Disparities in Health Care: Minority Elders at Risk

Abstract: Minority elders are at great risk for missed diagnoses, greater disabilities, and higher death rates unless health care providers acknowledge that disparities in healthcare do exist and adjust their way of providing care. In the next 30 years, the current elderly population of 35 million is predicted to increase to 72 million. Minority elders are expected to account for 50% of this population. Research has shown that minority elders have a higher incidence of certain diseases but do not receive the same care as their white counterparts (Baldwin, 2003). Differences in the incidence, prevalence, mortality, and burden of disease among minority elders indicate that disparities in healthcare are consistently found in a variety of settings (Jett, 2006). Poor communication and distrust in the health care system have been found to be major factors affecting the quality of healthcare for these individuals. This article discusses healthcare disparities experienced by minority elders and suggests ways to curtail this problem. Culturally sensitive care is suggested to save lives and improve quality of life for these vulnerable individuals. Understanding the cultural practices of minority elders and negotiating a plan of care that respects their beliefs will increase patient compliance, improve care, improve outcomes, and decrease healthcare disparities among minority elders.

Key Words: Elders, Disparities, Minority, Culturally Sensitive Care, Communication, Quality of Care, Distrust

BACKGROUND

Literature documents that 20% of the elderly population in the U.S. are considered to be in minority groups, which includes African Americans, Asians, Hispanics, and those of Pacific Island descent. Minority elders are expected to account for 50% of the elderly population by the year 2050 (Jett, 2006). The overall health of our elderly population is improving; but minority elders are disproportionately affected by differences in availability and utilization of healthcare services.

Research has shown that minority elders are less likely to receive routine medical care and are more likely to receive a markedly lower quality of care than their white counterparts (Baldwin, 2003). Health care disparities are unjust, costly, and can lead to poorly managed care (Sampselle, 2007). Health care disparities could lead to missed diagnoses, complications from preventable and avoidable diseases, greater disabilities, untoward impacts on individual health, decreased quality of life, and decreased life expectancy (Baldwin, 2003; Graham, 2007; Russo & Elixhauser, 2006). Therefore, in order to devise a plan to help eliminate this problem, it is essential to understand the phenomena of health care disparity as it relates to access to care for minority elders.

SIGNIFICANCE OF THE PROBLEM

Healthcare disparities among minority elders began to receive more attention when Healthy People 2000 was being formulated (Jett, 2006). Research has found that minority groups of elders received lower quality of care even when variables such as insurance, co-morbidity, education, and socio-economic status were accounted for. By definition, this is a health disparity (National Institute of Health |NIH|, 2004). Elders in minority groups were found to have a higher incidence of developing certain diseases but did not receive the same health care as their white counterparts (Baldwin, 2003; CDC, 2007; Mechanic, 2005). Table 1 demonstrates the dramatic differences in health status among minority populations when compared to their white counterparts; and Table 2 demonstrates the serious health outcomes.

Social characteristics vary across communities. These variations are: socioeconomic status, cultural context, family structures, racial/ethnic composition and language (Johnson & Smith, 2002). But substantial heterogeneity exists in all communities; and an understanding of disparities can be advanced by focusing on the properties of social and...
physical environments as well as mechanisms which can be influenced to improve health and health outcomes (Johnson & Smith, 2002).

Johnson and Smith (2002) contend that many African American elders in the South have a distrust of the healthcare system. This distrust may stem from the memories of African Americans being used as involuntary medical research subjects and mistreatment of study subjects in the Tuskegee syphilis and sterilization initiatives. It is also noted that many minority elderly populations disproportionately receive less health care in hospital emergency settings; care that is more costly; and care that is more problem focused than routine health care (Baldwin, 2003). Other causes have been identified as contributing to health disparities in minority populations: poor education, poverty, environmental factors, and the health behaviors of minority groups (Baldwin, 2003).

FACTORs INFLUENCING HEALTH CARE DISPARITIES

Minority elders can take necessary precautions to minimize risks of their well-being. Understanding the physiological changes that occur with aging and with illnesses is paramount; personal responsibility is central to healthy aging and instrumental in maintaining independence and control (American Nurses Association [ANA], 2006). It is the responsibility of health care providers to offer information, education, and resources that foster informed decisions regarding health care. But minority elders may not be adequately educated about preventive health care or offered the same health services when illnesses occur. These differences create disparities (Schwartzberg & Handelman, 2005).

There are multiple factors influencing health disparities towards minority elders including: 1) the manner in which patients understand and seek healthcare; 2) the attitudes of healthcare providers; 3) the way providers approach offering healthcare services; and 4) the organizational system. Health care providers determine what healthcare is needed but, at times, do not offer the same care to all patients including screening tests, procedures, and medications due to many factors such as costs and compliance issues (Schwartzberg & Handelman, 2005).

The prescriptive plan is the responsibility of healthcare providers to determine; but patients must take an active part in complying with medical regimens (Schwartzberg & Handelman, 2005). This may be difficult for certain patients because often instructions are complex and poorly written which increase the incidence of misunderstanding, medication errors, and poorer outcomes (Schwartzberg & Handelman, 2005). Often times this occurrence of non-compliance can be compounded in minority elders by the fact that the elderly have co-existing health problems such as: 1) loss of vision and hearing; 2) chronic illness and pain; and 3) potentially cognitive decline (Schwartzberg & Handelman, 2005). Health seeking behaviors of minority elders is influenced by family, cultural values, and either personal or immigrant experience in their use of health resources (Pang, Jordan-Marsh, Silverstein, & Cody 2003). Researchers contend that minority elders combine Western health care modalities with cultural treatments and have a dependence on neighbors and friends for advice in complying to prescribed plans of care (Pang et al., 2003). Many elderly individuals rely heavily on home remedies in the day-to-day management of their health; and research indicates that ethnic minority groups use home remedies routinely (Grywacz et al., 2006).

Researchers postulate that there are many reasons that home remedies were (and still are) used. The reasons are: 1) economic hardship-rates of poverty are nearly 3 times greater in ethnic minority elders; 2) relatively greater burden of disease-minority elders experience more debilitating chronic conditions such as arthritis for which conventional care offers little relief; and 3) relative unavailability of conventional health care services-minority elder groups frequently live in areas with fewer primary health care providers and need to travel greater distances to receive health services (Grywacz et al., 2006; Dancy, 2002).

Differences in the incidence, prevalence, mortality, and burden of diseases among minority elders indicate that disparities are consistently a common theme across a wide range of clinical services and are associated with higher mortalities (Jett, 2006). Disparities resulting in disproportional utilization of healthcare were evident even after the variables for differences in access to care were accounted for. African Americans elders were 62% less likely to receive anticoagulants after experiencing a transient ischemic attack; and Mexican American elders received 36% fewer prescriptions post myocardial infarction (Institute of Medicine [IOM], 2002; Betancourt, Green, Carrillo, & Park, 2005).

Similarly, effective communication may be another barrier. Compliance to a prescribed plan of care can be affected by different degrees of understanding of the medical condition due to low educational status or in language

### Table 1. Diseases in Minority Elderly Populations compared to their White Counterparts

<table>
<thead>
<tr>
<th></th>
<th>Compared to White Counterparts</th>
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<tbody>
<tr>
<td>African Americans</td>
<td>1.5 times more likely to have a stroke</td>
</tr>
<tr>
<td></td>
<td>1.5 times more likely to have hypertension (HTN)</td>
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<tr>
<td></td>
<td>2.5 times more likely to have diabetes mellitus (DM)</td>
</tr>
<tr>
<td>American Indians</td>
<td>2 times more likely to have DM</td>
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<tr>
<td>Hispanics</td>
<td>2 times more likely to have DM</td>
</tr>
<tr>
<td>Native Hawaiians</td>
<td>5.7 times more likely to have DM</td>
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<tr>
<td>Puma Indians</td>
<td>1.5 times more likely to have DM</td>
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</tbody>
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*adapted from IOM Report 2002; Baldwin, 2003

### Table 2. Health Outcomes of Minority Elderly Populations compared to their White Counterparts

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<thead>
<tr>
<th></th>
<th>Compared to White Counterparts</th>
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<tbody>
<tr>
<td>African Americans</td>
<td>50% more likely to die of the stroke</td>
</tr>
<tr>
<td></td>
<td>20% more likely to die of heart disease</td>
</tr>
<tr>
<td></td>
<td>30% more likely to die of cancer</td>
</tr>
<tr>
<td></td>
<td>30% more likely to have DM related amputations</td>
</tr>
<tr>
<td>Hispanics</td>
<td>50% more likely to die from DM related complications</td>
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*adapted from IOM Report 2002; Baldwin, 2003
differences (Dell’Orto, 2007). Elders with low literacy may have difficulty in effectively communicating complaints and may have trouble understanding medical conditions. They may be less active in participating in decision-making and may not understand the necessity to adhere to a medical regimen (Schwartzberg & Handelman, 2005). Speaking on the same level and language as the patient can facilitate effective communication which is essential in understanding the importance of adhering to a plan of care and the consequences of noncompliance (Sampselle, 2007). Healthcare providers can learn the language of the community in which they work to facilitate developing medical history questions designed to elicit responses that allow the practitioner to know how to proceed in a culturally sensitive manner. In addition, the practitioner can tailor teaching methods and materials to account for ethnic origin to increase understanding about medications, diet, and activities (Jett, 2006). When creating teaching materials, especially about diets, the practitioner should learn the ethnic food groups; include them in these materials; and consider using pictures for illiterate individuals (Jett, 2006).

Affordability is another major factor to consider. Some minority elders have minimal and/or fixed incomes, or lack health insurance which leads to difficulty affording healthcare, medications, or treatments (Jett, 2006). Healthcare providers can implement alternative ways of negotiating the health care system by considering sliding scale payment systems; developing partnerships with other agencies for referrals; and seeking grants to supplement income and assist in covering clinic costs (Jett, 2006).

Compliance with medications can be encouraged by ensuring patients can afford the prescriptions, ensuring prescribed medications are from preferred lists or finding ways to assist coverage. Performing a price comparison in the area or searching pharmaceutical websites for indigent care programs are ways to assist.

SUGGESTIONS FOR IMPROVEMENT

Healthcare providers must acknowledge these issues, seek ways to diminish healthcare disparities, attempt to make access more conducive to minority elders, and enhance patient compliance. Positive relationships with patients and effective communication are essential to promote the quality of healthcare (Schwartzberg & Handelman, 2005). Communication has been identified as a key factor in improving the health status of minority elders (Schwartzberg & Handelman, 2005). Paramount to caring for the minority elder community is understanding and this can only be done by identifying and accepting cultural practices of the community. Understanding behaviors of this ethnic diverse population is paramount to developing an appropriate plan of care (Friedman, 2005; Mechanic, 2005). And for the plan of care to be utilized, it must coincide with acceptable practices of the community and of the patient (Jett, 2006).

Hence, culturally competent care is provided when practitioners understand the health beliefs, cultural practices, and folk remedies of the major culture of their patients (Friedman, 2005). Healthcare providers must reach out to the community to gain the trust and acceptance of the community as reliable and credible providers. Minority elders will often choose to seek health care from providers who have treated them; and who have been accepted by others in the community. Reputation is a major factor in choosing a provider (Dell’Orto, 2007). Reaching out to communities where people feel comfortable encourages utilization of health care services. Lee (2005) postulated that many African Americans in the South are more accepting of information and education they received at their church. The authors also contended that recent campaigns have been successful in Mississippi and South Carolina that targeted healthcare education via area churches (Lee 2005).

Comparatively, increasing availability of services where minority elders reside will encourage utilization (Lee, 2005). Clinical services should be available in the community where minority elders reside (Lee, 2005). But gaining entry into the health care system is only the first step for these elders; healthcare providers must assist patients in understanding and navigating the complex health care system when treatments extend beyond the initial access point (Sampselle, 2007). In the rural South, many minority elders do not drive. They depend upon friends or relatives for transportation to appointments. Ways to increase accessibility is to alter clinic hours to accommodate early morning or evening appointments. Transportation can be arranged by state services; or neighbors can be encouraged to make appointments that are close in time to foster carpooling (Jett, 2006). Assistance in making appointments, making arrangements to get to appointments, and understanding the treatment plan are ways to increase adherence to medical management.

Healthcare providers can inquire about acceptable decision making practices and include the patient’s previous health seeking behaviors in the teaching plan (Fletcher, 2000). Relational characteristics of the African American culture have been described as social networks comprised of multigenerational relatives, friends and neighbors (Baker, 1999). In the South, the African American population often relies on advice of the grandmothers and other community members who have experienced similar health problems (Fletcher, 2000).

Finally, one of the most important facets to consider when creating a plan of care that will be utilized by the patient is to consider the values and concerns of the patient. The differences in patient and health care provider’s values should be respected and incorporated into the plan of care (Pang et al., 2003). Health care providers must educate minority elders on health, diseases, treatments, and realistic expectations for care. Culturally specific phrasing and patterns of expression must be used to gain compliance (Srinivasan & Sakauye, 2005).

While plans of care are crafted by healthcare practitioners, the plans must be in cooperation with a patient. Berlin and Fowkes (1983) created a plan to negotiate patient compliance. This plan is referenced as the LEARN method. It consists of:

• Listening to the patient and family or other persons the elder relies on for healthcare advice;
• Explaining in the patient’s language—at a level the patient can understand and in terms that are important to the patient;
• Acknowledging the patient’s understanding of an illness and the plan of care;
• Recommending what you, as the healthcare provider thinks should be the plan of care, asking what the patient thinks should be the plan of care; and
• Negotiating what the actual plan of care will be with either the patient or the decision maker of the patient.

When negotiating, take recommendations, acknowledge the understanding of the patients and agree on a mutual plan of care. To avoid disparities, it is especially important to acknowledge cultural differences and attempt to provide care to all patients in the same manner. Healthcare providers must
be cognizant to and address the issues of the patient, the patient’s values in healthcare and the patient’s goals for healthcare; and the motivation of the patient to comply with the prescribed plan of care. Minority elders should not be rushed through visits with healthcare providers. Time being given to each individual patient as to ensure needs and concerns are addressed.

CONCLUSION
Disparities in healthcare within the minority elder population are impacting our nation and will worsen as group increases in numbers in the years to come (He et al., 2005). The elderly population will quadruple by the year 2050 and minority elders will account for half of this population (Jett, 2006). Minority elders carry a greater burden of many chronic diseases; and studies have shown that minority elders have poorer outcomes as well as higher death rates (Johnson & Smith, 2002). Utilization of health care services and patient compliance are important issues for health care providers to consider when planning care. Discrimination occurs when health care is not accessible or equivalent to people of differing ethnic and/or cultural origins. This review of literature has shown that disparities exist in the care of minority elders; and there have been few suggestions for solutions to the problem.

Healthcare providers are educated in assessing, diagnosing, and developing plans of care but often these are generic plans for all populations. Understanding the minority elder population, catering to them to provide culturally appropriate healthcare, and improving health as well as outcomes are essential in eradicating the aforementioned disparities (Lee, 2005). Understanding the goals of the patient and working to create a plan of care to accomplish the wishes of the patient while providing quality care is the key to providing a service that diminishes disparities (Srinivasan & Sakauye, 2005). There are many disparities in healthcare for minority elders. Healthcare providers must acknowledge these disparities; understand the cultural beliefs and practices of minority elders; and make efforts to provide care that promotes compliance to a mutually negotiated plan of care.

Nurse Practitioners, especially in the geriatric arena, can make a difference and diminish disparities by making practices welcoming to minority elders. Plans of care should be catered to educational levels to enhance compliance. Utilize the LEARN method to plan care: listen, explain, acknowledge, recommend, and negotiate (Berlin and Fowkes, 1983). This method promotes the values of the patient and the goals of care; creates a plan to meet these needs; ensures the comprehension of the patient; and possibly increases compliance with a prescribed plan of care. Increasing availability, accessibility, acceptability, and affordability are key to making healthcare better utilized by minority elders.

The healthcare system can no longer ignore this problem as evidence has shown disparities do exist for minority elders. For the issue of disparities to be addressed, individual healthcare providers must acknowledge the problem exists and examine their current practices. Elders in minority communities are at high risk for missed diagnoses, greater disabilities, and higher death rates unless healthcare providers acknowledge disparities in healthcare exist and adjust their way of providing care. Culturally sensitive care will save lives and improve quality of life for these vulnerable individuals. As the population of minority elders quadruples in the next 50 years, the healthcare system must be prepared and must be sensitive to the needs of the community. Developing ways to diminish health care disparities and increasing patient compliance are subjects for future research to develop innovative ways to combat this problem as the baby boomer generation gray and this population explodes.

REFERENCES
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