FOCUS ON HEALTH CARE DISPARITIES

THE HENRY J. KAISER FAMILY FOUNDATION

KEY FACTS

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Disparities in Health and Health Care: Five Key Questions and Answers

EXECUTIVE SUMMARY

1. What are Health and Health Care Disparities?

Health and health care disparities refer to differences in health and health care between population groups. "Health disparity," generally refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group. A "health care disparity" typically refers to differences between groups in health coverage, access to care, and quality of care. While disparities are commonly viewed through the lens of race and ethnicity, they occur across many dimensions, including socioeconomic status, age, location, gender, disability status, and sexual orientation.

2. Why do Health and Health Care Disparities Matter?

Disparities in health and health care limit continued improvement in overall quality of care and population health and result in unnecessary costs. Recent analysis estimates that 30% of direct medical costs for Blacks, Hispanics, and Asian Americans are excess costs due to health inequities and that the economy loses an estimated $309 billion per year due to the direct and indirect costs of disparities. As the population becomes more diverse, with people of color projected to account for over half of the population by 2050, it is increasingly important to address health disparities.

3. What is the Status of Health and Health Care Disparities Today?

Today, a number of groups are at disproportionate risk of being uninsured, lacking access to care, and experiencing worse health outcomes, including people of color and low-income individuals. Hispanics, Blacks, and American Indians/Alaska Natives as well as low-income individuals all are much more likely to be uninsured relative to Whites and those with higher incomes. Low-income individuals and people of color also face increased barriers to accessing care, receive poorer quality care, and ultimately experience worse health outcomes.

4. What Key Initiatives are in Place to Address Disparities?

Recognizing the continuing problem of disparities, in 2010, the Department of Health and Human Services (HHS) developed an action plan for reducing racial and ethnic health disparities. The HHS Disparities Action Plan establishes a vision of, "a nation free of disparities in health and health care," and sets out a series of priorities, strategies, actions, and goals to achieve this vision. The action plan builds on existing HHS initiatives, such as the Healthy People initiative. States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities.

5. How Does the Affordable Care Act Impact Health and Health Care Disparities?

The Affordable Care Act (ACA) advances efforts to reduce disparities and to improve health and health care for vulnerable populations. The ACA health coverage expansions will significantly increase coverage options for low- and moderate-income populations and particularly benefit vulnerable populations. The ACA also includes provisions to strengthen the safety-net delivery system, improve access to providers, promote greater workforce diversity and increase cultural competence, strengthen data collection and research efforts, and implement an array of prevention and public health initiatives.

INTRODUCTION

Disparities in health and health care in the United States have been a longstanding challenge resulting in some groups receiving less and lower quality health care than others and experiencing poorer health outcomes. This brief provides an introductory overview of health and health care disparities, including what disparities are and why they matter, the status of disparities today, and key efforts to address disparities, including provisions in the Affordable Care Act (ACA).

1. WHAT ARE HEALTH AND HEALTH CARE DISPARITIES?

Health and health care disparities refer to differences in health and health care between populations. Disparities in "health" and "health care" are related concepts, but they are not one and the same. A "health disparity" refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group.[1] A "health care disparity" typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care. More specifically, health and health care disparities often refer to differences that cannot be explained by variations in health care needs, patient preferences, or treatment recommendations. Several related terms, such as health inequality and health inequity also are often used interchangeably[2] to describe differences that are socially-determined and/or deemed to be unnecessary, avoidable, or unjust.[3]

Health Disparity vs. Health Care Disparity

Health disparity: A higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group.

Health care disparity: Differences between groups in health insurance coverage, access to and use of care, and quality of care.

A complex and interrelated set of individual, provider, health system, societal, and environmental factors contribute to disparities in health and health care. Individual factors include a variety of health behaviors from maintaining a healthy weight to following medical advice. Provider factors encompass issues such as provider bias and cultural and linguistic barriers to patient-provider communication. How health care is organized, financed, and delivered also shapes disparities as do social and environmental factors, such as poverty, education, proximity to care, and neighborhood safety.

While health and health care disparities are commonly viewed through the lens of race and ethnicity, they occur across a broad range of dimensions. The populations most vulnerable to health and health care disparities are often referred to as priority or vulnerable populations.[4,5] Vulnerable populations include groups that are not well integrated into the health care system across a variety of characteristics, including race, ethnicity, socioeconomic status, age, geographic location, language, gender, disability status, citizenship status, and sexual identity and orientation. These groups are not mutually exclusive and often interact in important ways. Disparities also occur within subgroups of populations. For example, among Hispanics, there are differences in health and health care based on length of time in the country, primary language, and immigration status.[6,7]

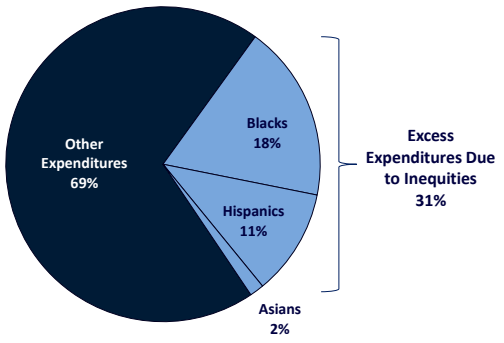
Health and health care disparities in the United States are a long-standing and persistent issue. Disparities have been documented for many decades and, despite overall improvements in population health over time, many disparities have persisted and, in some cases, widened.[8] Moreover, the recent economic downturn has likely contributed to a further widening of disparities.[9] Research also suggests that disparities occur across the life course, from birth, through mid-life, and among older adults. [10, 11]

2. Why do Health and Health Care Disparities Matter?

Disparities in health and health care limit continued improvement in overall quality of care and population health and result in unnecessary costs. Addressing disparities in health and health care is not only important from a social justice standpoint, but also for improving the health of all Americans by achieving improvements in overall quality of care and population health. Moreover, health disparities are costly, resulting in added health care costs, lost work productivity, and premature death. Recent analysis estimates that 30% of direct medical costs for Blacks, Hispanics, and Asian Americans are excess costs due to health inequities (Figure 1) and that, overall, the economy loses an estimated $309 billion per year due to the direct and indirect costs of disparities.[12]

Figure 1

Excess Medical Expenditures Due to Health Inequities



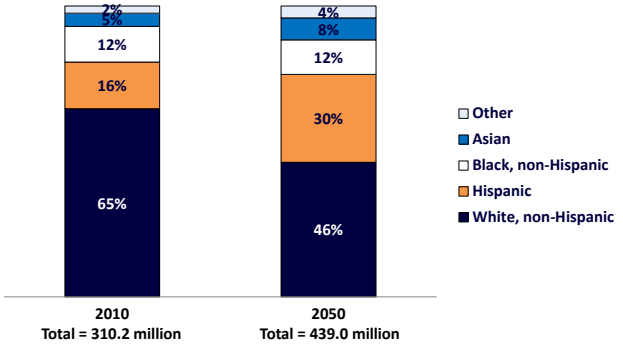
Total Expenditures 2003-2006 = $749 Billion

SOURCE: LaVeist, T., Gaskin, D., and P. Richard, "The Economic Burden of Health Inequalities in the United States," Joint Center for Political and Economic Studies, September 2009,

As the population becomes more diverse, it is increasingly important to address health disparities. Over time the population is becoming increasingly heterogeneous. It is projected that people of color will account for over half of the population by 2050, with the largest growth occurring among Hispanics (Figure 2). Moreover, the gaps between the richest households and poor and middle income households are wide and growing in most states, with the richest 5% of households having an average income of $272,500, 13 times the average income of $20,500 for the bottom 20% of households (Figure 3).[13] Given that people of color make up a disproportionate share of the low-income[14] and the uninsured[15] relative to their size in the population, the growth of communities of color and widening of income gaps amplify the importance of addressing health and health care disparities.

Figure 2

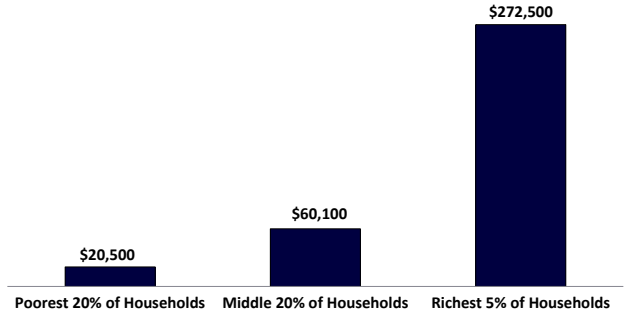
Distribution of U.S. Population by Race/Ethnicity, 2010 and 2050



NOTES: All racial groups non-Hispanic. Other includes Native Hawaiians and Pacific Islanders, Native Americans/Alaska Natives, and individuals with two or more races. Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marina Islands.
SOURCE: U.S. Census Bureau, 2008, Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: July 1, 2000 to July 1, 2050. http://www.census.gov/population/www/projections/downloadablefiles.html.

Figure 3

Gaps Between Average Income of the Richest and Poorest Households in the United States



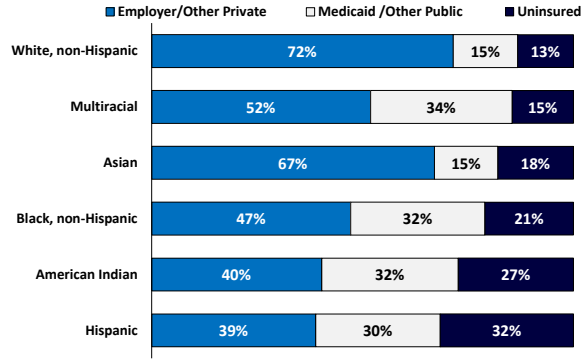
SOURCE: Economic Policy Institute/Center on Budget and Policy Priorities analysis of U.S. Census Bureau Data. Income is post-federal tax and includes the value of the EITC, food stamps, and housing subsidies. Income is adjusted for inflation (to 2009 dollars) and for household size. Pulling Apart, A State-by-State Analysis of Income Trends, November 15, 2012, http://www.cbpp.org/cms/index.cfm?fa=view&id=3860.

3. What is the Status of Health and Health Care Disparities Today?

Today, a number of groups are at disproportionate risk of being uninsured, including people of color and low-income individuals. As seen in Figures 4 and 5, people of color and low-income individuals are more likely to be uninsured relative to Whites and those with higher incomes. Moreover, nonelderly adults have a higher risk of being uninsured compared to children (21% vs. 10%). Where an individual lives also impacts his or her likelihood of having coverage, as uninsured rates vary widely across states, from 4% in Massachusetts to 24% in Texas.[16]

Figure 4

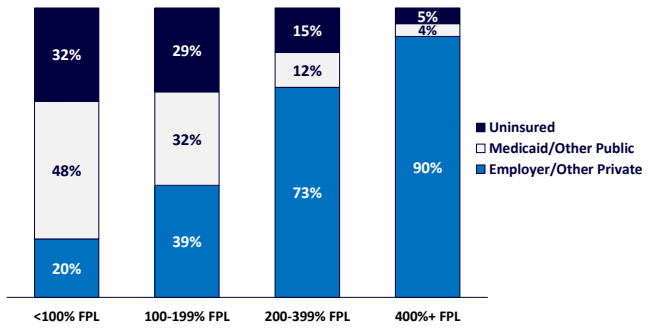
Insurance Coverage of Nonelderly by Race/Ethnicity, 2011



NOTES: Asian group includes Pacific Islanders. American Indian group includes Aleutian Eskimos. Data may not total 100% due to rounding.
SOURCE: KCMU/ Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Figure 5

Insurance Coverage of Nonelderly by Income, 2011



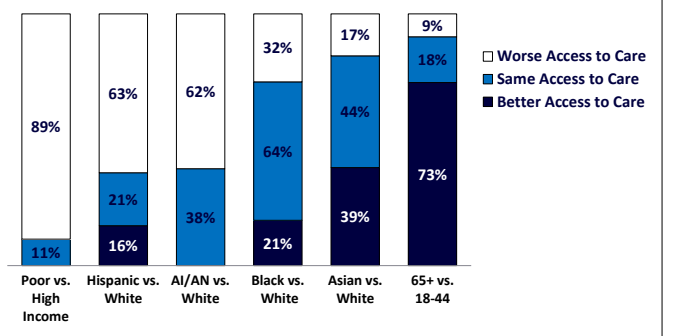
NOTES: FPL -- The federal poverty level was $22,350 for a family of four in 2011. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Vulnerable populations face increased barriers to accessing care and receive poorer quality care when they get it. In its 2011 reports on health care quality and disparities, the Agency for Healthcare Research and Quality (AHRQ) finds that low-income individuals and people of color experience more barriers to care (Figure 7) and receive poorer quality care. Moreover, other research shows that individuals with limited English proficiency are less likely than those who are English proficient to seek care even when insured.[17] Research also finds differing patient experiences and levels of satisfaction by race, gender, education levels, and language.[18,19,20]

Figure 6

Disparities in Access to Care for Selected Groups

Percent of access measures for which groups experienced worse, same, or better access to care:



NOTES: AI/AN = American Indian or Alaska Native.
SOURCE: AHRQ, "National Healthcare Disparities Report, 2011, http://www.ahrq.gov/qual/qrdr11.htm

Vulnerable populations have higher rates of health conditions and experience worse health outcomes. People of color frequently report higher prevalence of health conditions, such as diabetes and obesity. One of the most striking disparities is the disproportionate burden of AIDS cases among Black men. In 2004, the rate of new AIDS cases for Black men was 104.1 per 100,000, compared to 13.7 for White men, and 8.0 for Asian men.[21] Low-income people of all races report worse health status than higher income people and differences by race and ethnicity persist even within income groups.[22] Disparities also occur in life expectancy and mortality. While the average life expectancy has increased since 1970, these gains have not been evenly distributed. Infant mortality rates are significantly higher for Black and American Indian and Alaska Native babies compared to other groups. Black males of all ages have the shortest life expectancy compared to all other groups.[23]

4. What Key Initiatives are in Place to Eliminate Disparities?

Significant recognition of health and health care disparities began about a decade ago with several landmark reports and the first major legislation focused on reduction of disparities. Health and health care disparities first gained significant federal recognition with the release of two Surgeon General's reports in 2000 that showed disparities in tobacco use and access to mental health services by race and ethnicity. These reports were followed with the first major legislation focused on reduction of disparities, the Minority Health and Health Disparities Research and Education Act of 2000, which created the National Center for Minority Health and Health Disparities and authorized AHRQ to regularly measure progress on reduction of disparities. Soon after, the Institute of Medicine released two seminal reports documenting racial and ethnic disparities in access to and quality of care. Over the last decade, awareness of disparities has increased at all levels of government and among the general public, although substantial gaps in awareness remain, particularly among the public.[24,25,26]

In 2010, the Department of Health and Human Services (HHS) developed an action plan for eliminating racial and ethnic health disparities. The HHS Disparities Action Plan establishes a vision of, "a nation free of disparities in health and health care," and sets out a series of priorities, strategies, actions, and goals to achieve this vision.[27] The action plan builds on existing HHS initiatives, such as the Healthy People initiative, which includes, "to achieve health equity, eliminate disparities, and improve the health of all groups" as part of its 2020 health goals for the nation. Moreover, HHS identifies several key initiatives and programs that present opportunities to reduce disparities, including the Community Putting Prevention to Work program, which provides funding for community-based interventions that affect social determinants of health, and the establishment of national standards for Culturally and Linguistically Appropriate Services (CLAS), which seek to ensure that all people receive care in a culturally and linguistically appropriate manner.

States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities. For example, through Racial and Ethnic Approaches to Community Health (REACH) grants funded by the Centers for Disease Control, a number of states, local health departments, universities and non-profit groups have implemented community-focused interventions to reduce specific neighborhood-based disparities. [28] These interventions are varied in scope and focus on outreach, cultural competency training, and education.[29] A number of private foundations have also developed significant initiatives aimed at reducing disparities and providers are increasingly undertaking disparities-focused efforts.[30]

While the impact of interventions to reduce disparities is difficult to measure, some best practices have emerged. As much remains to be learned about the most effective interventions to reduce disparities, many current initiatives aim to develop and share a more robust set of best practices. To date, the most effective efforts address multiple determinants of health. Moreover, there is increasing recognition that eliminating health and health care disparities will require sustained efforts from both within and beyond the health care system given the broad range of social and environmental factors that contribute to them.

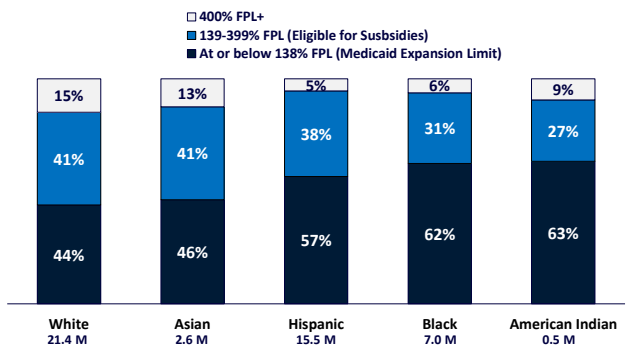
5. How Does the Affordable Care Act Impact Health and Health Care Disparities?

The Affordable Care Act (ACA) advances efforts to reduce health and health care disparities and to improve health and health care for vulnerable populations.[31] These provisions affect multiple dimensions of health and health care, including health coverage, access to care, delivery system reforms, provider supply and capacity, and public health and prevention efforts. Some of the provisions explicitly focus on disparities, whereas others have broader goals with important benefits for vulnerable populations. In addition, the ACA increases federal priorities to address disparities by elevating the National Center for Minority Health and Health Care Disparities to an institute within the National Institutes of Health and creating Offices of Minority Health within key HHS agencies to coordinate disparity reduction efforts.

Health coverage expansions that will significantly increase coverage options for low- and moderate-income populations and reduce the number of uninsured are a major component of the ACA. The ACA establishes a new continuum of coverage options that includes an expansion of Medicaid to a national eligibility floor of 138% FPL ($26,344 for a family of three in 2012) and the creation of new Health Benefit Exchanges with tax credits for individuals up to 400% FPL ($76,300 for a family of three in 2012). These expansions will help reduce wide variations in access to health coverage across states and significantly increase availability of coverage for low- and moderate-income populations. These expansions are particularly significant for people of color, who make up a disproportionate share of the uninsured[32] and of low-income populations.[33] Roughly 60% of nonelderly uninsured Blacks, Hispanics, and American Indians/Alaska Natives have income below the Medicaid expansion limit of 138% FPL and over 90% have incomes below 400% FPL (Figure 7). However, non-citizens will continue to face specific eligibility restrictions for Medicaid coverage and targeted outreach and enrollment efforts will be key for translating eligibility into coverage, particularly for vulnerable populations.

Figure 7

Income of Uninsured by Race/Ethnicity, 2011



The federal poverty level was $18,530 for a family of three in 2011. Asian group includes Pacific Islanders. American Indian group includes Aleutian Eskimos. Two or more races excluded. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

The ACA includes provisions to increase access to providers, promote workforce diversity and cultural competence, strengthen data collection and research efforts, and expand prevention and public health efforts. For example, the ACA expands funding for community health centers, which are an important source of coverage for low-income individuals and people of color, and temporarily increases Medicaid payments for primary care services. The ACA also provides increased funding to support training of health care professionals and support for cultural competence training and education materials. The ACA strengthens data collection and research efforts by requiring all federally-funded health programs and population surveys to collect and report data on race, ethnicity, primary language and supporting a number of disparities research efforts. Lastly, the ACA includes a wide array of prevention and public health initiatives, including a national oral health education campaign with an emphasis on racial and ethnic disparities, and permanently reauthorizes the Indian Health Care Improvement Reauthorization Extension Act of 2009, which includes provisions designed to address the health and health care needs of American Indians and Alaska Natives, including preventive programs.

CONCLUSION

In conclusion, health and health care disparities remain a persistent problem in the United States, leading to certain groups being at higher risk of being uninsured, having more limited access to care, experiencing poorer quality of care, and ultimately experiencing worse health outcomes. While health and health care disparities are commonly viewed through the lens of race and ethnicity, they occur across a broad range of dimensions and reflect a complex set of individual, social, and environmental factors. Disparities limit continued improvement in overall quality of care and population health and result in unnecessary costs and are increasingly important to address as the population becomes more diverse. For the past decade, there has been increased focus on reducing disparities and a growing set of initiatives to address disparities at the federal, state, community, and provider level. The ACA includes provisions that advance efforts to eliminate disparities. As the population becomes increasingly diverse, it will be important to increase focus on and recognition of disparities and for there to be broad and integrated efforts to address the wide range of factors that contribute to disparities, including social and environmental factors that extend beyond the health care system.

ENDNOTES

[1] Precise definitions of health disparity differ. For example, the Department of Health and Human Services describes health disparities as "differences in health outcomes that are closely linked with social, economic, and environmental disadvantage." In contrast, the National Institutes of Health defines a health disparity as a "difference in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States." ADD specific cites to where these definitions are

[2] However, they may have nuanced distinctions For example, a health disparity, which typically refers to differences caused by social, environmental attributes, is sometimes distinguished from a health inequality, used more often in scientific literature to describe differences associated with specific attributes such as income, or race. A health inequity implies that a difference is unfair or unethical. Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report – United States 2011. *Morbidity and Mortality Weekly Report.* January 2011. 60: 55-114. Carter-Pokras, O. and C. Baquet. What is a Health Disparity ? *Public Health Reports.* September-October 2002. 117 : 426-434.

[3] Centers for Disease Control and Prevention. "Social Determinants of Health: Definitions." January 2011. http://www.cdc.gov/socialdeterminants/Definitions.html.

[4] Agency for Healthcare Research and Quality. *National Healthcare Disparities Report 2011.*

[5] Agency for Healthcare Research and Quality. *Quality First: Better Health Care for All* Americans. March 1998. http://archive.ahrq.gov/hcqual/meetings/mar12/chap08.html.

[6] KCMU. "Key Facts on Health Coverage for Low-Income Immigrants." February 2012. http://www.kff.org/uninsured/8279.cfm.

[7] KCMU. "Overview of Health Coverage for Individuals with Limited English Proficiency." August 2012. http://www.kff.org/uninsured/8343.cfm.

[8] Singh, G. and M. Siahpush. Widened socioeconomic inequalities in US life expectancy 1980-2000. *International Journal of Epidemiology.* May 2006. 35: 969-979.

[9] Institute of Medicine. *How Far Have We Come In Reducing Health Disparities? Progress Since 2000.* September 2009.

[10] Ibid.

[11] Williams, D. "A Time for Action: the Enigma of Social Disparities in Health and How to Effectively Address Them." PowerPoint Presentation.

[12] LaVeist, T., Gaskin, D., and P. Richard, "The Economic Burden of Health Inequalities in the United States." Joint Center for Political and Economic Studies, September 2009. http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf.

[13] McNicol, E., et al, "Pulling Apart, A State-by-State Analysis of Income Trends." Center on Budget and Policy Priorities and Economic Policy Institute, November 15, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=3860.

[14] Kaiser Family Foundation. "Poverty Rate by Race/Ethnicity, states (2010-2011), U.S. (2011)." http://www.statehealthfacts.org/comparemaptable.jsp?ind=14&cat=1&sub=2&yr=274&typ=2.

[15] KCMU. "The Uninsured: A Primer." October 2012. http://www.kff.org/uninsured/7451.cfm.

[16] KCMU/ Urban Institute analysis of 2012 ASEC Supplement to the CPS.

[17] KCMU. "Overview of Health Coverage for Individuals with Limited English Proficiency." August 2012. http://www.kff.org/uninsured/8343.cfm.

[18] Peck, BM and M. Denney. "Disparities in the Conduct of the Medical Encounter: The Effect of Physician and Patient Race and Gender" *SAGE Open.* July-September 2012.
[19] Agency for Healthcare Research and Quality. *National Healthcare Disparities Report 2011.*
[20] Smith, DL. "Health Care Disparities for Person with Limited English Proficiency: Relationships from the 20006 Medical Expenditure Panel Survey." *Journal of Health Disparities Research and Practice.* Spring 2012. 3(3): 57-67.
[21] Kaiser Family Foundation. *Putting Men's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level.* September 2012.
[22] Braverman, P., et al. "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us." *American Journal of Public Health*. April 2010. 100(1): 186-196.
[23] Arias, E., B. L. Rostron, and B. Tejada-Vera. "United States Life Tables, 2005." *National Vital Statistics Reports.* 2010; 58(10). National Center for Health Statistics, Centers for Disease Control and Prevention.
[24] Kaiser Family Foundation. *March/April 2006 Kaiser Health Poll Report Survey*. April 2006 (Conducted April 2006).
[25] Kaiser Family Foundation. *National Survey of Physicians, Part 1: Doctors on Disparities in Medical Care*. 2002.
[26] Institute for Ethics. *Physicians are becoming engaged in addressing disparities. Preliminary Survey Brief*. April 2005. http://www.ama-assn.org/ama/pub/physician-resources/public-health/eliminating-health-disparities/commission-end-health-care-disparities/quality-health-care-minorities-understanding-physicians.page
[27] U.S. Department of Health and Human Services. National Partnership for Action to Health Disparities. Frequently Asked Questions.
[28] Centers for Disease Control and Prevention. "The Power to Reduce Health Disparities: Voices from Reach Communities." 2007.
[29] Ibid.
[30] See for example, the Cultural Quality Collaborative http://www.thecqc.org, which is a network of leading healthcare organizations that is working to share ideas, experiences, and solutions to real world problems that arise as a result of cross-cultural interactions that hinder the elimination of disparities in healthcare settings.
[31] See, Andrulis, D., et al, "Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations." Joint Center for Political and Economic Studies, July 2010. http://www.jointcenter.org/research/patient-protection-and-affordable-care-act-of-2010-advancing-health-equity-for-racially-and for a comprehensive and detailed overview of these provisions.
[32] KCMU. "The Uninsured: A Primer." October 2012. http://www.kff.org/uninsured/7451.cfm.
[33] Kaiser Family Foundation. "Poverty Rate by Race/Ethnicity, states (2010-2011), U.S. (2011)." http://www.statehealthfacts.org/comparemaptable.jsp?ind=14&cat=1&sub=2&yr=274&typ=2.

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