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Evaluating the Economic Causes and Consequences of Racial and Ethnic Health Disparities

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Racial and ethnic health disparities are differences in health status driven by social inequities. While most agree that disparities in health are a social justice issue, underlying economic issues that exacerbate these differences have not been recognized. This paper dissects the economic costs of disparities first, at the individual level in terms of adverse impacts on employment and greater out-of-pocket health care expenditures, and second, at the population level by evaluating costs to government and business. We also make the case that the adverse economic effects of racial and ethnic health disparities impact every American. In this way, we seek to provide new incentives for all Americans to take action to eliminate health disparities.

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The Recognition of Health Disparities

Disparities in health between Americans have been documented since the early 20th century. W.E.B. Dubois first observed racial and ethnic inequalities in health in 1906. The first published report of differences in cancer incidence and prevalence based on ethnicity was released in 1973 (Henschke et al., 1973). In spite of decades of awareness, most of the gaps in life expectancy, infant mortality and disease incidence between racial and ethnic groups have remained the same, while some have even widened. It is estimated that 83,000 deaths occur each year as a result of racial and ethnic health disparities (Satcher et al., 2005). In addition, racial and ethnic inequities in health care delivery are now well-established (Institute of Medicine, 2003). While racial and ethnic health disparities are a social justice issue, these inequities are also an economic issue that impact all Americans, regardless of race.

To describe the economic costs of health disparities, this report has been divided into two sections. The first section will describe the economic impact racial and ethnic health disparities have at the individual level, such as greater out-of-pocket health care costs and loss of income due to disability. The second section will describe the impact health disparities have at the societal level, such as the economic consequences of racial and ethnic health disparities to the larger population: increased competition for resources, lost labor productivity and greater spending for all taxpayers.

It should be noted that this report serves as a primer rather than an exhaustive analysis of the economics of health disparities. While it will touch on the broad economic consequences of health disparities, poor health and economics are inextricably linked in America in far more subtle ways than this report will document and warrant further study in future reports.

Indeed, uninsured patients are often charged more than insured patients for the same care, a practice known as 'discriminatory pricing.' Discriminatory pricing results when uninsured patients are billed the full gross charge while insured patients receive substantial discounts.

Part I: The Economic Impact of Health Disparities on Individuals and Communities

I. LOST INCOME AND LABOR PRODUCTIVITY. Racial and ethnic minorities suffer a disproportionate burden of disease that adversely impacts work force participation (National Center for Health Statistics, 2008). Increased incidence of heart disease, diabetes, cancer, and obesity among Blacks and Hispanics is associated with an increased number of missed workdays due to illness, as well as lower overall household earnings (Government Accountability Office, 2007). Given that these illnesses and health conditions tend to occur at younger ages in minorities, the number of work years may be shortened or spent in lower paying jobs. While many jobs offer paid sick leave for employees, significant numbers of hourly wage earners are not offered this benefit. Subsequently, employees without sick leave either miss work due to poor health or cannot meet performance standards while at work because of poor health. If a person becomes ill, then s/he may be unable to work for a period of time. Without paid sick leave, these missed hours of work equate to lost income when the person stays out of the workplace to recover. In instances of extended periods of illness, workers may lose their jobs, often their only source of income. This vicious cycle of lost income and missed work contributes to poor health as individuals are unable to afford the health care they need to recover and return to work.

On the other hand, many individuals may continue to work in spite of their poor health. While continuing to work maintains a relatively consistent income stream for most people, the quality of the work may suffer and result in loss of productivity. For those whose income depends on productivity levels, the effects can be even more devastating as ill persons continue to work for diminishing returns.

II. GREATER OUT-OF-POCKET HEALTH CARE COSTS TO INDIVIDUALS. Low-income racial and ethnic minorities spend a greater proportion of their disposable income on health care, due to a greater reliance on publicly financed health insurance programs and discriminatory pricing in health care facilities (Hospital Accountability Project, 2003; Institute of Medicine, 2003; Mayer et al., 2000). At the same time, a greater proportion of minority populations are uninsured or 'underinsured,' a term that identifies a group of people who have health insurance with disproportionately high premiums and deductibles (Hospital Accountability Project, 2003). While hospitals are required to provide emergency medical treatment to individuals regardless of their ability to pay, it does not require that the facility do so for free or at a reduced cost (Andrulis et al., 2003). Indeed, uninsured patients are often charged more than insured patients for the same care, a practice known as 'discriminatory

CASE STUDY #1
A little boy's death sheds light on our fractured health system

The case of Deamonte Driver, a young boy living in Maryland, highlights how lack of access to preventive services can lead to illness and even death, ultimately fueling health disparities. In 2007, Deamonte died at the age of 12 because of an infection from a tooth abscess. Initially, a lapse in Medicaid coverage made it impossible for the family to afford dental care. However, even after Medicaid coverage was obtained by Deamonte's mother, she had great difficulty finding a dentist that would accept Medicaid patients. As the abscess became worse, the infection travelled to Deamonte's brain and resulted in two brain operations, multiple weeks of hospital care, nearly $250,000 in hospital costs and ultimately, the death of this young boy. Economic barriers and lack of access to health care combined to keep Deamonte, who was black, from having a simple $80 tooth extraction that would have saved his life (Cohen, 2007). Clearly, access to health care is based on a number of social and economic factors that need to be working in synchronicity – not just whether someone is eligible for a government health care program.

pricing.' Discriminatory pricing results when uninsured patients are billed the full gross charge while insured patients receive substantial discounts (Table 1) (Wielawski, 2000). As a result, the charge to uninsured patients may be two to three times the amount charged to insured patients. Moreover, the gross charges for services to unisured patients can exceed the actual cost to the hospital (Hospital Accountability Project, 2003; Wielawski, 2000).

TABLE 1: AN EXAMPLE OF HOW DISCRIMINATORY PRICING WORKS

	Patient with Insurance	Uninsured Patient
Hospital's actual cost	$6,065	$6,065
Hospital's "gross charge" for service	$18,777	$18,777
Insurance company pays	$5,527	$0
Insurance company discount	$13,200	$0
Amount patient must pay	$50 (co-pay)	$18,777
Amount hospital profits on service	-$488	$12,712

Source: Hospital Accountability Project of the Service Employees International Union. (2003). Why The Working Poor Pay More, A Report on the Discriminatory Pricing of Health Care. Chicago, IL: Service Employees International Union.

III. LACK OF ACCESS AND LOWER QUALITY CARE. According to the Institute of Medicine's 2003 Unequal Treatment report: "To the extent that minority beneficiaries of publicly funded health programs are less likely to receive high quality care, these beneficiaries – as well as the taxpayers that support public health care programs – may face higher future health care costs" (Institute of Medicine, 2003). Racial and ethnic minorities who are unable to pay for quality health care may receive sub-standard health care early in the course of illness due to disparities in quality of care between communities (Institute of Medicine, 2003). A vicious cycle ensues as lack of access to quality health care results in a greater reliance on the health care system in the future due to untreated diseases. Individuals who postpone treatment to save money in the short term likely get sicker and ultimately spend more on health care resources in the long term.

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IV. NOT JUST AN INCOME PROBLEM. Perhaps the weakest argument among those who dispute the existence of health disparities is the 'personal responsibility' claim. This claim argues that if only people in poor health made better health choices or earned more money, their rates of disease would be equal to those of other Americans. This line of argument fails, however, when one considers that racial and ethnic health disparities exist at every income level, not just among the poorest Americans. Regardless of the size of their paychecks, racial and ethnic minorities experience worse overall health than their non-Hispanic white counterparts in the same income bracket (Institute of Medicine, 2003). In addition, this finding also demonstrates that at every income level, racial and ethnic minorities have fewer opportunities for prosperity and success because of health disparities. While the income field may be leveled for some individuals, the health advantages of increased wealth remains disproportionately in favor of non-Hispanic white Americans.

CASE STUDY #2
Health promotion in the workplace works

The Partnership for Prevention has done extensive research to demonstrate that employers who provide health promotion programs enjoy a more productive work force. Specifically, the indirect economic burden of employees who miss work or show up in ill health can be as high as 2 to 3 times the direct medical costs. Yet, studies show that employer health promotion programs result in a 28 percent reduction in sick leave, 26 percent reduction in health costs and a 30 percent reduction in workers compensation and disability claims. For every $1 an employer spends on worksite health promotion programs, $5.93 is saved. Clearly, employers who work to promote employee health serve their own economic interests as well.

Part II: The Economic Impact of Health Disparities on Society at Large

I. THE PUBLIC COST OF DISPARITIES. A disproportionate burden of disease among racial and ethnic minorities results in greater health care expenditures not only for these groups but for the rest of society. The Healthy People 2010 initiative notes that "the health of the individual is almost inseparable from the health of the larger community and…the health of every community in every State and territory determines the overall health status of the Nation" (U.S. Department of Health and Human Services 2000). This shared risk begs the question: What would the cost savings be for society as a whole if disease rates for all racial and ethnic groups were the same as those for non-Hispanic whites?

To demonstrate the economic impact if health disparities were completely eliminated, the state of Colorado made some hypothetical calculations (Colorado Department of Health, 2005). Between 1999-2002, there was a 5 percent greater prevalence of diabetes among black Medicaid recipients compared to non-Hispanic white Medicaid recipients. This 5 percent translates to 2,513 more black Medicaid recipients with diabetes compared to non-Hispanic white Medicaid recipients in Colorado. Given that the average annual cost for one Medicaid recipient with diabetes is $13,243 (in 2002 dollars) then the total cost of 2,513 cases of diabetes to the state of Colorado is $33,283,313. This is the amount of money that could have been saved or diverted to other resources if racial and ethnic disparities in diabetes did not exist in Colorado. The amount of suffering that could have been avoided among those 2,513 people is incalculable.

Federal efforts to reduce health disparities have been initiated. In the last decade, initiatives such as the Centers for Disease Control's Racial and Ethnic Approaches to Community Health Across the United States (REACH) program and the National Center for Primary Care at the Morehouse School of Medicine in Atlanta have sought to eliminate racial and ethnic health disparities (CDC, 2008). Other programs such as Head Start recognize the value of early childhood well-being across ethnic groups to level the playing field and improve health outcomes (Administration for Children & Families, 2008). Yet, such programs are consistently threatened

by budget cuts and remain a relatively low priority on many politicians' agendas (House Sub-Committee on Labor, Health and Human Services, and Education and Related Agencies, 2007). Without a strong public outcry and an awareness that health disparities is a problem that impacts all Americans, politicians will not maintain the political will to support the expansion of programs aimed at eliminating disparities.

II. THE COSTS OF HEALTH DISPARITIES TO BUSINESS. According to the U.S. Bureau of Labor Statistics, by 2015 racial and ethnic minorities will comprise 41.5 percent of the work force (U.S. Bureau of Labor Statistics, 2008). Recently, the business community has begun to recognize the impact of health disparities on the well-being of employees as well as the productivity of companies. The skyrocketing costs of health care and health insurance have forced employers to take a considered look at how to reduce costs. A recent report by the National Business Group on Health found that there are two major financial incentives to motivate businesses to care about reducing health disparities: first, the possibility of reducing direct health care costs, and second, the advantage of reducing the indirect costs that result from poor health and illness (National Business Group on Health, 2003). However, studies show that businesses are often forced to ask the question of whether there will be a 'return on investment' for efforts to reduce health disparities (Lurie et al., 2008).

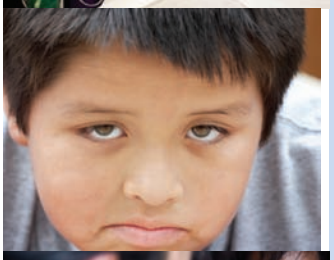
Businesses have a critical opportunity to leverage access to health care by providing quality employer-sponsored health insurance and health promotion programs in the workplace, and ultimately reduce health disparities.

DIRECT COSTS. Direct health care costs are those dollars companies spend to treat an employee's health condition, illness or disease; the bulk of these costs are insurance premiums. While employer-based health insurance is an expected benefit in 'white-collar' professional jobs, the cost of providing this benefit continues to grow exponentially each year (National Business Group on Health, 2003). For example, in 2002 large employers collectively spent more than $200 billion dollars in direct health expenditures for coronary heart disease (National Business Group on Health, 2003). This estimate doesn't even include the direct costs associated with other major causes of morbidity, including cancer and diabetes.

Given that the labor force is becoming more ethnically diverse, providing employer-sponsored health promotion programs to reduce health disparities would result in significant savings in health care expenditures (Partnership for Prevention, 2008). (See Case Study 2.) Rather than spending dollars on interventions to treat existing diseases, many companies are beginning to recognize it is more cost effective to promote health and prevent disease. Not only does this benefit the employee in terms of better quality of life, it benefits the employer by reducing the direct costs of treatment for preventable diseases and health conditions. Based on the disproportionate burden of disease that minorities suffer, efforts by large employers to institute wellness programs and promote preventive health care may begin to narrow the gap in health disparities.

INDIRECT COSTS. The indirect costs of health disparities are equally disruptive and costly to productivity and perhaps even more insidious (National Business Group on Health, 2003). Indirect health costs include compromised on-the-job productivity due to poor health or illness, as well as total loss of productivity due to absenteeism. One employee in poor health impacts the entire organization by creating stress on other employees as they attempt to fill the void, disrupting the work environment through disability leave and levying the extra costs of hiring and training new employees as replacements. While these observations may seem to ignore the plight of a sick or disabled employee, the point is to highlight the advantages to companies of investing in employees' health and well being to prevent these outcomes.

Reducing health disparities through prevention-based workplace programs is in the best interest of employers as well as employees. Ultimately, employers stand to be a critical mechanism for reducing health disparities on a national level. Businesses have a critical opportunity to leverage access to health care by providing quality employer-sponsored health insurance and health promotion programs in the workplace and ulitmately reduce health disparities.



Conclusions: The Costs of Health Disparities Can Be Reduced.

While barriers to eliminating health disparities exist, measures can be implemented to begin to turn the tide. Researchers have found that health care organizations that partner with community stakeholders can improve availability and quality of health care in under-served neighborhoods. The CDC's Racial and Ethnic Approaches to Community Health Across the United States (REACH) program has found community partnerships to be an effective strategy to improve quality of care and reduce disparities. While the return on investment for businesses who invest in employee health promotion may not be immediately apparent, researchers argue that continued efforts to reduce health disparities will become the norm over time, therefore improving the ratio of returns to costs in the future.

This report has explored some of the economic costs at both the individual and the societal level that result from the injustice of racial and ethnic health disparities. Some of the issues that have been discussed include the disproportionate out-of-pocket costs to the people directly impacted by health disparities, the costs to society at large and to employers who spend more dollars on intervention-based health insurance rather than prevention-based health promotion programs. Beginning to understand the far-reaching economic consequences of racial and ethnic health disparities can be the first step toward a national commitment to eliminating injustices in health.

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