Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?

Practice resources appear to be a determining factor in whether or not physicians treating predominantly minority patients deliver care of adequate quality.

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ABSTRACT: Racial and ethnic disparities in primary health care likely reflect the aggregate socioeconomic composition of a physician's patient panels as well as differences in individual patients' characteristics. National physician survey data indicate that physicians in high-minority practices depend more on low-paying Medicaid, receive lower private insurance reimbursements, and have lower incomes. These constrained resources help explain the greater quality-related difficulties delivering care reported by these physicians—such as coordination of care, ability to spend adequate time with patients during office visits, and obtaining specialty care—that relate directly to physicians' ability to function as their patients' medical home. [Health Affairs 26, no. 3 (2007): w222–w231 (published online 22 April 2008; 10.1377/hlthaff.26.3.w222)]

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delivering high-quality care than those treating fewer minority patients.

This study builds on a new line of research that goes beyond assessing an individual patient's characteristics to also examine the contribution to racial disparities from the aggregate socioeconomic and insurance composition of the pro-

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■ **Characteristics**

EXHIBIT 1
Characteristics Of Low-, Medium-, And High-Minority Primary Care Physician Practices, 2004–2005

Characteristic[a]	Percent minority patients		
	Low (<30%)	Medium (30–70%)	High (>70%)
Patient resources and clinical burden			
Median household income in physician practice ZIP code ($)	48,364	43,049[b]	35,346[b,c]
Uninsured in county (%)	12.4	15.3[b]	16.9[b,c]
Physicians reporting that inability to pay is a major problem for their patients (%)	22.8	24.4	35.0[b,c]
Patients with chronic conditions (%)	57.9	58.7	53.8
Patients who speak another language (%)	2.2	5.5[b]	6.8[b]
Revenue from Medicaid (%)	13.1	19.3[b]	33.7[b,c]
Revenue from Medicare (%)	31.7	28.2[b]	24.4[b,c]
Revenue from private sources (%)	55.4	52.5	42.5[b,c]
Hours of charity care in previous month	4.6	5.7[b]	7.3[b]
Physician characteristics			
Female (%)	32.0	33.7	43.7[b,c]
Practice owner (%)	56.6	51.7	30.8[b,c]
Race and ethnicity (%)			
Hispanic	2.6	6.6[b]	19.8[b,c]
White, non-Hispanic	80.1	68.5[b]	35.4[b,c]
Black, non-Hispanic	0.8	5.1[b]	21.6[b,c]
Other	16.5	19.8	23.2
Years in practice	16.9	15.3[b]	14.0[b]
Board certified in primary specialty (%)	89.2	87.9	80.4[b,c]
International medical graduate (%)	20.6	28.2[b]	38.8[b,c]
Specialty (%)			
Internal medicine	30.5	35.0	30.9
Family/general practice	50.6	40.3[b]	37.8[b]
Pediatrics	18.9	24.7[b]	31.4[b]
Practice characteristics			
Practice type (%)			
Solo/2 physicians	37.3	31.0[b]	30.6
Group with 3–10 physicians	18.2	17.4	7.1[b,c]
Group with >10 physicians	12.2	14.5	6.0[b,c]
G/S HMO	4.4	8.1	5.9
Hospital	16.0	11.2	8.0[b]
Medical school	3.6	5.6	10.3[b,c]
Community or state/local clinic	1.5	3.1[b]	12.2[b,c]
Other	6.8	9.1	19.9[b,c]
Practice revenue from managed care (%)	42.3	46.3	48.3[b]
Practice revenue that is capitated (%)	13.9	20.0[b]	22.5[b]
Number of health IT functions used	4.1	4.3	4.0
Physician income and work effort			
Net income from medical practice ($)	146,031	152,807	127,708[b,c]
Hours in medically related activities in previous week	51.5	52.1	48.5[b,c]
Insurance reimbursement			
GAO physician fee index	93.2	92.6	89.2[b,c]
Medicaid/Medicare fee ratio in state	70.5	74.1[b]	66.4[c]

SOURCE: Community Tracking Study Physician Survey, 2004–05.

NOTES: N = 3,320. G/S HMO is group/staff-model health maintenance organization. IT is information technology. GAO is Government Accountability Office.

[a] Variable descriptions are available in Appendix Exhibit A, online at http://content.healthaffairs.org/cgi/content/full/hlthaff.27.3.w222/DC2.

[b] Different from physicians in low-minority practices ($p \leq 0.05$).

[c] Different from physicians in medium-minority practices ($p \leq 0.05$).

Physician and practice characteristics. In 2004–05, PCPs in high-minority practices were more likely to be female and to be minorities themselves, compared with those treating fewer minority patients. Only 35 percent of physicians in high-minority practices were white, non-Hispanic. Conversely, very few (3.4 percent) physicians in practices with less than 30 percent minority patients were African American or Hispanic themselves. Physicians in high-minority practice

EXHIBIT 2
Problems Facing Primary Care Physicians By Percentage Of Minority Patients In Their Practices, Percentage Indicating Problem, And Simulated Percentage-Point Effect Of Raising Medicaid Reimbursements To Medicare Levels

	Percent indicating problem			Predicted percentage-point change with Medicaid-Medicare payment parity		
Access- or quality-related problem[a]	Low minority (<30%)	Medium minority (30–70%)	High minority (>70%)	Low minority (<30%)	Medium minority (30–70%)	High minority (>70%)
Unable to provide high-quality care to all patients	16.1	21.7[b]	26.0[b]	–0.5	–1.0	–3.2

Access to specialty care. Physicians with high-minority patient panels were more likely than those treating few minorities to report difficulties obtaining specialty care for their patients. Survey respondents were also asked whether they faced difficulties obtaining specialty care for specific reasons. Physicians in high-minority practices reported greater difficulty obtaining specialty care for their patients because patients were uninsured or had insurance coverage that posed access barriers, but not because of an inadequate supply of qualified specialists in the area.[14]

Physician-patient interactions. Although minorities are less likely to have a usual source of care than whites, physicians treating greater percentages of minority patients were not significantly more likely to report an inability to maintain continuity of care than those treating fewer minority patients. They were more likely to report other difficulties with physician-patient interaction, however. For example, physicians in high-minority practices were more likely than those in low-

minority practices to report language or cultural barriers to communication with patients as a major problem affecting quality. They also more frequently reported that inadequate time during office visits was a major problem that affected their a

Discussion And Policy Implications

The results of this

tative data on community health systems, the physician practices within that community, the physicians within those practices, and the patients treated by those physicians.

■ **Policy implications.** The results of this study suggest that racial and ethnic disparities in primary health care are in part systemic in nature, and the lower resources flowing to physicians treating more minority patients are a contributing factor. In particular, we illustrated that if Medicaid payments to physicians were on par with those paid by Medicare, disparities in reported difficulties between physicians whose patient panels were made up of greater versus smaller proportions of minorities would diminish, often substantially. Low payments may be leading PCPs to reduce the time s

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