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Addressing Disparities in Health and Health Care: Issues for Reform

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House of Representatives
Committee on Ways and Means
Health Subcommittee

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Mr. Chairman and Members of the Subcommittee on Health, thank you for the opportunity to testify on the issue of racial disparities in health and health care. I am Marsha Lillie-Blanton, Senior Advisor on Race, Ethnicity, and Health Care at the Kaiser Family Foundation, and also an Associate Research Professor in the George Washington University School of Public Health and Health Services.

Today, 1 in 3 Americans self-identify as either Hispanic/Latino, African American/Black, American Indian/Alaska Native, Asian American, or Native Hawaiian or Pacific Islander. By 2050, half of the U.S. population will be a person of color (*Figure 1*). This demographic shift in the population suggests that there are economic as well as health consequences of our failure to eliminate longstanding disparities in health status and in access to health care.

In the past half century, the United States has made remarkable progress in improving the health of all Americans, including Americans of color. We also have seen tremendous gains in access to medical care since the mid-1960s. Medicaid and Medicare, along with the enforcement of the 1964 Civil Rights Act, deserve much of the credit for improved access among low-income families, the elderly, and the disabled. Yet disparities in the health of the U.S. population persist and our health system inadequately cares for some and excludes millions of others.

My testimony today focuses on the role of health insurance in reducing disparities in health care and in health status, two distinct but related challenges. Disparities in health care – whether in insurance coverage, access, or quality of care – are one of many factors producing inequalities in health status in the U.S. Eliminating disparities in health among segments of the population (e.g., by race/ethnicity, education, income, gender, geographic location) was one of two overarching goals of Healthy People 2010, the federal government's blueprint for what it wanted to achieve in health by the end of this decade.

Let me begin with several examples of the urgency of these goals with two examples reflecting longstanding disparities, and one reflecting a more recent occurrence of a pattern of excess burden of disease that is unacceptable in a nation with the economic resources and technological know-how of the U.S. (*Figures 2-4*).

- A baby born to a Native American woman with a high school degree is almost twice as likely to die during the first year of life as a baby born to a Hispanic woman with the same years of education (9.2 vs. 5.3 per 1000 live births)
- A Black man earning less than $10,000 has a life expectancy at age 25 that is 3 years less than a White man earning the same income; and
- The rate of new AIDS cases among adults/adolescents is 3 times higher among Hispanics (26 per 100,000) than the rate among Whites (7 per 100,000).

Although the causes of health disparities are complex and result from multiple interrelated factors (some individual and some societal), differentials in *access* to care and in the *quality* of care contribute to these health disparities. Access to quality care matters. The extent to which medical care contributes to health outcomes may be relatively small when overall population mortality is the measure of health outcome (McGinnis et al 2002); however, the effects of medical care can be immeasurable for individuals with specific health problems such as asthma or heart disease or who need the guidance of the health system to help change personal behaviors. Nonetheless, efforts to address health care disparities are important for reasons far beyond their impact on health outcomes.

Why Addressing Health Care Disparities is Important

The racial divides in the United States – whether in education, employment or health care – reflect the Achilles heel of this nation. Healing the wounds that separate this nation is important if we are to move forward as one nation. The U.S. was founded on ideals of equality of opportunity and continuing efforts to realize those goals are warranted throughout all sectors of society. In the health system, assuring that individuals with similar health care needs are similarly treated is a basic matter of fairness.

The landmark IOM report, *Unequal Treatment,* provided compelling evidence that racial disparities in care persist. However, national surveys continue to show that a sizable share of the population is unaware that all Americans don't receive the same access to medical care (*Figure 5*). Some of the disbelief is rooted in concerns about the quality of

the evidence on racial disparities (i.e., whether the problem is real or largely explained by socio-economic differences in the population).

About five years ago, the Foundation working in partnership with a number of physician groups launched a campaign "Why The Difference" in an effort to increase awareness of health care disparities and ultimately encourage efforts to address them. We learned that the disbelief about whether a problem exists also extended to physicians. As such, a major component of the initiative was a thorough review of studies on racial differences in the care of patients with heart disease. We drilled down to the best studies designed to control for differences in heart disease severity, as well as socioeconomic status. The review, undertaken with the American College of Cardiology Foundation and Association of Black Cardiologists, provided credible evidence of lower rates of diagnostic and revascularization procedures for at least one of the minority groups under study in eight out of ten studies. This finding held true whether reviewing all studies meeting criteria for the review, the subset of studies defined as the most methodologically rigorous or that analyzed only clinical data (*Figure 6*). A number of efforts are now underway to improve the quality of cardiac care and reduce disparities in care, including one funded by the Robert Wood Johnson Foundation that is showing evidence of success.

The Role of Insurance in Racial Disparities in Care

Health insurance coverage provides the financial means to access care in the U.S. Whether or not one has health insurance or adequate insurance for their medical needs is linked to a number of factors including age, employment, state of residence, and even race/ethnicity.

Of the 47 million nonelderly Americans uninsured in 2006, approximately half -- 24 million -- are people of color (*Figure 7*). While younger adults are more likely than older adults to be uninsured, older adults, especially the near-elderly (adults age 55-64) are a particularly vulnerable group because health problems increase with age. A racial disparity in coverage also exists among Americans ages 55-64. For example, in 2006, 23 percent of American Indian/Alaska Natives and 19 percent of African Americans ages 55-64 were uninsured, as compared with 10 percent of Whites in that age group (*Figure 8*).

This disparity has consequences for Medicare costs since many of the uninsured in this age group will have unmet needs for medical care upon entering Medicare at age 65.

Insurance matters for adults of all ages. Uninsured adults across racial/ethnic groups are at least twice at likely as the insured to go without a doctor visit in the past year (*Figure 9*). Among Hispanic adults, for example, 21 percent of the insured had no doctor visit in the past year as compared with 53 percent of the uninsured. Numerous studies show that the consequences of being uninsured can be serious. When compared with the insured, the uninsured are less likely to have a regular doctor, and are more likely to be hospitalized for preventable conditions.

Medicare provides insurance coverage for virtually all persons ages 65 and older and for 7 million younger adults with permanent disabilities who qualify for Social Security. However, racial/ethnic differences in supplemental coverage among Medicare beneficiaries also can affect differentials in care. An estimated 18 percent of African Americans compared to 11 percent of Latinos and 11 percent of White Medicare beneficiaries lack supplemental coverage to fill in the gaps and pay for services not covered by Medicare (*Figure 10*). In addition, because Medicare beneficiaries of color are disproportionately low-income, they are more likely than Whites to have supplemental coverage from Medicaid and thus are greatly affected by federal-state Medicaid policies that influence access to care. Without insurance or adequate insurance coverage, access to medical care suffers and can ultimately compromise one's health.

In a review of multiple studies on the contribution of health insurance to racial disparities in care, health insurance was found to be the single largest factor explaining racial disparities in whether an individual had a regular source of medical care (Lillie-Blanton & Hoffman 2005). For example, one study in that review found that health insurance explained approximately 42 percent of the access disparity between African Americans and Whites, and about 20 percent of the access disparity between Hispanics and Whites in having a regular source of medical care (*Figure 11*), a well recognized measure of one's ability to obtain access to timely and quality care.

Disparities in Care Among the Insured

Although the uninsured are clearly the most vulnerable for getting less than adequate care, disparities in access and in quality of care exist even among the insured. Evidence of racial/ethnic disparities in care among individuals who are similarly insured is particularly disturbing.

The National Academy of Social Insurance recently completed a study panel on Medicare and racial disparities (NASI 2006). After a review of the research, the panel concluded that racial disparities exist not only among the privately insured but also among Medicare beneficiaries in fee-for-service and managed care. One study cited in the report analyzed Healthcare Effectiveness Data Information Set (HEDIS) measures for elderly White and Black beneficiaries enrolled in Medicare managed care plans between 1997 to 2003 (Trivedi et al 2005). The study found that the White-Black gap narrowed for seven of nine HEDIS measures but was not eliminated in any category, and it widened for two measures: glucose control among patients with diabetes and cholesterol control among patients with heart conditions. Another study of Medicare patients with breast, colorectal, lung, and prostate cancers shows that disparities persist in treatment of these conditions as well (Gross et al 2008).

Evidence from the Medicare program also provides a positive example of how expansion in insurance coverage can diminish health care disparities (Daumit and Powe 2001). A nationwide study found that the racial disparity in cardiac procedure use among patients with chronic renal disease – a group at high risk for heart disease – was sharply reduced after patients qualified for Medicare (*Figure 12*). African American men and women were a third as likely as White men (the study reference group) to receive catheterization, angioplasty, and bypass surgery before enrolling in Medicare. After enrolling in Medicare and entering into a comprehensive system of care, there was no difference in cardiac procedure use between African American women and White men. For African American men, however, the disparity persisted. In other words, insurance coverage reduced the disparity for both population groups, and eliminated it for one population group.

Tools for Tracking Changes in Healthcare Disparities

One of the most important tools for tracking disparities in access and quality of care is the annual National Health Care Disparities Report (NHDR), which examines differences in patterns of care across different segments of the population. The 2007 NHDR shows that disparities between racial/ethnic groups continue to exist for a number of conditions and services and that progress in reducing disparities has been modest at best. The NHDR found that there was either no change or worsening of disparities in quality on more than half (57% - 69%) of the 16 indicators tracked over time for the four racial/ethnic groups of color compared to Whites (*Figure 13*).

It is important to note, however, that of the 42 quality indicators included in the 2007 NHDR, data on only 16 indicators were available to track over time for all racial/ethnic and income groups. Increasing our knowledge on health care disparities and effective interventions will require routinely collecting, analyzing, and reporting on data on health care use across population demographic characteristics such race/ethnicity, income and education. These efforts are needed to benchmark and track our health care system's performance in serving all Americans, regardless of their background characteristics or where they live.

Race and Coverage Matter, but so do Other Factors

Race and ethnicity clearly matter in our health system, but so do many other factors – such as the geographic availability of health services or the language capability of the provider. We live in a society that remains highly residentially segregated by race/ ethnicity and by income. People of color tend to live in close proximity to each other and people of limited financial means and those of great wealth tend to live in the same neighborhoods. As a result, education, employment, and health care opportunities tend to cluster along those divides. This reality complicates our ability to neatly define the causes of the problems or their solutions.

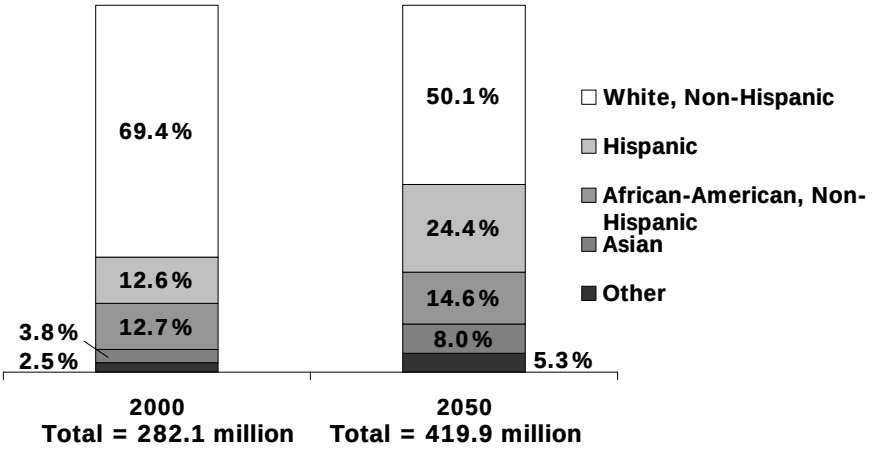
The wealth of evidence, however, that insurance makes a difference in opening the door to the health system suggests that reducing the number of uninsured would be one effective first step in reducing racial/ethnic disparities in care. African Americans,

Latinos, Native Americans, and some Asian and Pacific Islander Americans are disproportionately uninsured, and thus will face greater financial burden in obtaining access to care. Racial disparities among persons who are insured, however, are an indication that expansions in coverage, though necessary, are not sufficient. Efforts are needed to increase the knowledge base of what works and then apply that knowledge to help close the gap. Finally, collecting data to better track performance measures on our health system is important to monitor our progress in reducing disparities in care.

I appreciate the opportunity to testify before the Committee today and welcome your questions. Thank you.

Figure 1

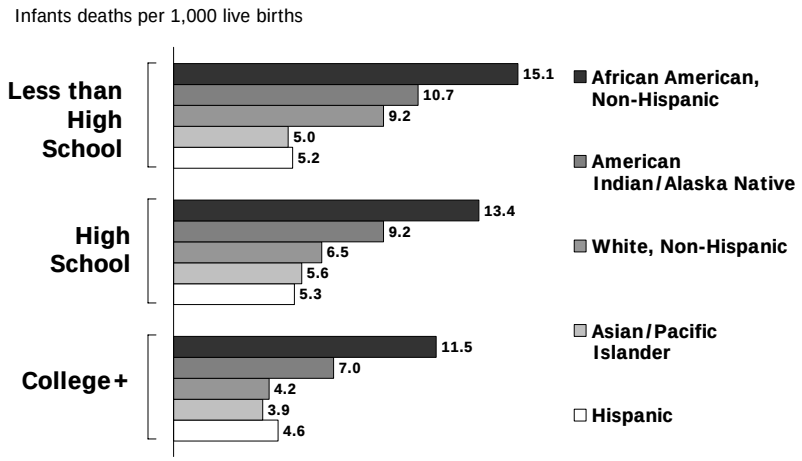
Distribution of U.S. Population by Race/Ethnicity, 2000 and 2050



NOTES: Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marina Islands. "Other" category includes American Indian/Alaska Native, Native Hawaiian or Other Pacific Islander, and individuals reporting "Two or more races." African-American, Asian, and Other categories jointly double-count 1% (2000) and 2% (2050) of the population that is of these races and Hispanic; thus, totals may not add to 100%.
SOURCE: Kaiser Family Foundation, based on http://www.census.gov/population/www/projections/popproj.html, U.S. Census Bureau, 2004, US Interim Projections by Age, Sex, Race, and Hispanic Origin.

Figure 2

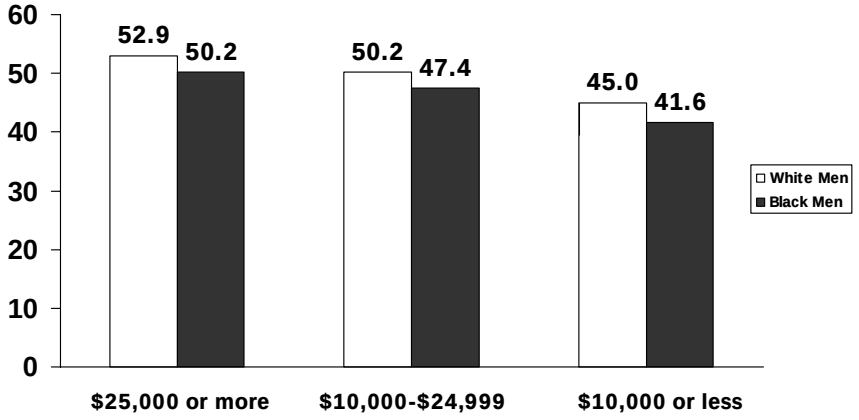
Infant Mortality Rates for Mothers Age 20+, by Race/Ethnicity and Education, 2001-2003



SOURCE: Kaiser Family Foundation, based on Health, United States, 2006, Table 20, using data from the National Center for Health Statistics, National Vital Statistics System, National Linked Birth/Infant Death Data.

Figure 3

Life Expectancy at Age 25 for U.S. Black and White Men with Similar Income Levels*

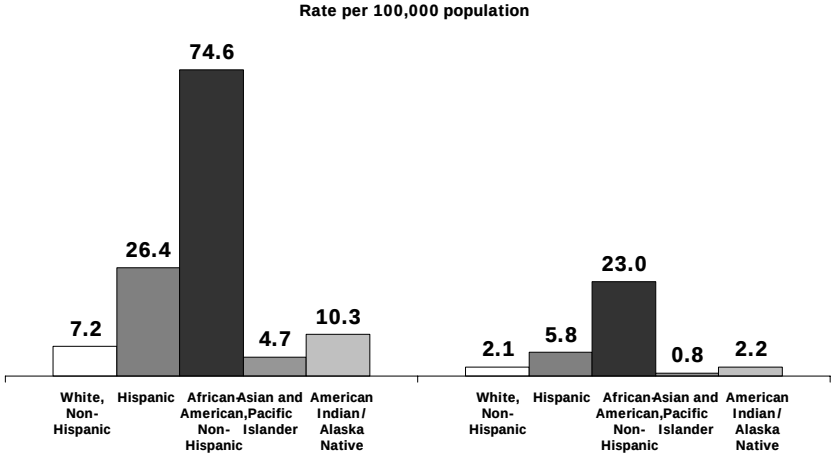


* 1980s income levels

SOURCE: NLMS: Lin et al 2003 and Nancy E. Adler, Health Disparities: Measurement, Mechanisms, and Meaning presentation, NIH

Figure 4

New AIDS Cases and HIV-Infection Deaths by Race/Ethnicity

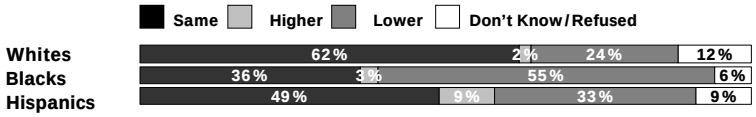


SOURCE: Kaiser Family Foundation, based on the National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html, using data from the Centers for Disease Control and Prevention, HIV/AIDS Surveillance System and National Vital Statistics System.

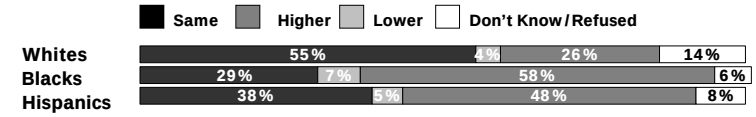
Figure 5

Perceptions of Disparities in Health Care

When going to a doctor or health clinic for health care services, do you think most African Americans receive the same quality of health care as whites, higher quality of care or lower quality of health care as most whites?



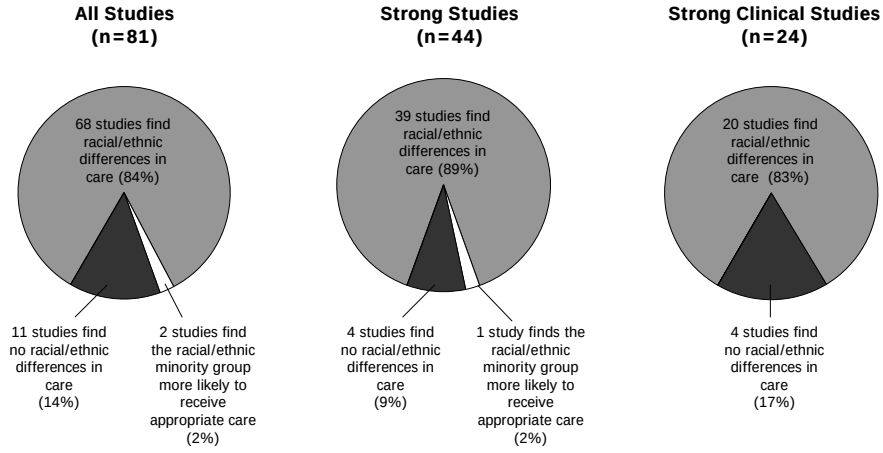
When going to a doctor or health clinic for health care services, do you think most Latinos receive the same quality of health care as whites, higher quality of care or lower quality of health care as most whites?



SOURCE: Kaiser Family Foundation, *March/April 2006 Kaiser Health Poll Report Survey*, April 2006 (Conducted April 2006)

Figure 6

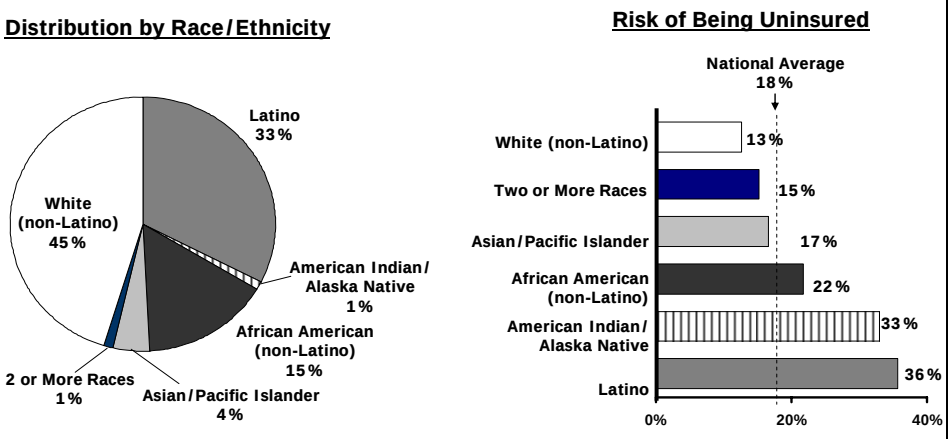
Evidence of Racial/Ethnic Differences in Cardiac Care, 1984-2001



Source: Kaiser Family Foundation/American College of Cardiology Foundation, Racial/Ethnic Differences in Cardiac Care:The Weight of the Evidence, 2002.

Figure 7

Nonelderly Uninsured by Race/Ethnicity, 2006

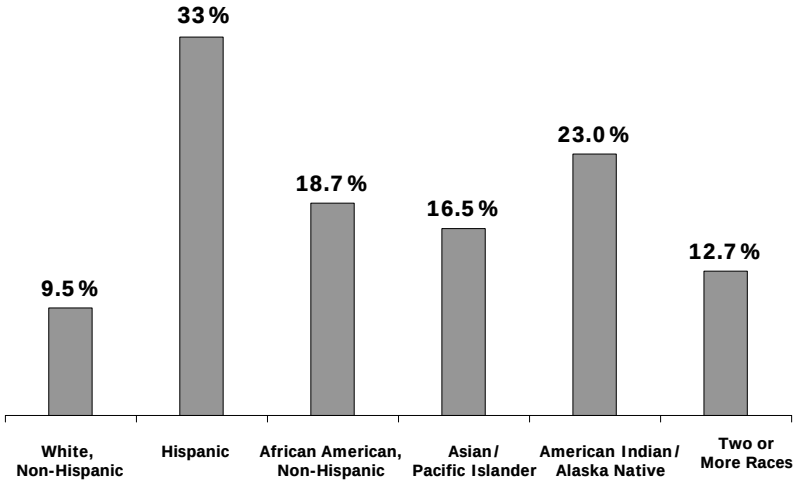


Total = 46.5 Million Uninsured

NOTE: American Indian group includes Aleutian Eskimos.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of the March 2007 Current Population Survey.

Figure 8

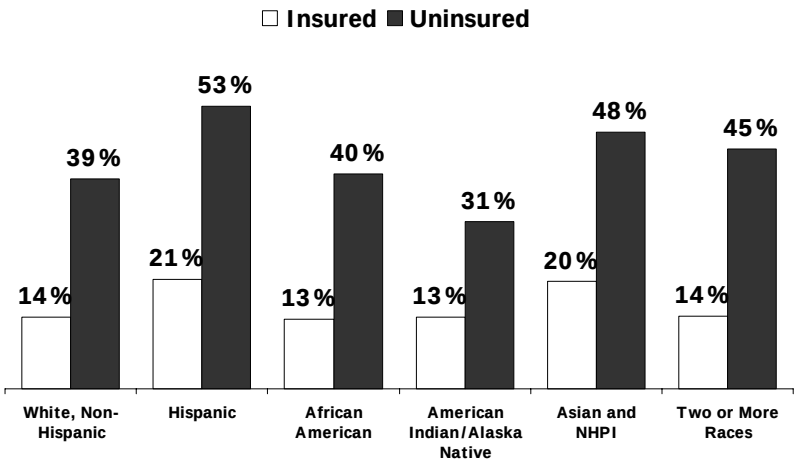
Percent Uninsured, Ages 55-64, by Race/Ethnicity, 2006



DATA: March 2007 Current Population Survey
SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates.

Figure 9

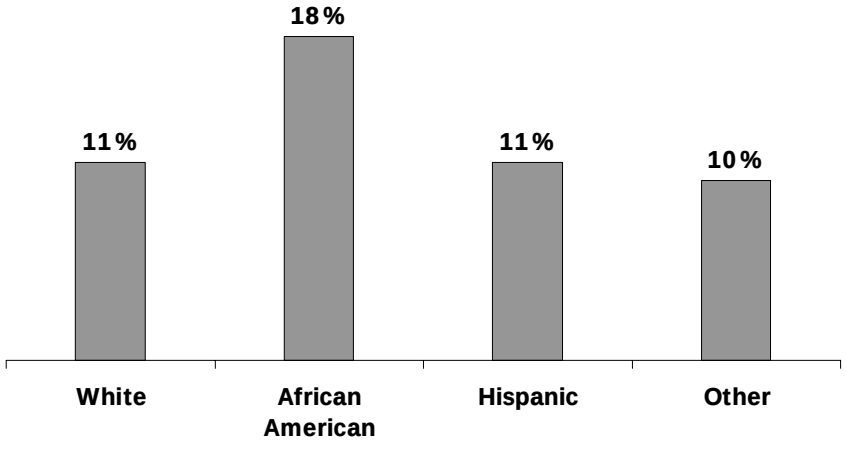
No Doctor Visit in Past Year for Nonelderly Adults by Race/Ethnicity and Insurance Status, 2005-2006



SOURCE: Kaiser Family Foundation and Urban Institute analysis of the National Health Interview Survey, 2005 and 2006, two-year pooled data.

Figure 10

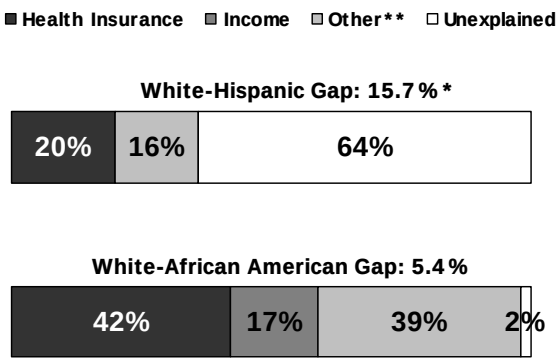
Percentage of People on Medicare with No Supplemental Coverage, by Race/Ethnicity, 2006



SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2006 Access to Care File.

Figure 11

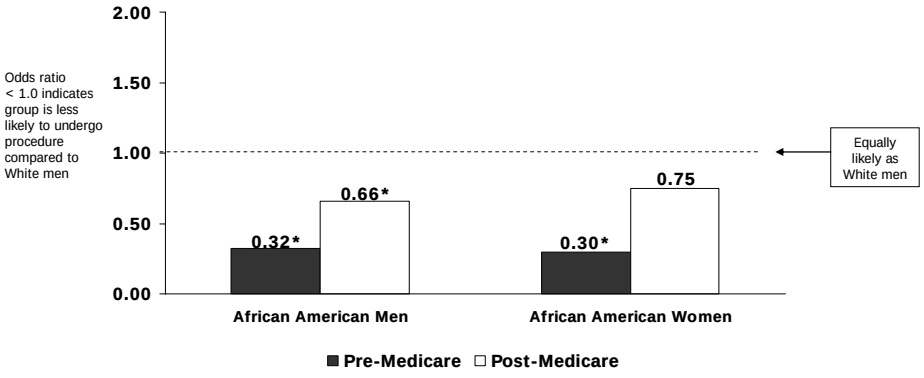
Role of Health Insurance in Explaining Racial/Ethnic Gap in Having a Regular Source of Care



*Researchers did not separate income from other personal socio-economic factors
**Other refers to local area demographics and health care system factors
SOURCE: Zuvekas & Taliaferro, 2003, analyzing 1998 MEPS data

Figure 12

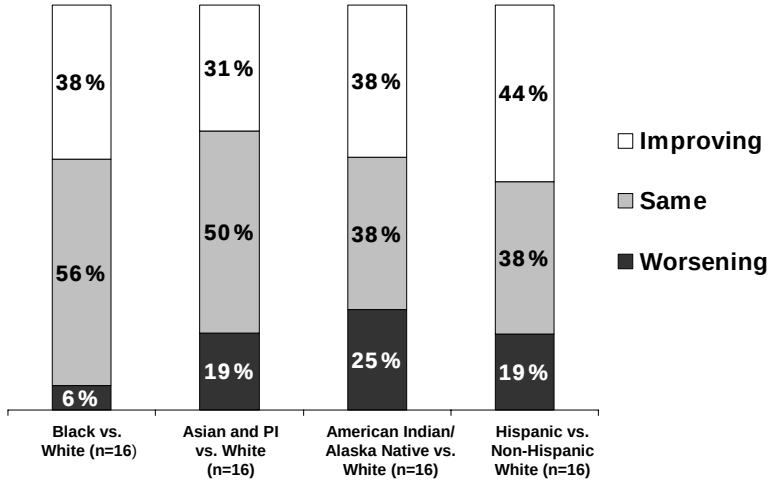
Disparities in Cardiac Care for Chronic Renal Disease Patients by Race and Gender, 1986-1992



*Difference is statistically significant after adjustment
Note: Odds ratios are adjusted for age, sex, insurance, socioeconomic status, health status, and disease severity.
SOURCE: Daumit and Powe, *Seminars in Nephrology*, Vol. 21, No. 4 (July), 2001.

Figure 13

Changes in Quality of Care Disparities Over Time: Summary by Race/Ethnicity



NOTES: "Improving" means disparity is becoming smaller over time; "worsening" means disparity becoming larger over time. Data presented here are a subset of the core measures set that has data for all groups; "n" refers to the number of measures on which the groups were compared. Totals may not add to 100% due to rounding. Data presented are the most recent data available.
SOURCE: Kaiser Family Foundation, based on AHRQ, National Healthcare Disparities Report, 2007, available at http://www.ahrq.gov/qual/qrdr07.htm.

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