

Health Care Quality and Disparities and the Health Care Provider: What We Can Do

BY CRESHELLE R. NASH, MD, MPH

The current debate about health care reform has centered primarily on controlling the cost of health care and health insurance access. The third essential component of health policy—health care quality—must be addressed as well. Despite a lack of media attention, health care quality initiatives are significant components of health care reform. However, racial and ethnic health care disparities receive much less attention in discussions of health care reform and quality. This debate represents an opportunity for health care providers to address health care quality for all Arkansans.

HEALTH CARE QUALITY AND HEALTH CARE DISPARITIES

Quality health care in the United States should be safe, effective, patient-centered, timely, efficient and equitable. Equitable health care is care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. While the U.S. spends 16.2% of its GDP on health care, our health care delivery system does not provide consistent, high-quality medical care to all people.

“Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm.”¹ Racial and ethnic minorities fall into this chasm. Eliminating racial and ethnic health disparities is a key component of improving health care quality in the United States.

Racial and ethnic health disparities are defined as differences in the incidence and prevalence of disease, access to health care, quality of care or health outcomes by racial/ethnic subgroups. There has been extensive documentation of racial and ethnic health disparities over time and across many disease states. The cause of these disparities is a complex interaction of social, economic, community, behavioral and health care system factors. The Agency for Healthcare Research and Quality’s 2008 National Health Care Disparities Report found that for blacks, Asians, American Indians/Alaska natives, Hispanics, and people with low incomes, at least 60% of measures of quality of care either stayed the same or worsened.²

A report from the Institute of Medicine found that minority patients are less likely than whites to receive the same quality of health care, even when they have similar insurance or ability to pay for care.³ It also identi-

fied three potential sources of health care disparities:

- Health care systems, hospitals, and clinics may adopt policies or practices that are based on good intentions but may harm minority patients’ ability to access care.
- Some minority patients do not trust health care professionals, and so may put off seeing a doctor until their illness is too far along to treat effectively.
- Health care providers’ biases, prejudices, and uncertainty when treating minorities can contribute to health care disparities.

DISPARITIES IN ARKANSAS

Health care disparities are seen in most diseases.⁴ With respect to quality of care measures and hospital admissions that are potentially preventable by quality health care, African-Americans in Arkansas are:

- More than twice as likely to be admitted for hypertension and congestive heart failure
- 3.3 times more likely to be admitted for uncontrolled diabetes
- Almost twice as likely to die in infancy

While data is more limited on the Hispanic population, they are

2.7 times likely to be admitted with uncontrolled DM.⁴

WHAT CAN HEALTH CARE PROVIDERS DO?

In 2007, a comprehensive review of interventions to reduce health care disparities in cardiovascular disease, diabetes, depression and breast cancer examined multiple-level activities with individual provider and patient interventions. It also examined improvements in the health care organization, links to the community, and policies affecting the behavior of individuals and organizations.⁵ Some specific examples include patient education and self-management; provider reminders and information technology; team-based case management; community lay health workers; community coalition building and advocacy; and cultural competency initiatives. While there are no definitive answers, three themes emerged:

- Multiple-level interventions (patient, providers, health care system, policy and community) are more effective than single-level interventions
- Culturally tailored quality improvement may be more effective than general measures
- Nurse-led interventions within the context of wider system change may be more effective than interventions that target physicians and the clinical encounter

While the causes of health care disparities are tied to larger societal issues such as income, education, poverty and health care access, health care systems and individual providers in those systems can be a part of the solution.

Learn about racial and ethnic health disparities nationally and locally. Providers must understand

Arkansas' age-adjusted mortality rates per 100,000 population, 2006

DISEASE CATEGORY	WHITE MORTALITY*	BLACK MORTALITY*	PERCENT DIFFERENCE
Heart Disease	226.3	293.03	+29%
Cancer	196.5	244.6	+24%
Stroke	54.2	95.0	+75%
Diabetes	23.1	58.4	+152%
Infant mortality	7.2	13.6	+89%

SOURCE: Kaiser Family Foundation State Health Facts

these complex issues to address them in their patient population.

Understand and practice culturally competent care. Be aware of the multiple cultural perspectives of our patients and how our assumptions can affect health outcomes through lack of clear communication, missed opportunities for education, prevention and quality treatment. Consider cultural competency training, use of interpreters, links with community partners and community health workers.

Include equity in your health care quality improvement process. Examine your practice with respect to health care quality by race and ethnicity, and examine your office process to identify barriers to quality care for racial and ethnic minorities.

Advocate for the elimination of disparities in health care reform efforts. While access to health care is critically important, it will not solve the problem. We must also address health care system factors such as quality, cultural competency, work force diversity and racial and ethnic health disparities specifically.

The elimination of racial and ethnic health care disparities is critical to the improvement of health care quality. While these disparities are persistent, and the causes and solu-

tions are complex, we now have a new opportunity to move forward. Health care providers must be involved at the individual level if we are to improve the health of all Arkansans.

Creshelle R. Nash, MD, MPH, is medical director of the Arkansas Minority Health Commission and assistant professor of health policy and management at the University of Arkansas for Medical Sciences.

REFERENCES:

1. Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001.
2. *National Healthcare Disparities Report,* 2008. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; 2009. AHRQ Publication No. 09-0002.
3. Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Smedley B, Stith A, Nelson R, eds. *Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press; 2003.
4. Kaiser Family Foundation. State Health Facts. Available at <http://www.state-healthfacts.kff.org/index.jsp>.
5. Chin M, Walters A, Cook S, Huang E. Interventions to reduce racial and ethnic disparities in health care. *Med Care Res Rev.* 2007;64:7S-28S.