



# Racial and Ethnic Disparities in Health Care

December 7, 2007



# Agenda

**Moderator** – Brian Quinn, Ph.D.,  
Robert Wood Johnson Foundation

**Introduction** – Bruce Siegel, M.D., M.P.H.  
George Washington University

**Synthesis Findings** – José J. Escarce, M.D., Ph.D.  
UCLA and RAND

## Panelists

Nicole Lurie, M.D., M.S.P.H.  
RAND

Bruce Siegel

**Questions and Discussion** – Brian Quinn



Robert Wood Johnson Foundation

THE SYNTHESIS PROJECT  
NEW INSIGHTS FROM RESEARCH RESULTS

# Racial and Ethnic Disparities in Access to and Quality of Care

Synthesis Report and Brief Available at  
[www.policysynthesis.org](http://www.policysynthesis.org)

José J. Escarce, M.D., Ph.D.  
UCLA and RAND



## Why is this issue important to policymakers?

- Eliminating health disparities is one of two overall goals established in *Healthy People 2010*
- Eliminating *health* disparities will require addressing *health care* disparities
- Strategies to reduce disparities are an important part of efforts to improve health care quality



This synthesis takes a critical look at the best research evidence on disparities in access to and quality of health care

The goals of the synthesis are to:

- Assess whether disparities remain after adjusting for insurance, socioeconomic status and other factors
- Quantify the contributions of insurance, socioeconomic status and other factors to disparities



## We focus on research studies that meet three criteria

- Data were collected since 1996
- Data have a national scope
- Use statistical methods to adjust for individual, area and health care system factors



## We first look at the findings on disparities in access to care

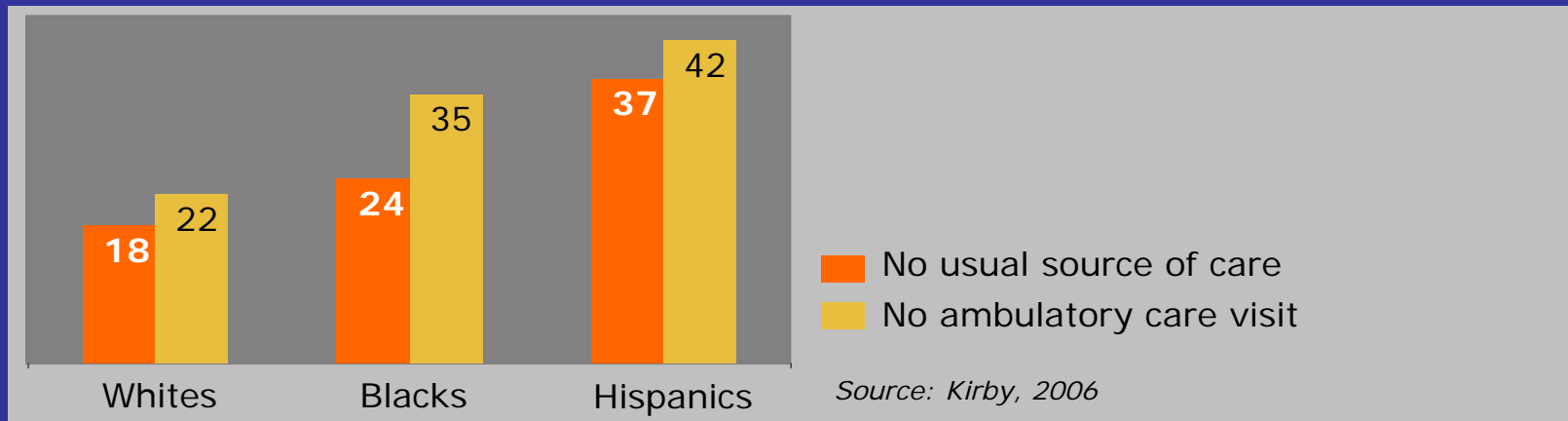
- Both potential and realized access are important
  - Potential access: Presence or absence of barriers to obtaining appropriate and timely care
  - Realized access: Whether needed care is actually received
- Potential access is commonly measured by having a usual source of care
- Realized access is often measured by having an ambulatory care visit in the last year



## Blacks and Hispanics fall below whites on both measures of access...

- Black and Hispanic adults and children are less likely than whites to have a usual source of care or ambulatory care visit

*Percent of adults with no usual source of care or ambulatory visit in the last year, unadjusted*





## Blacks and Hispanics fall below whites on both measures of access...

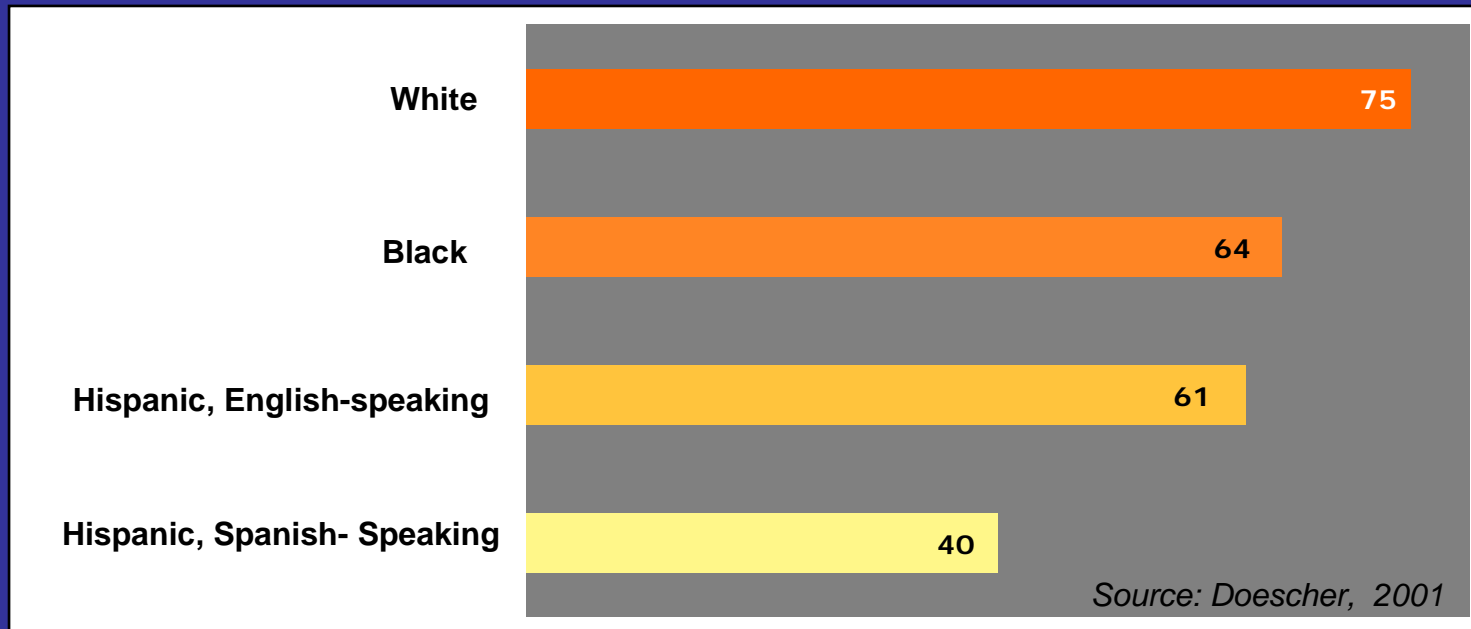
- The black-white gap in usual source of care is nearly eliminated in several studies after adjustment for income, insurance status and other factors
- The Hispanic-white gap in usual source of care that remains after adjustment depends on language
  - English speakers, 3 percentage points
  - Spanish speakers, 20 percentage points
- Sizable black-white and Hispanic-white gaps in the likelihood of having an ambulatory visit remain after adjusting for insurance, income and other factors



## ...And they are less likely to have a physician as their usual source of care

- Continuity of care is higher when a usual source is a physician's office, rather than a facility

*Percent of adults whose usual source of care is a physician's office*





## Next we look at gaps in health care quality

The synthesis examines two types of quality measures:

- Process measures

- Appropriate use of screening and preventive services, medications and laboratory tests
- Appropriate use of newer therapies and invasive procedures (e.g., acute reperfusion and coronary angiography after admission for certain coronary symptoms)

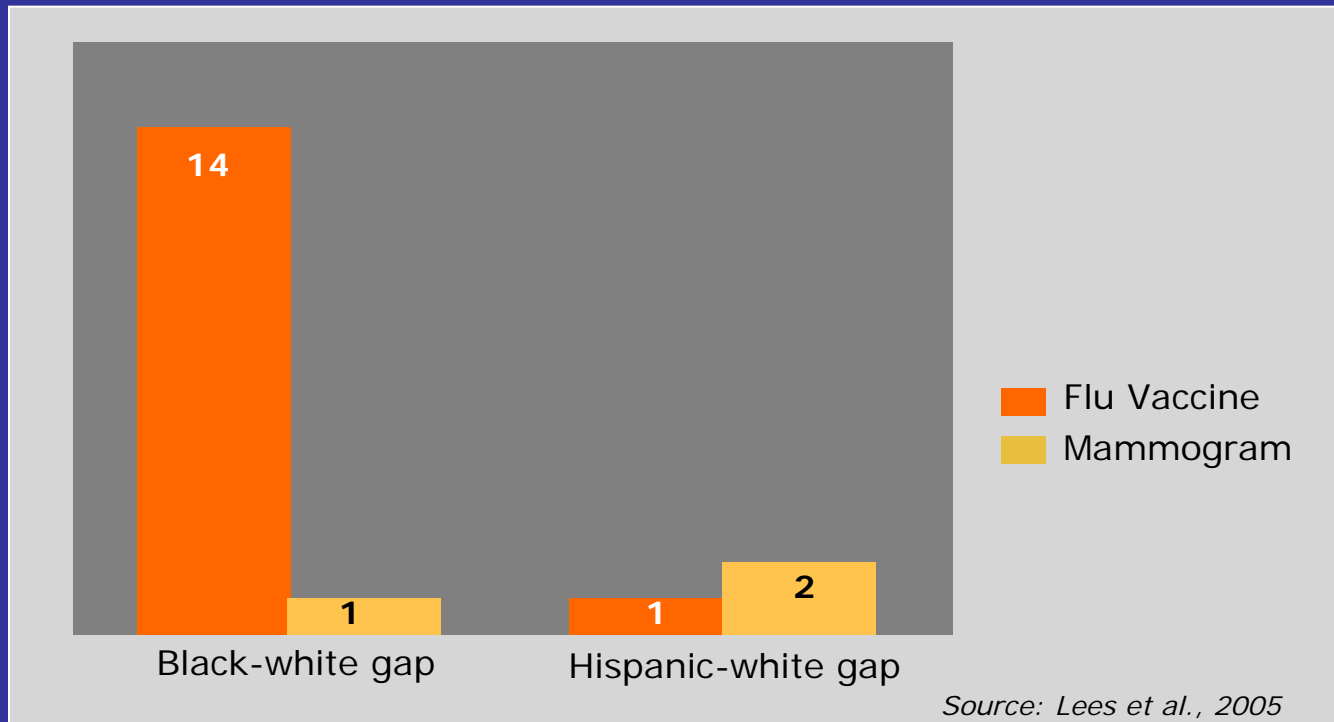
- Intermediate outcomes

- Control of risk factors such as LDL cholesterol levels in diabetics and heart disease patients or blood sugar in diabetics



# Disparities in receipt of screening and preventive services vary across services

*Percent less likely for blacks and Hispanics compared to whites (adjusted)*





## Disparities in receipt of recommended processes of care are small

- After adjusting for other factors, disparities in other recommended processes of care—e.g., medications and laboratory tests—tend to be small or nonexistent (with a few exceptions)
- A landmark study found that black and Hispanic patients who are receiving care are as likely as white patients to receive recommended processes of care
  - These findings are unlikely to be generalizable to all patients because blacks and Hispanic patients are less likely than whites to receive care

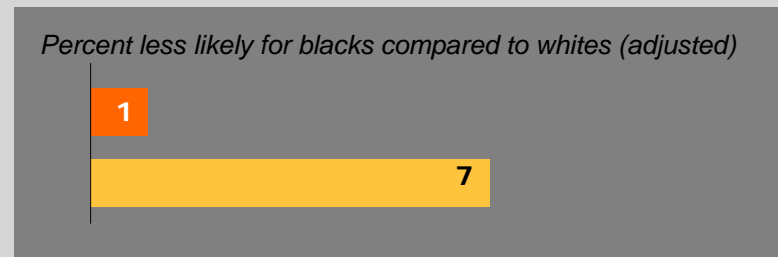


## Disparities are larger for intermediate outcomes

- Black and white diabetic and heart disease patients illustrate the different patterns for processes and intermediate outcomes

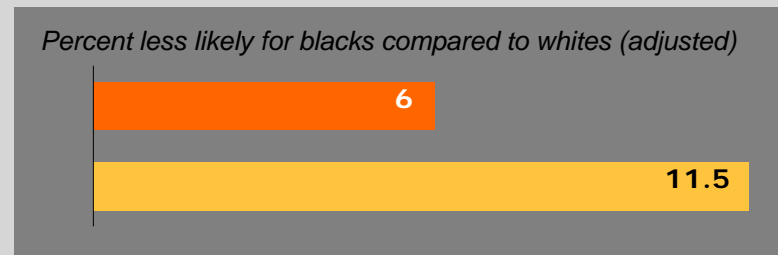
***There is a small gap between black and white diabetics for glycosylated hemoglobin screening, but a much larger gap for control***

***Process of care:*** Glyco Hgb Screening  
***Intermediate outcome:*** Glyco Hgb Control



***Similarly, there is a narrower difference in LDL cholesterol screening rates for black and white heart disease patients than for LDL control***

***Process of care:*** Cholesterol Screening  
***Intermediate outcome:*** Cholesterol Control



Source: Trivedi 2005 and 2006



## Disparities are also larger for use of newer therapies and invasive procedures

### ■ Examples from cardiac care reflect the overall pattern

- Black and Hispanic patients hospitalized with unstable angina or myocardial infarction are less likely than whites to receive recommended acute reperfusion or coronary angiography
- Disparities in recommended medications on admission and at discharge are small and are further reduced or eliminated after adjustment for other factors

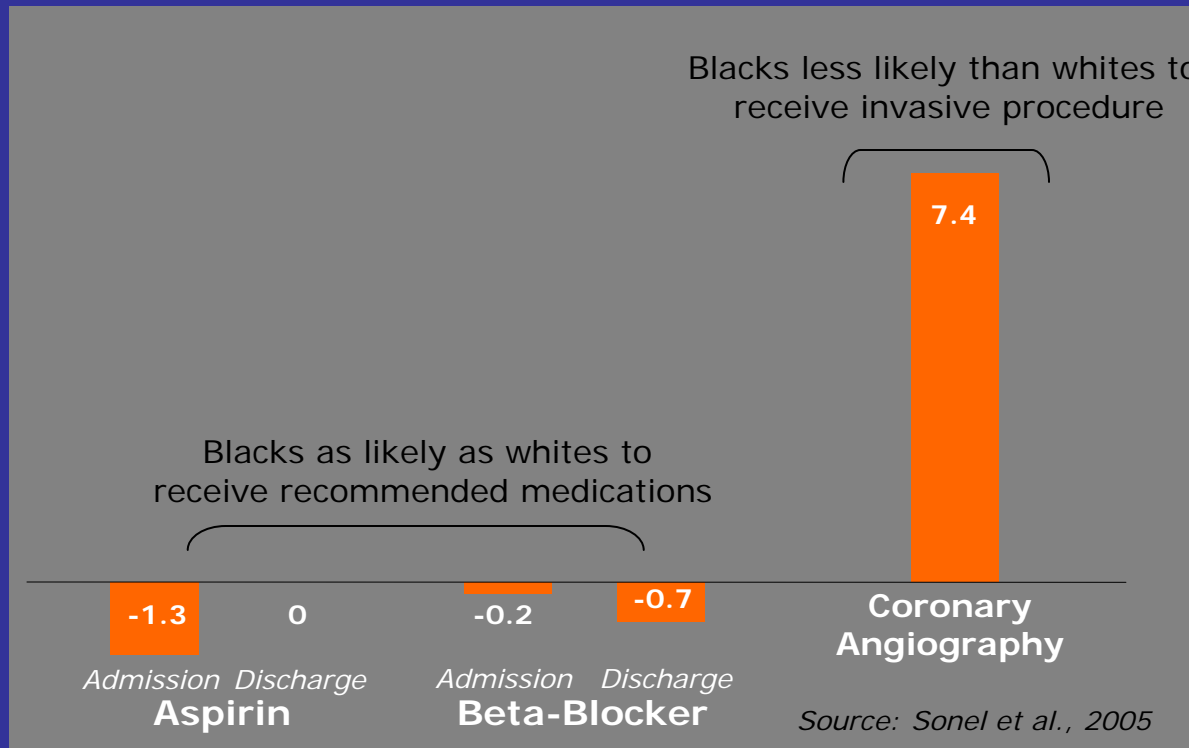
### ■ Examples from cancer care are illustrative as well

- Black Medicare enrollees with certain cancers are less likely than whites to receive invasive procedures for staging and aggressive therapy



## Disparities are also larger for use of newer therapies and invasive procedures

“Gap” in receipt of recommended medications and coronary angiography, comparing black and white hospitalized patients with unstable angina or threatened heart attack (percent less likely for blacks compared to whites, adjusted for other factors)





## Policy implications

- Expansions in insurance coverage would reduce, but not eliminate, access disparities
- Access barriers might be further reduced by:
  - Initiatives to provide culturally and linguistically appropriate care
  - Efforts to establish medical homes by linking black and Hispanic patients to individual physicians
- Increasing adherence to evidence-based guidelines will improve care for all, and is likely to reduce quality disparities
  - Special attention should be given to controlling risk factors and ensuring appropriate use of newer therapies and interventions



## Findings in context: Comments from the field

Nicole Lurie, M.D., M.S.P.H.  
RAND

- Quality/disparities connection
- Policy levers to address health care disparities

Bruce Siegel, M.D., M.P.H.  
George Washington University

- Reducing disparities and improving quality for cardiac care



## Project Information

Web site: [www.policysynthesis.org](http://www.policysynthesis.org)

E-mail: [synthesisproject@rwjf.org](mailto:synthesisproject@rwjf.org)

### Contacts

RWJF: Brian Quinn

Synthesis Project: Sarah Goodell