IDEAS IN ACTION

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Taking Action
Making Change
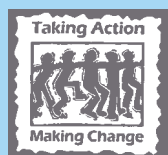
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THE **HEALTH EQUITY** CHALLENGE
People of Color are Living Sicker and Dying Younger in California

Introduction

Racial and ethnic disparities in health constitute a crisis, one that requires the attention of health care providers, policymakers, and communities alike. In California, and across the nation, people of color consistently face higher rates of sickness and mortality than whites. These higher rates are experienced not just for one or two diseases, but across a very broad spectrum of illnesses and injuries.[1] People of color in California are also more likely to be among the 47 million people in the U.S. without health insurance.[2]

Across California and nationwide, health care reform has become a key priority. Health disparities harm all members of a community, and securing a guarantee of quality, affordable health care for everyone in America requires attention to racial disparities in health care. This report discusses some of the key health disparities in California and the United States and makes recommendations for addressing those disparities.

People Of Color Suffer From Poorer Health

Nationwide and in California, people of color suffer from worse health than do whites on a range of indicators. Whether one looks at maternity health, infant health, chronic illnesses such as diabetes, or mortality rates, the disturbing fact remains – there are serious racial and ethnic disparities in health.

The early years

The racial gap appears early in life. The rate of infant mortality among African Americans in California is two times higher than for any other ethnic group, and two and a half times that of whites. (See Figure 1.) Native American infants also die at a rate almost 25 percent greater than the national average. (See figure 1.) African American mothers give birth to the highest percentage of babies with low birth weights.[3]

Infant mortality by 1,000 live births by race and ethnicity in California

Race/Ethnicity	Rate
White	4.6
African American	11.4
Latino	5.0
Native American	6.2
Asian or Pacific Islander	4.2
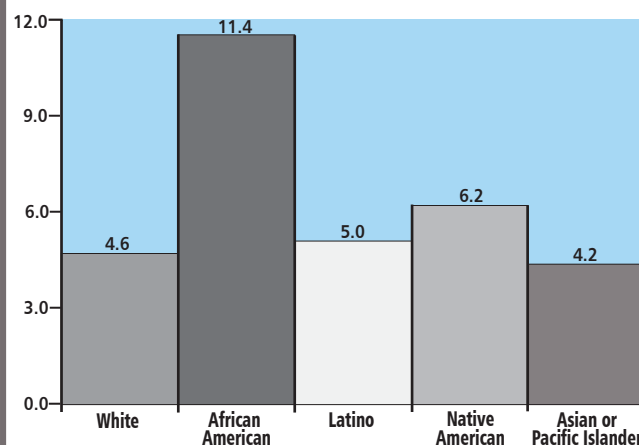
Source: National Vital Statistics Reports, Vol 57, No 2," National Center for Health Statistics. 2008

Figure 1

Cancer

A 2008 report from the California Cancer Registry on cancer by race and ethnicity indicated that though the rates of new cancer cases and cancer deaths have declined, racial and ethnic disparities persist. While white women have higher rates of new cancer cases than women of other racial/ethnic groups, African American women suffer the highest morbidity from cancer. African American men have the highest overall rates of both new cancer cases and cancer deaths.[4]

Diabetes

Almost 12 percent of African American adults in California have diabetes, a rate 45 percent greater than the rate for whites. Latino adults are over 35 percent more likely to have diabetes than are white adults. (See figure 2.)
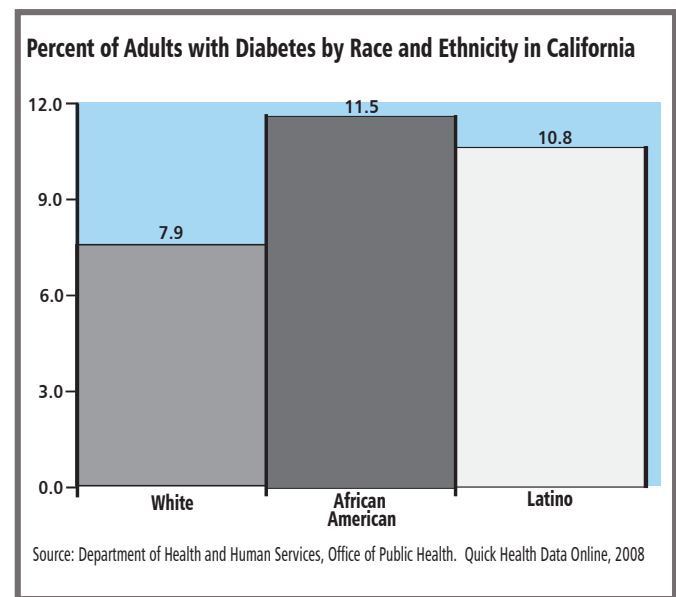
Percent of Adults with Diabetes by Race and Ethnicity in California

White	African American	Latino
7.9	11.5	10.8

Source: Department of Health and Human Services, Office of Public Health. Quick Health Data Online, 2008

Figure 2

Asthma

African Americans have the highest rates of adult asthma in California – almost 15 percent. The rate of adult asthma for African Americans is almost three times that for Latinos and almost 60 percent higher than that for whites. (See figure 3.)
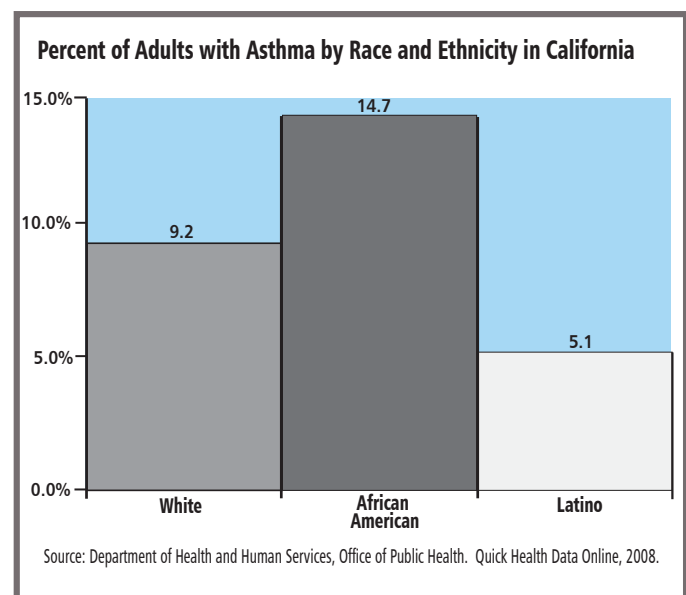
Percent of Adults with Asthma by Race and Ethnicity in California

White	African American	Latino
9.2	14.7	5.1

Source: Department of Health and Human Services, Office of Public Health. Quick Health Data Online, 2008.

Figure 3

Access Matters

The high cost of health care is a well known barrier to quality care in the United States. Nearly two thirds of personal bankruptcy filings are linked to medical expenses.[5] The cost barrier is exacerbated for people of color, who are more likely to be uninsured[6] and are often unable to afford quality care. Compared to whites, African Americans and Latinos more often go without health care due to cost.[7]

The importance of insurance

Nationwide, African Americans are nearly twice as likely and Latinos nearly three times as likely to be uninsured as whites.[8] In California, disparity also exists: Native Americans are twice as likely and Latinos nearly three times as likely as whites to be uninsured. (See figure 4.)
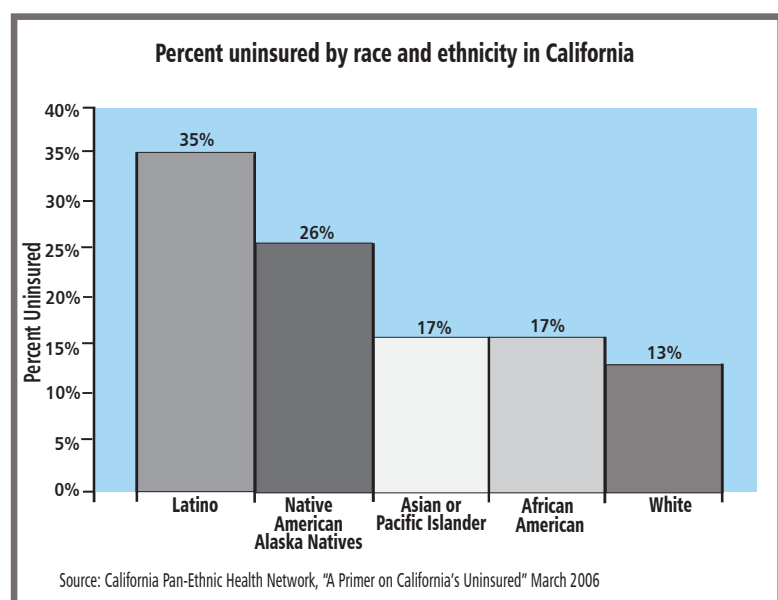

Figure 4

Without insurance coverage, people are less likely to receive medical care, more likely to have poor health, and more likely to die early.[9] Lack of insurance has been shown to be fatal; a 2002 report from the Institute of Medicine found that 18,000 people die each year as a result.[10]

People of color are over-represented among the uninsured for a number of reasons. They tend to be concentrated in low-income jobs that are less likely to offer affordable health insurance, and they also face eligibility barriers to public programs related to immigration status.[11]

Even for those with employer-provided insurance, access is withering. According to a 2008 report from the California HealthCare Foundation, between 1987 and 2007 employer-sponsored coverage in California dropped almost eight percent.[12] Furthermore, despite small increases in Medicaid and individually purchased coverage, over 20 percent of Californians remain uninsured.[13] This is especially significant because of California's large population: the number of people without insurance — 6.6 million — is the highest of any state.[14]

Health care infrastructure is failing people of color

In many places across the country, there is simply less health care infrastructure for people of color to turn to even when they have insurance. There is increasing evidence that hospitals are often located farther away from communities of color and serve people of color less frequently.[15] The community health centers that tend to serve patients of color[16] face work-force shortages.[17] Additionally, patients at these clinics often have difficulty getting referrals for services offered outside the clinics, such as specialty care, diagnostics, and mental health and substance dependency treatment.[18]

Not surprisingly, people of color in California receive less necessary health care than do whites. For example, during 2003-2005, almost 25 percent of babies born to Native American mothers did not receive prenatal care. (See figure 5.) This is more than two and a half times the rate for babies born to white mothers. (See figure 5.) Meanwhile, babies born to African American mothers were almost 75 percent more likely not to receive prenatal care compared to babies born to white women. (See figure 5.)
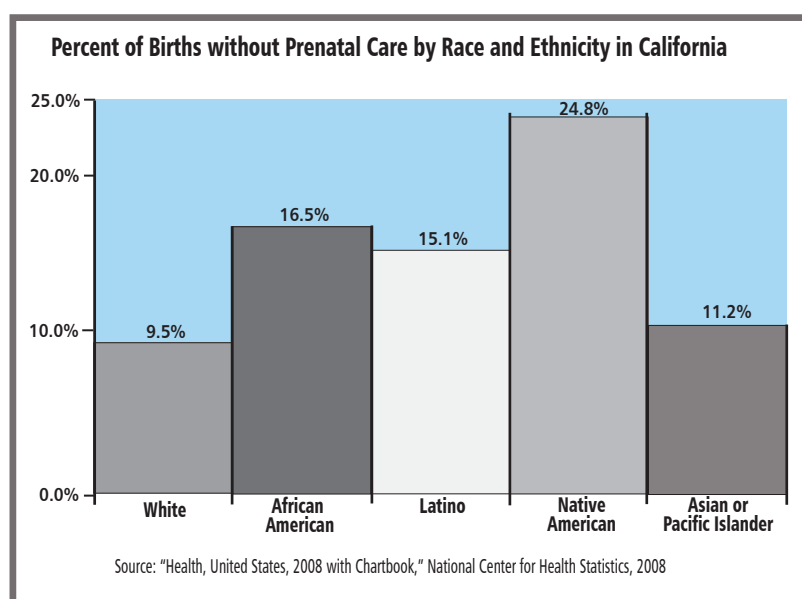

Percent of Births without Prenatal Care by Race and Ethnicity in California

White: 9.5%
African American: 16.5%
Latino: 15.1%
Native American: 24.8%
Asian or Pacific Islander: 11.2%

Source: "Health, United States, 2008 with Chartbook," National Center for Health Statistics, 2008

Figure 5

In California, Latino, Native American, African American and Asian/Pacific Islander babies are all more likely to be born without early prenatal care. (See figure 5.) This is likely related to the fact that a greater proportion of African American and Latino adults in the U.S. lack a usual place of health care – with Latinos more than twice as likely as whites to lack a regular doctor.[19]

People of color receive lower quality care

Even when people of color gain access to health care services, they are more likely than whites to receive inadequate care. Wait times for seeing a doctor are longer for people of color.[20] People of color are given tests to determine risk of heart attack or stroke less frequently.[21] And Asians and Latinos are more likely to die from complications during hospitalization.[22]

Stereotypes and biases can interfere with effective communication between patients and doctors and other health care staff. More than 50 percent of Asians and over 40 percent of Latinos have reported that their doctors do not listen to them.[23] Almost 40 percent of African Americans have reported not entirely trusting their specialist physician.[24]

Cultural and Linguistic Barriers

Lack of professional interpretation also hurts the quality of care. Nearly 20 percent of people in the U.S. speak a language other than English at home,[25] yet health care facilities often fail to provide interpretation and translation.[26]

In a 2002 national study, 33 percent of Latinos cited communication problems with their doctor (versus 16 percent of whites).[27] Despite apparent communication difficulties, less than half of non-English speakers were consistently provided an interpreter.[28]

In California this takes on increased urgency, as almost 40 percent of Californians speak a language other than English at home.[29] Nonetheless, barely a third of Spanish-speaking patients in one study said that a majority of the health care professionals they visit are able to accommodate them. One in five Spanish-speaking patients said they had not pursued care when needed because the provider neither spoke Spanish nor provided an interpreter.[30]

When hospitals and clinics fail to provide language services they are effectively shutting their doors to patients of limited English. They also seriously increase the possibility of misdiagnosis and treatment that falls short of professional standards. For instance, one study of hospital data found that patients who did not speak English as their primary language were more likely to experience adverse health outcomes not related to their underlying medical condition.[31]

Lastly, differences in background and misunderstandings of culture can cause a doctor and patient to understand illness differently.[32] For example, doctors may not appreciate or understand the role of Native American rituals in healing.

Mental health

In California, approximately five million people have a mental illness and approximately 1.3 million Californians experience severe mental illness.[33] In 2001, the Surgeon General reported striking disparities in mental health care for racial/ethnic minorities in terms of access and availability of services and treatment quality. These issues make it hard to determine actual incidence rates of mental health problems. However, African Americans are "more likely to experience a mental illness than their white counterparts," American Indian/Alaska Natives "appear to suffer disproportionately from depression," and Asian Americans and Pacific Islanders "are more likely to be misdiagnosed as 'problem-free'."[34]

The California Institute of Mental Health identifies overlapping social and physical health problems as important factors that need to be addressed in reducing or eliminating racial disparities in mental health. For example the fact that African Americans are overrepresented among HIV+, homeless, and foster care populations.[35]

Recommendations to address health inequities

Race and ethnic health inequities are not natural or inevitable. As the country discusses health care reform, access issues that particularly affect people of color must also be addressed. The following measures should be implemented to move toward health equity and the elimination of racial disparities in health.

- **Quality, affordable health coverage for all.** All people living in the United States should be guaranteed coverage that meets their needs. Moreover, recent research showing the reduction of health disparities through Medicare coverage points to the potential effectiveness of the choice of a public health insurance plan and reimbursement mechanisms that promote quality care.[36]

- **Expand investments in health care infrastructure and workforce development in communities of color.** The community health centers, public hospitals, and other facilities upon which patients of color rely should be guaranteed adequate funding. Financial support should be provided for the development of a diversified health care workforce committed to treating patients of color. The investment in the health care infrastructure should also include provisions for primary care, medical homes focusing on total wellness, and community health workers.

- **Ensure language access and cultural competence.** Resources and standards for language access and cultural competence should be integrated into any health care reform proposal, including access to professional, adequately funded language and translation services for all clinical encounters. Measures to improve cultural competence should involve sensitivity training, access to traditional treatments, and community health programs that incorporate cultural traditions.

- **Build a robust public health system.** Substantial improvements in health will be achieved by addressing the social determinants of health, such as a clean environment, occupational safety, access to nutritious food, and safe neighborhoods. A robust public health system, at a minimum, will invest in health planning, undertake prevention strategies, conduct disease surveillance and management, increase health literacy, and foster a health care safety net through community health care workers and clinics. Strong public health systems should also establish the utilization of health impact assessments (HIAs) during the policy-making process to ensure government accountability for both the positive and negative health consequences of public policy decisions.

- **Provide for the collection and reporting of data related to health disparities.** Data collection on race and ethnicity, as well as monitoring methodologies, must be improved and standardized in order to fully understand health inequities and develop effective interventions. Moreover, racial/ethnic disparities should be included in performance measures, and support should be provided for research (including community-specific studies) to take steps toward developing appropriate best practices in treatment and service delivery.

- **Ensure public accountability.** Effective health policies and programs should be adopted, with ongoing evaluation of obstacles and progress toward achieving health equity. Federal agencies, such as the Office of Civil Rights, should be provided adequate funding and authority to protect patients from discrimination. Additionally, patients should be guaranteed an opportunity to enforce their rights to non-discriminatory treatment.

Notes

In this report, the terms white, African American, Asian, Pacific Islander, and Native American refer to groups that are non-Hispanic unless otherwise noted.

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14 Ibid.

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16 National Association of Community Health Centers, "America's Health Centers," March 2009.

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22   "National Healthcare Disparities Report, 2008," Agency for Healthcare Research and Quality, 2008, p. 100.

23   "Racial and Ethnic Disparities in U.S. Health Care: A Chartbook," The Commonwealth Fund, March 2008, pp. 89, 93.

24   *Ibid.*

25   "National Healthcare Disparities Report, 2008," Agency for Healthcare Research and Quality, 2008, p. 214; see also, "Report to Congress. Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency," Office of Management and Budget, March 14, 2002, p. 4, viewed at: http://www.omhrc.gov/assets/pdf/checked/cultural12.pdf, accessed June 16, 2009. (The twenty most common foreign languages spoken in the United States are, in order of frequency, Spanish, French, German, Italian, Chinese, Tagalog, Polish, Korean, Vietnamese, Portuguese, Japanese, Greek, Arabic, Hindi, Russian, Yiddish, Thai, Persian, French Creole, and Armenian).

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