Disparities in Health Care among African Americans

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Abstract

Many variables determine the quality of health care received by persons of color in the United States. Differences in disease detection, diagnosis, and management of health care outcomes in African Americans date back to slavery. There are race differences, gender differences, and epidemiological differences in the treatment of African Americans in our health care system. Diseases such as prostate and colorectal cancer, infant mortality, chronic diseases like hypertension and diabetes all are very high among African Americans as compared to white Americans. The high rate of infectious diseases like Pneumonia and AIDS are consistently higher among African Americans. Contributing factors for these occurrences are a lack of regular sources for Primary care, social, financial, cultural, insurance related and linguistic barriers that increases the burden of disease and unresolved disparities in the U.S. healthcare system. Elimination of these healthcare disparities must take place in order to better manage healthcare and provide unbiased equal care and quality of life to all Americans. This article examines factors leading to healthcare disparities and identifies essential tasks to improve the quality of care received by African Americans and other racial minority groups.

Health Care Disparities among African Americans

Many variables determine the quality of healthcare received by persons of color in the United States. These variables include the type of health care system; health care delivery and setting in which services are provided; and type of health care provider and finances. Each of these variables affect the quality of health care provided to minorities within the United States. Currently our healthcare system is plagued with inequality in diagnosis and treatment across racial and ethnic lines, especially as it relates to African Americans and occurrences of over diagnosis of certain mental illnesses, or under diagnosis.

Health care disparities among racial and ethnic minorities are well documented in the United States (Ayanian 2000) and there are noted differences among population groups. These differences in health care often are called "disparity" or "inequity" or "inequality"; and are the result of several contributing factors such as social, economic and environmental disadvantage. Historically African Americans have not always received equity in health care, access to health care and equality in treatment, which has led to poorer overall health status than Caucasians.

The Institute of Medicine (IOM) report on unequal treatment confirmed the existence of racial and ethnic disparities in healthcare and deemed them unacceptable because of the consequent negative health outcomes (Smedley 2001). The IOM report has defined inequity in health care in terms of access, clinical needs, preferences,

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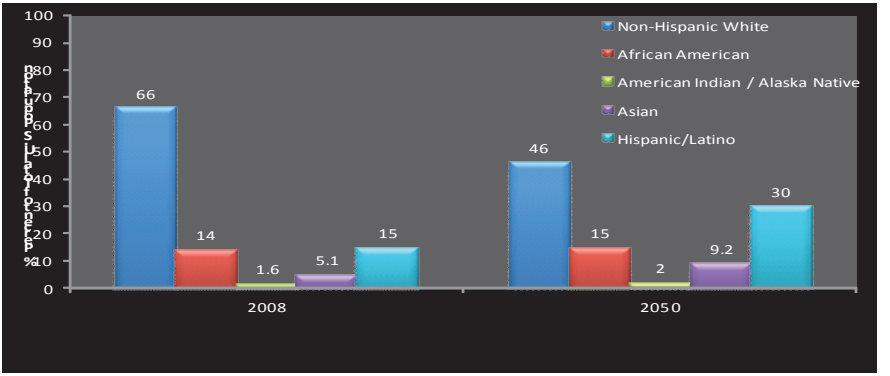
and appropriate interventions in the Kathleen G. Sebelius, Secretary of Health and Human Services, confirms the importance of health equity for the nation (Smedley 2001). Health disparities are defined as differences in health outcomes and these differences are determined by social, demographic, environmental, and geographic attributes (Carter-Pokras 2002). Health inequalities, which is sometimes used interchangeably with the term health disparities, is more often used in scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes such as income, education, or race/ethnicity (Asada 2010).

The 2011 Census Bureau estimates that there are approximately 40.9 million African Americans living in the U.S., comprising 13 percent of the total population. The African American population is not homogenous and includes individuals whose ancestors were brought to the U.S. as slaves, as well as recent immigrants from other countries. Of the approximately 3 million foreign-born African Americans, the majority were born in the Caribbean (54 percent) or Africa (34 percent). The African American population is not equally dispersed throughout the U.S., but is concentrated in New York, California, and the South (US Census Bureau 2004). Table 1 shows national population projections through 2050, and minority groups continue to reflect lower population group numbers.

Table 1: National Population Projections, 2008 – 2050 (US Census Bureau 2008)



The low numbers of minority groups, particularly African Americans, in these projections raises serious questions for the authors especially as we note that disparities are associated largely to a matter of socioeconomic status differences among race/ethnic groups and that public policies link health insurance to employment or citizenship. Using today's economy as a measure, African Americans will continue to be under-represented in health care for heart disease, stroke, cancer, diabetes, obesity, HIV/AIDS, prenatal care, immunizations, asthma, and mental health services, primarily due to poor or inadequate economic access to care. This is reiterated by Mukamel (2007), Palacio (2002), and Smedley (2003) in their report that non-Caucasian patients are less likely than Caucasian patients are to receive appropriate medical treatment across a variety of conditions and treatment types.

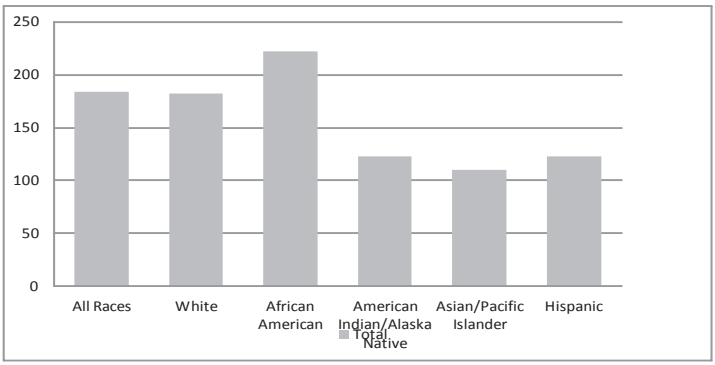
Obesity

Obesity is one of the most common examples of diseases where disparities are evident in the United States. Seven out of 10 African Americans ages 18 to 64 are obese or overweight, and African Americans are 15 percent more likely to suffer from obesity than the Caucasian population. Recent increases in obesity likely result from the interaction of biologic, social, and cultural factors with an environment char¬acterized by sedimentary behaviors and an abundance of high-calorie foods (French 2001; Kuczmarski and Flegal 1994).

Cancer

The incidence rate of cancer among African Americans is 10 percent higher than Caucasians. African American men are 50 percent more likely to have prostate cancer than White men are; and they are more likely to suffer from colorectal cancer than any other racial group is (AHRQ 2009). Forty-eight percent of the African American adult population suffers from a chronic disease compared to 39 percent of the general population (Mead 2008). Table 2 shows that African Americans have consistently higher cancer death rates.

Table 2: Cancer: Age-Adjusted Death Rates per 100,000 Persons by Race & Hispanic Origin: U.S., 2005



African Americans are more likely to develop and die from cancer than any other racial or ethnic group. African Americans typically are diagnosed at later stage of development, tend to have fewer screening examinations than Whites do, and are less likely to communicate about their symptoms and illnesses with health care professionals. In addition, their five-year survival rate is substantially less when compared to whites at any stage or form of cancer. Every year mortality rates in African Americans due to colorectal cancer are disproportionately higher than they are for white Americans. Colorectal cancer incidence rates among African American men and women are about 17 percent higher than in white men and women. African-American women have a lower incidence rate of breast cancer than white women. Yet African American women are more likely to die of breast cancer than white women are (American Cancer Society 2008).

AIDS and Pneumonia

The rate for new cases of AIDS in African Americans was almost 10 times higher than the rate for Caucasians (AHRQ 2009). In 2006, 76.9 percent of African American patients with pneumonia, 75.8 percent of Asian patients with pneumonia, and 74.2 percent of Hispanic patients with pneumonia received recommended hospital care. This is compared to 81.5 percent of white patients (AHRQ 2009).

Diabetes Mellitus

Adult African Americans have approximately twice the risk as Caucasians of developing Diabetes Mellitus. African Americans have a 20 percent higher mortality rate from cardiovascular disease than Caucasians. During the period 2003-2006, only 54.6 percent of all adults with diagnosed diabetes had their hemoglobin A1c under optimal control. There also was a substantial gap between African Americans and whites for this measure; 43.0 percent of Americans had their hemoglobin A1c controlled, compared with 60.5 percent for whites (AHRQ 2009).

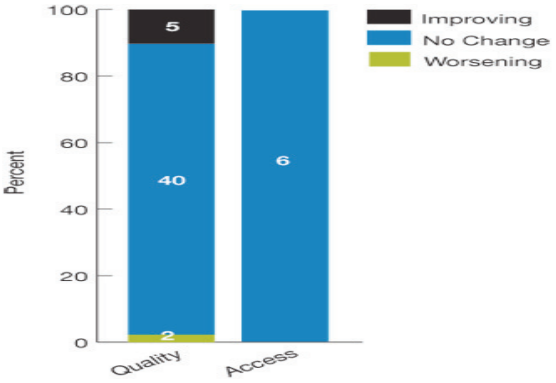
Hypertension

Hypertension among African Americans is 42 percent compared to 28.8 percent among whites. African Americans have 20 percent higher rates of mortality from cardiovascular disease than Caucasians. They are also much more likely to die of heart disease and stroke than their white counterparts are. Coronary heart disease and stroke are not only the leading causes of death in the United States, but also account for the largest proportion of inequality in life expectancy between whites and African Americans, despite the existence of low-cost, highly effective preventive treatment approaches (CDC 2011).

Infant Mortality

The 2007 preterm birth rate for non-Hispanic African American infants (18.3 percent) was 59 percent higher than the rate for non-Hispanic white infants (11.5 percent) and 49 percent higher than the rate for Hispanic infants (12.3 percent). Infants born to African American women are 1.5 to 3 times more likely to die than are infants born to women of other races and ethnicities (CDC 2011). Table 3 outlines measures for which African Americans have poorer outcomes than white Americans do. Figure 1 provides a chart of health care quality and access over time for Core Measures using the most recent and oldest data used in the NHDR. Only 53 core report measures could be tracked over time for Blacks. African Americans receive less preventive care. They are seen less by medical specialists and have fewer technical and expensive procedures ordered by doctors, especially by non-ethnic minority doctors. In order to eliminate health care disparities, health care professionals first must address those variables that cause inequities within our health care system.

Figure 1: Change in Black-White Disparities over time for all Core Measures



Improving: Black-White difference becoming smaller at an average annual rate greater than 1 percent.
Same: Black-White difference not changing.
Worsening: Black-White difference becoming larger at an average annual rate greater than 1 percent.
(Source: *National Healthcare Disparities Report* (AHRQ 2010)

Table 3: Measures for which African Americans were worse than Whites in most recent year and their Trends over Time

Topic	Blacks worse than Whites and Getting Better
Diabetes	Hospital admissions for short-term complications of diabetes per 100,000 population
HIV and AIDS	New AIDS cases per 100,000 population age 13 and over
Functional Status Preservation and Rehabilitation	Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement
Cancer	Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over
	Breast cancer deaths per 100,000 female population per year
	Adults age 50 and over who ever received colorectal cancer screening
	Colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over
	Colorectal cancer deaths per 100,000 population per year
Diabetes	Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes
Maternal and child health	Children ages 2-17 who had a dental visit in the calendar year
	Children ages 19-35 months who received all recommended vaccines
Mental health and substance abuse	Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months
	People age 12 and over treated for substance abuse who completed treatment course
Respiratory diseases	Adults age 65 and over who ever received pneumococcal vaccination
	Hospital patients with pneumonia who received recommended hospital care
Supportive and palliative care	High-risk long-stay nursing home residents with pressure sores
	Short-stay nursing home residents with pressure sores
	Adult home health care patients who were admitted to the hospital
	Hospice patients who received the right amount of medicine for pain
Timeliness	Adults who needed care right away for an illness, injury, or condition in the last 12 months who got care as soon as wanted
	Emergency department visits where patients left without being seen
Access	People with a usual primary care provider
	People with a specific source of ongoing care

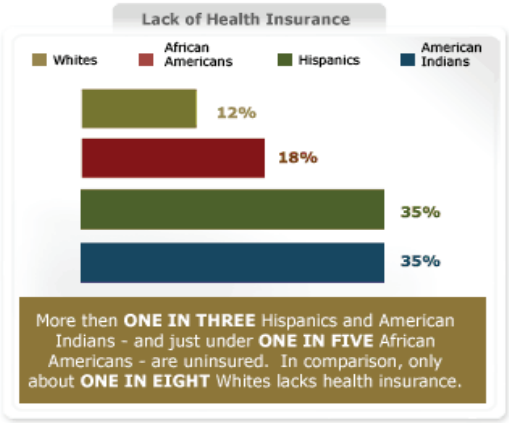
(AHRQ 2010: Chapter 10, Priority Populations)

Lack of Insurance

Health care insurance supports the quality the care provided to patients and is a venue to better healthcare outcomes for consumers. In the United States, many racial and ethnic minorities and low-income populations do not have insurance or are under insured. As such, they experience serious disparities and access to health care. People who have health insurance receive more preventive care, regular checkups, and screenings; consequently, they die less prematurely than those individuals who are uninsured or under insured.

More than 1 in 3 Hispanics and American Indians and less than 1 in 5 African Americans are uninsured. By comparison, only about 1 in 8 White Americans are without health insurance (Holly 2008). See Figure 2 below. It t is also noteworthy that African Americans go without health insurance for greater periods than their white counterparts do (James 2010).

Figure 2: Lack of Health Insurance



Low Income/ Poverty

Four in 10 low-income Americans do not have health insurance, and half of the nearly 46 million uninsured people in the United States are poor. About one-third of the uninsured have a chronic disease, and they are 6 times less likely to receive care for a health problem than the insured. In contrast, 94 percent of upper-income Americans has health insurance (US Census Bureau 208). People with low incomes have poorer health outcomes and are more likely to die prematurely (Adler 2002). In general, poor populations have reduced access to high-quality care. While people with low incomes are more likely to be uninsured, income-related differences in quality of care that are independent of health insurance coverage also have been demonstrated (DeNavas-Walt 2006). Between 2009 and 2010, the poverty rate increased for non-Hispanic Whites from 9.4 percent to 9.9 percent and for African Americans from 25.8 percent to 27.4 percent (DeNavas-Walt, Proctor, and Smith 2011).

Lack of Regular Source of Care

Approximately 19 percent of all U.S. adults are without usual sources of care and 53 percent of uninsured adults have no usual source of care (James 2010). Thirty five percent of African Americans report that they do not have regularly scheduled doctor visits or do not see a primary care doctor for their health problems, as compared to 25 percent white Americans. The lack of regular source of care is attributable primarily to insurance and financial stability. In 2008, the percentage of people with a specific source of ongoing care was 77.5 percent for poor people and 92.1 percent for high-income people (Hargraves 2002).

Lack of Financial Resources

Minority Americans without insurance earn less money than uninsured whites do. In 2001, more than half of uninsured whites had an income greater than 200 percent of the poverty level, or $17,180 annually for a single person. By contrast, only one third of uninsured African Americans have an income greater than the poverty level (Hargraves 2002).

Structural Barriers: Inadequate Transportation

African Americans have low incomes and most of them live below the poverty threshold. Lack of transportation and access to hospitals or clinics play a major role in African Americans' failure to access proper health care providers (Spector 2002).

Health Literacy

Literacy is lower among minority groups. Poor literacy contributes to poor communication with health care providers, lack of understanding, medical noncompliance, diagnosis and treatment. It also leads to poor health outcomes and prognosis. Therefore improved literacy, effective communication and cultural understanding can lead to better understanding between health care providers and consumers. Knowledge of personal health and awareness of one's own health status also contribute to improved health outcomes and resources to care for African Americans and other minority groups.

Stigma

Many African Americans have a negative perception of healthcare because of their personal history or racism. For many African Americans, their fear and lack of trust in doctors, personal and observed experiences, and repeated failures of doctors to treat equitably and judiciously compounds myths, stereotypes and stigma associated with the healthcare system. Spector reported that some African Americans perceive the healthcare system as a degrading, demeaning or humiliating experience. Long wait lines, medical jargon, racism, feelings of identity loss, and a sense of helplessness also contribute to resentment and fear of health clinics (Spector 2002).

Lack of Culturally Competent Health Care Providers

The lack of understanding of African American culture also is a factor that widens the gap between health care providers and African American patients. Culturally competent physicians can help decrease the communication barriers between patients and clinicians (Spector 2002).

Possible Solutions

Differences in health care based on race, ethnicity, or economics can be reduced when there is a realistic assessment of how disparities impede medical outcomes and acknowledgement of the role of health care providers in standing up against inequity within the health care system. Creating better outreach to African Americans, improving patient-physician relationships, and understanding the rudiments of culture, environment, economics, socialization patterns and language are key indices towards overcoming disparities. Becoming proactive in access to care, affordable insurance practices, and changes in public policy on state, national and local levels are first steps towards meeting this goal. Special programs that are universally available to everyone and that target African American communities are essential to reduce disparities.

References

Adler, Nancy E. and Katherine Newman. 2002. "Socioeconomic Disparities in Health: Pathways and Policies. Health Affairs 21 (2):60-76.

AHRQ. 2008. National Healthcare Disparities Repor, 2008. Retrieved December 03, 2011 (http://www.ahrq.gov/qual/nhdr08/Chap4b.htm#low).

AHRQ (Agency for Healthcare Research and Quality). 2009. AHRQ Activities to Re duce Racial and Ethnic Disparities in Health Care. AHRQ Publication No. 09(10)-P008. Retrieved December 03, 2011 (http://www.ahrq.gov/qual/dis parities.htm).

AHRQ. 2009. Key Themes and Highlights From the National Healthcare Disparities Report. Retrieved November 29, 2011 (http://www.ahrq.gov/qual/nhdr09/Key.htm).

AHRQ. 2010. National Healthcare Disparities Report, 2010, Chapter 10.Priority Popu lations. Retrieved December 03, 2011 (http://www.ahrq.gov/qual/nhdr10/ Chap10.htm).

American Cancer Society. 2008. "Cancer Disparities: Key Statistics." Retrieved De cember 03, 2011 (http://www.cancer.org/Cancer/news/Features/cancer-dispar ities-key-statistics).

Asada, Yukiko. 2010. "A summary measure of health inequalities for a pay-for-pop ulation health performance system." Preventing Chronic Disease 7(4):A72. Retrieved November 29, 2011 (http://www.cdc.gov/pcd/issues/2010/ jul/09_0250.htm).

Ayanian, John Z., Joel S. Weissman, Eric C. Schneider, Jack A. Ginsburg, and Alan M. Zaslavsky. 2000. "Unmet Health Needs of Uninsured Adults in the United States." Journal of the American Medical Association (JAMA) 284 (16): 2061-2069.

Carter-Pokras, Olivia and Claudia Baquet. 2002. "What is a 'health disparity'?" Public Health Reports 117(5): 426–434.

CDC (Centers for Disease Control and Preventiion). 2011. Fact Sheet-CDC Healt Dis parities and Inequalities Report-U.S., 2011. Retrieved December 03, 2011 (http://www.cdc.gov/minorityhealth/reports/CHDIR11/FactSheet.pdf).

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bu reau, Current Population Reports, P60-239. 2011. Income, Poverty, and Health Insurance Coverage in the United States: 2010. Washington, D.C: U.S. Gov ernment Printing Office.

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bu reau, Current Population Reports, P60-231. 2006. Income, Poverty, and Health Insurance Coverage in the United States: 2005. Washington, D.C: U.S. Gov ernment Printing Office.

French, Simone A., Mary Story, and Robert W. Jeffery. 2001. "Environmental influences on eating and physical activity." Annual Review of Public Health 22: 309–335.

Hargraves, J. Lee. 2002. The Insurance Gap and Minority Health Care, 1997-2001. Tracking Report No. 2, Center for Studying Health System Change. Retrieved December 03, 2011 (http://hschange.org/CONTENT/443/#1).

Kirby, James B. and Toshiko Kaneda. 2010. "Unhealthy and Uninsured: Exploring Racial Differences in Health and Health Insurance Coverage Using a Life Ta ble Approach." Demography 47 (4):1035-1051.

Kuczmarski, Robert J. Katherine M. Flegal, Stephen M. Campbell, and Clifford L. Johnson. 1994. "Increasing Prevalence of Overweight among US Adults: The National Health and Nutrition Examination Surveys, 1960 to 1991." Journal of the American Medical Association (JAMA) 272 (3): 205–211.

Mead, Holly, Lara Cartwright-Smith, Karen Jones, Christal Ramos, Kristy Woods, and Bruce Siegel. 2008. Racial and Ethnic Disparities in U.S. Health Care: A Chartbook, The Commonwealth Fund. Retrieved November 29, 2011 (http://www.com monwealthfund.org/Publications/Chartbooks/2008/Mar/Racial-and-Ethnic-Disparities-in-U-S--Health-Care--A-Chartbook.aspx#notes).

Mukamel, Dana B.. David L. Weimer, Thomas C. Buchmueller, Heather Ladd, and Al vin I. Mushlin. 2007. "Changes in Racial Disparities in Access to Coronary Ar tery Bypass Grafting Surgery Between the Late 1990s and Early 2000s." Medi cal Care 45 (7): 664-671.

Palacio, Herminia, James G. Kahn, T. Anne Richards, and Stephen F. Morin. 2002. "Ef fect of race and/or ethnicity in use of antiretrovirals and prophylaxis for oppor tunistic infection: a review of the literature." Public Health Reports, 117 (3): 233-251.

Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson, eds. 2003. Unequal Treat ment: Confronting Racial And Ethnic Disparities In Health Care. Washington, DC: National Academies Press.

Spector, Rachel E. 2002. "Cultural Diversity in Health and Illness." Journal of Transcul tural Nursing 13 (3): 197-199.

U.S. Census Bureau. 2004. Interim Projections by Age, Sex, Race, and Hispanic Origin: 2000-2050, Detailed data files. Retrieved December 03, 2011 (http://www.cen sus.gov/ipc/www/usinterimproj/).

U.S. Census Bureau. 2008. National Population Projections 2008. Retrieved Decem ber 03, 2011 (http://www.census.gov/Press-Release/www/releases/archives/population/012496.html).