



Disparities in Health Care Quality Among Racial and Ethnic Minority Groups: Selected Findings From the 2010 National Healthcare Quality and Disparities Reports

Introduction

Each year since 2003, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving health care quality and reducing health care disparities. As mandated by the U.S. Congress, the National Healthcare Quality Report (NHQR) focuses on “national trends in the quality of health care provided to the American people” while the National Healthcare Disparities Report (NHDR) focuses on “prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.” Priority populations include racial and ethnic minorities, low-income groups, women, children, older adults, residents of rural areas and inner cities, and individuals with disabilities and special health care needs.

Racial and Ethnic Minorities

In 2000, about 33% of the U.S. population identified themselves as members of racial or ethnic minority groups. By 2050, it is projected that these groups will account for almost half of the U.S. population. For 2007, the U.S. Census Bureau estimated that the United States had almost

38.8 million Blacks or African Americans (12.9% of the U.S. population); more than 45.5 million Hispanics or Latinos (15.1%); almost 13.4 million Asians (4.4%); more than 0.5 million Native Hawaiians and Other Pacific Islanders (NHOPIs) (0.2%); and more than 2.9 million American Indians and Alaska Natives (AI/ANs) (1.0%), of whom 57% reside on Federal trust lands. Racial and ethnic minorities are more likely than non-Hispanic Whites to be poor or near poor. In addition, Hispanics, Blacks, and some Asian subgroups are less likely than non-Hispanic Whites to have a high school education.

Disparities in quality of care are common:

- Blacks and AI/ANs received worse care than Whites for about 40% of measures.
- Asians received worse care than Whites for about 20% of measures.
- Hispanics received worse care than non-Hispanic Whites for about 60% of core measures.
- Poor people received worse care than high-income people for about 80% of core measures.



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Priority Populations

Disparities in access are also common, especially among Hispanics and poor people:

- Blacks had worse access to care than Whites for one-third of core measures.
- Asians and AI/ANs had worse access to care than Whites for one of five core measures.
- Hispanics had worse access to care than non-Hispanic Whites for five of six core measures.
- Poor people had worse access to care than high-income people for all six core measures.

Few disparities in quality of care are getting better:

- Fewer than 20% of disparities faced by Blacks, AI/ANs, Hispanics, and poor people showed evidence of narrowing.
- The Asian-White gap was narrowing for about 30% of core measures, the largest proportion of any group, but most disparities were not changing.

Largest racial, ethnic, and socioeconomic disparities that are not improving*

Black compared with White	Relative rate
Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes	2.0
Emergency department visits where patients left without being seen	1.7
Adults age 65 and over who ever received pneumococcal vaccination	1.5
Asian compared with White	
Adults age 65 and over who ever received pneumococcal vaccination	1.4
People with a usual primary care provider	1.3
Adults who had a doctor's office or clinic visit in the last 12 months whose health providers listened carefully, explained things clearly, respected what they had to say, and spent enough time with them	1.2
American Indian or Alaska Native compared with White	
People under age 65 with health insurance	1.7
Hospital patients with heart failure who received recommended hospital care	1.7
Adults age 50 and over who ever received colorectal cancer screening	1.6
Hispanic compared with Non-Hispanic White	
New AIDS cases per 100,000 population age 13 and over	3.3
People under age 65 with health insurance	2.7
People with a specific source of ongoing care	2.0
Poor compared with High Income	
People under age 65 with health insurance	4.7
Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement	3.6
People with a specific source of ongoing care	2.9

* To compare relative rates (RRs), measures were framed negatively. An RR > 1 indicates that a group is receiving poorer quality of care or facing larger problems with access to care compared with the reference group. For example, an RR of 1.3 indicates that Asians are 1.3 times more likely than Whites not to have a usual primary care provider.

Barriers to Access and Quality Health Care

Access to care measures include facilitators and barriers to care and health care utilization experiences of subgroups defined by race and ethnicity, income, education, availability of health insurance, limited English proficiency, and availability of a usual source of care.

Health Insurance Status

- Overall, there was no significant change from 1999 to 2008. In 2008, about 83.2% of people under age 65 had health insurance.
- In 2008, Asians under age 65 were more likely than Whites to have health insurance (86.1% compared with 83.3%). AI/ANs under age 65 were less likely than Whites to have health insurance (71.6% compared with 83.3%). There were no statistically significant differences for other racial groups.
- In 2008, Hispanics under age 65 were less likely than non-Hispanic Whites to have health insurance (66.7% compared with 87.5%).
- From 1999 to 2008, while the percentage of people with health insurance increased for poor people (from 66.2% to 71.0%), the percentage worsened for middle-income people (from 86.4% to 83.4%). In 2008, the percentage of people with health insurance was significantly lower for poor, near-poor, and middle-income people than for high-income people (71.0%, 69.4%, and 83.4% respectively, compared with 93.8%).
- In 2008, the percentage of people with health insurance was about one-third lower for people with less than a high school education than for people with at least some college education (56.9% compared with 89.0%).

Specific Source of Ongoing Care

- Overall, 86.1% percent of people had a specific source of ongoing care in 2008.

- In 2008, the percentage of people with a specific source of ongoing care was lower for Blacks than for Whites (84.7% compared with 86.3%) and significantly lower for Hispanics than for non-Hispanic Whites (77.1% compared with 88.6%).
- In 2008, the percentage of people with a specific source of ongoing care was significantly lower for poor people than for high-income people (77.5% compared with 92.1%).
- The percentage of people with a specific source of ongoing care was lower for people with less than a high school education and for people with a high school education than for people with at least some college education (74.2% and 82.2%, respectively, compared with 88.9%).

Quality and Access to Care for Populations With Limited English Proficiency

Limited English proficiency is a barrier to quality health care for many Americans. Of the 281 million people age 5 and over in the United States in 2007, 55.4 million individuals (20%) reported speaking a language other than English at home. Many of these people lack health insurance.

- Compared with patients who speak English at home, patients who speak Spanish at home were more likely to report poor communication with nurses while patients who speak some other language at home were more likely to report poor communication with both nurses and doctors.
- In 2007, Hispanic adults were significantly more likely than non-Hispanic adults to have a usual source of care with language assistance.
- In 2007, White adults with limited English proficiency were significantly more likely than Asians to have a usual source of care with language assistance.

- In 2007, non-Hispanic White patients in California were significantly less likely than Hispanic patients to need a translator during their last doctor visit. Non-Hispanic Whites were also less likely than Mexicans and Central Americans to need a translator. Asians were significantly more likely than non-Hispanic Whites to need a translator during their last doctor visit (4.1% compared with 0.7%). There were, however, no statistically significant differences between the overall Asian population and Chinese or Vietnamese patients. There were also no significant differences between Chinese and Vietnamese patients.
- In California, patients under age 65 with public insurance and uninsured patients were less likely than patients with private insurance to find it easy to read the instructions on a prescription bottle.

Summary

The 2010 NHQR and 2010 NHDR emphasize the need to accelerate progress if the Nation is to achieve higher quality and more equitable health care for all Americans in the near future. Among the themes that emerge from the reports are:

- Health care quality and access are suboptimal, especially for minority and low-income groups.
- Quality is improving; access and disparities are not improving.
- Urgent attention is warranted to ensure improvements in quality and progress on reducing disparities with respect to certain services, geographic areas, and populations, including:
 - Cancer screening and management of diabetes.
 - States in the central part of the country.
 - Residents of inner-city and rural areas.

- Disparities in preventive services and access to care.
- Progress is uneven with respect to eight national priority areas:
 - Two are improving in quality: (1) Palliative and End-of-Life Care and (2) Patient and Family Engagement.
 - Three are lagging: (3) Population Health, (4) Safety, and (5) Access.
 - Three require more data to assess: (6) Care Coordination, (7) Overuse, and (8) Health System Infrastructure.
 - All eight priority areas showed disparities related to race, ethnicity, and socioeconomic status.

Additional Information

The 2010 National Healthcare Disparities Report is available online at <http://www.ahrq.gov/qual/qdr10.htm>.

Additional information on programs and activities related to minority health at the Agency is available on the AHRQ Web site at <http://www.ahrq.gov/research/minorix.htm> or by contacting:

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