SYNOPSIS

Racial disparity in health care utilisation

Racial disparity in health care is a widely discussed topic in South Africa, and with the emergence of democracy in our country universal access to medical treatment has taken priority in the minds of government, patients, insurers and not least among health care providers.

An article by Skinner *et al.* in the *New England Journal of Medicine* (2003; **349**: 1350-1359) reported on a study of racial disparities in the rates of knee arthroplasty among Medicare patients in the USA. It was found that the rates of knee arthroplasty were higher for non-Hispanic white women (5.97/1 000) than for Hispanic women (5.37/1 000) and black women (4.84/1 000). Among men, non-Hispanic white men (4.82/1 000) and Hispanic men (3.46/1 000) underwent approximately double the number of procedures compared with black men (1.84/1 000).

In an accompanying editorial, Lavizzo-Mourey and Knickman (*New England Journal of Medicine* 2003; **349**: 1379-1380) examine the results of this research, and suggest ways of addressing racial and ethnic disparities in health care utilisation.

Previous research has shown that the patterns of health care utilisation vary markedly among communities and that valuable insights into the improvement of health care delivery can be gained by examining the association between these patterns and outcomes in various regions. The study of geographical variation together with data about racial and ethnic variations can provide additional information as to the association between residential community and low utilisation rates and poor outcomes. Communities can be identified where disparities are more likely to result from something particular to the experiences of minority groups within the health care system.

In Skinner *et al.*'s article, the focus is on one treatment, and of course the patterns observed with regard to one treatment may differ from those observed with others. Disparities were noted not only between ethnic groups, but also between the sexes. Focusing on specific treatments and conditions is essential in order to reach a point where physicians and health care delivery managers can start to think about attacking the problems of disparities.

Many questions are highlighted as a result of Skinner *et al.*'s research. Hopefully the answers to those questions will provide further insight into ways of reducing ethnic and racial disparities.

The next critical step is further research to determine how much of the differences is due to beliefs and preferences among the patients, and how much is due to bias or stereotyping on the part of health care providers.

First, researchers should identify effective, practical approaches that health care providers can use to reduce disparities. They need to address the causes of disparities: poor quality of care by some providers, racial bias and stereotyping, lack of trust in health care providers, and differences in the preferences of patients for certain medical interventions.

Second, health care providers, insurers, and payers must obtain data about racial and ethnic disparities among their own populations. The rate of disparity is a key measure of quality of care. All the role players have a part to play in the elimination of racial and ethnic disparities — without their commitment, the disparities will persist.

Third, more timely data regarding patterns of utilisation are essential; Skinner *et al.*'s data are 3 - 5 years old. With the advent of electronic billing and medical records, it is possible to process timely data, and the rapid transformation of claims files into analysis files must become a priority for the government, health plans and employees.

However, the collection of data on race, ethnic group and socio-economic status raises a host of questions about privacy; these questions need to be confronted head-on so that racial disparities can be addressed.

The need now is for a rapid and comprehensive plan of action involving research, education of providers and patients and some reform of the health care system to set the [US] nation on a path that will eliminate these disparities in health care.

While these articles were written with the US health care system in mind, much of what is suggested is applicable to the South African situation. It is probable that if comparable research is conducted in local hospitals, a similar situation will be found in terms of health care utilisation, extending from surgery such as knee arthroplasty, to attendance at clinics to seek treatment for both minor and major ailments. The steps suggested by the authors of the editorial should perhaps be considered by the research community in our country.

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