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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 groups that are closely linked with social, economic, and/or environmental disadvantage. 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 gains in quality of care and health for the broader population and result in unnecessary costs. Addressing health disparities is increasingly important as the population becomes more diverse. It is projected that people of color will account for over half (52%) of the population in 2050.

3. What is the current status of disparities?

Although the Affordable Care Act (ACA) lead to large coverage gains, some groups remain at higher risk of being uninsured, lacking access to care, and experiencing worse health outcomes. For example, as of 2018, Hispanics are two and a half times more likely to be uninsured than Whites (19.0% vs. 7.5%) and individuals with incomes below poverty are four times as likely to lack coverage as those with incomes at 400% of the federal poverty level or above (17.3% vs. 4.3%).

4. What are key initiatives to address disparities?

The ACA's coverage expansions and funding for community health centers increased access to coverage and care for many groups facing disparities, and other provisions explicitly focused on reducing disparities. At the federal level, the Department of Health and Human Services is engaged in a range of actions to implement its 2011 action plan to eliminate racial and ethnic health disparities. States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities, which increasingly encompass a focus on social factors influencing health.

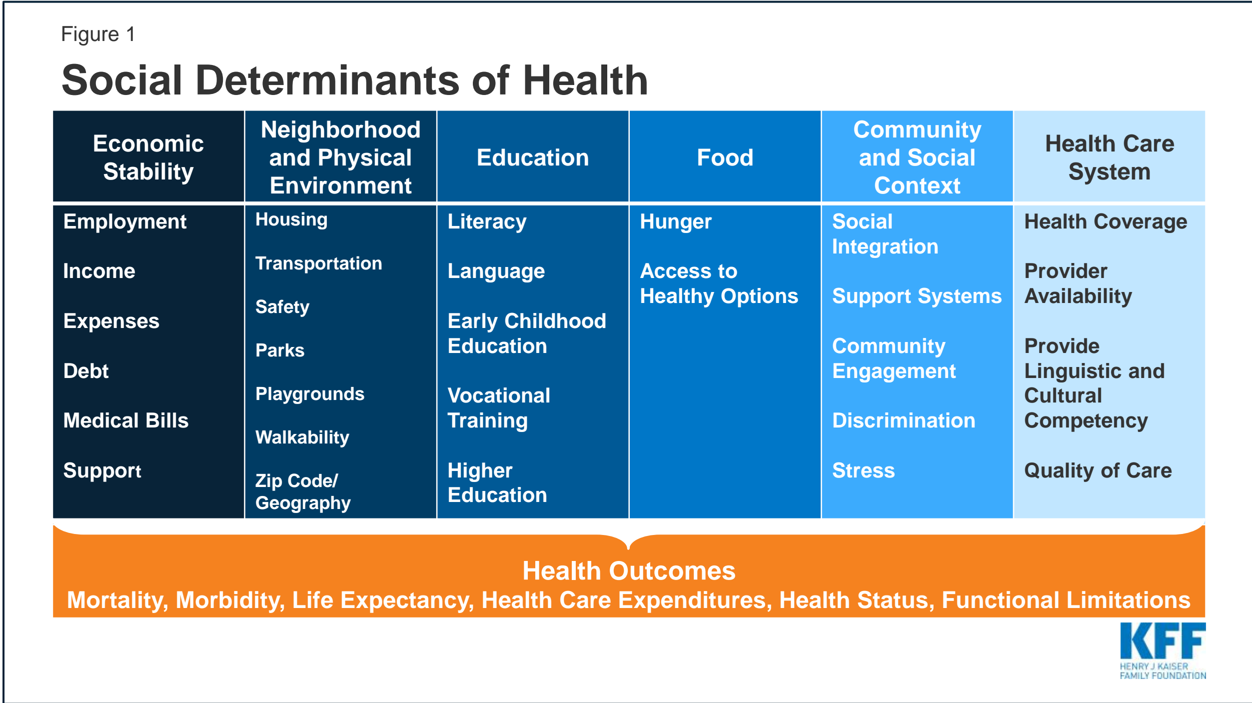
5. What are current challenges to addressing disparities?

Recent policy changes and current priorities may lead to coverage declines moving forward. Beyond coverage, there are an array of other challenges to addressing disparities, including limited capacity to address social determinants of health, declines in funding for prevention and public health and health care workforce initiatives, and ongoing gaps in data to measure and understand disparities.

1. What are health and health care disparities?

Health and health care disparities refer to differences in health and health care between groups. A "health disparity" refers to a higher burden of illness, injury, disability, or mortality experienced by one 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. Health and health care disparities often refer to differences that are not explained by variations in health needs, patient preferences, or treatment recommendations and are closely linked with social, economic, and/or environmental disadvantage. The terms "health inequality" and "inequity" also are used to refer to disparities.[2,3]

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. Moreover a broad array of social and environmental factors affect individuals' health and ability to engage in healthy behaviors (Figure 1).[4]



Health and health care disparities are commonly viewed through the lens of race and ethnicity, but they occur across a broad range of dimensions. For example, disparities occur across socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation. Federal efforts to reduce disparities focus on designated priority populations who are vulnerable to health and health care disparities, including 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.[5,6,7] 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.[8,9] Research also suggests that disparities occur across the life course, from birth, through mid-life, and among older adults.[10,11]

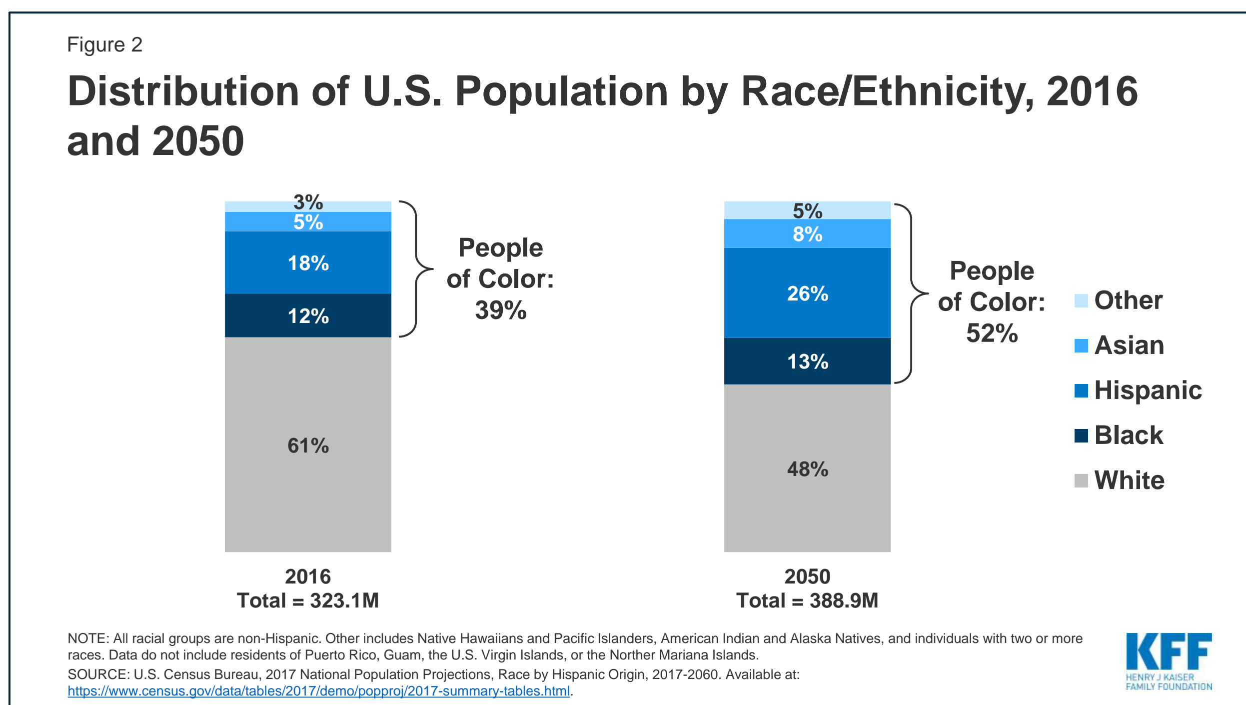
2. Why do health and health care disparities matter?

Addressing disparities in health and health care is important not only from an equity standpoint, but also for improving health more broadly by achieving improvements in overall quality of care and population health. Moreover, health disparities are costly. Analysis estimates that disparities amount to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year as well as economic losses due to premature deaths.[12]

It is increasingly important to address health disparities as the population becomes more diverse. It is projected that people of color will account for over half (52%) of the population in 2050, with the largest growth occurring among Hispanics (Figure 2). There also are wide gaps in income across the population. As of 2018, the richest 20% of households have an average income of $234,000, nearly 17 times the average income of $14,000 for the bottom 20% of households (Figure 3).[13]

Figure 2

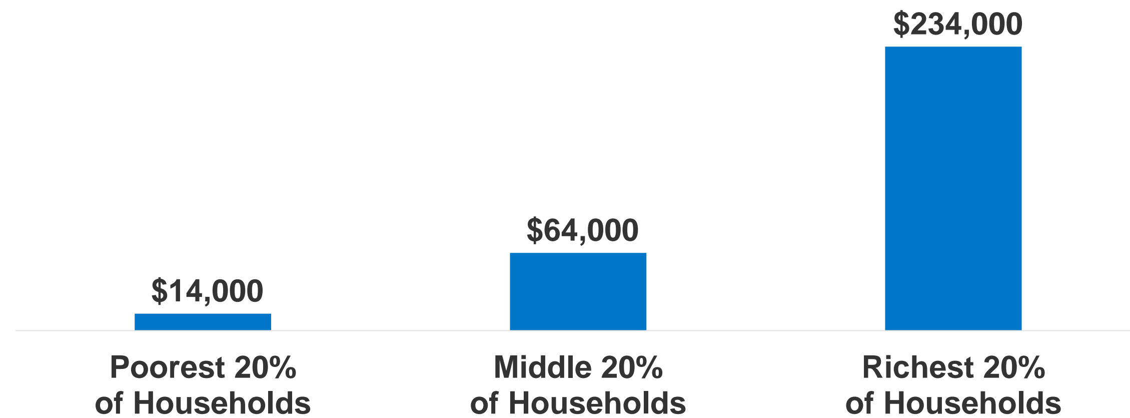
Distribution of U.S. Population by Race/Ethnicity, 2016 and 2050



NOTE: All racial groups are non-Hispanic. Other includes Native Hawaiians and Pacific Islanders, American Indian and 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 Norther Mariana Islands.
SOURCE: U.S. Census Bureau, 2017 National Population Projections, Race by Hispanic Origin, 2017-2060. Available at: https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.

Figure 3

Gaps Between Average Annual Income of Richest and Poorest Households in the United States, 2018



NOTE: Totals rounded to the nearest 100.
SOURCE: Semega, Jessica, et al. "Income and Poverty in the United States: 2018." Table A-4. Current Population Reports. United States Census Bureau, September 2019, https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-266.pdf.

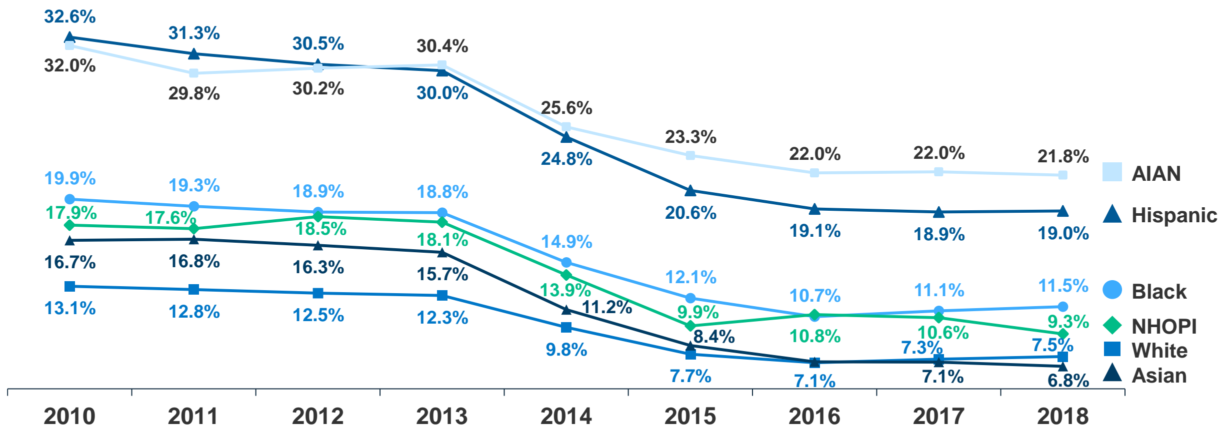
What is the current status of disparities?

Despite overall improvements in population health over time, many disparities have persisted and, in some cases, widened.[14] People of color and low-income individuals historically have faced greater barriers to accessing care, including a higher uninsured rate, compared to Whites and those at higher incomes.[15] Data also show that disparities in some health outcomes, such as heart disease mortality rates among Blacks and diabetes mortality rates among AIANs, have widened over time.[16]

The ACA led to large coverage gains for many groups facing disparities. The ACA created new coverage options, including a Medicaid expansion and health insurance marketplaces. Following enactment of the ACA in 2010, there were large coverage gains across racial and ethnic groups, with the sharpest increases after implementation of the Medicaid and marketplace expansions in 2014 (Figure 4).[17] Groups of color experienced larger coverage gains compared to Whites as a share of the population, which narrowed percentage point differences in uninsured rates between groups of color and Whites.[18] However, most groups of color remained more likely to be uninsured compared to Whites as of 2018. Moreover, the relative risk of being uninsured compared to Whites did not improve for some groups. For example, Blacks remained 1.5 times more likely to be uninsured than Whites between 2010 and 2018, and the Hispanic uninsured rate remained over 2.5 times higher than the rate for Whites.[19] Lower-income individuals also experienced large coverage gains that narrowed percentage point differences in uninsured rates for poor (<100% of the federal poverty level, FPL) and near-poor (100-299% FPL) individuals compared to those at higher incomes (400% FPL and above). Relative disparities by income also narrowed. For example, in 2010, the uninsured rate for poor individuals was five times higher than the rate for those at higher incomes (400% FPL or above) (30.3% vs. 6.0%), while in 2018, it was four times higher (17.3% vs. 4.3%). However, low-income groups remained more likely to be uninsured than those at higher incomes.

Figure 4

Uninsured Rates for the Nonelderly Population by Race and Ethnicity, 2010-2018

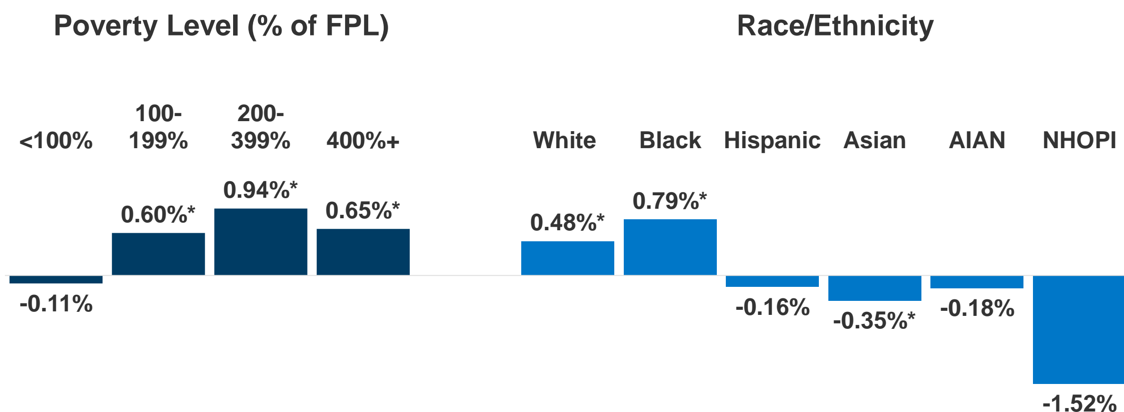


NOTE: Includes individuals ages 0 to 64. AIAN refers to American Indians and Alaska Natives, NHOPI refers to Native Hawaiians and Other Pacific Islanders.
SOURCE: KFF analysis of the 2010-2018 American Community Survey.

Beginning in 2017 and continuing in 2018, coverage gains stalled and reversed for some groups. The uninsured rate for the total nonelderly population increased from 10.0% in 2016 to 10.4% in 2018.[20] This reversal in coverage trends eroded some of the progress achieved in reducing uninsured rates for Whites and Blacks as well as for groups with incomes above the poverty level (Figure 5).

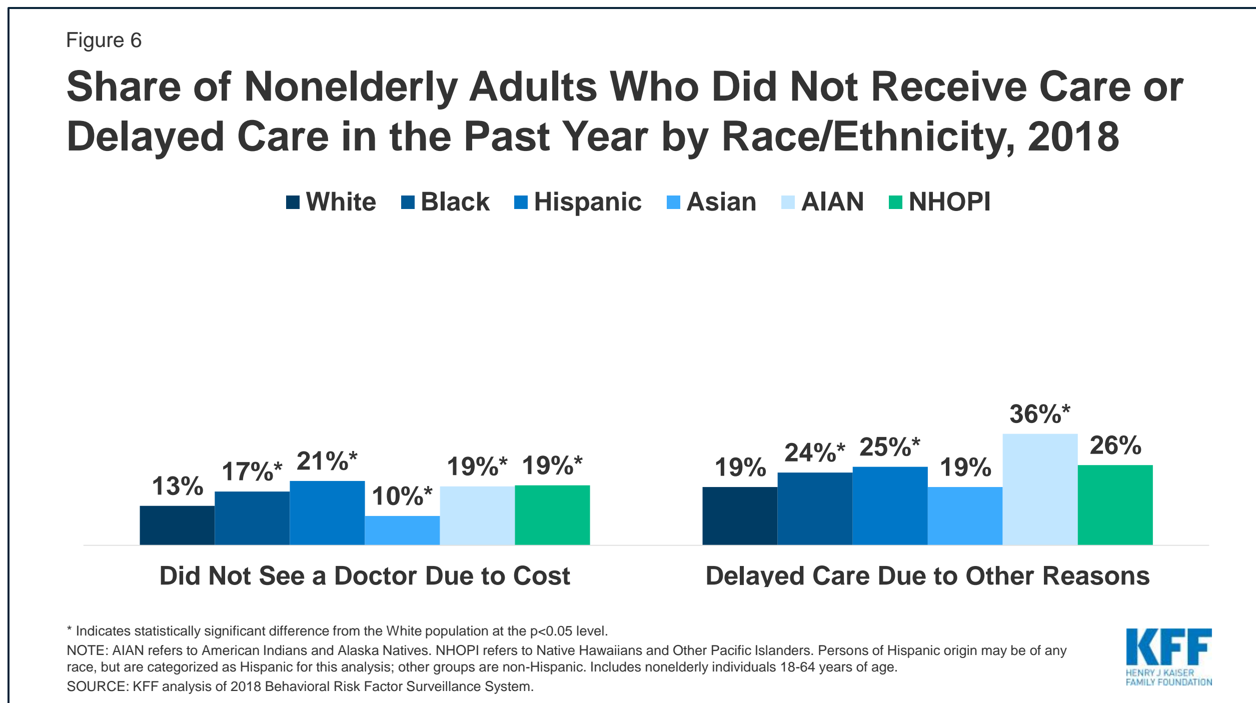
Figure 5

Change in Uninsured Rate among the Nonelderly Population by Selected Characteristics, 2016-2018



* Indicates a significant percentage-point change from 2016 to 2018.
NOTE: Includes nonelderly individuals age 0 to 64. AIAN refers to American Indiana and Alaska Native. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Changes are percentage-point changes from 2016 to 2018. The US Census Bureau's poverty threshold for a family with two adults and one child was $20,212 in 2018.
Source: KFF analysis of 2016 and 2018 American Community Survey, 1-Year Estimates.

Many groups continue to face significant disparities in access to and utilization of care.[21] 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 6). 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.[22] Low-income individuals also experience more barriers to care and receive poorer quality care than high-income individuals.[23] Disparities in access and use also occur across other dimensions. For example, individuals living in rural areas face a range of barriers to accessing care.[24]

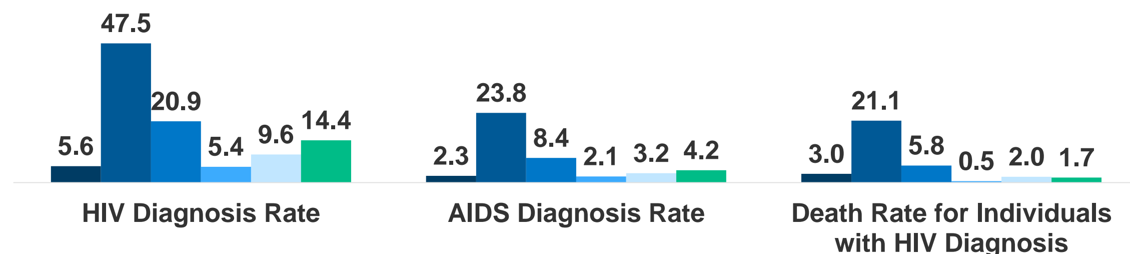


Additionally, some groups are at higher risk for health conditions and experience poorer health outcomes compared to other groups. For example, Blacks and American Indians and Alaska Natives are more likely than Whites to report a range of health conditions, including asthma and diabetes; American Indians and Alaska Natives also have higher rates of heart disease compared to Whites.[25] Health disparities are particularly striking in AIDS and HIV diagnoses and death rates (Figure 7).[26] Infant mortality rates are higher for Blacks and American Indians and Alaska Natives compared to Whites,[27] and Black males have the shortest life expectancy compared to other groups.[28] Low-income people of all races report worse health status than higher income individuals.[29] 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.[30]

Figure 7

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

■ White ■ Black ■ Hispanic ■ Asian ■ AIAN ■ NHOPI



NOTE: Data based on surveillance data reported by states to the CDC. 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 2018 and death rate data are as of 2017. Death rates for individuals with HIV are deaths due to any cause, not only from HIV-related illness.

SOURCE: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2018.

3. What are key initiatives to eliminate disparities?

Major recognition of health and health care disparities began nearly two decades ago. Two Surgeon General's reports in the early 2000s showed disparities in tobacco use and access to mental health services by race and ethnicity.[31,32] The first major legislation focused on reduction of disparities, the Minority Health and Health Disparities Research and Education Act of 2000,[33] created the National Center for Minority Health and Health Disparities, and authorized the Agency for Healthcare Research and Quality to regularly measure progress on reduction of disparities. Soon after, the Institute of Medicine released two seminal reports showing racial and ethnic disparities in access to and quality of care.[34,35]

The ACA included provisions that advanced efforts to reduce disparities.[36] The ACA's broad coverage expansions and increased funding for community health centers improved access to coverage and care for many groups facing disparities. Other ACA provisions explicitly focused on reducing disparities, such as creating Offices of Minority Health within HHS agencies to coordinate disparity reduction efforts. The ACA also promoted workforce diversity and cultural competence, increasing funding for health care professional and cultural competence training and education materials, and strengthened data collection and research efforts. Moreover, the ACA included prevention and public health initiatives and created the Prevention and Public Health Fund. It also permanently reauthorized the Indian Health Care Improvement Reauthorization Extension Act of 2009.

As the federal level, the Department of Health and Human Services (HHS) has engaged in a range of initiatives focused on addressing disparities. In 2011, HHS developed an action plan for eliminating racial and ethnic health disparities, which built on the Healthy People 2020 goal to achieve health equity

and eliminate disparities.[37,38,39] Since the release of the report, HHS has undertaken various efforts to implement the 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.[40] In 2013, HHS 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.[41] In 2013, the Centers for Medicare and Medicaid Services (CMS) released an equity plan for improving quality in Medicare, and, in 2018, it released a new rural health strategy.[42] Other CMS equity initiatives include the "From Coverage to Care" initiative focused on connecting individuals to primary and preventive services and a minority research grant program focused on designing and testing interventions that may reduce disparities in readmissions and/or patient experience.[43]

States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities, which increasingly encompass a focus on social factors influencing health.[44] State actions to reduce disparities vary considerably. A federal review found that 23 states or territories had a strategic plan addressing minority health or health equity and that one of the most common goals and activities of states is measure development and data collection/analysis.[45] Other activities identified included Medicaid expansion, immunization programs, and chronic disease management efforts.[46] The review further found that many states' disparity reduction efforts focus on particular populations, such as children, refugees, and/or individuals experiencing homelessness.[47] Private funders, local communities, managed care plans, and providers also are engaged in disparities reduction efforts.[48]

4. What are current challenges to addressing disparities?

As noted, there were large coverage gains following the ACA, but coverage gains stalled and began reversing in recent years. Recent policy changes and current priorities may lead to continued declines moving forward. For example, the federal government has decreased funds for outreach and enrollment assistance, Congress negated the ACA individual requirement to have coverage, CMS has encouraged and approved waivers from states to add new eligibility restrictions for Medicaid coverage, and the Department of Homeland Security made immigration policy changes that have increased fears among immigrant families about participating in Medicaid and CHIP. Further, the Trump administration is pursuing additional changes, such as supporting litigation to overturn the ACA, releasing guidance allowing states to cap federal funding for Medicaid, and adding eligibility verification requirements to Medicaid that could further curtail coverage and lead to increases in the uninsured rate.

Beyond coverage, there are an array of other challenges to addressing disparities, including limited capacity to address social determinants of health, declines in funding for prevention and public health and health care workforce initiatives, and ongoing gaps in data. As noted, a range of activities are underway to address disparities, and many of these initiatives encompass a focus on social determinants of health. Within the health care system, these efforts often are occurring through payment and delivery system models that focus on providing whole person care and paying for value or outcomes instead of services.[49] However, the administration has begun phasing out and changing the direction of

some health care payment and delivery system reforms, which may reduce resources to address social determinants of health.[50] Moreover, addressing social determinants of health will require tackling issues that are beyond the health care system's capacity to address, including large deficiencies in resources to meet social needs, such as affordable housing, and structural and institutional biases and racism. Maintaining support for public health and prevention and expanding and diversifying the health care workforce to increase access to culturally and linguistically appropriate care also underpin efforts to address disparities. However, funding for prevention and public health has been reduced through cuts to the Prevention and Public Health Fund and the President's Fiscal Year 2021 budget includes further cuts in this area .[51,52] Further, although the ACA included provisions to enhance capacity of the health care workforce, many of these provisions were time-limited and have not received continued funding.[5354]

The outcome of the 2020 national elections will have important implications for disparities moving forward. Democratic candidates have proposed or endorsed plans, including a Medicare-for-All option and a public option, that are designed to further expand coverage to individuals and fill in some of the remaining gaps in coverage. Several candidates have also put forth proposals to specifically target racial/ethnic and urban/rural health disparities, especially in maternal health. In contrast, the Trump Administration has pursued policies focused on restricting eligibility for Medicaid, capping funding for the program, and decreased resources for outreach and enrollment assistance. In addition, litigation challenging the ACA with support from the Trump administration is ongoing. Moving forward, whether policies continue to focus on expanding coverage or lead to roll-backs in available coverage options, including restrictions to Medicaid and/or elimination of the ACA, will have major implications for disparities.

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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