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A Study of Perceived Racial Discrimination in Black Men Who Have Sex with Men (MSM) and its Association with Healthcare Utilization and HIV Testing

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Abstract

In HPTN 061, a study of Black Men Who Have Sex with Men (MSM), we evaluated the association of healthcare-specific racial discrimination with healthcare utilization and HIV testing among 1167 HIV-negative participants. Median age was 38 years, 41% were uninsured, and 38% had an annual household income < \$10,000. Overall, 19% reported healthcare-specific racial discrimination directed toward family, friend, or self; 61% saw a healthcare provider in the previous 6 months and 81% HIV tested within the past year. Healthcare-specific racial discrimination was positively associated with seeing a provider (adjusted odds ratio (AOR)=1.4 [1.0, 2.0]) and HIV testing (AOR=1.6 [1.1, 2.4]) suggesting that barriers other than racial discrimination may be driving health disparities related to access to medical care and HIV testing among Black MSM. These results contrast with previous studies, possibly due to measurement or cohort differences, strategies to overcome discrimination, or because of greater exposure to healthcare.

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Keywords

HIV; Black Men Who Have Sex with Men (MSM); Racial Discrimination; Healthcare Utilization; HIV Testing

Introduction

Racial/ethnic disparities in health outcomes have been well documented over the years, indicating that Blacks have been shown to have higher morbidity and mortality compared with Whites across multiple conditions, such as cardiovascular disease, cancer, and HIV/AIDS (1, 2). Currently, epidemiologic data demonstrate that Black men who have sex with men (MSM) are disproportionately impacted by HIV/AIDS and have higher morbidity and mortality from this disease than other groups (3). It is estimated that Black MSM accounted for 37% of new HIV infections among all MSM in 2009 and that new HIV infections among young (aged 13-29 years) Black MSM increased 48% from 2006-2009 (3, 4). This disproportionately higher HIV incidence among Black MSM is not explained by higher levels of individual behavioral risk such as substance use or a larger number of sex partners (5, 6).

Over the last decade, HIV prevention research has highlighted some of the structural factors (e.g., lower socioeconomic status and greater likelihood of being uninsured) as root causes of health disparities for Blacks in the US (7-10). Furthermore, the Institute of Medicine Report *Unequal Treatment* highlighted that racial and ethnic disparities in healthcare exist, even when controlling for socioeconomic factors, patient preferences, and patient health status/comorbidities (7). Based on empirical research on health disparities combined with the socio-historical context of both de jure and de facto segregation and discrimination in the US, it is reasonable to contend that racial discrimination serves a role in the persistence of health disparities (11-16). Moreover, the literature has documented that provider bias/stereotyping occurs among medical providers (7, 17, 18).

Given the importance of HIV testing on entry into the HIV treatment cascade, it is essential to identify and understand the key factors associated with the disproportionate impact of HIV and AIDS among Black MSM and decipher why 46% of HIV seropositive Black MSM are unaware of their status (19). Based on previous research, one plausible hypothesis is that some Black MSM experience racial discrimination when interacting with the healthcare system and providers (7, 17, 18, 20-22). This, in turn, may affect patient-provider trust, healthcare utilization, HIV testing, and adherence to HIV regimens (23, 24). There is limited research on the impact of racial discrimination on Black MSM, and specifically relating to HIV testing. In this study, we investigated the association between perceived healthcare-specific racial discrimination on access to care (as measured by healthcare utilization) and HIV testing among HIV-negative Black MSM.

Methods

The study's methods have been described in detail elsewhere (25). HPTN 061 was a study for Black MSM to determine the feasibility and acceptability of a multi-component HIV

prevention intervention in Atlanta, Boston, Los Angeles, New York City, San Francisco and Washington DC. Study recruitment began in July 2009 and continued until October 2010. Study participants were recruited from the community or as sexual network partners referred by index participants. All institutional review boards at participating institutions approved the study.

The following criteria made individuals eligible to participate in the study: self-identified as a man or male at birth and as Black, African American, Caribbean Black, or multiethnic Black, were at least 18 years old, reported at least one instance of unprotected anal intercourse (UAI) with a man in the past six months, resided in the metropolitan area and did not plan to move away during the time of study participation, and provided informed consent for the study. Men were ineligible to participate in the study if they were concurrently enrolled in any other HIV interventional research study, if they had been a participant in an HIV vaccine trial or were a community-recruited participant in a category that had already reached its enrollment cap. Data on demographic and social sexual network information was captured by interview at enrollment. Audio computer-assisted self-interview (ACASI) was utilized to collect self-reported data on HIV testing history. ACASI was used to minimize the risk of social desirability to influence answers. This analysis was limited to HIV-negative participants.

Measures

Interviewer-administered healthcare questions—Healthcare related questions were asked including current health insurance status, recent visits to a healthcare provider, and barriers to receiving healthcare. Healthcare utilization was defined in this study by the following interviewer administered question: “In the last 6 months, have you seen a healthcare provider?”

ACASI-administered HIV test and discrimination questions—Healthcare-specific racial discrimination was collected by ACASI using the following question: “Have you, a family member, a friend, or someone you know been treated unfairly due to race or ethnic background when getting medical care?” HIV testing was defined in ACASI by the following question: “How many times have you been tested for HIV in the past year?” All questions were composed by the HPTN 061 protocol committee.

Statistical Analysis

Univariate logistic regression was used to assess association between socio demographic variables and the three outcomes of interest (perceived healthcare-specific racial discrimination, healthcare utilization in the last 6 months and HIV testing within the prior year). Variables that were statistically significant from the univariate model were included in the multivariate logistic regression models to assess independent association, while adjusting for site. All analyses were performed using statistical software SAS version 9.2.

Results

This analysis included men who were HIV-negative (N=1167) at baseline from any of the six HPTN 061 study sites. Overall, 98% of the participants identified as male, and 2% as transgender. Median age across sites was 38 years, more than half had no college education, 65% were unemployed, 41% were uninsured and nearly 40% had an annual household income under \$10,000. In the cohort, 39% had not seen a healthcare provider in the past 6 months and 19% had not tested for HIV in the past year. Overall, 19% of participants reported previous healthcare-specific racial discrimination directed toward self, family, or friends. Among the 1167 HIV-negative participants, 1149 answered the question on discrimination. Notably, a higher proportion of participants reporting healthcare-specific racial discrimination had at least a partial college education, were unemployed, and had healthcare insurance compared to those not reporting healthcare-specific racial discrimination (see Table I).

In a multivariate model controlling for site, factors that were significantly associated with perceived healthcare-specific racial discrimination included older age (adjusted odds ratio (AOR) per 10-year increase: 1.1, 95% CI: 1.0-1.3), having attended college (AOR: 1.9, 95% CI: 1.4-2.6) and being unemployed (AOR: 1.9, 95% CI: 1.3-2.7). Notably, 148 (12.7%) HIV-negative Black MSM reported that they had needed healthcare in the last 6 months but did not receive it. Responses reported as reasons for not receiving care included the following: 73% of individuals indicated it was too expensive or not covered by insurance, 25% reported other reasons, 11% reported that they did not have a place to go, and 4% reported that they could not get an appointment. None of these men chose the following option as a reason they did not receive care: "There was no place I felt comfortable because of my race/ethnicity."

Table II demonstrates factors significantly associated with having seen a healthcare provider in the previous 6 months, and having received an HIV test in the previous year from separate multivariate models controlled by site. Perceived healthcare-specific racial discrimination was found to have a positive association with both recent healthcare visits (AOR 1.4, 95% CI 1.0-2.0) and HIV testing in the prior year (AOR 1.6, 95% CI 1.1-2.4). Older men were more likely to have seen a healthcare provider, but less likely to have had recent HIV testing. Men who had health insurance were more likely to have seen a healthcare provider, but no more likely to have received an HIV test in the prior year.

Discussion

Our findings indicated that almost one-fifth of participants in one of the largest cohort studies of Black MSM in the US reported healthcare-specific racial discrimination directed toward self, family, or friends. While the method of evaluation and frequency of perceived healthcare-specific racial discrimination vary greatly in the literature, among larger cohorts of Blacks (those with at least 500 Black participants), our prevalence estimate for healthcare-specific racial discrimination is on the upper end possibly because of the inclusion of family and friends in the definition (20, 22, 26, 27). However, the inclusion of family and friends provides further information on perceptions of racial discrimination

among those within their familial and social networks. Research also has indicated that individuals can be impacted by racial discrimination experienced by people close to them in their social network (28). Others have reported that perceived healthcare-specific racial discrimination may have a role in the development of cultural mistrust of the provider and the medical system, as well as the appropriateness of care provided to patients, which reflects an area of concern for Black MSM (24).

In this study, healthcare utilization was found to be positively associated with insurance coverage and older age, as might be expected. Individuals without health insurance are more likely to forgo medical care and adults 65 and older (who have access to universal healthcare through Medicare) have the highest healthcare spending in the United States (29, 30). However, unlike most prior literature, we found a positive association between healthcare utilization and perceived healthcare-specific racial discrimination (20, 26, 27, 31). In particular, much of the previous research in this area has not focused on at risk HIV seronegative Black MSM and uses divergent measures of perceived healthcare-specific racial discrimination (with general discrimination serving as a proxy at times) and healthcare utilization (e.g., medical needs, chronic/preventive disease screening, and the delaying of tests). In our study, we found HIV testing to be positively associated with reported healthcare-specific racial discrimination. Based on this finding, one key consideration relates to the directionality of the association between perceived healthcare-specific racial discrimination, healthcare utilization, and HIV testing. The positive relationship between reported healthcare-specific racial discrimination with receipt of health services may be due to increased exposure to the medical system.

Perceived racial discrimination was more common with older age, any college education, and unemployment. It is possible that older and more educated individuals might feel more comfortable expressing their perception of discrimination in the healthcare setting. It may also be true that for older individuals race is more central to their perception of self due to the racial history of the US. Studies have shown that racial centrality is positively associated with subsequent perceived racial discrimination (32). A number of factors could explain the higher rates of healthcare-related discrimination by unemployed participants, including features of the setting in which such care is delivered or provider attitudes towards unemployed patients. The literature is mixed as to the relationship between perceived racial discrimination and demographic characteristics and the vast majority of literature on the topic has not focused on Black MSM (33).

Undoubtedly, a complex interplay of factors likely contributes to whether individuals seek healthcare or HIV testing. These data seem to suggest that perceived healthcare-specific racial discrimination is not the major factor contributing to the sub-optimal frequency of HIV testing and healthcare visits in this cohort of Black MSM or that other variables such as optimism or social support have buffered the impact of perceived discrimination (34-36). We do not contend that discrimination has a positive impact on access to care but that it does not appear to be the major contributor to lack of access, particularly as no participants identified this as a barrier to care. This might suggest that Black MSM are more integrated into care than Blacks in general.

The study revealed that insured individuals received care regardless of perceived healthcare-specific racial discrimination, a finding with important policy implications for healthcare expansion. However, it is possible that those reporting perceived healthcare-specific racial discrimination may be receiving care in episodic settings such as emergency rooms and urgent care, where there is less continuity and possibly a higher likelihood for individuals to perceive discrimination (37). HIV testing in the previous 12 months was substantially more common in this cohort of Black MSM than in a recent national survey (81% vs. 67%) (38). However, nearly one-fifth of Black MSM had not received an HIV test in the previous 12 months, contrary to CDC recommendations (39). Insured individuals were no more likely to have had an HIV test in the previous 12 months, pointing to the need for continued education on HIV testing guidelines for healthcare workers and patients. HIV test sites such as Whitman Walker or Us Helping Us in Washington, DC may provide additional testing options in an affirming setting for Black MSM uncomfortable receiving services in traditional health settings.

We cannot exclude that other unmeasured factors may mediate the relationship between perceived racial discrimination and healthcare utilization. Stress that is caused by factors such as perceived discrimination in healthcare may be mitigated by personality factors such as optimism (40). A recent article showed that Black sickle cell disease patients who reported high perceived discrimination and high optimism had greater healthcare utilization than patients that reported either low perceived discrimination or low optimism (35). Increased social support has also been shown to buffer the effects of perceived discrimination. Another recent study noted that Black heterosexual men reporting high levels of perceived discrimination had less sexual risk when they had higher levels of social support, highlighting that perceived discrimination can be mitigated by other factors (36).

When interpreting these results, several methodological limitations must be noted. First, the healthcare-specific racial discrimination question used in ACASI inquired not only about the individual, but also about friends or family, without restrictions on recency of experience. The question also only measured that an event occurred, not the frequency or magnitude of impact of the perceived healthcare-specific racial discrimination on the individual in contrast to the use of a previously validated discrimination scale. In terms of generalizability, these data may not reflect populations of Black MSM in other cities, nor of HIV seropositive Black MSM. In particular, Black MSM who have experienced racial discrimination may be less likely to participate in research studies, or less likely to attend some of the venues from which these participants were recruited, leading to selection bias. Self-perceived discrimination may not capture institutionalized and provider-based racial discrimination, which may contribute to health utilization disparities (41, 42). Despite these potential limitations, this paper provides data on perceived healthcare-specific racial discrimination among Black MSM, a topic lacking extensive investigation in a community significantly impacted by HIV disease burden. Additionally, as HIV incidence is highest among Black MSM in the US, we must continue to look for the reasons accounting for this disparity such as differences in frequency/timing of HIV testing (impacting knowledge of infection), rates of sexually transmitted infections, and enrollment in HIV treatment/viral load suppression (43,44).

These data suggest that a multiplicity of structural related factors (e.g. availability of culturally appropriate care, insurance status, and socioeconomic barriers) need to be considered in HIV health disparities as they pertain to Black MSM. It is possible that within larger society and within healthcare, sexual orientation discrimination and stigma have a larger impact on Black MSM than racial discrimination (45). It is also possible that the intersection of racial, sexual, and socioeconomic discrimination combine to impact healthcare utilization and HIV testing in Black MSM (46). Future research should focus on the role of perceived healthcare-specific racial discrimination in respect to frequency, intensity, and individual response in relation to healthcare utilization and HIV testing.

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Table I

Demographic and behavioral characteristics of HPTN 061 participants by report of perceived healthcare related racial discrimination against self, family, or friends.

Characteristic	% Total sample N=1149 ^I	% Perceived Racial discrimination N=220 (19%)	% No Perceived Racial discrimination N=929 (81%)	P value
Age (median)	38 years	40 years	36 years	<.0001
Education				.002
Some high school	18	20	17	
High school degree	36	24	37	
Some college	32	37	31	
College degree	10	13	10	
Advanced degree	4	5	4	
Employed	35	25	37	<.001
Annual household income				NS
<\$10,000	38	38	38	
\$10,000-\$29,999	33	35	33	
\$30,000-\$49,999	16	18	15	
\$50,000-\$69,999	6	5	7	
\$70,000	7	4	7	
Insured	59	68	57	<.01
Visit to health care provider	61	70	58	<.01
HIV testing, previous year	81	85	80	.002

^I Data on discrimination missing for 18 participants (total cohort N=1167)

Table II

Multiple logistic regression of factors associated with recent visit to healthcare provider and with recent HIV testing¹

Variable	Seen medical provider previous 6 months			Had HIV test previous year		
	Adjusted OR	95% CI	P value	Adjusted OR	95% CI	P Value
Racial Discrimination	1.4	1.0-2.0	.04	1.6	1.1-2.4	.03
Age	1.2	1.1-1.3	<.01	0.9	0.8-1.0	.05
Any college	1.3	1.0-1.7	.05	1.1	0.8-1.4	NS
Insured	2.5	1.9-3.3	<.01	1.0	0.7-1.4	NS
Employed	0.8	0.6-1.1	NS	1.4	1.0-2.0	.06

¹ Models controlled by site