

## Executive Summary

The overall health of Americans has improved dramatically over the last century. Just in the last decade, the United States has seen significant reductions in infant mortality, record-high rates of childhood vaccinations, declines in substance abuse, lower death rates from coronary heart disease, and promising new treatments for cancer.<sup>1</sup> Never before have Americans had so many primary care providers, specialists, hospitals, and health plans from which to choose. Except in the most remote frontier areas, some form of health care is available 24 hours a day, 7 days a week. Most Americans are never very far from medical help, and the revolution in health information technologies could bring care even closer. Indeed, recognizing the superiority of the U.S. system, patients come from around the globe to benefit from health care available nowhere else.

However, people of lower socioeconomic status (SES) and racial and ethnic minorities have in the past experienced poor health and challenges in accessing high quality care. Recent studies have also raised questions regarding differences in clinical care provided to women, children, the elderly, and those with chronic illnesses. These differences are often grouped together under the broad heading of “health care disparities.”

Findings from the 2000 Census indicated continued diversification of the U.S. population and growth in some groups considered to be at high risk for missing the benefits of health care. Gaps in income between the richest and poorest households in America are widening, and some racial and ethnic minorities are growing at a much more rapid pace than the majority white population. By the year 2050, it is estimated that nearly 1 in 2 Americans will be a member of a racial or ethnic minority—i.e., black, Hispanic, Asian, or American Indian.<sup>2</sup> These demographic changes have different implications for communities across the Nation and the systems of care available to their residents.

This report is the first in an annual series that, in the words of the U.S. Congress, tracks “prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.”<sup>1</sup> This document provides a comprehensive view of the scope and characteristics of differences in health care quality and access associated with patient race, ethnicity, income, education, and place of residence. To date, no report has provided such extensive cross-group comparisons that could provide a national roadmap to inform local efforts to reduce disparities.

Closing the health gap for minorities and other priority populations is a major priority of the Department of Health and Human Services (HHS). Addressing these differences in care is a cornerstone of the Department’s disease prevention programs. HHS is fulfilling this priority through a comprehensive effort to increase the percentage of the Nation’s children and adults who have access to health care services and expand consumer choices. Specifically, activities under this priority will create new, affordable health

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<sup>i</sup> These populations are women, children, the elderly, minority groups, low income groups, residents of rural areas, and individuals with special health care needs. See Public Law 106-129, section 901(c).

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insurance options, strengthen and expand the health care safety net; improve the delivery of services in rural and underserved areas; eliminate racial and ethnic disparities; strengthen and improve the Medicare program; expand access to health care services for targeted populations with special health care needs; and increase access to health care services for American Indians and Alaska Natives.

### What Are “Health Care Disparities”?

There are a number of definitions of “disparities.” For example, in pursuit of its overarching goal of eliminating health disparities, *Healthy People 2010*<sup>1</sup> considers all differences in its measures as evidence of disparities. At the other end of the spectrum, a recent report by the Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,<sup>3</sup> defined health care disparities as differences that remain after taking into account patient needs and preferences and the availability of health care; notably, after an exhaustive literature review, the IOM report concluded that no study ever conducted has met this most rigorous definition of disparities. Still others associate health care disparities with adverse health outcomes, personal responsibility, or provider prejudice.

In the absence of consensus on the definition of disparities, this report will focus on presenting the facts. Where we find variation among populations, this variation will simply be described as a “difference.” By allowing the data to speak for themselves, there is no implication that these differences result in adverse health outcomes or imply prejudice in any way.

### Why a National Healthcare Disparities Report?

Public Law 106-129, the Healthcare Research and Quality Act of 1999 (now section 903(a)(6) of the Public Health Service Act), directed the Agency for Healthcare Research and Quality (AHRQ) to develop two annual reports: a National Healthcare Quality Report and a National Healthcare Disparities Report. As noted, the directive calls upon this annual report to track “prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.”<sup>4</sup>

With guidance from the IOM, AHRQ developed a common conceptual framework for both reports and, in fact, a focus on quality is at the heart of both documents. The IOM concluded that the “plan to make health care quality a major focus of this report...is appropriate since disparities often represent an ‘inequality in quality.’”<sup>5</sup> As a result, both reports are being released simultaneously and readers are urged to review them together to develop a more comprehensive snapshot of the performance of our health care system, its strengths, and areas that should serve as a focal point for future improvement. The performance measures underlying the two reports will be used to monitor the Nation’s progress toward improved health care delivery.

## Differences in the Quality of Health Care

Despite the high quality of care available, some studies and commentators have suggested that a gap exists between ideal health care and the actual health care that Americans sometimes receive.<sup>6</sup> At times, patients may receive care that does not meet clinical standards for “best practice” or that responds insufficiently to their individual needs. As medical knowledge and practice become more complex, quality-related problems may persist or be reduced by new and improved ways of delivering care.

While some research examines the question of racial and ethnic differences in health care,<sup>3</sup> less is known about the magnitude and extent of differences in the quality of health care related to socioeconomic factors. Moreover, only recently have scientists and quality improvement experts begun to address the issue of how best to measure, track, and improve quality of health care in diverse populations.<sup>7</sup>

This report examines five aspects of quality of care:

- Effectiveness—care based on scientific knowledge; it is provided to all patients who could benefit and not provided to patients unlikely to benefit.
- Safety—care that avoids injuring patients through care intended to benefit them.
- Timeliness—care that reduces delays in use of care.
- Patient Centeredness—care that is respectful and responsive to the individual needs, preferences, and values of patients.
- Equity—care that encompasses the need for health care systems to provide care that does not vary in quality because of personal characteristics (such as gender, ethnicity, geographic location, and SES).

## Differences in Access to Health Care

Even with the expanding health care infrastructure, not all Americans have equal access to the highest quality health care available in this country. People of lower socioeconomic status, rural populations, and some racial and ethnic minorities are disproportionately represented among those who say they have problems with access to care.

Access to health care,<sup>8</sup> defined as “the timely use of personal health services to achieve the best health outcomes,”<sup>9</sup> is an essential prerequisite to obtaining high quality care and increasing the quality and length of life. Indeed, a recent IOM report asserts that “access-related factors may be the most significant barriers to equitable care, and must be addressed as an important first step toward eliminating healthcare disparities.”<sup>10</sup>

Many of the reports on access have relied upon “receipt of care measures.”<sup>11, 12, 9</sup> With input from the IOM, the public, and the Interagency Work Group for the National

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Healthcare Disparities Report, access measures were selected and organized into four main categories:

- Entry Into the Health Care System—these measures focus on ease of gaining initial entrance into the health care system itself.
- Structural Barriers—these measures focus on the difficulty of getting care (e.g., transportation, ability to schedule appointments, and referrals to specialists).
- Patients’ Perceptions—these measures focus on patient-provider communication and relationships, cultural competency, health literacy, and health information.
- Utilization of Care—these measures focus on use of health care (i.e., routine, acute, and chronic care), including hospital admissions for conditions that are treatable with ambulatory care (often called “avoidable admissions”).

### Differences Across Priority Populations

While substantial work has been done on the impact of ethnicity and race on health care differences, quality, and outcomes,<sup>3</sup> much less is known about the independent consequences of income, education, and geographic location. Therefore, this report presents data on the role of SES, insurance status, and geographic location where possible on health care differences *within and across* priority populations (e.g., comparing low income women with high income women).

The statutory mandate for this report refers to “priority populations,” defined in AHRQ’s authorizing legislation (section 901(c) of the Healthcare Research and Quality Act of 1999) as encompassing both specific population groups as well as geographically defined groups. In accordance with these guidelines and AHRQ’s congressional mandate, this report includes data and analysis, and highlights selected findings, on the following populations only:

- Women
- Children
- Elderly
- Racial and ethnic minority groups
- Low income groups<sup>ii</sup>
- Residents of rural areas
- Individuals with special health care needs, specifically children with special needs, the disabled, people in need of long-term care, and people requiring end-of-life care.

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<sup>ii</sup> Income categories for each of the populations described in this report are as follows: “poor” is defined as having family income of less than 100% of the Federal poverty threshold; “near poor” is defined as having family income between 100% and 199% of the Federal poverty threshold; “middle income” is defined as having family income between 200% and 399% of the Federal poverty threshold; “high income” is defined as having family income of 400% or more of the Federal poverty threshold.

## Key Findings

This report presents six key findings to policymakers, clinicians, health system administrators, and community leaders who seek to use this information to improve health care services for all populations:

1. Americans have exceptional quality of health care; but some socioeconomic, racial, ethnic, and geographic differences exist.
2. Some “priority populations” do as well or better than the general population in some aspects of health care.
3. Opportunities to provide preventive care are frequently missed.
4. Management of chronic diseases presents unique challenges.
5. There is still a lot to learn.
6. Greater improvement is possible.

### **1. Americans have exceptional quality of health care; but some socioeconomic, racial, ethnic, and geographic differences exist.**

Although some research studies have suggested differences in health care services among different groups of Americans, these examinations are often limited to specific populations with specific conditions, e.g., care for black and white Medicare beneficiaries with heart attacks.<sup>13</sup> By using nationally representative data sets, this report attempts to provide a national picture of socioeconomic, racial, and ethnic differences in health care available to date. Further editions of this report will include analyses of the relationship between the multiple factors that may explain differences between and among these populations.

This first report finds that, while most Americans receive exceptional quality of health care and have excellent access to needed services, some socioeconomic, racial, and ethnic differences exist.

Examples are:

- Most Americans have access to public or private health insurance, but poor people and some minorities are less likely to be insured. Those same populations, if insured, are more likely to have public insurance.
- People of lower SES and blacks have higher death rates for all cancers combined.
- Hispanics and American Indians or Alaska Natives (AI/ANs) are less likely to have their cholesterol checked.
- People of lower SES and some minorities are less likely to have a usual source of care.
- Rates of admissions for conditions that are usually treatable with ambulatory care are generally higher for people who live in low income areas compared with those who live in high income areas.

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### **2. Some “priority populations” do as well or better than the general population in some aspects of health care.**

While this report identifies differences in health care by race, ethnicity, and SES, it also identifies areas where significant differences are not observed. Often, these areas coincide with public and private initiatives to reduce health care differences. Successes documented in this report demonstrate what is possible to achieve.

Examples are:

- Asians or Pacific Islanders (APIs) and AI/ANs have a lower death rate from all cancers.
- APIs have lower hospitalization rates for complications of diabetes.
- Black and Hispanic patients are more likely to report that their provider usually asks about medications from other doctors.
- Hispanics and APIs have lower rates of hospitalization from influenza.

### **3. Opportunities to provide preventive care are frequently missed.**

Contemporary medicine often focuses on care after symptomatic illness begins, rather than preventive services that could potentially prevent or delay the illness or reduce its adverse effects. Secretary Thompson recently observed that addressing health care disparities is essential to achieving the goals of prevention.<sup>14</sup> This report illustrates that there are significant differences in the use of evidence-based preventive services for certain populations, particularly people of lower SES and some minorities. Given the impact on morbidity, mortality, outcomes, and costs of care, efforts to promote preventive services to populations most at risk would be an important aspect of any improvement initiative.

Examples are:

- People of lower SES and some minorities are less likely to have colorectal and breast cancer screening.
- People of lower SES and Hispanics are less likely to have blood pressure and cholesterol screening as well as counseling and treatment for some cardiac risk factors.
- People of lower SES and blacks are less likely to have recommended childhood immunizations before age 4.
- Children of lower SES and some minority children are less likely to have dental care.
- Lower SES, black, and Hispanic adults are less likely to have recommended immunizations for influenza and pneumococcal disease.

### **4. Management of chronic diseases presents unique challenges.**

Patients with chronic diseases often require multiple health care services for treatment and to minimize complications. For example, good diabetes care usually includes the

following services: periodic hemoglobin A1c measurement to maintain optimal glycemic control; screening for diabetic eye and foot complications; screening for elevated lipids, which is often associated with diabetes; and immunization against influenza, which can be particularly severe among diabetic patients.

In addition, patients with chronic disease may benefit from consultation with specialists. A skilled primary care provider who effectively coordinates the activities of a disease management team and clearly communicates treatment regimens with patients also may be helpful. Incomplete access to these services may result in lower quality of care for people with chronic diseases. Some examples presented in this report are important for the general population but particularly significant for people with chronic diseases.

Examples are:

- People of lower SES with diabetes are less likely to have retinal eye examinations. Blacks and Hispanics have higher hospitalization rates for diabetic complications.
- The percent of adults with hypertension whose blood pressure is under control is lower among those with less than a high school education.
- Black children have higher hospitalization rates for asthma.
- Lower income individuals, blacks, and Hispanics report difficulty obtaining referrals to specialists.
- People of lower SES and Hispanics are more likely to report one or more communication difficulties with their physicians.
- People of lower SES, Asians, and Hispanics report greater difficulty understanding health care information from their doctor's office.

## **5. There is still a lot to learn.**

Gaps in national data exist. Currently collected national data are useful but not sufficient for examining many racial, ethnic, and socioeconomic differences in U.S. health care. For particular racial groups and specific priority populations, there are often too few cases to provide reliable estimates. In addition, Federal data often do not collect certain types of demographic information, do not cover some aspects of patient care, and further, do not differentiate between patient responsibility and health care system responsibility. More complete health care data could enhance understanding of why differences in health and health care exist and would help to determine the appropriate intervention for specific populations.

Examples are:

- Nationally, sample sizes are often inadequate for the study of American Indians or Alaska Natives and Native Hawaiians or Other Pacific Islanders. This is especially true when examining racial and ethnic differences within populations.
- Many data sets often do not include information about patient SES, language, population subgroup, understanding of health information, cultural competency, and special health care needs.

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### 6. Greater improvement is possible.

This Nation aspires to equal opportunities for all its citizens. Congress, HHS, and other public and private entities recognize that eliminating health care differences resulting from unequal opportunities must continue to be a public policy priority.

The Department of Health and Human Services believes that addressing health disparities is a cornerstone of disease prevention, and it has developed a significant portfolio of important initiatives aimed at eliminating these differences.

- Black women have slightly higher screening rates for cervical cancer than white women and a similar presentation by stage as white women. While it would not be possible to demonstrate a causal link, the significant investment in community-based cancer screening and outreach programs for cervical cancer, such as the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program, may be responsible for similar stage presentation and may help to explain why death rates for black women, although about twice those of white women, have been falling at about twice the rate in recent years.<sup>15</sup>
- Among end-stage renal disease patients receiving hemodialysis, there is no evidence of significant racial or ethnic differences in management of anemia. This lack of difference follows extensive efforts by the Centers for Medicare & Medicaid Services' End-Stage Renal Disease Clinical Performance Measures Project to improve quality of care for all dialysis patients.<sup>16</sup>
- Blacks are more likely to report blood pressure monitoring than whites. A greater perceived risk for cardiovascular disease among blacks may result in appropriately increased screening rates for high blood pressure. Public education campaigns about cardiac risk factors, such as the National Heart, Lung, and Blood Institute's National High Blood Pressure Education Program, may play an important role in the similar rates of blood pressure monitoring.

This report is a first step in identifying and understanding differences in access to and quality of health care services among priority populations. Future reports will serve as a report card on efforts to address these differences. Working together, using tools like this report, among others, public- and private-sector policymakers and health system leaders can help make full access to high quality health care a reality for all Americans.

## References

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