black physicians were found to practice where the proportion of black residents is nearly five times as high as where other physicians practice. Likewise, Hispanic physicians work in communities with twice the proportion of Hispanic residents when compared to non-Hispanic physicians. Additionally, both black and Hispanic physicians are more likely than white physicians to treat Medicaid and uninsured patients.
Disparities in Health Care Delivery

Racial and ethnic disparities in health status and health outcomes are partly attributable to differences in how various groups are treated within the medical system. That is, not all racial and ethnic groups are treated alike in terms of quantity and quality of health care services received. Two possible sources of the differences in treatment include patient-provider communication problems and discriminatory behaviors of physicians.

Patient-Provider Communication Problems

Communication between patients and physicians is critical to the delivery of appropriate and effective treatment and care. Regardless of patient race or ethnicity, miscommunication can lead to incorrect diagnosis, improper use of medications, and failure to receive follow-up services—all of which can adversely affect health or contribute to death.

- More than half of all Hispanics report having difficulty understanding prescription medicine instructions and health education materials provided by the doctor. A Passaic, New Jersey, child is lucky to be alive after her Hispanic mother gave the girl 11 teaspoons of cough medication because she thought the word “ounce” was equivalent to “once,” the Spanish word for 11.

- Compared to whites, African Americans, Hispanics, and Asian Americans are more likely to report that their doctor did not listen to everything they said, they did not fully understand their doctor, or they had questions during the visit but did not ask them.

- African Americans and Hispanics are more likely than whites to feel they have been treated disrespectfully during a health care visit—spoken to rudely, talked down to, or ignored.

- African Americans (55 percent), Hispanics (50 percent), and Asian Americans (63 percent) are less likely than whites (70 percent) to inform their physician that they are using alternative therapies. This communication breakdown can lead to dire consequences, particularly in cases in which alternative herbal medicines interfere with or alter the effects of traditional medications.

Among non-English-speaking populations (about 18 percent of the total population), the linguistic barrier is even greater. Hispanics using Spanish as their primary language report more problems communicating with their physician than Hispanics who speak English at home. This problem is exacerbated by limited access to language interpreters. Less than half of the non-English speakers that said they needed an interpreter during a health care visit reported always or usually having one. Not having an interpreter can lead to dire consequences. A non-English-speaking Hispanic man with stomach pains was prescribed three medications at a Virginia hospital emergency room, with no translator present. As a result, the patient failed to understand the instruction that he was not to take the medications all at once. Misuse of the medications caused his death.

In a survey of doctors and Spanish-speaking Latinos conducted for Hablamos Juntos, an organization whose mission is to develop affordable models for health care organizations to offer language services, providers and patients were asked to list their concerns when dealing with a cross-lingual encounter. Their responses, presented in Table II (opposite page), shed light on the miscommunication dangers inherent in such an encounter.
Although the use of on-site interpreters may be valuable in improving communications, it is not a guarantee that errors—some of which can have clinical consequences—will not be made. Studies show that the use of professionally trained interpreters results in fewer errors than relying on nurses, social workers, or family members to serve in that role. Still, in some cases, translation barriers can have negative consequences. For instance, in the Hmong language, there is no translation for chemotherapy; when a translator described the procedure to a patient as “We’re going to put a fire in you,” the patient refused care.

Additional communication problems stem from a lack of cultural understanding among largely white providers and their minority patients. In 1999, filmmaker Maren Grainger-Monsen developed a documentary film with associated teaching modules to demonstrate how culture influences patient experience in the health care system and how doctors can be more sensitive to cultural differences when communicating with patients and families. Through four personal stories, the film reminds doctors that beliefs, values, and concerns about health and illness are culturally based, can vary within cultural groups and within families, and may be influenced by acculturation and generational differences. Patient health decisions, for instance, are influenced by religious beliefs, mistrust of Western medicine, and familial and hierarchical roles. In a nationwide survey, 32 percent of Asian Americans and 26 percent of Hispanics said they did not follow their doctor’s advice because it was against their personal beliefs.

### TABLE II: Miscommunication Dangers in Cross-Lingual Encounters

<table>
<thead>
<tr>
<th>Providers</th>
<th>Spanish-Speaking Latinos</th>
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</thead>
<tbody>
<tr>
<td><strong>Areas Most Compromised by Language Differences</strong></td>
<td><strong>Aspects of Receiving Medical Care Made More Difficult by Language Differences</strong></td>
</tr>
<tr>
<td>Patient’s ability to fully understand doctor’s treatment advice and medical conditions/disease</td>
<td>Ability to fully explain symptoms and ask questions</td>
</tr>
<tr>
<td>Increased risk when medications or home remedies being used are not discovered</td>
<td>Ability to follow through with filling prescriptions</td>
</tr>
<tr>
<td>Patient’s ability to fully explain symptoms, problems, and concerns to providers</td>
<td>Trust that doctor understands patient’s medical needs</td>
</tr>
<tr>
<td>Incomplete or inaccurate medical history</td>
<td>Ability to understand the doctor’s recommendations</td>
</tr>
<tr>
<td>Follow through on doctor’s recommendations</td>
<td>See doctor as often as needed</td>
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Provider Discrimination

The IOM’s 2002 report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,” suggests that unconscious or conscious discrimination on the part of providers accounts for a portion of the unequal, inferior treatment of minorities as opposed to whites. Differences in treatment by race and ethnicity are particularly well-documented for cardiovascular disease, diabetes, kidney disease, HIV, and cancer. The IOM Report cites studies to support that, even after adjusting for socioeconomic status and health insurance coverage, minorities are less likely than whites to receive antiretroviral therapy and protease inhibitors for HIV, to undergo cardiac catheterization and bypass surgery for cardiovascular disease, to receive hemodialysis for kidney failure, to be referred for a kidney transplant once on dialysis, or to receive pain medication in the emergency room for a long bone fracture. According to the report, other studies investigating the appropriate level of care found that such disparities are not due to overuse of services by whites.

For example, the IOM Report cites a study done by Kevin Shulman in 1999 that presented 700 physicians with videos of black and white male and female “patients” (actually actors and actresses) describing chest pain. The doctors were asked whether they would refer the patients for cardiac catheterization. The patients had identical symptoms, electrocardiogram (EKG) results, and health insurance. Schulman found, as cited by the IOM Report, that African Americans were 40 percent less likely than whites to undergo catheterization.

Discriminatory tendencies on the part of providers are supported by another study that is based on actual clinical encounters. In that study, “doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients’ income, education, and personality characteristics were taken into account.” 82 In addition, there is evidence of unequal treatment on the part of providers when it comes to patient medical bills. In a study by the Allegheny County Health Department in Pennsylvania, African Americans were more likely to be asked about their ability to pay for treatment (independent of insurance status), less likely to receive payment allowances, and more likely to be referred to medical bill collection agencies than their white counterparts.83 Furthermore, patient perceptions of care reflect questionable treatment. Minority populations believe they are treated disrespectfully relative to whites, and believe that they would receive better health care if they were of a different race or ethnicity.84

The IOM Report contends that physicians inappropriately rely on “cognitive shortcuts” or stereotyping in clinical encounters, and may be affected by unconscious biases when making diagnoses and treatment decisions. The report suggests that doctors should be color-blind when making diagnoses and prescribing treatments, and that race is purely a social and categorical construct that does not reflect any real biological distinctions among groups. Indeed, the Human Genome Project found that 99.9 percent of the human genetic complement is the same in everyone regardless of race, and that human genetic variation is greater within groups than between groups.

Critics of the IOM Report take issue with many of the studies it cited. First, they point out that that several months after publication of the Schulman study, an analysis of the data by another team of researchers found that the referral rate for all black “patients” in the study was only 7 percent lower than for whites, not 40 percent.85 Second, the IOM relied on retrospective studies that analyzed provider practices based on reviewing patient charts or Medicare-claims databases.86 These types of
studies fail to capture critical events that may have transpired during a patient-provider encounter that would justify the provider practice. Items not captured by retrospective studies include prevention advice, health education, patient or family preferences for treatment, details of the clinical presentation (severity of symptoms, co-morbidities), and medical services provided but not recorded because Medicare does not cover them.87

IOM Report critics favor the use of prospective studies for identifying inappropriate care due to racial or ethnic bias or discrimination. Prospective studies ask doctors and patients how they made treatment decisions. Even the National Healthcare Disparities Report acknowledged this need when it stated, “For example, a patient may receive fewer medications because of differences in underlying disease processes, individual choice, systemic barriers to obtaining needed medications, or some combination of these reasons. When we observe differences in health care for different populations, it may not be possible to clarify causal pathways directly.”88 Critics of the IOM Report support the use of more audit studies for examining disparate care. Audit studies alter only one variable—race—while keeping all other variables constant.89

Dr. Sally Satel, practicing physician and scholar at the American Enterprise Institute, has been a vocal opponent of the IOM Report. She argues that the 0.1 percent of genetic variation is medically very meaningful.90 While she agrees that there is no pure race, Dr. Satel argues that skin color is a clue to genetic differences (e.g., enzyme and receptor biology) that influence disease and response to treatment. She and others say that certain diseases and treatments cluster by ethnicity and that there are biological differences in clinical presentation and response to treatment, particularly with prescription drugs.

Dr. Satel states, for example, that 40 percent of African Americans are slow to metabolize antidepressant drugs. Therefore, she always prescribes a lower initial dosage for African Americans than for whites to be sure that side effects do not cause the patient to refuse treatment in the future.91 This idea of different reactions to drugs by race is supported by a recent set of clinical trials for the heart failure drug BiDil. When the drug failed to affect whites but showed promise for African Americans in the initial trial, the drug’s producer initiated a follow-up study on African Americans alone. In July 2004, the trial was halted because the drug was found to be so effective at extending life that it was deemed unethical to continue giving some patients the placebo.92

Dr. Satel and others contend that although physicians are taught to make clinical decisions based on two factors—the presentation of symptoms and the probability of disease—the realities of medical practice (e.g., time limitations, stressful environments, multitasking) make this process less expeditious than relying on a set of hallmark symptoms as well as patient characteristics to make clinical decisions.93 The so-called use of “priors,” or statistical norms and experiences, is common. Dr. Jerome Kassirer, former editor of the *New England Journal of Medicine*, describes it this way: “Rather than casting our net broadly, doctors quickly focus on a problem by recognizing patterns that have clinical significance. Typically, the clinician generates an initial hypothesis merely from a patient’s age, sex, appearance, presenting complaints—and race.”94
In order to ensure consistency and equity of care across racial and ethnic groups, the IOM Report promotes the use of evidence-based guidelines. Although support for evidence-based medicine is growing, some physicians are careful to note the difference between evidenced-based guidelines and evidence-based rules. Rule-based treatment protocols have the potential to lead to bad medicine because they can be too restrictive, failing to account for each patient’s unique set of circumstances, including co-morbidities, medical history, heredity influences, allergies, and preferences. A study published in the *Journal of the American Medical Association* found a number of problems associated with guidelines. Many guidelines are of poor quality, are not based on the best science, are only partially supported by evidence, and are heavily biased by the developers’ preferences and social priorities. When different international guidelines were applied for treating a group of about 900 patients at risk for hypertension, “82 percent needed treatment when the U.S. guideline was applied versus 53 percent under the UK guideline and 15 percent under the Canadian guideline.”

As the IOM Report recognized, there is a need for further research in the area of provider discrimination: “Indirect evidence indicates that bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may be contributory factors to racial and ethnic disparities in health care… However, few studies have attempted to assess these mechanisms, and therefore, direct evidence bearing on the possible role of these factors, especially prejudice, is not yet available.”
How Can We Eliminate Racial and Ethnic Disparities?

A recent Commonwealth Fund report reviewing state policy agendas for the elimination of disparities contains a comprehensive, informed list of key items state leaders should consider in developing policies to eliminate racial and ethnic disparities. Just as our framework for understanding the causes of health disparities involves patient, provider, and health system characteristics, so, too, do the solutions.

Following is a list of the Commonwealth Fund report’s recommendations:

• Consistent racial/ethnic data collection
• Effective evaluation of disparities—reduction programs
• Minimum standards for culturally and linguistically competent health services
• Greater minority representation within the health care workforce
• Establishment or enhancement of state offices of minority health
• Expanded access to services
• Involvement of all health system stakeholders in minority health improvement efforts

Consistent Racial/Ethnic Data Collection

The value of data collection efforts is highlighted in the IOM Report: “Data on patient race, ethnicity, and primary language would allow for disentangling the factors that are associated with health care disparities, help plans to monitor performance, ensure accountability to enrolled members and payers, improve patient choice, allow for evaluation of intervention programs, and help identify discriminatory practices.” Collecting health data by race and ethnicity, however, presents the following challenges:

• There is no uniform standard across state and federal agencies regarding which groups or subgroups to define or how to classify multiracial groups. The IOM recommends reporting racial and ethnic data according to the Office of Management and Budget categories, but encourages the use of subpopulation groups where possible.

• Some population groups are too small in size to yield meaningful analysis and must be reassigned to other groups.

• Misclassifications can arise in cases in which the intake representative records a different race than would be reported by the patient or the patient’s relative.

The Office of Management and Budget (OMB) standards for federal data on race and ethnicity set the minimum categories for race as: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; and White. Respondents are allowed to select one or more races when they self-identify. The OMB also set two minimum categories for ethnicity: Hispanic or Latino and Not Hispanic or Latino; Hispanics and Latinos may be of any race. The 2000 Census adopted the OMB standards but added a sixth racial category of Some Other Race. U.S. Census Bureau, “Racial and Ethnic Classifications Used in Census 2000 and Beyond.” http://www.census.gov/population/www/socdemo/race/racefactcb.html (accessed 9/1/04).
How Can We Eliminate Racial and Ethnic Disparities? (continued)

- Patients, providers, and insurers may be reluctant to cooperate with the effort to collect data. Patients may decline to volunteer such information if they fear it will lead to racial discrimination or will be used for medical (or life) insurance underwriting purposes.

- The fear of being sued for discrimination or “racial profiling” may prevent some hospitals, physicians, and insurers from collecting the data. Thus, any data collection effort must be explained in a way that makes it clear that any data collected will be used only for the purpose of improving the quality of health care.

Nevertheless, progress is being made toward mobilizing efforts to collect racial and ethnic health care data. Recently, a consortium of six leading hospitals and health systems across the nation, along with the Health Research and Educational Trust, developed a program called Eliminating Disparities Through Community and Hospital Partnerships that aims to create a uniform framework for collecting data on race, ethnicity, and primary language, as well as collecting clinical and administrative data for assessing the organization’s cultural competency levels, appropriateness of care, and disparities in quality of care. In addition, a recent survey by the Robert Wood Johnson Foundation revealed that 51 percent of the nation’s health plans surveyed already are collecting data on patient race upon enrollment. Some states, however, restrict collection of this information for fear it violates patient privacy and invites discrimination.

Efforts to measure and eliminate health disparities in Ohio are progressing. In the last few years, the Ohio Department of Health (ODH) created the Minority Health Data Unit to study the agency’s methodology for and consistency in collection of racial and ethnic data, and to make recommendations on how to improve upon the quality and completeness of the data. An assessment of ODH databases in 2003 revealed that, while the majority of databases collected racial and ethnic data, there was no uniform system of classification, there was a significant amount of data missing, and the response rate among minorities was on the decline. Based on these findings, the Minority Health Data Unit developed a set of recommendations to rectify these problems.

Effective Evaluation of Disparities-Reduction Programs

When the Commonwealth Fund initially set out to document its review of state policies regarding disparities in health, the authors intended to describe a set of best practices. Because of the lack of evaluation done on existing programs, however, they had to settle for describing promising practices. Formal program evaluation is needed if we are to understand which interventions work and which do not work in eliminating health disparities among racial and ethnic groups.

Program evaluation is only as good as the underlying intervention design. Table III (opposite page) details a set of recommended guidelines for designing interventions that was developed by a team of researchers for an Agency for Healthcare Research and Quality conference in 1999.
Minimum Standards for Culturally and Linguistically Competent Health Services

Healthy People 2010 defines cultural competency as “the design, implementation, and evaluation process that accounts for special issues of select population groups (ethnic and racial, linguistic) as well as differing educational levels and physical abilities.”

Among the many suggestions for achieving culturally and linguistically competent health services are the following:

- Develop patient education programs to increase patients’ knowledge of how to best access care and participate in treatment decisions.

### TABLE III: Guidelines for Designing Interventions

| Objectives | Establish extent to which intervention reduces differences between groups  
|            | Focus on health or immediate outcomes that show clear causal relationships with health |
| Research Design | Use experimental design whenever possible  
|            | Randomize individuals, patients, providers, systems, and communities  
|            | Guard against threats to internal and external validity |
| Interventions | Use culturally and linguistically appropriate media, settings, and agents  
|            | Incorporate patient and community input at all stages of research  
|            | Use multifaceted, intensive, and interactive approaches |
| Measurements | Measure variables at individual level, and use standard methods  
|            | Derive outcome variables from objectives, and use validated methods  
|            | Take into account expected time lags between intervention and effect  
|            | Collect process variables  
|            | Collect cost information |
| Dissemination | Establish and maintain linkages with stakeholders  
|            | Provide mentoring and training for future health service researchers |

How Can We Eliminate Racial and Ethnic Disparities? (continued)

• Use community-based organizations to provide culturally relevant and appropriate training and education to consumers. Where possible, use the Latin American model of having local community members serve as peer-educators, liaisons, and translators. For example, through a federal grant, the Ohio Department of Health administers the Ohio Community Access Program, which hires, trains, and provides college credit to community care coordinators from low-income neighborhoods to connect families in their communities with health and social services. ODH operates five demonstration sites around the state targeting the Amish, Somalis, African Americans, Hispanics, migrant workers, and residents of Appalachia.105

• Encourage the use of professional interpreter services or the use of headsets to provide translation. One way to expand this service would be for more states, including Ohio, to apply for federal funds that are available to reimburse nonhospital providers, private physicians, and community health centers for providing interpreters to patients at no cost. Under Title IV of the Civil Rights Act of 1964, health care providers that receive federal funding must provide interpreters, a mandate that is expensive to fulfill for these providers.106

• Develop multilingual forms, patient care instructions, and educational materials. For example, nurses in the OSU Medical Center’s Women and Infant Unit are voluntarily learning Spanish and translating patient informational packets.107 Also, the Ohio Medicaid program provides a Spanish hotline service to answer consumer questions.

• Start a formal discourse among patients and providers to discuss issues of bias or prejudice, whether perceived or actual. Sometimes just being aware of the problem can make people more sensitive.

• Integrate cross-cultural education into the training of all current and future health professionals. In the past, cross-cultural training focused on becoming knowledgeable about a cultural group’s beliefs, behaviors, and values and developing a set of “dos and don’ts” for clinical encounters with members of the group. Today, with the extent of variability within minority groups and the increasing degree of acculturation among these groups, such prescriptive methods for dealing with entire categories of individuals may, in fact, contribute to racial stereotyping. A more effective form of cross-cultural training would focus less on culture-specific knowledge and more on the process of communicating with and caring for patients from a range of diverse backgrounds. This form of cross-cultural training would incorporate classes on communication styles, gender differences, decision-making styles, patient participation, and issues of mistrust, bias, and racism.108

In the pursuit of cultural competence, physicians and other health care providers must walk a fine line in treating patients in a manner that respects their individual and cultural characteristics but is not inappropriately different from the way they treat patients of other racial or ethnic groups (especially white patients).

Greater Minority Representation within the Health Care Workforce

A lack of diversity among health care providers contributes to racial and ethnic disparities in access to care and delivery of care, particularly with respect to cultural competency and linguistics. Although
minorities currently comprise over a quarter of the U.S. population, they represent only 5 percent of the medical school faculty, 15 percent of medical school graduates, and 13 percent of dental school graduates. Similarly, a study by the American Medical Student Association found that only about 6 percent of practicing physicians are Latinos, African Americans and Native Americans, and that under-represented minority faculty (i.e., African Americans, Puerto Ricans, Mexican Americans, Native Americans) account for only 4 percent of the nation’s medical school faculty (and of this number, approximately 20 percent are clustered at just six schools).

Federal, state, and private university programs promoting diversity in the health care workforce may help to reduce racial and ethnic disparities in health. Incentive programs such as scholarships for minority students, loan forgiveness for those committed to practicing in their own communities, and internship opportunities would encourage minorities to enter the medical field. Mentoring programs and outreach efforts by practicing physicians also can be helpful.

For example, the Center of Excellence for Multicultural Medicine at the Ohio University College of Osteopathic Medicine, supported by a HHS grant, strives to “contribute to the diversity of the health care workforce by reaching out to minority and disadvantaged students interested in health careers and enabling them to participate in a pipeline of enrichment and support programs that will facilitate their entry and success in college and health professions degree programs at Ohio University.” In addition, the Cleveland Clinic Foundation and El Barrio, a local Hispanic community organization, jointly support Creando Possibilidades, a program that recruits Spanish-speaking residents of a low-income Hispanic community to train to become nurses in the Cleveland area.

Diversity among the institutional leadership is also important, since organizational structures and systems reflect the cultural and personal backgrounds of those who design them. Minority leaders are more likely to design health care delivery systems that best meet the needs of minority population. Practice hours would be designed around community work patterns, bureaucratic intake procedures would be simplified, and waiting times would be reduced to accommodate tight work and transportation schedules.

**Establishment or Enhancement of State Offices of Minority Health**

Thirty-five states have a designated entity to address minority health. Ohio established its Commission on Minority Health in 1987 as an autonomous state agency to promote health and prevent disease among members of minority groups (defined as “blacks, American Indians, Hispanics, and Orientals”) and to eliminate disparities in health status between majority and minority populations (Ohio Rev. Code Ann. 3701.78 (1987)). The commission is funded by a biennial appropriation of $3.5 million in general revenue funds.

The programming of the Ohio Commission on Minority Health is clearly geared toward promoting prevention, education, and behavioral change among minority populations. The commission funds “culturally appropriate” projects that reduce disease incidence or risk by changing fundamental attitudes, beliefs, and behaviors among these groups. The commission has published a number of resources—many of them multi-lingual—targeted to encouraging healthier lifestyle choices and behaviors among Ohio’s minorities. These include booklets on substance abuse and violence prevention, healthy cooking, and prenatal care.
Expanded Access to Services

Access to medical care by minorities can be improved through expanded insurance coverage. Whether this coverage should be provided through the public or private sector is a question of great debate. Both sectors face financial constraints in the wake of rising health care costs. The challenge is to develop innovative, budget-neutral ways of expanding insurance coverage.

One fairly inexpensive way to expand insurance coverage under Medicaid and SCHIP is to improve participation rates among those who are eligible by simplifying the enrollment process and developing outreach programs that educate poor minorities about how to enroll in and access services. In addition, many states, including Ohio, have not taken advantage of available federal matching funds under Medicaid and SCHIP to expand care for non-citizen immigrants. Also, states can increase access by encouraging the expansion of community health care centers, particularly in rural areas. Federal funding is available to establish qualified health centers in “medically underserved” areas or in areas with a majority of “medically underserved populations.”

Involvement of All Health System Stakeholders in Minority Health Improvement Efforts

In a 2000 speech, Dr. Marcia Brand, deputy director of the federal Office of Rural Health Policy, stated that Healthy People 2010 “called on the nation to move forward toward a balanced community health system; one that makes access to quality care available to all; that balances early detection of disease with health promotion and disease prevention; and that draws on the assets of the entire community including homes, schools, churches and other faith-based organizations and civic and local groups. Reducing disparities is more a matter of human cooperation than scientific inspiration.”

Dr. Brand’s message is reflected in the many creative ways that Ohio’s governmental agencies, nonprofit organizations, foundations, schools, businesses, health care workers, hospitals, and community-based organizations have found to increase access to and delivery of care in the state’s racial and ethnic communities. Following are some of these innovative programs:

- Through a program called Healthy Smiles—Bright Futures, Case Western Reserve Dental School in Cleveland has brought dental care to inner city elementary schools. The Healthy Smiles Program is sponsored by the Case School of Dental Medicine and the Saint Luke’s Foundation of Cleveland, with additional support from the Robert Wood Johnson Foundation Local Initiatives Program.

- La Clinica Latina, a free clinic established in Columbus to “educate Latinos on health care issues and provide free primary care in a bilingual and bicultural atmosphere,” provided 721 patient visits in 2001 and served 300 families.

- The Cleveland Clinic recently announced the establishment of the Minority Men’s Health Center in Cleveland to reduce health disparities among minority men, with particular focus on the early detection of prostate cancer and kidney disease. The center will offer free
prostate screenings and blood pressure checks. It will work with community groups and churches to advertise its services, and will accept all patients regardless of whether or not they are insured. Eligible patients who are not yet enrolled in Medicaid or other public health programs will be assisted with the process.118

• The Mt. Carmel Community Outreach Program provides door-to-door immunization services in communities housing refugees and immigrants. The center also runs the Mobile Medical Coach, a van that travels to shelters, rest homes, community centers, and neighborhoods offering medical care, patient education, and assistance from caseworkers, who help the underserved—many of whom are minorities—gain access to needed social and medical services.119

• The Ohio State University Care Connection supports a range of community services designed to increase access to care among minorities. The James Cancer Hospital’s Diversity Enhancement Program educates underserved communities about the signs and symptoms of cancer, and encourages participation in clinical trials to ensure these populations have access to the latest cancer treatments. The Taking Health to Heart program visits community centers and churches to educate minorities about the importance of keeping their blood pressure under control. In addition, the University Hospital sponsors an asthma education program at the Columbus Metropolitan Library.120

• CareNet, a program in Toledo, provides low-cost primary and hospital health care services for low-income, uninsured residents of Lucas County.121 Services are provided on a sliding-fee schedule, and the public transportation system provides free bus transportation to doctor appointments. Lucas County has one of the highest populations of Hispanics in the state at 4.5 percent.122

• Access Health Columbus is a community-wide collaboration among more than 150 individuals and organizations whose goal is to connect vulnerable people with free medical services. A network of primary and specialty care physicians, clinicians, labs and diagnostic centers, hospitals, and hearing, vision, dental, and surgical centers agreed to offer a percentage of their available services to patients at no cost. Access Health Columbus hopes to enroll 3,000 patients this year.123

• The Ohio Association of Free Clinics (Oafc) provides medical care to uninsured Ohioans, many of whom are minorities. In 2003, Oafc served over 34,000 individual patients at a total value of medical care equal to $22 million. On average, every dollar invested in free clinics brought in $3.50 worth of care to these patients.124

• The Center for Closing the Health Gap of Greater Cincinnati is dedicated to eliminating racial and ethnic health disparities in Greater Cincinnati through advocacy, education, and community outreach. Throughout the year, the center sponsors workshops, conferences, and health fairs to promote the awareness of health disparities.
Recent Federal Initiatives

As stated earlier, the national momentum and commitment to eliminating racial and ethnic health disparities is strong. The latest federal policy developments with respect to this issue come in the form of legislative proposals.

For example, Senate Majority Leader Bill Frist (R-TN) introduced a bill this past February called “Closing the Health Care Gap Act of 2004.” The bill calls for: 1) improved health care quality and data efforts; 2) expanded access to quality health care; 3) strong national leadership, cooperation, and coordination; 4) professional education, awareness, and training; and 5) enhanced research to identify sources of racial and ethnic health disparities and assess promising intervention strategies.\textsuperscript{125}

In addition, Senator Joseph Lieberman (D-CT) introduced FairCare, legislation that would increase Medicare payments to hospitals and increase federal grants to health centers that achieve measurable results in improving health care quality for minority patients. The quality standards would be developed and awarded by a nonprofit organization representing all stakeholders in the health care system.\textsuperscript{126}
Conclusion

Sorting through the underlying causes of racial and ethnic health disparities is difficult and sometimes controversial. What is clear, however, is that patients, providers, and systemic factors all play a role in the problem, and therefore must all play a role in its solution. Although this paper offers several broad-brush intervention strategies, more targeted measures are needed. Because we cannot understand that which we cannot measure, data collection and program evaluation are two critical keys to addressing health disparities in access to and delivery of care.

It is important to remember that improvement in two of the dimensions of the health disparities framework highlighted in this paper—access to health care and health care delivery—will not guarantee a healthier minority population. Socioeconomic conditions, environmental conditions, and personal behaviors play an important, and likely larger, role in determining health. Thus, while it is important to continue to identify sources of disparities in access and delivery and to evaluate strategies to address them, it is equally important to investigate interventions that would reduce the need for medical services in the first place. Programs aimed at improving the safety of housing, increasing community green space, reducing air and water pollution, and reducing alcohol and tobacco use will help to eliminate access and delivery disparities by reducing the need for services.
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For more information about health disparities and minority health issues in Ohio, please visit the website of the Ohio Commission on Minority Health at http://mih.ohio.gov.

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