



Talking Points:

Racial and Ethnic Health Disparities

In the U.S., racial and ethnic minorities have higher rates of disease, injury, premature death and disability. Disparities exist in both access to care and care received by minorities. For them, these disparities can mean shorter life expectancy, decreased quality of life, loss of economic opportunities and social inequality.¹

✓ What Are the Causes of Racial and Ethnic Health Disparities?

- Socioeconomic factors, lifestyle behaviors, social environment and access to clinical and community preventive services contribute to racial and ethnic health disparities.¹
- Patient attitudes and health provider biases may also contribute to disparities. Some people do not trust health care professionals, and therefore may delay seeing a doctor until their illness is too far along or may not follow their doctor's instructions.²

✓ Why Should State Legislators Be Concerned?

- For society, these disparities translate into decreased productivity, increased health care costs and social inequity.¹
- By 2020, racial and ethnic minorities will account for more than 40 percent of the total U.S. population.³ If these populations continue to experience poor health status, the expected demographic changes will magnify the adverse impact of such disparities on public health and health care costs in the United States.¹

✓ What Can State Legislators Do?

- Encourage collaboration and coalition building across many sectors in efforts to reduce disparities.
- Work with local communities to develop assessment and audit tools.
- Support adoption of health information technology.
- Expand eligibility for insurance programs.
- Work to improve trust in the health care system and providers.
- Work on efforts to improve cultural competency of the health care work force.
- Authorize state government entities to target disparities and provide financial resources to help them do so.
- Work to reduce geographic challenges that influence disparities.

Actions for State Legislators

Collaboration

- Coalitions that have improved health outcomes and increased access to care often include local health providers and representatives from community-based, faith-based, grassroots and state and local health care organizations that serve the target populations.

Local Community Action

- Work with communities as they create assessment and audit tools to identify disparities and improve health care. These may include assessments of health risks, community health needs and the cultural competency of area health providers. Encourage the use of these tools in the development of community action plans that reach out to minorities where they live, worship, work, shop, play and seek health care.

Information Systems

- Support adoption of health information technology in health care organizations including electronic disease registries and remote monitoring systems to track and analyze chronic disease trends in all populations, and identify areas where disparities exist.
- Support legislation and provide support to facilitate the collection, integration, standardization and analysis of health and demographic data to help identify disparities.
- Authorize creation of databases to gather information on the social, cultural and economic characteristics (including language preferences) of specific regions in order to identify health personnel, facility and other resource needs and reallocate accordingly (see New Mexico S.B. 786, 2005).

Access to Care

- Expand eligibility for Medicaid and State Children's Health Insurance Programs, which make available otherwise unobtainable coverage for many.
- Examine ways to encourage expansion of health clinics and hospitals into communities impacted by disparities.
- Create or authorize agencies or commissions to work to eliminate disparities in access to quality health care (see New Jersey H.B. 1986, 2006).

Public Information Campaigns

- Work to improve overall trust in the health care system and health providers by:
 - Encouraging members of your community to seek appropriate care, including preventive care.
 - Encouraging the use of culturally sensitive media campaigns and community promotions to increase the health literacy of specific communities about risk factors for disease, appropriate standards of care, and availability of services.

Health Care Work Force

- Work on efforts to improve the cultural competency of the health work force and its capacity to reduce disparities by:
 - Improving the cultural and linguistic competency of providers and the training of medical students. Consider making cultural competence training for physicians a condition of licensure (see New Jersey S.B. 144, 2005);
 - Developing incentive programs to foster a more diverse health work force;
 - Alleviating provider and facility shortages in minority communities; and
 - Supporting programs to encourage individuals from populations impacted by disparities to become physicians and health professionals.

State Oversight & Monitoring

- Authorize state departments of health to target health disparities (see South Carolina H.B. 4810, 2006). Ensure that state minority health offices have adequate financial resources to:
 - Gather data and identify unique health care needs among specific groups, such as Native Americans (see New Mexico H.B. 642, 2005);
 - Formulate and implement programs;
 - Conduct advocacy and community outreach;
 - Oversee grant programs; and
 - Promote collaboration among partners in seeking to reduce health disparities.

Healthy Environments

- Work to reduce geographic challenges that influence disparities. Help minority neighborhoods to improve the physical environment to contribute to healthier lifestyles including increased physical activity. Examine ways to encourage grocery stores and food suppliers to expand their businesses and provide access to nutritious foods in communities impacted by disparities.

Key Facts on Health Disparities

Disparities in Access to Health Care for Minorities

- Minority population groups such as African–Americans, Hispanics, Asians and American Indians/Alaska Natives have poorer access to care than whites.⁴
- They are far more likely to be uninsured. More than half of the uninsured in the U.S. belong to racial and ethnic minorities.⁵ Studies show that people who are uninsured receive less medical care and have worse outcomes following an accident or the onset of a new chronic condition than those with insurance.⁶
- They are less likely than whites to have a place where they regularly receive care.⁷
- Minority communities often have fewer sources of health care than white communities.⁴

Disparities in Health Care Services Received by Minorities

- Minority populations generally receive lower quality health care than whites.⁴
- They often miss out on preventive care that is crucial to maintaining good health and preventing serious health problems.⁷
- Many minority patients experience difficulties in communicating with their health care providers. A lack of patient health literacy caused by cultural barriers or limited English proficiency can result in problems locating providers and services, filling out health forms, sharing medical history with providers, seeking preventive care, understanding directions on medicine⁹ and even trusting providers in general.²
- Health care provider bias against minorities, greater clinical uncertainty when interacting with them, and provider beliefs or stereotypes may also play a role in causing disparities. Cross–cultural education may be an important tool in eliminating health disparities. Research demonstrates education is effective in improving provider knowledge of cultural and behavioral aspects of health care and building effective communication strategies.²
- Minorities are underrepresented in health care professions. Latinos, African–Americans and American Indian/Alaska Natives account for 25 percent of the U.S. population but represent only 6 percent of practicing physicians. Eighty–six percent of registered nurses are white, while whites account for about 69 percent of the U.S. population.²

Sources:

¹ Centers for Disease Control and Prevention. “Health Disparities Experienced by Racial/Ethnic Minority Populations.” *Morbidity and Mortality Weekly Report*. 2004; 53(33): 755. Accessed from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5333a1.htm> May 2, 2007.

² IOM. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” Accessed from <http://www.iom.edu/?id=4475&redirect=0> May 2, 2007.

³ U.S. Census Bureau. “Projected Population of the United States, by Race and Hispanic Origin: 2000 to 2050.” Accessed from <http://www.census.gov/ipc/www/usinterimproj/natproptab01a.pdf> May 2, 2007.

⁴ Agency for Healthcare Research and Quality. “2005 National Healthcare Disparities Report.” Accessed from <http://www.ahrq.gov/qual/nhdr05/nhdr05.pdf> May 2, 2007.

⁵ U.S. Census Bureau. “Health Insurance Coverage in the United States: 2002.” Accessed from <http://www.census.gov/prod/2003pubs/p60-223.pdf> May 2, 2007.

⁶ Hadley, Jack. “Insurance Coverage, Medical Care Use, and Short–term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition.” *Journal of the American Medical Association*. 2007; 297:1073–1084.

⁷ CDC. “Health, United States 2002.” Table 78, 231–232. Accessed from <http://www.cdc.gov/nchs/data/hus/02.pdf> May 2, 2007.

⁸ Institute of Medicine. “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce.” 2004. Abstract available from http://www.nap.edu/catalog.php?record_id=10885#toc May 2, 2007.

⁹ Health Resources and Services Administration. “Health Literacy.” Accessed from <http://www.hrsa.gov/healthliteracy/> May 2, 2007.

Information on health disparities legislation from 2005 & 2006 can be found here:

2005: <http://www.healthystates.csg.org/NR/rdonlyres/D14C71C2-E34F-4977-BDCB-0F308C7B0645/0/FINAL2005Report.pdf>

2006: <http://www.healthystates.csg.org/NR/rdonlyres/E97163A4-9EAF-4F16-A7AC-A4511FB6D1AF/0/Chapter4HealthDisparities.pdf>