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# Health Care Disparities Influenced by Where Minorities Seek Care

Study after study has documented that differences exist between the quality of health care received by minority patients and nonminority patients. Even after accounting for differences in health insurance coverage and socioeconomic status, minority patients still experience a "lower quality of care across a wide range of conditions."[1]

Though health care disparities have been well documented, their causes are not fully known or understood. We do know that multiple factors drive disparities, including systems-level factors such as fragmentation of care and financial and other barriers, and individual-level factors such as communication and cultural barriers and even bias.[2] But few studies have examined whether disparities occur within or between hospitals for specific inpatient processes of care.

A recent study by the Health Research and Educational Trust (HRET) found that where minority patients get health care can influence the quality of care they receive and may be a major underlying cause of health care disparities. The study used Hospital Quality Alliance (HQA) inpatient quality of care indicators to assess racial and ethnic disparities.

This study is the first to use the HQA patient-level measures to assess disparities between hospitals. It is also the first to examine racial and ethnic disparities in patient counseling measures.

## Examining Quality of Care Measures

Working with national data from the University HealthSystem Consortium (UHC), the study used HQA core measures. The UHC is an alliance of academic medical centers and their affiliate hospitals in the United States. The HQA core measures address recommended treatments for three clinical conditions: acute myocardial infarction (AMI), congestive heart failure (CHF), and community-acquired pneumonia (CAP). These measures have been endorsed by the National Quality Forum, a national standard-setting entity.

The HQA data are likely to be the foundation of hospital quality assessments for the foreseeable future and provide a unique opportunity to better understand the quality of care patients receive nationwide.

This study assessed whether disparities in 13 HQA measures were within hospitals, between hospitals, or both.

## Hospital and Patient Characteristics

Researchers examined data for 123 teaching hospitals reporting to the UHC, which provided important information about the quality of care and disparities within and between this subset of teaching hospitals. Sixty-two percent (62%) of the hospitals had at least 300 beds, and the hospitals were distributed by region: 10.8% in the Northeast, 19.2% in the Mid-Atlantic, 18.3% in the Southeast, 35.9% in the Midwest, and 15.8% in the West.

For this study, minority patients were identified as black or African American, Hispanic, Asian, or other. Of the 320,970 patients included in the study's analyses, 40% were racial/ethnic minorities. The proportion of minority patients varied across measures, ranging from 25% for AMI–ß-blocker at hospital discharge to 61% for CHF–smoking cessation counseling.

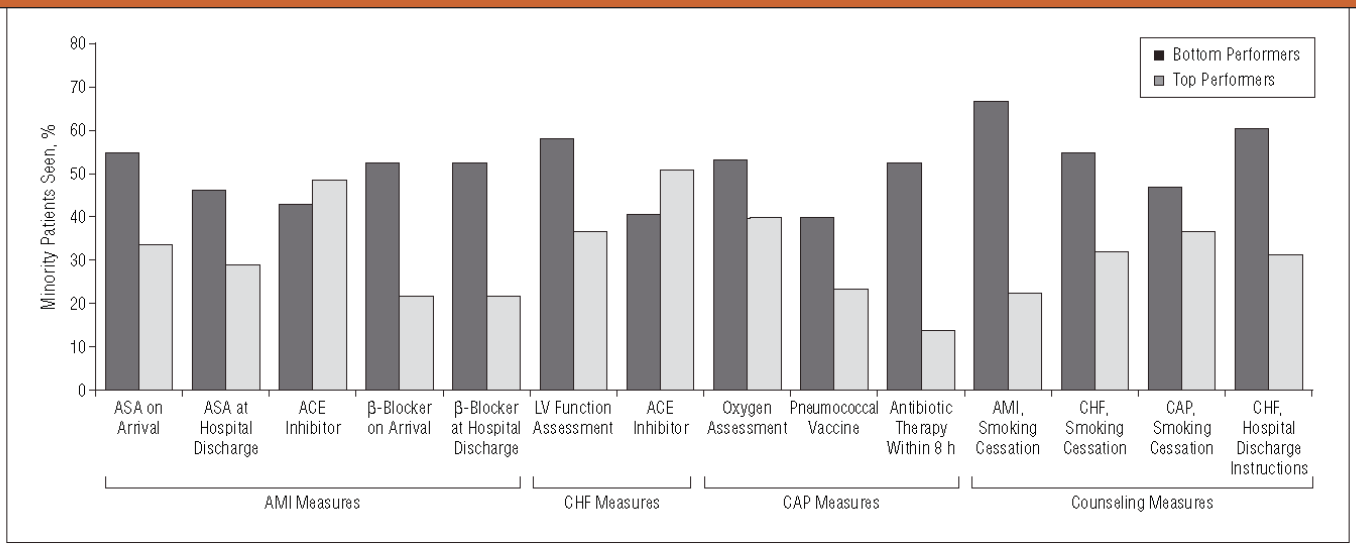
## Differences in Quality of Care

In the study, researchers found consistent differences between minority and nonminority patients in the quality of care, across 8 of the 13 quality measures for acute myocardial infarction, congestive heart failure, community-acquired pneumonia, and patient counseling. Furthermore, hospitals that underperformed on many of the quality measures served a higher percentage of minority patients.

For example, on the quality measure "recommend that patients with congestive heart failure receive discharge instructions," only 31% of patients were minorities in top-performing hospitals, but 60% were minorities in the lowest-performing hospitals on this same measure. Interestingly, this trend was reversed for the two angiotensin-converting enzyme (ACE) inhibitor measures; the top-performing hospitals had a higher percentage of minority patients than did the lower-performing hospitals (see figure).

The magnitude of the racial and ethnic disparity varies among measures. Several of the HQA measures show small disparities. Disparities are much greater for counseling measures, which are communication sensitive (see table).

After adjusting for site of care, the magnitudes of the 8 disparities decreased substantially and 3 disparities were




Percentage of minority patients cared for in top-performing and bottom-performing hospitals, by measure. ACE indicates angiotensin-converting enzyme; AMI, acute myocardial infarction; ASA, acetylsalicylic acid (aspirin); CAP, community-acquired pneumonia; CHF, congestive heart failure; and LV, left ventricular.

entirely eliminated, again suggesting that an underlying cause of disparities may be that minority patients are more likely to receive care in lower-performing hospitals.

## Minorities and Underresourced Hospitals

Another explanation for differences in quality of care may be that minority patients seek care in underresourced hospitals. Several factors can characterize hospitals as underresourced, such as nurse staffing shortages, inadequate budgets, lack of technical support (for example, health information systems), and lack of capital. [3,4] Yet, these same hospitals may have providers who are hardworking and efficient, providing care with fewer resources to more disadvantaged patients.

It is important to emphasize that though this study highlights site of care as a factor that drives health care disparities, other systems-level and individual-level factors should not be ignored.

**Crude Success Rates for HQA Counseling Measures for Nonminority and Minority Patients***

| HQA Counseling Measures | Nonminority Patient | Minority Patient | *P* Value† |
|---|---|---|---|
| AMI–smoking cessation | 78.3 (16.7 to 98.9) | 69.4 (16.5 to 100) | <.001 |
| CHF–smoking cessation | 56.4 (0.0 to 94.7) | 48.0 (9.6 to 94.7) | <.001 |
| CAP–smoking cessation | 49.9 (0.0 to 98.8) | 35.4 (2.4 to 98.0) | <.001 |
| CHF–discharge instructions | 37.6 (0.0 to 77.5) | 28.1 (0.0 to 82.4) | <.001 |

Abbreviations: AMI, acute myocardial infarction; CAP, community-acquired pneumonia; CHF, congestive heart failure; HQA, Hospital Quality Alliance.
*Data are given as percentage (range) of facility success rate.
†*t* Tests.

The study's findings have important implications for policymakers. To address the root causes of health care disparities, more resources may be needed at hospitals that care for a large number of minority patients.

Partners in this study were Northwestern University's Feinberg School of Medicine, the Henry Ford Health System, Massachusetts General Hospital, the Commonwealth Fund, Harvard Medical School, and the University HealthSystem Consortium.

Results of this study were first published in: Hasnain-Wynia R, Baker DW, Nerenz D, Feinglass J, Beal AC, Landrum MB, Behal R, Weissman JS. Disparities in health care are driven by where minority patients seek care: Examination of the hospital quality alliance measures. *Archives of Internal Medicine*. 2007; 167:1233-1239. You can access the complete article at **www.hret.org**.

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## Notes

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