



WELLESLEY INSTITUTE
advancing urban health

Policy Challenge Paper

Health Reform in the United States: Building Equity In

Introduction

Canadians generally consider the United States to be a place with severe health disparities (especially between the insured and the uninsured – a disparity that is much more significant in the U.S. than in Canada). And it is undeniable that significant disparities do exist south of the border. In [Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care](#), the Institute of Medicine noted that the U.S. has vast disparities in health care quality and health outcomes across race, ethnicity, socioeconomic status, gender, place of residence (particularly urban vs. rural) and language skills.

In response to persistent disparities, the federal government's current health care reform proposals actually include significant provisions that are intended to reduce health disparities, although these provisions have largely gone unnoticed. Moreover, several states have taken the initiative to develop and implement a range of innovative disparity-reduction strategies that could provide insight and options for Canadian policymakers looking to improve health equity.

Federal Health Care Reform

With round-the-clock coverage of U.S. health care reform and thousands of journalists, commentators, "experts" and bloggers who dissect every word that key policymakers say or write about the issue, it is amazing that any part of the proposed reforms could be ignored altogether. But that is indeed what has happened with the proposed legislation's attempt to reduce health disparities.

While pending House and Senate health care reform proposals include elements designed to significantly reduce health disparities, those elements – and the need to address health disparities – have been lost in the shuffle of heated ideological discussions surrounding the "public option," "death panels" and the "government take-over of health care." Few Americans are aware that one of the stated goals of the House Tri-Committee bill is to reduce health disparities or that the bill has an entire section devoted to the issue.

The House bill ([H.R. 3200, America's Affordable Health Choices Act of 2009](#)) contains several mechanisms to reduce health disparities. For example, the bill provides that:

- The Secretary of Health and Human Services shall ensure that reducing health disparities is an explicit goal in her national priorities for quality improvement in health care (sec. 1441).
- Health care quality improvement measures should be designed to assess disparities, especially those associated with race, ethnicity and language (sec. 1441).
- Medicare will provide reimbursements "for culturally and linguistically appropriate services" in order to promote access to medical services for Medicare beneficiaries with limited English proficiency. This provision (sec. 1222) has actually been referenced by some opponents of health care reform because it is purported to give Medicare coverage to illegal immigrants, which it plainly does not do.

- The Centers for Medicare and Medicaid Services (CMS) will fund and carry out a demonstration project to improve effective communication between providers and Medicare beneficiaries in underserved communities; these demonstration projects are intended to improve access to care, utilization of services, efficiency, patient satisfaction and health outcomes for disadvantaged and low English proficiency populations (sec. 1222).
- The Secretary of Health and Human Services and the Institute of Medicine shall study, analyze and publish a report on the impact and cost of providing of culturally and linguistically appropriate services to limited English proficiency populations (sec. 1223).
- The Centers for Disease Control (CDC) shall establish a program for the delivery of community-based preventive and wellness services. At least 50 percent of the funds for this program must spent on planning or implementing wellness services whose *primary purpose is to achieve a measurable reduction in one or more health disparities* (sec. 2301).

The federal government is trying to explicitly address health disparities for the first time since Congress passed the [Minority Health and Health Disparities Research and Education Act](#) sponsored by the late Senator Ted Kennedy in 2000. In the meantime, however, states (and some local governments) have taken a leading role in recognizing, addressing and trying to eliminate health disparities and – in their role as laboratories for policy experiments – have passed numerous initiatives to improve health equity. Canadian policymakers could learn some valuable lessons from these states and municipalities – including Massachusetts (and the City of Boston in particular), California, New Jersey and Washington State – that have developed promising health equity strategies over the past few years.

State and Local Equity Initiatives

Massachusetts

The state of Massachusetts implemented comprehensive (and controversial) health care reforms in 2006. [Chapter 58 of the Acts of 2006](#) has created near-universal health insurance coverage which has improved access to health insurance for many previously underserved populations. The legislation also contains several provisions which deal explicitly with health disparities:

- **Section 160** creates a Health Disparities Council in the Office of Minority Health. The Council is required to develop health care quality improvement goals that reduce disparities and must submit an annual report to the governor or legislature with recommended strategies to eliminate disparities in access to and use of health care services. It is also specifically authorized to “address diversity and cultural competency in the health care workforce, including but not limited to doctors, nurses and physician assistants.”

- **Section 16 L (a)** creates the Health Care Quality and Cost Council whose objective is to “promote high-quality, safe, effective, timely, efficient, **equitable**, and patient-centered care” It is charged with reducing costs while “improving the quality of care.” The reduction of racial and ethnic health disparities is a key quality measure.
- **Section 110** requires the Department of Public Health to conduct a study to determine the possibility and cost-effectiveness of using Community Health Workers (CHWs) to reduce racial and ethnic health disparities. The *Community Health Worker Advisory Council* met for the first time in February 2008. It has been subdivided into four sub-groups, including the *Survey Workgroup*, the *Workforce Training Workgroup*, the *Finance Policy Workgroup* as well as the *Research Workgroup* which is currently investigating the impact of CHWs on increasing access to care, quality of care and eliminating health disparities among vulnerable populations. The Advisory Council’s full legislative report is expected soon.

Subsequent to the 2006 reforms, Massachusetts has remained committed to addressing health disparities. The Disparities Action Network (DAN) which includes more than 50 private, public and non-profit sector members, wrote legislation entitled [*An Act to Eliminate Racial and Ethnic Health Disparities in the Commonwealth*](#) which was introduced in the House and Senate. The legislation has been held up in committees, but Governor Deval Patrick implemented its main provision when he created the [Office of Health Equity](#) and allocated it \$1 million in the 2009 budget. To address disparities in a systematic, cohesive and coordinated manner, the Office will improve uniform data collection, oversee grant programs and demonstrate best practices from a central location within the state. It will also provide direction, support and resources for state and local public health departments and other agencies.

Massachusetts has been extremely progressive and pro-active in its approach to reducing and ultimately eliminating health disparities. Possible lessons for Canadian policymakers include:

- First, in order to successfully tackle the issue of health disparities, provinces (and the federal government) could create a coordinating body (such as an Office of Health Equity) to oversee, monitor, evaluate the results from disparities-reduction efforts that take place at the community or regional health authority level. These coordinating bodies could also disseminate best practices for reducing disparities across each province. Currently, the Public Health Agency of Canada (PHAC) is moving in this direction to some degree, but the Massachusetts Office of Health Equity has a far more comprehensive mandate.
- Second, Massachusetts policymakers understand the importance of having a uniform data collection and analysis system. Improving, standardizing and coordinating data collection is a crucial element for measuring, evaluating and addressing health disparities.
- Third, Massachusetts has recognized the critical need to improve diversity within the health care workforce. In the United States (as in many parts of Canada, particularly the urban areas), [the health professional workforce does not match the demographics of the patients](#). Latinos, African-Americans and Native Americans account for 25 percent of the U.S. population but only 6 percent of practicing physicians, and while 86 percent of

registered nurses are white, whites make up only 69 percent of the population. These statistics are significant because minority physician residents are twice as likely to practice in federally designated shortage areas, three times more likely to see minority patients and accept a greater proportion of Medicaid (poor and disabled) patients. Moreover, as the [Institute of Medicine](#) notes, “racial concordance of patient and provider is associated with greater participation in care processes, higher patient satisfaction, and greater adherence to treatment.” In short, a diversified workforce leads to decreased disparities in health and health care and improved outcomes.

- Fourth, health disparities require broad, systemic solutions that address the health care system as well as the environmental and social determinants of health. Collaboration is required among multiple groups of private, public and non-profit stakeholders in order to develop the knowledge, skills, resources and political power that are required to drive a health equity agenda.

The City of Boston

Prior to the comprehensive reforms in Massachusetts, the City of Boston became the first U.S. city to establish [a comprehensive plan to eliminate racial and ethnic health disparities](#) in 2005. The Disparities Project, an initiative of Mayor Thomas M. Menino and the Boston Public Health Commission, studied the effects of health disparities in the city and made 12 concrete recommendations. The recommendations, which included both long-term objectives for change and short-term immediate action steps, concerned the health care system as well as the environment, housing, poverty, stress and neighbourhood infrastructure, which all affect health disparities. Key recommendations included: requiring health care organizations to gather uniform patient data on race, ethnicity, language and socioeconomic status and use these data to identify and reduce disparities in clinical practices and health outcomes; developing skills to enable community members to become better informed and equipped patients; providing cultural competence education and training; increasing resources to improve workforce diversity through the recruitment, training and retention of graduates from underrepresented groups in the health care field; and increasing public awareness of the issue.

Through The Disparities Project, approximately \$1 million in grants was given to 33 health care and community-based organizations to collect data, measure quality improvement and implement the recommendations. One year into the Project, [the City of Boston saw significant results](#):

- There was significant progress towards building a uniform data collection system to ensure that health care organizations had critical indicators to assess and improve the health care of their racial and ethnic minority patients.
- More than 460 health care professionals completed the Harvard Pilgrim’s cultural competency training (although it should be noted that most of the people who participated in the course were administrative staff and that very few doctors and nurses completed the training).

- Nearly 3,000 Boston residents (mostly from underserved communities) received direct patient education and support through individual case management, clinical screening or referral services.
- Another 3,000 Bostonians were directly involved in targeted community-wide education, training and advocacy efforts focused on building long-term capacity to address health disparities.
- The Boston Neighbourhood Network (BNN) – a local television station with an audience of approximately 50,000 – created an eight-segment television series about The Disparities Project which aired several times, resulting in expanded coverage of the issue.

In total, more than 6,100 Bostonians directly participated in education, training, advocacy, planning and direct services focused on understanding and addressing health disparities, and thousands more were reached through media outlets that reported on the issue.

The Disparities Project's [Year One Report](#) concluded by noting that through Boston's progressive approach to reducing health disparities, "numerous health and social service agencies trained staff and mounted programs that paved the way for improved services to help reduce disparities in health status. There are notable outcomes from those efforts, including standardized disparities-related data collection in hospital settings, expanded health care quality improvement activities, enhanced patient navigation models, and innovative workforce development efforts."

The City of Boston convened a Task Force and implemented several crucial cross-sectoral recommendations in order to reduce disparities across the city. It also drew considerable legislative, media and public attention to the issue of health equity and made it a key municipal political issue. This experience certainly has implications for Canadian cities with significant minority populations and health disparities (such as Toronto, Vancouver, Montreal and Ottawa). Some cities, such as [Toronto](#) and [Saskatoon](#), have already studied health disparities and developed comprehensive strategies to address them.

California

California's [Health Care Language Assistance Act](#) (SB 853) was developed by the [California Pan Ethnic Health Network](#) and it went into full effect on January 1, 2009. SB 853 requires health plans within the state to provide linguistically appropriate services to their patients. It also requires the California Department of Managed Health Care to develop standards for medical interpreter services, translation of vital materials, and the collection of race, ethnicity and language data. The bill and its companion regulations have [several key elements](#):

- Public and private health plans must conduct a **needs assessment** to calculate threshold languages and collect race, ethnicity and language data from their enrollees

- Health plans must provide quality, accessible and timely access to interpreters **at all points of contact and at no cost to the enrollee**
- Health plans must translate vital documents into threshold languages (vital documents include applications, consent forms, letters containing important information regarding eligibility and participation in a plan, etc.)
- Health plans must ensure that interpreters are trained and competent, and that translated materials are of high quality
- Health plans must notify their enrollees of the availability of no cost interpreter and translation services
- Health plans must train staff on language access policies and procedures and on working with interpreters and limited-English-proficiency patients

In his [Health Equity Discussion Paper](#) for the Toronto Central Local Health Integration Network (LHIN), the Wellesley Institute's Dr. Bob Gardner noted that "there is considerable research, evidence, clinical practice and provider consensus that language is a crucial barrier to equitable access and to good quality care for many patients who are unable or uncomfortable in speaking English." If patients are unable to communicate effectively with their health care providers, they face increased risks of misdiagnoses, misunderstandings and reduced adherence to medication or prevention instructions. A [Kaiser Family Foundation study](#) further noted that language barriers can cause doctors to rely on extensive, costly and unnecessary tests, resulting in treatment that takes 25 to 50 percent longer and costs more than treatment for English-speaking patients.

California is clearly leading the way on making high-quality, trained interpretation and translation services available at all points of contact in the health care system. This should greatly reduce disparities based on language within the state. Provinces and regional health authorities with diverse linguistic populations should follow California's lead by providing interpreters and translating vital medical documents. Doing so would reduce health disparities and may even lead to more efficient and effective health care (and reduce costs caused by misunderstandings and redundant tests and procedures).

New Jersey

In 2005, New Jersey became the first state to enact a law to address equity through mandatory cultural competency training for physicians. [The law](#) (SB 144) requires medical professionals to receive cultural competency training in order to receive a diploma from a New Jersey medical school or to get (or renew) a license to practice medicine in the state. In addition, each medical school in the state is required to provide this training.

Cultural differences affect how people access, process and use health information. A lack of awareness about cultural differences can, therefore, make it difficult for both providers and patients to achieve the best, most appropriate care. Improving the cultural competence of

medical professionals is [widely recognized as integral to the reduction of health disparities](#). Improving cultural competence improves access to appropriate high-quality care for diverse populations and leads to a health care system that is more responsive to the needs of all of its patients.

Washington State

In 2006, Washington State passed four bills that specifically address minorities' health disparities through a Governor's Interagency Coordinating Council on health disparities, biennial surveys of the race and ethnicity makeup of the health care provider workforce and reviews to assess the impact of pending laws on health disparities.

- [Senate Bill 6193](#) requires biennial surveys of licensed health professionals to determine their characteristics (including race, ethnicity and language) in an effort to improve health care workforce diversity.
- [Senate Bill 6194](#) requires the development of an ongoing multicultural health awareness and education program.
- [Senate Bill 6196](#) adds a health official from a federally recognized Indian tribe as a representative on the State Board of Health.
- [Senate Bill 6197](#) creates the Governor's Interagency Coordinating Council on Health Disparities to help eliminate health disparities and collaborate with the State Board of Health on health impact reviews. The Council has the following tasks:
 - By 2012, create an action plan for eliminating health disparities in Washington;
 - Hold hearings, conduct research and issue recommendations for improving the availability of culturally appropriate health literature and interpretive services in public and private health-related agencies;
 - Promote communication among state agencies and between state agencies and minority communities, the public and private sectors to address health disparities;
 - Work to understand how the actions of the state government mitigate or contribute to health disparities through public hearings, inquiries and studies;
 - Develop "health impact reviews" to determine how pending legislation will affect health disparities.

Washington State has developed a "state-wide health resources strategy" that is designed to survey the state's demographics, inventory existing health facilities and practitioners, and assess health care needs across the state. The Governor's Coordinating Council has the overall goal of eliminating health disparities and critical objectives that it must attain along the way. Canadian provinces could benefit from Coordinating Councils that promote communication among provincial ministries that affect health disparities (such as health, environment, taxation, housing, etc). It would also be beneficial if all Canadian provinces adopted health impact reviews to determine how pending legislation would ameliorate or contribute to health disparities.

Conclusion

Other states such as Pennsylvania, Illinois, Colorado and Michigan have also developed plans or proposed legislation to reduce health disparities and improve workforce diversity. As of [February 2009](#), forty states had Offices of Minority Health and six states had either created an Office of Health Equity or developed initiatives which explicitly involve eliminating racial and ethnic disparities in health. While the federal government is currently trying to introduce legislation that addresses health disparities, during the substantial period of federal inaction on the issue, leading states and municipalities have pro-actively addressed health disparities by instituting cultural competency training for health care professionals; recruiting and training a diverse health care workforce; eliminating language barriers in hospitals; and collecting quality, uniform data to inform health care providers and insurers.

Canadian policymakers should assess these initiatives and evaluate whether similar policies would effectively reduce health disparities north of the border.