

Perceptions of Racial and Ethnic Differences in Access to Healthcare

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Interest in racial and ethnic differences in health and healthcare during the past 15 years has tended to focus, with growing sophistication, on differences in procedure use, referrals, and health outcomes. This research has been accompanied by studies of communication in provider-patient relationships and, more recently, an increasing interest in patients' and physicians' perceptions of barriers to high-quality healthcare for different racial and ethnic groups. In this commentary, we briefly review some recent studies of perceptions of barriers to care. We focus especially on our group's recent research in Durham County as a way of highlighting the importance of focusing on the experiences of local communities in studies of barriers to care.

Public Perceptions

The Henry J. Kaiser Family Foundation (KFF) conducted a survey in 1999 of a nationally representative sample of 3,884 adults in the United States.¹ The survey explored public perceptions of associations between race/ethnicity and healthcare and found that these perceptions varied by race and ethnicity. Black and Latino respondents perceived greater unfairness in the nation's healthcare system and expressed greater concern about financial barriers to healthcare than did white respondents. Following on the KFF national survey, our group collaborated with The Duke Endowment, El Centro Latino, and North Carolina Central University to conduct a similar survey in Durham County. Friedman et al.² sought to understand perceived barriers to care in the Durham County healthcare system and how those local perceptions compared to the national findings of the KFF survey.

The Durham County survey has provided data for several analyses. Van Houtven et al.³ found that residents of Durham County who perceive that they are treated unfairly in the healthcare system have greater odds of delaying or forgoing medical tests and treatments, controlling for economic constraints such as unemployment and lack of health insurance. Hong et al.⁴

examined associations between self-rated health status and barriers to healthcare (i.e., lack of health insurance, lack of a usual source of care, problems with transportation, limited English-language ability, and perceived scarcity of physicians in the area). Greater barriers or perceived barriers on all but the variable for usual source of care were associated with lower self-rated health status. Voils et al. examined levels of concern among respondents that their health would be harmed by disease, diet, lack of exercise, and inability to follow physicians' recommendations.²⁴ Latino and black respondents in Durham County tended to be more concerned than white respondents about their ability to follow physicians' recommendations.

According to another study by Voils et al.,⁵ racial and ethnic groups in Durham County also have differing levels of trust in health institutions, and perceived trustworthiness differs by type of institution. For example, Latinos in Durham County were more trusting overall than white and black respondents. Also, whereas Latinos tended to trust various types of health institutions equally, white and black respondents were less trusting of insurance companies and state and federal governments and were more trusting of physicians, public hospitals, and county health services. Williams et al. recently completed an analysis of respondents' trust in sources of health information in Durham County.²⁵ They found that black and Latino respondents were more likely than white respondents to trust the health department, ministers and churches, and television and radio as sources of health information. Trust in physicians, nurses, friends, and relatives was similar across racial and ethnic groups; however, Latinos were less likely to trust pharmacies as sources of information.

Physician Perceptions

Research on physicians' perceptions of racial/ethnic disparities and barriers to healthcare is limited. A study by Schulman et al.,⁶ using identical case descriptions presented by patient-actors of

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different races and genders, identified a race-gender interaction term as a significant predictor of referral for cardiac catheterization. The investigators also found racial differences in physicians' perceptions of patients' personality characteristics and socioeconomic status. These secondary outcomes pointed to some additional areas of potential concern.

In a series of reports, researchers examined physicians' and patients' beliefs regarding access to kidney transplantation. They found racial differences in patients' preferences and expectations, but these did not account for differences in referral for transplantation.⁷ Epstein et al.⁸ found that racial differences in kidney transplantation could be explained both by differences in clinical characteristics and by underuse among black patients and overuse among white patients. The investigators also found that physicians were more likely to believe that black patients would not experience a survival benefit from kidney transplantation.⁹ Many physicians also viewed donor availability, patient adherence, and patient preferences as explanations for why black patients are less likely to be evaluated for kidney transplantation.⁹

Another recent study by Bach et al.,¹⁰ using the 2000-2001 Community Tracking Study Physician Survey, found that primary care visits by black Medicare beneficiaries were concentrated in a small subgroup of physicians and that visits by black patients tended to be with physicians who were not board-certified. Moreover, visits by black patients were more often with physicians who reported limited access to high-quality medical services. In other words, physicians in the study who were most likely to see black patients reported having less training and restricted access to high-quality specialist, hospital, and ancillary services.¹⁰

Preparatory work for our group's Durham County survey provided some information about physicians' views of racial/ethnic disparities in healthcare. In a small survey of physicians practicing in Durham County, our group asked respondents to identify the "special challenges" they faced in treating patients from different cultures.¹¹ Three quarters of the physicians identified language barriers as a problem, ranging from some patients' lack of English-language ability to physicians' difficulty understanding regional English-language dialects. Several physicians noted problems obtaining access to translators for Spanish-speaking patients, and others emphasized the lack of Spanish-speaking physicians and other providers.

Local Research for Local Circumstances

Accompanying the report of the KFF national study in *Medical Care Research and Review*,¹ Waidmann and Rajan¹²

reported racial and ethnic differences in access to and use of healthcare resources both nationally and in individual states. They concluded that "efforts to eliminate disparities in access to quality healthcare may need to be tailored to the specific needs of states." Strategies for one racial or ethnic group in one location will not necessarily be successful for other racial and ethnic groups in other locations. For example, the Latino populations of Florida, New York, and Texas differ considerably in their ethnic and cultural characteristics (e.g., national origin).

Not surprisingly, their experiences with and demands on the healthcare system also vary.¹²

From 1990 to 2000, for example, the Latino population of the Raleigh-Durham metropolitan area increased by 631% as a proportion of the overall population.¹³ Latino populations in Charlotte, Greensboro-Winston-Salem, and Raleigh-Durham have experienced "hypergrowth"—increases of more than 300% (i.e., twice the national average)

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in the 20-year period from 1980 to 2000.¹³ Growth in Latino populations has also been accompanied by growth in Asian-Pacific Islander communities. In Durham County, for example, the proportion of Asian-Pacific Islander residents increased twofold, a trend mirrored in neighboring Orange and Wake Counties.¹⁴

Because the large majority of Latinos in Durham County were born outside of the United States, compared to only about half of Latinos nationwide, it is reasonable to expect that Durham Latinos have unique attitudes, concerns, and patterns of behavior about health and healthcare. In their effort to identify concerns unique to Durham County, Friedman et al.² compared findings from their survey of Durham County residents to findings from the KFF national sample. They found a number of important differences in the perceptions and experiences of respondents from Durham County, as compared to the national survey. These included substantial differences among Latinos with respect to demographic characteristics, English-language ability, and health insurance status. Durham Latinos were relatively young, and a much greater proportion of them were men, compared to the national sample. Latinos in the Durham County survey also expressed greater concern than those in the national survey about their clinical encounters, including perceptions of being treated unfairly because of their ethnicity.

Several studies have documented the unique experiences of Latinos in North Carolina. For example, Buescher¹⁵ describes how the major health problems of North Carolina Latinos can be tied to the population's relative youth and limited access to healthcare services. Many of the recommendations of the

Latino Health Task Force¹⁶ emphasize the need for more bilingual healthcare providers, and several studies have pointed to links between North Carolina Latinos' health needs and the large number of recent immigrants and migrant workers in the population.¹⁵⁻¹⁹

Heterogeneity at regional, state, and local levels—in racial/ethnic composition, socio-economic status, health infrastructure and resources, and any number of other community characteristics—has important implications for the ways researchers, providers, and policy makers approach public health issues. As readers of the *North Carolina Medical Journal* know, collaborations between community organizations, foundations, academic institutions, and local and state governments can foster important research in these areas. They will also lead to the development of innovative, sophisticated methods for targeted public health interventions.²⁰⁻²²

Concern about health disparities in local communities leads

to a broader question about meeting the needs of patients in a complex healthcare system. Barriers to high-quality healthcare may reflect, in part, individual encounters with individual providers. However, it is more likely that barriers arise in a series of complicated steps in the medical decision-making process. For example, Einbinder and Schulman²³ described eight steps in the referral process for invasive cardiac procedures—from the patients' recognition of symptoms through the physician's referral for a procedure—and discussed the evidence for racial/ethnic differences and disparities in each step. Healthcare is a process, not a single encounter, and at each step in that process the most vulnerable patients are the least likely to successfully navigate the system and receive the healthcare they need. Efforts to understand racial and ethnic differences and reduce disparities will have to take an account of a broader range of clinical, socio-economic, and structural variables than have been considered to-date. **NCMJ**

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