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Disparities in Health and Health Care: Five Key Questions and Answers

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Executive Summary

1. WHAT ARE HEALTH AND HEALTH CARE DISPARITIES?

Health and health care disparities refer to differences in health and health care between population groups. Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation.

2. WHY DO HEALTH AND HEALTH CARE DISPARITIES MATTER?

Disparities in health and health care not only affect the groups facing disparities, but also limit overall improvements in quality of care and health for the broader population and result in unnecessary costs. As the population becomes more diverse, with people of color projected to account for over half of the population in 2045, it is increasingly important to address health disparities.

3. WHAT IS THE STATUS OF DISPARITIES TODAY?

Many groups are at disproportionate risk of being uninsured, lacking access to care, and experiencing worse health outcomes, including people of color and low-income individuals. Hispanics, Blacks, American Indians/Alaska Natives, and low-income individuals are more likely to be uninsured relative to Whites and those with higher incomes. Low-income individuals and people of color also face increased barriers to accessing care, receive poorer quality care, and experience worse health outcomes.

4. WHAT ARE KEY INITIATIVES TO ADDRESS DISPARITIES?

The 2011 Department of Health and Human Services (HHS) Disparities Action Plan and the Affordable Care Act (ACA) advance efforts to reduce health disparities. The HHS Disparities Action Plan sets out a series of priorities, strategies, actions, and goals to achieve a vision of "a nation free of disparities in health and health care." The ACA increases coverage options for low- and moderate-income populations and includes other provisions to address disparities. States, local communities, private organizations, and providers are also engaged in efforts to reduce health disparities.

5. HOW HAS THE ACA AFFECTED HEALTH COVERAGE DISPARITIES?

The ACA sharply reduced uninsured rates for people of color and low-income populations, but coverage disparities remain. Continued enrollment efforts may further narrow disparities, but eligibility for coverage under the ACA among the remaining nonelderly uninsured varies by race and ethnicity.

Introduction

Disparities in health and health care in the United States have been a longstanding challenge resulting in some groups receiving less and lower quality health care than others and experiencing poorer health outcomes. This brief provides an introductory overview of health and health care disparities, including what disparities are and why they matter, the status of disparities today, and key efforts to address disparities, including provisions in the Affordable Care Act (ACA) and their impact on health coverage disparities.

1. What are Health and Health Care Disparities?

Health and health care disparities refer to differences in health and health care between populations. Disparities in "health" and "health care" are related, but not synonymous, concepts. A "health disparity" refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another.[1] A "health care disparity" typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care. More specifically, health and health care disparities often refer to differences that cannot be explained by variations in health care needs, patient preferences, or treatment recommendations. Several related terms, such as health inequality and health inequity, are also often used interchangeably[2] to describe differences that are socially-determined and/or deemed to be unnecessary, avoidable, or unjust.[3]

A complex and interrelated set of individual, provider, health system, societal, and environmental factors contribute to disparities in health and health care. Individual factors include a variety of health behaviors from maintaining a healthy weight to following medical advice. Provider factors encompass issues such as provider bias and cultural and linguistic barriers to patient-provider communication. How health care is organized, financed, and delivered also shapes disparities as do social and environmental factors, such as poverty, education, proximity to care, and neighborhood safety.
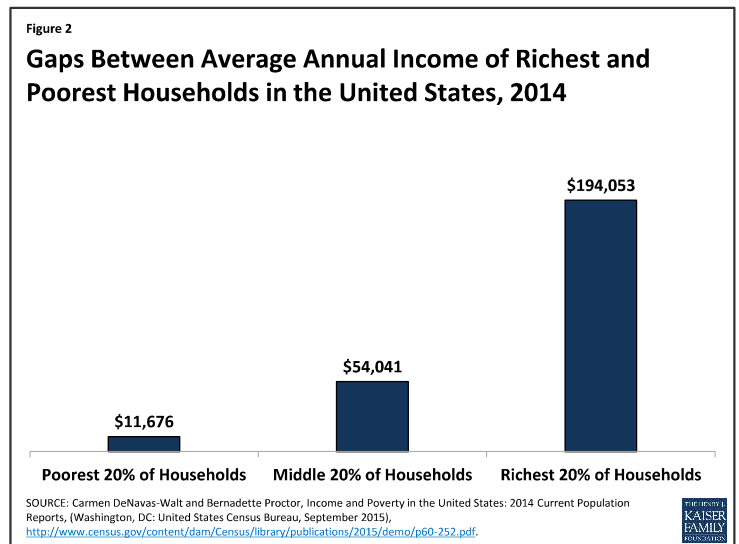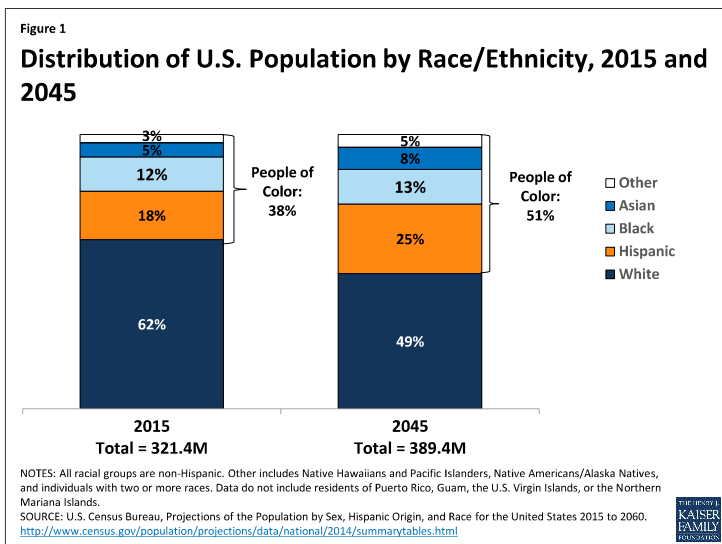
Health and health care disparities are commonly viewed through the lens of race and ethnicity, but they occur across a broad range of dimensions. Examples of characteristics across which disparities occur include socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation. Federal efforts to reduce disparities include a focus on designated priority populations who are particularly vulnerable to health and health care disparities.[4,5] These priority populations include people of color, low-income groups, women, children, older adults, individuals with special health care needs, and individuals living in rural and inner-city areas.[6] These groups are not mutually exclusive and often interact in important ways. Disparities also occur within subgroups of populations. For example, there are differences among Hispanics in health and health care based on length of time in the country, primary language, and immigration status.[7,8]

Health and health care disparities in the United States are a long-standing and persistent issue. Disparities have been documented for many decades and, despite overall improvements in population health over time, many disparities have persisted and, in some cases, widened.[9] Research also suggests that disparities occur across the life course, from birth, through mid-life, and among older adults.[10,11]

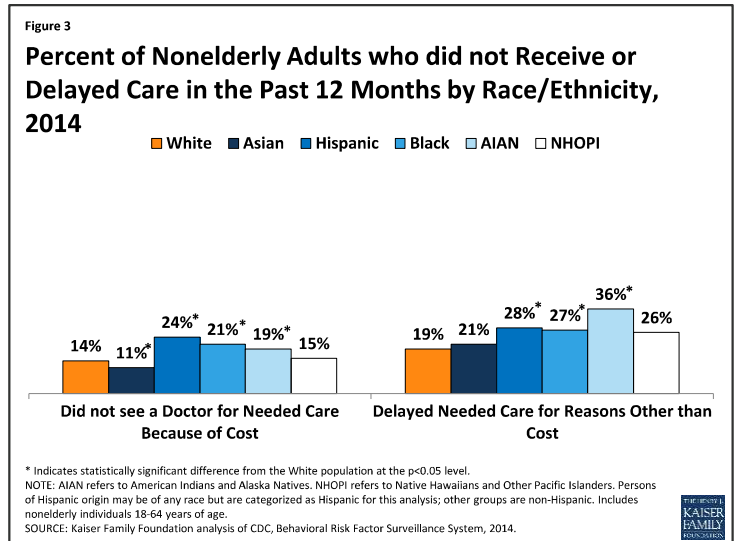# 2. Why do Health and Health Care Disparities Matter?

Disparities in health and health care not only affect the groups facing disparities, but also limit overall improvements in quality of care and health for the broader population and result in unnecessary costs. Addressing disparities in health and health care is not only important from a social justice standpoint, but also for improving the health of all Americans by achieving improvements in overall quality of care and population health. Moreover, health disparities are costly. One analysis estimates that approximately 30% of total direct medical expenditures for Blacks, Hispanics, and Asians are excess costs due to health inequities.[12] Disparities also result in economic losses due to indirect costs associated with lost work productivity and premature death.[13]

As the population becomes more diverse, it is increasingly important to address health disparities. Over time the population is becoming increasingly heterogeneous. In 2015, nearly four in ten (38%) individuals living in the United States were people of color. It is projected that people of color will account for over half of the population in 2045, with the largest growth occurring among Hispanics (Figure 1). Moreover, the gaps between the richest households and poor and middle income households are wide and growing in most states. As of 2014, the richest 20% of households have an average income of $194,053, nearly 17 times the average income of $11,676 for the bottom 20% of households (Figure 2).[14] Given that people of color make up a disproportionate share of the low-income[15] and the uninsured[16] relative to their size in the population, the growth of communities of color and widening of income gaps amplify the importance of addressing health and health care disparities.

Figure 1

Distribution of U.S. Population by Race/Ethnicity, 2015 and 2045

NOTES: All racial groups are non-Hispanic. Other includes Native Hawaiians and Pacific Islanders, Native Americans/Alaska Natives, and individuals with two or more races. Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands.
SOURCE: U.S. Census Bureau, Projections of the Population by Sex, Hispanic Origin, and Race for the United States 2015 to 2060. http://www.census.gov/population/projections/data/national/2014/summarytables.html

Figure 2

Gaps Between Average Annual Income of Richest and Poorest Households in the United States, 2014

SOURCE: Carmen DeNavas-Walt and Bernadette Proctor, Income and Poverty in the United States: 2014 Current Population Reports, (Washington, DC: United States Census Bureau, September 2015), http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf.
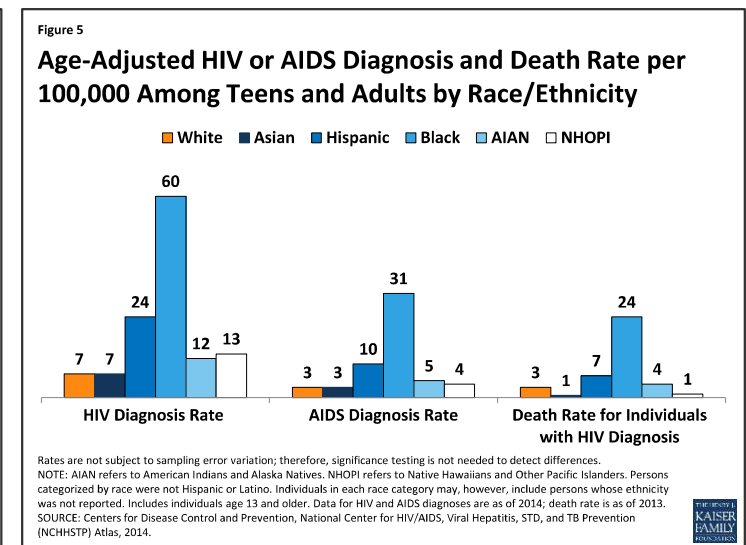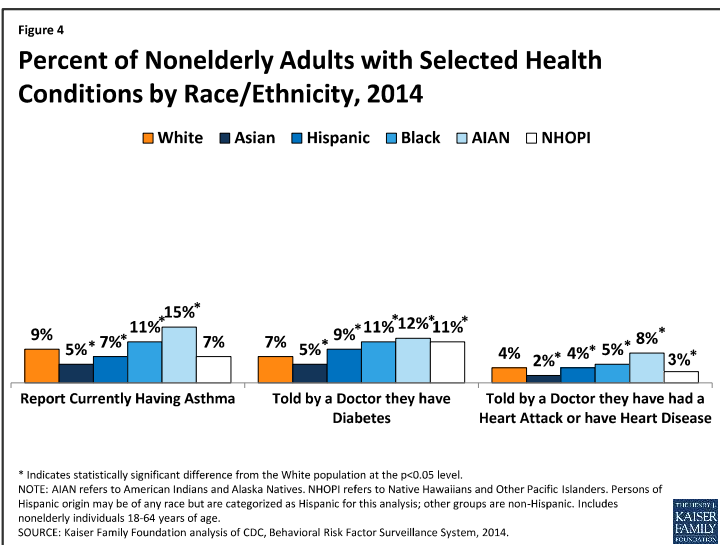
3. What is the Status of Disparities Today?

Today, many groups face significant disparities in access to and utilization of care. People of color generally face more access barriers and utilize less care than Whites. For example, among nonelderly adults, Hispanics, Blacks, and American Indians and Alaska Natives are more likely than Whites to delay or go without needed care (Figure 3).[17] Moreover, nonelderly Black and Hispanic adults are less likely than their White counterparts to have a usual source of care or to have had a health or dental visit in the previous year.[18] Low-income individuals also experience more barriers to care and receive poorer quality care than high-income individuals[19], and lesbian, gay, bisexual, and transgender (LGBT) individuals are more likely to experience challenges obtaining care than heterosexuals.[20] In addition, individuals with limited English proficiency are less likely than those who are English proficient to seek care even when insured.[21] Patient experiences and satisfaction levels also differ by race, gender, education levels, and language.[22,23,24]

Figure 3

Percent of Nonelderly Adults who did not Receive or Delayed Care in the Past 12 Months by Race/Ethnicity, 2014

Legend: White, Asian, Hispanic, Black, AIAN, NHOPI

Did not see a Doctor for Needed Care Because of Cost: 14%, 11%*, 24%*, 21%*, 19%*, 15%

Delayed Needed Care for Reasons Other than Cost: 19%, 21%, 28%*, 27%*, 36%*, 26%

* Indicates statistically significant difference from the White population at the p<0.05 level.
NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 18-64 years of age.
SOURCE: Kaiser Family Foundation analysis of CDC, Behavioral Risk Factor Surveillance System, 2014.

Additionally, some groups have high rates of certain health conditions and experience poor health outcomes. Blacks and American Indians and Alaska Natives fare worse than Whites on many measures of health status and health outcomes. For example, among nonelderly adults, Blacks and American Indians and Alaska Natives have a higher prevalence of asthma, diabetes, and cardiovascular disease (Figure 4). Health disparities are particularly striking in the burden of AIDS and HIV diagnoses and death rates, with Blacks experiencing over eight and ten times higher rates of HIV and AIDS diagnoses than Whites (Figure 5).[25] Infant mortality rates are significantly higher for Blacks and American Indians and Alaska Natives compared to Whites[26], and Black males have the shortest life expectancy compared to other groups.[27] Low-income people of all races report worse health status than higher income individuals.[28] Further, research suggests that some subgroups of the LGBT community have more chronic conditions as well as higher prevalence and earlier onset of disabilities than heterosexuals.[29]

Figure 4

Percent of Nonelderly Adults with Selected Health Conditions by Race/Ethnicity, 2014

Legend: White, Asian, Hispanic, Black, AIAN, NHOPI

Report Currently Having Asthma: 9%, 5%*, 7%*, 11%*, 15%*, 7%

Told by a Doctor they have Diabetes: 7%, 5%*, 9%*, 11%*, 12%*, 11%*

Told by a Doctor they have had a Heart Attack or have Heart Disease: 4%, 2%*, 4%*, 5%*, 8%*, 3%*

* Indicates statistically significant difference from the White population at the p<0.05 level.
NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 18-64 years of age.
SOURCE: Kaiser Family Foundation analysis of CDC, Behavioral Risk Factor Surveillance System, 2014.

Figure 5

Age-Adjusted HIV or AIDS Diagnosis and Death Rate per 100,000 Among Teens and Adults by Race/Ethnicity

Legend: White, Asian, Hispanic, Black, AIAN, NHOPI

HIV Diagnosis Rate: 7, 7, 24, 60, 12, 13

AIDS Diagnosis Rate: 3, 3, 10, 31, 5, 4

Death Rate for Individuals with HIV Diagnosis: 3, 1, 7, 24, 4, 1

Rates are not subject to sampling error variation; therefore, significance testing is not needed to detect differences.
NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons categorized by race were not Hispanic or Latino. Individuals in each race category may, however, include persons whose ethnicity was not reported. Includes individuals age 13 and older. Data for HIV and AIDS diagnoses are as of 2014; death rate is as of 2013.
SOURCE: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2014.

4. What are Key Initiatives to Eliminate Disparities?

Significant recognition of health and health care disparities began over a decade ago with several landmark reports and the first major legislation focused on reduction of disparities. The release of two Surgeon General's reports in the early 2000s showed disparities in tobacco use and access to mental health services by race and ethnicity.[30,31] The first major legislation focused on reduction of disparities, the Minority Health and Health Disparities Research and Education Act of 2000,[32] created the National Center for Minority Health and Health Disparities, and authorized the Agency for Healthcare Research and Quality (AHRQ) to regularly measure progress on reduction of disparities. Soon after, the Institute of Medicine released two seminal reports documenting racial and ethnic disparities in access to and quality of care.[33,34]

In 2011, the Department of Health and Human Services (HHS) developed an action plan for eliminating racial and ethnic health disparities. The HHS Disparities Action Plan sets out a series of priorities, strategies, actions, and goals to achieve its vision of, "a nation free of disparities in health and health care."[35] Since the release of the report, HHS has undertaken various efforts to implement the Disparities Action Plan, including coordinating programmatic and policy efforts to advance health equity, expanding access and quality of coverage and care, and strengthening the health care infrastructure and workforce.[36] In 2013, HHS also updated the national standards for Culturally and Linguistically Appropriate Services (CLAS), which seek to ensure that people receive care in a culturally and linguistically appropriate manner.

The ACA advances efforts to improve health and health care and reduce disparities.[37] Some provisions explicitly focus on disparities, including creating Offices of Minority Health within key HHS agencies to coordinate disparity reduction efforts. Others have broader goals that will benefit groups facing disparities, such as the major health coverage expansions and increased funding for community health centers. The ACA also promotes workforce diversity and cultural competence, increasing funding for health care professional and cultural competence training and education materials, and strengthens data collection and research efforts. Lastly, the ACA includes prevention and public health initiatives, like a national oral health education campaign with an emphasis on racial and ethnic disparities, and permanently reauthorizes the Indian Health Care Improvement Reauthorization Extension Act of 2009.
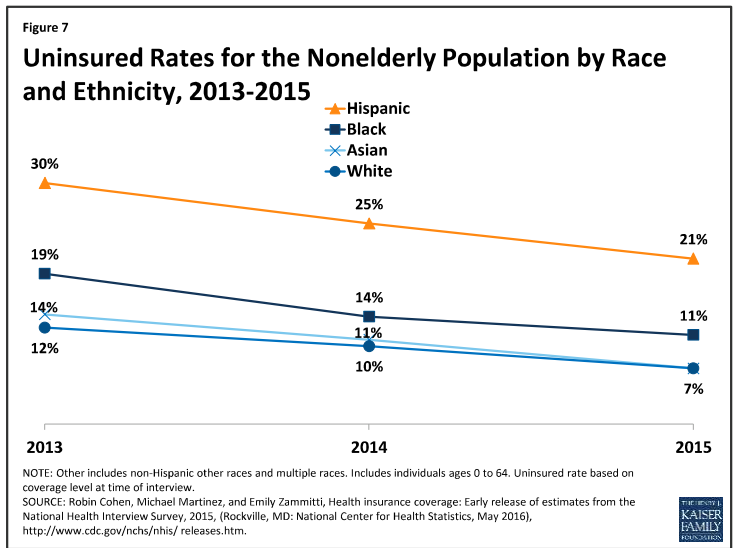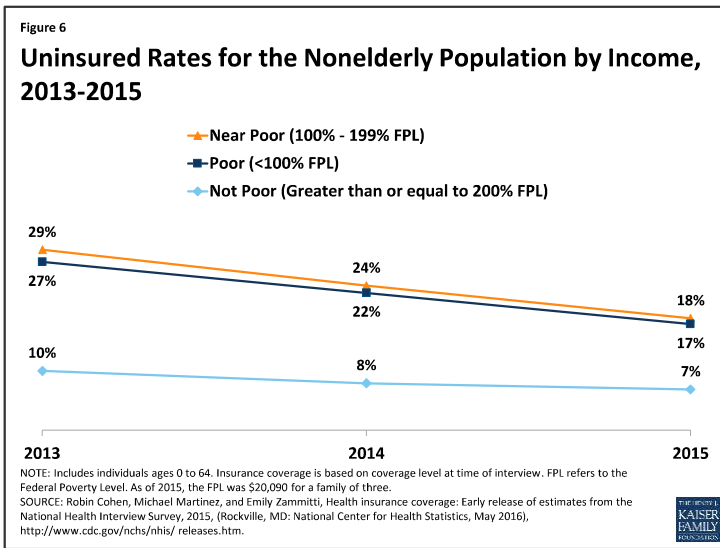
States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities. Through Racial and Ethnic Approaches to Community Health (REACH) grants funded by the Centers for Disease Control and Prevention, a number of states, local health departments, universities and non-profit groups implemented community-focused interventions to reduce specific neighborhood-based disparities.[38] These interventions vary in scope and focus on outreach, cultural competency training, and education.[39] Private foundations have also developed significant initiatives aimed at reducing disparities and providers are increasingly undertaking disparities-focused efforts.[40]

Growing efforts to integrate social and environmental needs into the health care system may support continued reductions in disparities. A number of states are engaged in payment and delivery system reforms that focus on population health and recognize the role of social determinants of health. The Centers for Medicare & Medicaid Services also launched a new Accountable Health Communities initiative to test delivery approaches that address health-related social needs through clinical-community linkages.[41]
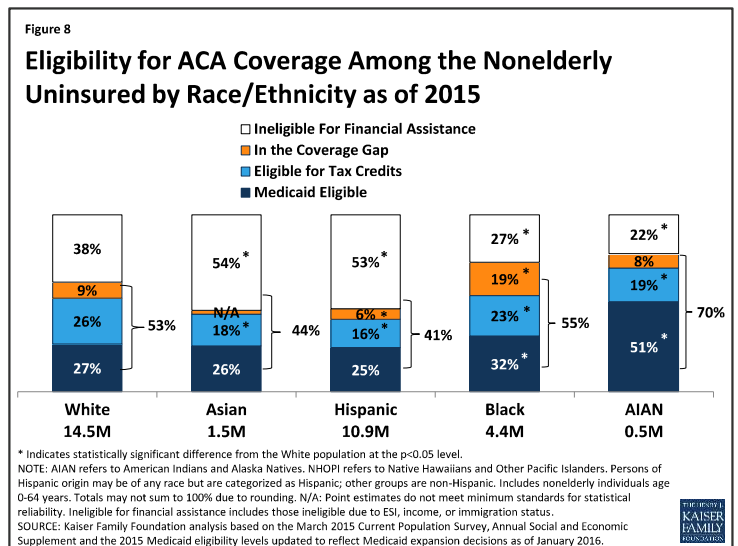
5. How has the ACA Affected Health Coverage Disparities?

The ACA sharply reduced the uninsured rate for low-income groups and people of color, but coverage disparities remain. The ACA significantly increased coverage options for low- and moderate-income populations. Under the ACA, Medicaid coverage is extended to low-income adults with incomes up to 138% of the federal poverty level (FPL) ($27,724 for a family of three in 2016) in the 32 states that have implemented the Medicaid expansion to date, and tax credits are available for middle-income people who purchase coverage through health insurance Marketplaces established under the ACA. Since these coverage provisions took effect in 2014, uninsured rates for the nonelderly population have decreased, falling from 17% in 2013 to 11% in 2015.[42] Uninsured rates declined most sharply among the poor or near-poor and among Hispanics, Blacks, and Asians (Figures 6 and 7). Although these reductions have narrowed disparities for these groups, they remain more likely to be uninsured compared to higher income people and Whites.

Figure 6

Uninsured Rates for the Nonelderly Population by Income, 2013-2015

- Near Poor (100% - 199% FPL)
- Poor (<100% FPL)
- Not Poor (Greater than or equal to 200% FPL)

29% 27% 10% (2013) — 24% 22% 8% (2014) — 18% 17% 7% (2015)

NOTE: Includes individuals ages 0 to 64. Insurance coverage is based on coverage level at time of interview. FPL refers to the Federal Poverty Level. As of 2015, the FPL was $20,090 for a family of three.
SOURCE: Robin Cohen, Michael Martinez, and Emily Zammitti, Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2015, (Rockville, MD: National Center for Health Statistics, May 2016), http://www.cdc.gov/nchs/nhis/ releases.htm.

Figure 7

Uninsured Rates for the Nonelderly Population by Race and Ethnicity, 2013-2015

- Hispanic
- Black
- Asian
- White

30% 19% 14% 12% (2013) — 25% 14% 11% 10% (2014) — 21% 11% 7% (2015)

NOTE: Other includes non-Hispanic other races and multiple races. Includes individuals ages 0 to 64. Uninsured rate based on coverage level at time of interview.
SOURCE: Robin Cohen, Michael Martinez, and Emily Zammitti, Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2015, (Rockville, MD: National Center for Health Statistics, May 2016), http://www.cdc.gov/nchs/nhis/ releases.htm.

Continued efforts to enroll eligible individuals into coverage will contribute to ongoing coverage gains and narrowing of disparities, but eligibility for coverage under the ACA among the remaining nonelderly uninsured varies by race and ethnicity. American Indians and Alaska Natives have the highest share of nonelderly uninsured who are eligible for Medicaid or tax credits at 70%, followed by Blacks at 55% (Figure 8). However, Blacks are twice as likely as Whites to falls into the coverage gap that exists in the 19 states that have not expanded Medicaid. Consistent with immigrants accounting for large shares of uninsured Asians and Hispanics, over half of these groups remain ineligible for coverage options.

Figure 8

Eligibility for ACA Coverage Among the Nonelderly Uninsured by Race/Ethnicity as of 2015

- ☐ Ineligible For Financial Assistance
- ■ In the Coverage Gap
- ■ Eligible for Tax Credits
- ■ Medicaid Eligible

	White 14.5M	Asian 1.5M	Hispanic 10.9M	Black 4.4M	AIAN 0.5M
Ineligible For Financial Assistance	38%	54%*	53%*	27%*	22%*
In the Coverage Gap	9%	N/A	6%*	19%*	8%
Eligible for Tax Credits	26%	18%*	16%*	23%*	19%*
Medicaid Eligible	27%	26%	25%	32%*	51%*
(combined)	53%	44%	41%	55%	70%

* Indicates statistically significant difference from the White population at the p<0.05 level.
NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic. Includes nonelderly individuals age 0-64 years. Totals may not sum to 100% due to rounding. N/A: Point estimates do not meet minimum standards for statistical reliability. Ineligible for financial assistance includes those ineligible due to ESI, income, or immigration status.
SOURCE: Kaiser Family Foundation analysis based on the March 2015 Current Population Survey, Annual Social and Economic Supplement and the 2015 Medicaid eligibility levels updated to reflect Medicaid expansion decisions as of January 2016.

CONCLUSION

In conclusion, health and health care disparities persist in the United States, leading to certain groups being at higher risk of being uninsured, having more limited access to care, experiencing poorer quality of care, and ultimately experiencing worse health outcomes. While health and health care disparities are commonly viewed through the lens of race and ethnicity, they occur across a broad range of dimensions and reflect a complex set of individual, social, and environmental factors. Disparities not only affect the groups facing disparities but also limit continued improvement in overall quality of care and health for the broader population and result in unnecessary costs. It is increasingly important to address disparities as the population becomes more diverse. For over the past decade, there has been increased focus on reducing disparities and a growing set of initiatives to address disparities at the federal, state, community, and provider level. In addition, the ACA includes provisions that advance efforts to eliminate disparities. The ACA's coverage expansions have resulted in notable coverage gains for low- and moderate-income populations and people of color that have helped narrow differences in coverage rates, but disparities in coverage for these groups remain. As the population becomes increasingly diverse, broad and integrated efforts to address the wide range of factors that contribute to disparities, including social and environmental factors that extend beyond the health care system, will be important.

Endnotes

[1] Definitions of health disparity differ. For example, the Department of Health and Human Services describes health disparities as "differences in health outcomes that are closely linked with social, economic, and environmental disadvantage" while the National Institutes of Health defines a health disparity as a "difference in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States." United States Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, (Washington, DC: Department of Health and Human Services, April 2011), http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf. "NIH Announces Institute on Minority Health and Health Disparities," National Institutes of Health, published September 2010, https://www.nih.gov/news-events/news-releases/nih-announces-institute-minority-health-health-disparities.

[2] However, they may have nuanced distinctions. For example, a health disparity, which typically refers to differences caused by social, environmental attributes, is sometimes distinguished from a health inequality, used more often in scientific literature to describe differences associated with specific attributes such as income, or race. A health inequity implies that a difference is unfair or unethical. Centers for Disease Control and Prevention, "CDC Health Disparities and Inequalities Report – United States 2011," *Morbidity and Mortality Weekly Report* 60 *(*Jan 2011):55-114. Olivia Carter-Pokras and Claudia Baquet. "What is a Health Disparity?" *Public Health Reports* 117 *(*Sep-Oct 2002):426-434.

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[6] Agency for Healthcare Research and Quality, *Agency for Healthcare Research and Quality: Division of Priority Populations,* (Rockville, MD: Agency for Healthcare Research and Quality, 2016)*,* http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/factsheets/priority-populations/prioritypopulations_factsheet.pdf.

[7] Kaiser Commission on Medicaid and the Uninsured, *Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2013), http://www.kff.org/uninsured/8279.cfm.

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[39] Ibid.

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that is working to share ideas, experiences, and solutions to real world problems that arise as a result of cross-cultural interactions that hinder the elimination of disparities in healthcare settings.

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