

PLENARY SESSION I: INEQUALITIES IN HEALTH

BEYOND RHETORIC: WHAT WE NEED TO KNOW TO ELIMINATE DISPARITIES

Racial and ethnic disparities in health care are well documented and can be discussed in 3 broad categories: health system factors, patient-level factors, and patient/provider interaction. Clinicians and others working in health care and related fields are knowledgeable about disparities in health, but the general US population is not. Racial/ethnic disparities are most striking in life expectancy, infant mortality, and lack of health insurance. The inaugural edition of the National Healthcare Disparities Report, due out in 2003, will provide valuable insights into the state of health care in America, including a comprehensive view of disparities in health care. The Agency for Healthcare Research and Quality is conducting and supporting research, data collection, and other initiatives aimed at reducing racial/ethnic disparities in health care. The documented disparities in health care represent a critical opportunity for quality improvement that requires input from all sectors, including policymakers, providers, community leaders, and patients. (*Ethn Dis.* 2003; 13[suppl3]:S3-9-S3-11)

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INTRODUCTION

Unequal Treatment, an Institute of Medicine (IOM) report published in 2002, documents the pervasiveness, persistence, and elusiveness of racial and ethnic disparities in health care.¹ Disparities in health care persist even after adjustments are made for clinical settings, stage of disease presentation, comorbidities, age, and severity of disease. Disparities in clinical care and in the delivery of healthcare services are associated with higher mortality among minority and low-socioeconomic groups.

In discussing the sources of healthcare disparities, the IOM report identifies 3 broad categories: health system factors, patient-level factors, and factors related to provider/patient interaction. Health system factors include the way care is structured—how services are organized and how care is financed.¹ Patient-level factors—including patient preferences and adherence to treatment—also have an impact on disparities. Factors related to provider/patient interaction include communication and trust. Research suggests that the content and manner of communication may influence health care disparities.² Provider/patient communication and trust-related issues deserve much more attention from policymakers and clinicians than they have received in the past. Although there is an indisputable need for more research that clarifies effective communication strategies, existing evidence should stimulate awareness among patients and clinicians as a prerequisite to improvement.

AWARENESS AND PUBLIC PERCEPTIONS ABOUT DISPARITIES

Clinicians, people working in the health policy sector, and others who are involved in healthcare management and related fields are, for the most part, knowledgeable about disparities in health. A relatively recent development emphasized by the IOM report is the evidence that disparities in health care associated with race and ethnicity play an important role in disparities in health. However, the American public is not aware of these disparities. Infant mortality, for example, continues to be much higher among minority populations.³ About 14 of every 1,000 African-American infants born alive in 1997 died before the age of one. For White Americans, 6 of every 1,000 infants born alive that year died before age one. According to a survey conducted in 1999 by the Kaiser Family Foundation, 54% of White Americans and 58% of Black Americans were not aware of this disparity.³

The situation is similar for life expectancy. As of 1996, life expectancy for African Americans was on average 6.6 years less than for Whites. When asked about life expectancy, nearly 6 of 10 Whites and 5 of every 10 African Americans said they were not aware of this disparity.

There is also a lack of awareness about who does and does not have health insurance, which is so vital for access to care. Data from the Agency for Healthcare Research and Quality (AHRQ)-sponsored Medical Expenditure Panel Survey indicate that in 1998,

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20% of African Americans and 12 percent of Whites were uninsured.⁴ The number is even higher for Hispanics: 30% of Hispanics lacked health insurance in 1998. When asked about disparities in health insurance, 60% of Whites and 40% of Blacks believed that Blacks had similar or better rates of health insurance coverage than Whites.³ Similarly, nearly half of Latinos were unaware of the disparities in health insurance.

NATIONAL REPORT ON DISPARITIES IN HEALTHCARE

The National Healthcare Disparities Report (NHDR), an annual report mandated by the United States Congress, will provide to Congress, providers, other policymakers, and the general American public a comprehensive view of disparities in health care, rather than isolated snapshots.⁵ The NHDR will present facts and figures on prevailing disparities in healthcare delivery as they relate to race and socioeconomic factors in rural and priority populations. These priority populations include: low income groups; members of minority groups; women; children; the elderly; and individuals with special healthcare needs (for example, people with disabilities). Past research has shown that these groups are most affected by disparities in health and healthcare delivery.⁶ The inaugural report, along with a companion

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report on quality of care in the general US population, is due out later this year.

The NHDR will report on several dimensions of health care: access to care (eg, entry into the healthcare system, structural barriers to care such as inadequate transportation, and the ability of providers to effectively communicate with patients); utilization of services (eg, use of doctors' offices and hospitals, specialty care, mental health, and prescription medications); the cost of services (ie, the cost associated with use of services); and quality of care. The report will include nearly 300 measures. In reporting on the quality of care, this document will compare the racial/ethnic and socioeconomic differences in safety, timeliness, and patient centeredness of health care—all building blocks of a high quality health system.⁷ Racial and ethnic disparities in health care will be analyzed in ways that take into account the effects of socioeconomic status.⁸

According to the Institute of Medicine report that provided guidance to the development of the NHDR, future reports could be strengthened by addressing several gaps in research.⁸

MEASUREMENT FOR IMPROVEMENT

First, a research initiative is needed to develop accurate and meaningful measures of socioeconomic status as it

relates to healthcare access, service, and quality of care. We also need better data on healthcare delivery in rural and frontier areas. In addition, we lack data on the healthcare experiences of Hispanic Americans, Asian Americans, and American Indians/Alaska Natives. Most of the work done in the area of disparities has focused on Black/White differences in access to care, quality, and outcomes. Growing diversity in the US population suggests that more research is needed to document the experiences of other racial and ethnic groups, as well as different socioeconomic groups.

Elimination of disparities in health and health care will not be possible absent public and private-sector investments for the collection and analysis of race and ethnicity data. Finally, the authors of the guidance report also recommend that public and private organizations that sponsor the development of measures and the collection of data should work together to standardize data development and collection efforts.

The NHDR will provide valuable insights into the state of health care in America. However, this report will not address why and how disparities occur. A better understanding of what proportion of the observed disparities are amenable to change and strategies that will eliminate these disparities are also needed.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

AHRQ is an agency of the US Department of Health and Human Services. AHRQ is the lead federal agency charged with research to improve healthcare outcomes, access to care, quality, and patient safety, as well as research on the cost of care and ways to improve its cost-effectiveness. For more than 3 decades, AHRQ has conducted and supported research, data collection, and other activities aimed at reducing and ultimately eliminating racial/ethnic

disparities in health care. AHRQ encourages the inclusion of priority populations—including racial/ethnic minorities, women, disabled individuals, and others—in all research sponsored by the agency.

AHRQ's Racial and Ethnic Disparities Program

AHRQ's efforts address several of the aforementioned research needs. First, AHRQ's Excellence Centers for the Elimination of Racial and Ethnic Disparities (EXCEED) is a 5-year, \$45-million research program that studies the underlying etiologies of racial and ethnic healthcare disparities and tests interventions to eliminate these disparities.⁹

AHRQ and the Health Resources and Service Administration's (HRSA's) Bureau of Primary Health Care issued a joint funding announcement, *Changing Practices: Changing Lives*, to support assessments of the HRSA-sponsored Health Disparities Collaboratives, which were initiated in 1998.¹⁰ These Collaboratives represent a major sustained effort to enhance the quality of care provided through HRSA's community health centers and ultimately improve the outcomes of disadvantaged groups. There have been some compelling, albeit anecdotal, success stories about the Collaboratives, but this research effort should provide us with more definitive information about their activities and progress. Understanding which approaches are effective for specific contexts is essential to widespread implementation of improved practices.

The Agency's Practice-Based Research Networks program will enhance

our capacity to implement research interventions that are designed to eliminate disparities in primary care practice settings. In addition, AHRQ is supporting minority researchers and minority-serving institutions, as well as other researchers who are working in the areas of minority health and disparities through its Minority Research Infrastructure and Support Program.

Finally, the Agency has increased its efforts in community-based participatory research, an approach to research that promises to increase the relevance of research and the uptake of findings by increasing the active participation of communities and other stakeholders.

TAKING ACTION TO ELIMINATE DISPARITIES

Eliminating healthcare disparities related to race and ethnicity is a national priority.¹¹ The knowledge, tools, and interventions developed by AHRQ and others are essential, but they are not the total solution for the elimination of disparities.

The action needed to solve health disparities will come from clinics, and offices, and community centers, as well as neighborhoods. Patients, community leaders, providers, health system leaders, and policymakers may individually and collectively serve as change agents for the elimination of disparities.

The documented disparities in health care represent a critical opportunity for quality improvement. Identifying, analyzing, acting on, and monitoring disparities are all elements of our national strategy to eliminate disparities in

health care. Overcoming racial and ethnic disparities in health care is much too important not to get these elements right.

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