Racial and Ethnic Health Disparities

What State Legislators Need to Know
The National Conference of State Legislatures is the bipartisan organization that serves the legislators and staffs of the states, commonwealths and territories.

NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are:

• To improve the quality and effectiveness of state legislatures.

• To promote policy innovation and communication among state legislatures.

• To ensure state legislatures a strong, cohesive voice in the federal system.

The Conference operates from offices in Denver, Colorado, and Washington, D.C.
Americans are living longer, healthier lives than ever before because of social, public health and medical technology advances. Not every community benefits equally from these improvements, however. Persistent and well-documented health disparities exist between various racial and ethnic populations, even when accounting for economic status. Health disparities—differences in health outcomes among groups—often are driven by the social conditions in which people live, learn, work and play. In the United States, these differences are caused by a complex array of factors, which makes it impossible to devise a single policy solution for all instances of health inequality.

This brief provides state legislators with an overview of health disparities that affect various ethnic and racial minorities, existing strategies used to address them, and policy options for lawmakers to consider that may offer effective solutions to these issues.

Social Determinants of Health

Factors influencing health may be biological, socioeconomic, psychosocial, behavioral or social in nature. Scientists generally recognize the following five determinants of health for a population.¹

- Biology and genetics (e.g., gender and age).
- Individual behavior (e.g., alcohol abuse, unhealthy diet, lack of exercise, injection drug use [needles], unprotected sex and smoking).
- Social environment (e.g., discrimination, income and gender).
- Physical environment (e.g., physical conditions where a person lives, works, goes to school and plays).
- Health services (e.g., access to quality health care, having a usual source of care, and having or not having health insurance).

On average, medical services rendered by a doctor, clinic or hospital determine about 20 percent of a patient’s overall health, according to a study by the University of Wisconsin Population Health Institute—other studies have found this percentage to be even less. About 80 percent of people's health is the result of socioeconomic status, physical environment, health behaviors and biology. Thirty percent of overall health, for example, is determined by individual lifestyle choices and behavior, such as smoking, excessive alcohol use, poor diet, lack of exercise and unsafe sexual activity. In the past, much of the money invested in and strategies used to address health disparities centered on clinical services. More recently, policymakers also are turning to innovative models to address the social determinants of health.

Health outcomes include whether a disease or condition gets better or worse, what the costs of care are, and how satisfied patients are with the care they receive. It focuses not on what is done for patients, but what results from what is done.

Source: [http://myhealthoutcomes.com/faqs/3000](http://myhealthoutcomes.com/faqs/3000)
It is important to recognize that the determinants of health do not occur in isolation of each other, however. Therefore, a continual challenge for lawmakers in discussing the social determinants of health is which, if any, policies can make a difference. Education practices that improve reading comprehension and high school completion rates, for instance, can help people manage their health. In addition, health varies with education; people with higher education levels experience better health. Policies that ensure healthy food is available for purchase and create safe communities for citizens to walk and bike also can have a long-term effect on health, as another example.

**Access to Quality Care**

One of the most noticeable health inequities between whites and minorities in the United States is insurance coverage. In 2011, the U.S. Department of Health and Human Services found whites were uninsured at a much lower rate (11.7 percent) than African Americans (20.8 percent) or Hispanics (30.7 percent). Of the nation’s 47 million uninsured, half are of minority backgrounds, although they represent only one-third of the U.S. population. Lack of insurance contributes to disparities in both access to health care and quality of care.

Uninsured racial and ethnic minority populations face multiple challenges in accessing health care; they often experience lower quality care and are less likely to receive preventive care and routine medical check-ups. The Agency for Healthcare Research and Quality found that race and ethnicity were the second and third leading indicators, after lack of insurance, in determining which Americans were unable to receive or experienced delays in receiving necessary health care, medication or dental care. Uninsured minorities also are less likely to have a usual source of care (a facility where one receives care regularly) and therefore are more likely to resort to more costly ambulatory care facilities such as emergency rooms. In 2006, for example, emergency room visits by African Americans were almost twice those made by whites. Less available access to nearby preventive care and usual care is an important factor that contributes to health disparities among Americans.

For some racial and ethnic minority people, a language barrier also affects health care access and quality. A study by the University of Missouri found that people who speak English were significantly more likely to have a usual source of care (82.3 percent) than those who speak Spanish (63.2 percent) or another language (71.9 percent). Spanish speakers were more than eight times as likely to never have had their blood pressure checked and almost twice as likely to never have had their cholesterol checked.
The Aging of Minorities

The population of minorities over age 65 is expected to expand rapidly in the future. Between 2010 and 2020, the proportion of elderly Americans who belong to a minority group will increase from 20 percent to 24 percent. There were 1.4 million elderly Asian Americans in 2010; in 2050, that number will grow to 7.6 million. The number of African-American elderly will expand from 3.3 million to 9.9 million in the same time period, and Pacific Islanders and American Indians will grow from 235,000 to almost 1 million. The most dramatic change will occur with Hispanics, where the elderly population will expand from 2.9 million to 17.5 million.

Minorities in Rural Communities

Rural Americans face disparities in health compared to their urban peers, and for minorities in rural areas, these disparities are even more pronounced. Rural minorities experience higher rates than their peers of illness and death from conditions such as asthma, diabetes, HIV/AIDS, heart disease, certain cancers and obesity, among others. Factors such as poverty, educational attainment, unemployment, lack of health insurance and health literacy contribute to these disparities. Inadequate access to care in rural areas—due to economic, geographic, cultural, linguistic and health care financing barriers—and the limited array of services provided in many rural communities also affect the health of rural minorities.

Health Disparities Are Costly

The Joint Center for Political and Economic Studies, a research institute, estimates that health inequalities and premature death in the United States cost $1.24 trillion in both direct and indirect costs between 2003 and 2006. In addition, about 30 percent of direct medical care expenditures for African Americans, Asians and Hispanics were incurred because of health inequalities. The Urban Institute estimated that the 2009 cost burden of chronic illness and poor comparative health of minority populations was $23.9 billion, of which Medicaid bore the highest burden—$15.6 billion. As the growing population of minorities age in the coming decades, the annual cost of health disparities is expected to surpass $50 billion, exclusive of growth in per capita health care spending.

Cultural Competency

According to the Commonwealth Fund, cultural competency can be defined as:

“The ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients’ social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, [language proficiency, literacy, age, gender, sexual orientation, disability, religion, or socioeconomic status].”
Cultural competence concerns providing services and interacting with patients and service recipients in a culturally competent and linguistically appropriate manner. Cultural context and linguistic limitations not only can affect how information is received and perceived, but also can predict treatment adherence and outcomes.

More than 20 states have passed legislation to improve cultural competency within the health care system. In 2007, for example, Illinois lawmakers created the Culturally Competent Healthcare Demonstration Program. It provides grants to health care organizations statewide to encourage collaboration and requires external evaluation of the program upon completion.

**National Culturally and Linguistically Appropriate Services (CLAS) Standards**

National Culturally and Linguistically Appropriate Services (CLAS) Standards were introduced in 2000 by the U.S. Department of Health and Human Services’ Office of Minority Health to provide a framework for health care providers to address cultural competency. Updated guidelines were added in April 2013 to broaden cultural considerations and to provide a more general guide in addition to the practices detailed in the earlier version. The standards are divided into four major categories, including the principal standard, to “Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.” The other three categories address governance, leadership and workforce; communication and language assistance; and engagement, continuous improvement and accountability.

Many states are considering or have implemented legislation that encourages adoption of the CLAS Standards. California, Connecticut, New Jersey, New Mexico and Washington passed legislation that requires cultural competency training. Maryland legislation strongly recommends the practice.

For more information, see www.thinkculturalhealth.hhs.gov/Content/LegislatingCLAS.asp.
Strategies to Reduce Health Disparities

Federal and state governments are responding to persistent health disparities with a variety of initiatives to improve access to and quality of care, address the social determinants of health, and eliminate other significant barriers to quality health care. In addition to the public sector, private industry and nonprofit organizations play an integral role in reducing health disparities.

The federal government, private sector organizations and other institutions have outlined plans and developed recommendations for states that are interested in reducing the detrimental human, social and economic effects of health disparities. This section first discusses two sets of goals proposed by the U.S. Department of Health and Human Services. It then lists some state-based recommendations from the Commonwealth Fund, which has studied the issue in depth, and provides an analysis of common approaches that various entities have recommended to reduce health disparities. Finally, this section includes some state program examples and a brief overview of what cultural competency means and why it matters.

What Can State Legislators Do to Reduce Health Disparities in Their Districts and States?

- Serve as community leaders/champions in developing initiatives to raise awareness; empower change that improves health and health care at a lower cost.

- Craft legislation and policies that are culturally and linguistically competent.

- Facilitate efforts to eliminate disparities in access, services, utilization and quality, such as in Medicaid.

- Support efforts to include requirements for cultural and linguistic competence in delivery systems, such as medical homes.

- Convene study groups and/or advisory groups and solicit input from community members and other stakeholders.

- Offer incentives to integrate cultural competence at all levels of education.

National Partnership for Action to End Health Disparities

In 2008, the U.S. Department of Health and Human Services' Office of Minority Health (OMH) established the National Partnership for Action to End Health Disparities (NPA), a “comprehensive, community-driven and sustainable” approach to reducing health disparities nationwide. By coordinating stakeholders—such as community- and faith-based organizations, businesses, health care and insurance industries, academia, cities, counties, states, tribes and federal agencies—this public-private collaboration aims to improve the effectiveness of programs that work to eliminate health disparities.

National Stakeholder Strategy for Achieving Health Equity. An important product of the NPA is the National Stakeholder Strategy (NSS), which was released in 2011. The NSS was developed with significant input from thousands of individuals and organizations nationwide. It provides a guide for strategic action to eliminate health disparities. It outlines five fundamental goals, supported by 20 specific strategies for action. Based on the principles of community engagement and leadership, creation of partnerships, cultural and linguistic competence of health care providers, and universal access to health care, these goals (listed in the box) serve as the central tenets of the National Partnership for Action (NPA).

All stakeholders, including regional and local groups can use the National Stakeholder Strategy to identify goals for their communities and adopt the most effective strategies and action steps to achieve them.

**National Stakeholder Strategy for Achieving Health Equity – Goals**

**Goal 1: Awareness.** Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic and underserved populations.

**Goal 2: Leadership.** Strengthen and broaden leadership for addressing health disparities at all levels.

**Goal 3: Health System and Life Experience.** Improve health and healthcare outcomes for racial, ethnic and underserved populations.

**Goal 4: Cultural and Linguistic Competency.** Improve cultural and linguistic competency and the diversity of the health-related workforce.

**Goal 5: Data, Research, and Evaluation.** Improve data availability and coordination, utilization and diffusion of research and evaluation outcomes.

HHS Action Plan to Reduce Racial and Ethnic Health Disparities. At the same time the NPA Stakeholder Strategy was released, the U.S. Department of Health and Human Services released its complementary, first-of-its-kind strategic action plan to address health disparities. Under the direction of HHS Secretary Kathleen Sebelius, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities was developed to promote integrated approaches, evidence-based programs and best practices among HHS agencies to reduce health disparities. The action plan also builds on many disparities-related provisions of the 2010 Affordable Care Act and other federal programs, such as Healthy People 2020, the First Lady's Let's Move initiatives and the President's National HIV/AIDS Strategy. The action plan aims to transform health care, strengthen infrastructure and workforce, advance Americans' health, promote scientific knowledge and innovation, and increase accountability of HHS programs using a variety of strategies and detailed action steps.

**HHS Action Plan to Reduce Racial and Ethnic Health Disparities – Goals**

- **Goal 1**: Transform health care.
- **Goal 2**: Strengthen the nation’s health and human services infrastructure and workforce.
- **Goal 3**: Advance the health, safety and well-being of the American people.
- **Goal 4**: Advance scientific knowledge and innovation.
- **Goal 5**: Increase the efficiency, transparency and accountability of HHS programs.


In 2004, the Commonwealth Fund, a private foundation dedicated to promoting a high-performing health care system, published A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities. The report’s intent was to provide guidance, expand knowledge and develop strategies for state policymakers to consider to eliminate racial and ethnic health disparities. Ten years later, the menu of policy interventions and recommendations provided in the agenda remain relevant. The promising strategies identified in the report revolve around eight key needs (see box). The final recommendation—directed to federal rather than state policymakers—acknowledges that, while states play a crucial role in developing and implementing successful strategies to eliminate health disparities, they need support not only from the federal government, but also from the private and nonprofit sectors.

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<tr>
<th>The Commonwealth Fund: State Disparities Agenda</th>
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<td>Key needs for state policymakers seeking to address health disparities:</td>
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<td>• Better and more consistent data collection.</td>
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<td>• Effective program evaluation.</td>
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<td>• Emphasis on cultural and linguistic competence in all disparities reduction activities.</td>
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<td>• Workforce development programs and improvement in the cultural competence of all health care professionals.</td>
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<td>• Health screening and access to services (primarily health insurance).</td>
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<td>• Focus on creating and/or improving state minority health offices and infrastructure.</td>
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<td>• Involvement of all health systems stakeholders.</td>
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<td>• Creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.</td>
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Best Practices for Improving Cultural Competency in the Health Care Workforce: Lessons Learned and Future Opportunities

In a 2013 NCSL webinar, Robert C. Like (MD, MS, professor and director, Center for Healthy Families and Cultural Diversity, Department of Family Medicine and Community Health, UMDNJ-Robert Wood Johnson Medical School) provided recommendations to legislators who are interested in improving cultural competency in the health care workforce. While these recommendations have a narrower focus, a few can be generalized to the broader legislative role in eliminating health disparities. Dr. Like recommends that policymakers serve as community leaders to raise awareness and craft general legislation that is both culturally and linguistically competent. In addition, he suggests that legislators consider the effects of any policy—not only health policy—on diverse communities.

Key Elements for Eliminating Health Disparities

State legislators play key roles in eliminating health disparities. The plans, reports and recommendations outlined above offer a wide variety of approaches to reducing health disparities. The following list includes the most common elements of activities to reduce health disparities as cited in the literature above, and provides a number of policy options for legislators to consider.

- **Data Collection.** Ensure quality data on all racial, ethnic and underserved populations are collected and available. Accurate, consistent data provide a foundation from which effective programs and sound policy can be implemented.

- **Research, Evaluation and Evidence-Based Programs.** Evaluate programs to determine which initiatives effectively reduce disparities. Coordinate research and ensure that research and evaluation findings are shared with policymakers and other public officials to help inform policies, programs and initiatives to reduce disparities. Increase the use of evidence-based programs to eliminate health disparities.

- **Cultural/Linguistic Competence.** Emphasize cultural and linguistic competence in all health-related activities, especially those intended to reduce disparities. Develop standards for culturally and linguistically competent health services and support and/or require cultural competence training and education for all health care providers. Refer to the HHS Office of Minority Health’s National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care.

- **Workforce Development.** Improve the diversity of the health care workforce and cultural competence of health professionals by increasing minority education in health care fields and participation in the health care workforce. Consider policies and programs that improve recruitment, retention and training of racially, ethnically and culturally diverse people. Develop pipeline programs, financial incentives and other workforce initiatives to encourage people of diverse backgrounds to join the health care workforce. Racial and ethnic minorities often are more likely to practice in medically underserved areas and to provide services to minorities.
• **Access to Care.** Improve access to health care for minorities and other underserved people by improving health insurance coverage and removing barriers to care. Support community health centers, the patient-centered medical home model of care, and other delivery systems that improve access to primary care and care coordination.

Promote use of community health workers, promotoras and navigators to provide health education and support to patients. Community health workers are integral components of the health care team, serving as liaisons between community members and health care providers. Support and/or provide reimbursement for culturally competent interpretation and translation services.

• **Stakeholder Involvement.** Develop and support partnerships among the public, private and non-profit sectors to increase awareness, facilitate action and ensure accountability.

Effective strategies to reduce health disparities involve engaging the legislative and executive branches of state government, the greater health sector and community-based organizations, among others. Stakeholder engagement, support and coordination are key components of initiatives to reduce disparities.

• **Social Determinants of Health.** Consider policies that create the social, environmental and economic conditions to reduce health disparities and address social determinants of health.

• **Leadership.** Strengthen and broaden leadership at all levels. Legislators can serve as community leaders and champions of initiatives to raise awareness about health care disparities. Build capacity at all levels of decision making to promote community solutions for eliminating health disparities.

• **State Health Equity Infrastructure.** Create a designated office, council, commission or advisory panel on minority health to advise state policymakers and state agencies on disparities, existing gaps, potential strategies and solutions, and opportunities to promote equitable outcomes through existing and new programs. Convene study groups, task forces, blue ribbon panels or other advisory groups to study the issue and provide feedback.
State Innovations to Promote Health Equity

States across the nation are implementing innovative programs to reduce health disparities. The initiatives described below represent only a few examples of state actions to address the issue. Each program includes many of the common elements highlighted in the previous section.

Maryland
The Maryland Health Improvement and Disparities Reduction Act of 2012 established a $4 million pilot project to reduce health disparities; improve access to care and health outcomes on indicators such as infant mortality, obesity, cancer and hospital readmissions; and reduce health costs in the state. Core components of the law include creation of geographically based Health Enterprise Zones (HEZs) that offer incentives—such as loan assistance repayment, tax credits, priority funding for electronic health records, and priority to enter the state patient-centered medical home program—for health care providers to establish or expand their practice in designated underserved communities; standardization of data collection on race, ethnicity and health disparities in both public and private health care systems; requirements that hospitals, health insurance companies and health profession training programs track and report their efforts to reduce health disparities; and establishment of a process to develop criteria on cultural competency, health literacy training and continuing education for health care providers. In addition, the law emphasizes the need for support from and participation of key stakeholders.

New Jersey
In 2005, the Legislature enacted a law requiring the New Jersey Board of Medical Examiners and the Commission on Higher Education to develop requirements for physician training in cultural competency. The final regulations, adopted in 2008, require all medical schools in New Jersey to provide cultural competency instruction to students as a condition of receiving a diploma from a college of medicine. In addition, state medical schools must provide continuing medical education in cultural competency for licensed physicians who did not receive such training during medical school.

Ohio
A diverse group in Ohio is working to eliminate health disparities in the state. With a nod to the National Stakeholder Strategy, the Ohio Statewide Health Disparities Collaborative (OSHDC) is composed of individuals representing nonprofits, health care organizations, government agencies, academia and private sector organizations that provide leadership to racial and ethnic minorities statewide. OSHDC developed the Ohio Plan for Action to End Health Disparities, a guide for addressing the health disparities in the state. The plan’s goals call for increasing access to care; establishing funding priorities to address health care disparities; building capacity—and, specifically, incorporating health disparities as a legislative priority; implementing communication strategies that foster cultural competence—such as promoting the CLAS standards and enacting legislative policy; and incorporating health disparities into the state’s health care agenda. In addition to outlining these overarching goals, the plan includes various strategies for achieving each objective.
Conclusion

Significant racial and ethnic disparities exist in several domains, such as environmental quality, housing conditions, quality and access to care, and levels of insurance coverage. Mitigating these problems has the potential to save hundreds of millions of dollars in the coming decades, although no simple solution exists for this broad and complex problem. Health disparities are the result of social, economic and environmental differences, and clinical care accounts for the health outcome of only about 20 percent of the population. Government agencies and other stakeholders have plans or provisions for addressing minority health disparities, and many states are pursuing innovative programs to address some of these concerns. Addressing only one or two of the social determinants of health may not successfully eliminate health disparities. Instead, a comprehensive and holistic approach that targets multiple social determinants of health is more likely to be successful. Such an approach can narrow the gap by educating patients and providers, increasing access to care where it is most needed, and implementing culturally competent care.
Notes


6. Ibid.


12. Ibid.


