

IX. DISCUSSION AND FURTHER RESEARCH SUGGESTIONS

DISCUSSION

Most of the previous literature on racial/ethnic health care comparisons has focused on African Americans and Hispanics/Latinos in comparison with the White majority, in part because other racial/ethnic minority groups represent a very small proportion of the population and, thus, sufficient data are not available to permit examination of their health care patterns. The CAHPS surveys, therefore, provide a unique opportunity to investigate groups that have heretofore gone unexamined.

This CHARTBOOK highlights a number of differences and similarities between the Medicare managed care (MMC) racial/ethnic subgroups surveyed in the CAHPS. Asian Americans have the best self-reported overall health and lowest health care utilization levels. Whites self-report good health but nevertheless are above-average utilizers. The group with the poorest self-reported health is American Indians/Alaska Natives, followed by African Americans. Hispanics/Latinos tend to be average in terms of self-reported health status and utilization of health care services. Female MMC enrollees report worse health, compared with males of the same racial/ethnic group. However, most females also report lower rates of several serious health conditions than their male counterparts.

It is also revealing to compare White males with female racial/ethnic groups. Black and White women are more likely to see a doctor at least once, compared with White males; other minority women, however, are less likely to see a doctor at least once. Women of all racial/ethnic groups are less likely to see a specialist than are White men. White and Asian women are less likely to use an emergency room than are White men; otherwise, non-Asian minority women are more likely to use an emergency room than are White men. Women of all racial/ethnic groups (except American Indians/Alaska Natives) are less likely than White men to be hospitalized. Asian women tend to differ from other minority women by being lower utilizers than White men of prescription medicines, special medical equipment, special therapy, and home health care, whereas non-Asian minority women are higher utilizers of these services than are White men.

Current smoking is most prevalent among American Indians/Alaska Natives and least prevalent among Asians—particularly female Asians. Among those who have ever smoked, Asians have the highest quit rates, along with Native Hawaiians/Pacific Islanders; Blacks and American Indians/Alaska Natives are least successful in quitting. Differences among the groups in a smoker being advised to quit are small.

FURTHER RESEARCH SUGGESTIONS

While the information in this CHARTBOOK reveals many differences between racial/ethnic groups, it does little by way of attempting to explain these differences, leaving new, unresolved questions. These questions could be addressed through further research. The following briefly describes a few projects that could make use of the MMC CAHPS information and are interesting in terms of sociodemographic comparisons and public policy.

Gender Comparisons

This CHARTBOOK presents some information separately for males and females. Segmenting more of the data by gender could reveal additional insights. That would make it possible to make additional comparisons between, for example, male and female African Americans and between persons of a given gender but different racial/ethnic groups.

Smoking and Health

Tables could be created that show rates of current smoking, former smoking, and never smoked, by gender, for each racial/ethnic group in the MMC CAHPS database. Various health conditions are understood by many health experts to be associated with tobacco use. Tables could be produced that show how health conditions and health care utilization are associated with current and former tobacco use among the Medicare managed care population. Additional tables could show, for each group of current smokers, the percentage reporting that a doctor has counseled them to quit. Statistical analysis could estimate how whether or not a smoker has been counseled to quit is related to a number of explanatory variables, such as race/ethnicity, gender, education, geographic location, and characteristics of the MMC plan.

Prescription Medicines

Medicare generally does not provide coverage for most medicines prescribed outside a hospital. Although many recipients get medicine coverage by enrolling in a Medicare HMO or by purchasing private supplemental insurance, one-third of senior citizens have no prescription medicine coverage.

The issue for Medicare has received increased attention in the last few years. Retail prescription medicine prices in the U.S. have been shown in some cases to greatly exceed those in foreign countries, particularly Canada. New compounds have been developed that present alternative treatments for other, more costly—and covered—therapies that involve surgery and hospitalization.

The MMC CAHPS questionnaire includes questions about prescription medicine coverage and use. The availability of this information facilitates answering the following questions: Which groups tend to exhibit greater prescription medicine use? What are the racial/ethnic patterns of prescription medicine coverage? How is medicine use related to coverage? In addition to race and ethnicity, how is coverage related to age, gender, educational attainment, income, poverty status, geographic location, and other socioeconomic characteristics?

It is of further interest to know whether or not the Medicare managed care plan covers prescription medicines, and if so, to what extent. These data obtained from CMS could be linked to CAHPS data because survey respondents are asked to provide the name of their Medicare managed care plan. The CAHPS prescription medicine use and other health information may then be further analyzed in terms of whether or not the plan offers outpatient prescription medicine coverage, the level of cost-sharing, and so on.

Biracial Individuals

The MMC CAHPS allows respondents to indicate up to five racial categories. Most respondents checked only one box. Approximately 2% of respondents, however, identified themselves as being of more than one race. The vast majority of these multiracials checked exactly two boxes. This issue is particularly timely because 2000 Census data are now becoming available in which the same racial categories were presented.

Some questions arise. How do these self-indicated biracial groups compare in terms of health and sociodemographic characteristics with the relevant single race groups? What should be the criteria for making such comparisons? Can any biracial individuals justifiably be grouped for analytical purposes with those of a single race? What should be the criteria for making such assignments? How do variations in health variables within race groups compare with variations in those variables across race groups?

Comparisons of biracials with single-race persons could be made for two purposes: (1) Comparing biracials to their two relevant races to see how they are similar or different; or (2) Assigning biracial individuals to a single race to increase sample size.