NCSL

# Health Care

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# State Approaches to Reducing Health Disparities

Health disparities—differences in health and health care experienced by groups based on social, economic and environmental factors—persist across the nation. Each year, health disparities lead to significant human and financial costs as certain people experience poorer living conditions, worse health status and treatment outcomes, and more difficulty accessing health care services than their peers in other population groups.

State legislators have pursued various policy approaches to reduce health disparities in their communities and states. Through legislative tracking, NCSL has identified multiple strategies being pursued by states, including increasing workforce diversity, improving cultural competence in health care services and addressing the social determinants of health. This brief explores health disparities with a focus on differences across racial and ethnic groups, recent state action to address disparities, and policy options for legislators to consider in their states.

## Health Disparities Affect State Budgets

In addition to their human toll, health disparities can significantly affect state budgets. With states spending, on average, 30 percent of their budgets on health care, disparities in health status—such as those for premature babies or groups with high rates of diabetes—can cost states millions of dollars.

*Sources: NCSL. Institute of Medicine, 2006.*

# Introduction

The United States has seen extraordinary advances in medicine, public health and technology that allow people to live longer, healthier and more productive lives. While health has improved for most Americans, some groups and communities are not experiencing the same gains.

Health disparities remain stubbornly persistent across the country, and have been well documented for decades. In 1985, the United States Department of Health and Human Services (HHS) released a landmark report documenting the existence of health disparities among racial and ethnic minorities in the United States. The report called these disparities "an affront both to our ideals and to the ongoing genius of American medicine."[1] Since then, researchers and government programs have added to the evidence recognizing health disparities through various studies and reports.[2]

In addition to the adverse consequences for individuals and communities, disparities have serious implications for the overall health of the nation and significant costs to states in areas like Medicaid and other health spending.

Despite calls to action and widespread recognition among researchers, federal agencies and policymakers, health disparities remain an issue. With an increasingly diverse population and widening differences in income, health disparities are likely to persist or increase.[3]

**"Disparities in health and health care not only affect the groups facing disparities, but also limit overall improvements in quality of care and health for the broader population and result in unnecessary costs. As the population becomes more diverse, with people of color projected to account for over half of the population in 2045, it is increasingly important to address health disparities."**

*–Kaiser Family Foundation*

# Health Disparities

Health disparities are measured as differences in health status or treatment outcomes between population groups in areas such as mental or physical health, disease or illness, injury and disability, and life expectancy. A disparity exists when a certain demographic or cultural group experiences negative health status at a greater rate than another group.

Health disparities are found across the spectrum of health status and outcome measurements, such as infant mortality, obesity, heart disease and life expectancy. Disparities among racial and ethnic groups are some of the most frequently cited, although health disparities can be found in the United States based on age, sex, income, disability status, sexual orientation, language, geographic location and other factors. For example, rural Americans are more likely than their urban counterparts to smoke, have an unhealthy weight, and to die from heart disease, cancer, unintentional injuries, chronic lower respiratory disease or stroke.[4]

Racial and ethnic minorities experience health disparities across a variety of health indicators, including birth outcomes, chronic diseases, oral health, health behaviors and access to health care services. The Centers for Disease Control and Prevention reported in 2013 that black adults are more likely to die earlier than their white peers due to heart disease or stroke. In addition, black, Hispanic and other or mixed-race adults experienced higher rates of diabetes than their white or Asian counterparts.[5] While some disparities have narrowed, gaps between racial and ethnic groups in rates of low-risk cesarean sections, flu vaccines and dental care widened between 1999 and 2014.[6]

### Racial and Ethnic Health Disparities

According to recent data from the Centers for Disease Control and Prevention:

- Life expectancy for black men and women was three to four years shorter than white adults and six to seven years shorter than Hispanic adults.
- Infant mortality rates for babies born to black women were almost twice the national rate.
- Obesity rates for Hispanic or Latino and black youth were higher than those for white and Asian youth.
- Black adults were more likely to have high blood pressure than other adults.

*Source: Centers for Disease Control and Prevention, 2016.*

## Determinants of Health

Improving health is traditionally considered to be under the purview of the health care system, and a lack of access to quality health care services is a key driver of health disparities. Access can include having health insurance, having a usual source of care (e.g., a facility or provider where one receives care regularly), encountering difficulties when seeking care, and receiving care when wanted, according to the Agency for Healthcare Research and Quality (AHRQ).[7]

Although many gaps have narrowed in recent years, AHRQ found that "racial, ethnic and income-related disparities in access persist."[8] For the nation as a whole, the number of uninsured individuals has decreased dramatically. African Americans and Hispanics, however, are still more likely to be uninsured than their white counterparts, as are poor households compared to those who are not poor. In addition, white people experienced better access to care and better quality care than black and Hispanic people, American Indians and Alaska Natives, and Asian people.[9]

Although medical care is essential to one's health, factors outside of the health care system also are linked to health and health disparities. Researchers agree that five major categories affect health and health disparities: genetics and biology (e.g., age or sex), individual behaviors (e.g., smoking or physical activity), health services (e.g., health insurance or access to providers), social circumstances (e.g., income or education) and physical environmental factors (e.g., neighborhood or school).[10]

Of these factors, some can be changed (e.g., behaviors, social circumstances and physical environmental factors) and some cannot (e.g., genetics). Even among those that can be modified by the individual, such as behaviors like smoking and physical activity, these factors are often shaped by social, economic and environmental circumstances.[11]

These social determinants of health—social, economic and environmental factors—are recognized extensively for their potential effects on health. Social determinants of health are "where we are born, live, learn, work, play, worship and age."[12] They can also be defined somewhat differently, and can be used to "refer broadly to any nonmedical factors influencing health."[13]

Experts agree that social determinants of health include factors like income, education, housing, access to health services, employment, transportation and neighborhood conditions. These factors also have complex relationships, interacting and potentially intensifying or reducing disparities.[14] For example, education can affect future employment and earnings, which in turn can have implications for health insurance and housing. Similarly, neighborhood and community features can influence education and employment opportunities, transportation options, and access to healthy foods and safe places to be physically active. The policy environment is also an important determinant of health, noted for its ability to shape the circumstances in which people live.[15]

## Recent State Actions

Many policymakers recognize the disparities experienced by various populations and the related financial costs to the health care system and the state. Since 2010, with support from the HHS Office of Minority Health, NCSL has tracked state health disparities legislation—both introduced and enacted—related to:

- Improving access to health care services
- Increasing health care workforce diversity and cultural competence
- Addressing disparities in chronic diseases and other health conditions racial and ethnic minorities experience
- Supporting task forces, committees or research focused on health disparities
- Addressing social determinants of health

In the 2015 and 2016 legislative sessions, state lawmakers considered more than 150 bills specifically related to health disparities. The state actions below highlight legislative trends from 2015 and 2016, including examples directly addressing health disparities among racial and ethnic groups or underserved communities.

For more detail, see NCSL's health disparities legislation webpages at ncsl.org.

### WORKFORCE

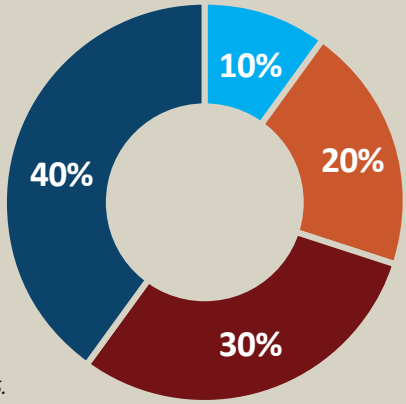
Health care workers who are "culturally competent," or able to understand and interact with different groups, help promote access to quality health care services. In addition, studies show that health care providers from racial and ethnic minority groups are more likely to practice in underserved areas and provide services to minorities—helping to reduce disparities in access to care.[16, 17] States looking to ensure an adequate workforce to address the needs of populations from different backgrounds, races and ethnicities, and languages spoken may pursue a variety of strategies.

Common pathways to recruit and retain health care practitioners to provide services to underserved communities include scholarships, loan repayment programs and other incentives.[18] Through the State Loan Repayment Program, at least 36 states and Washington, D.C., receive federal cost-sharing grants from the National Health Service Corps. These grants help fund state loan repayment programs for primary care providers who practice in health professional shortage areas (HPSAs). States also operate other incentive programs. Nevada, for instance, expanded the criteria for health workers receiving financial support or loan forgiveness in 2015 to include those who provide services to medically underserved populations and locations. New Hampshire allocated funds to provide grants to health care providers who service medically underserved populations through its health and human services department state loan repayment program.

### What Affects Health?

Researchers at the University of Wisconsin Population Health Institute estimated the percentage of people's health—including length and quality of life—that is affected by factors that can be changed or modified (i.e., excluding genetics).

*Source: Park, H., Roubal, A.M., Jovaag, A., Gennuso, K.P., and Catlin, B.B., 2015.*

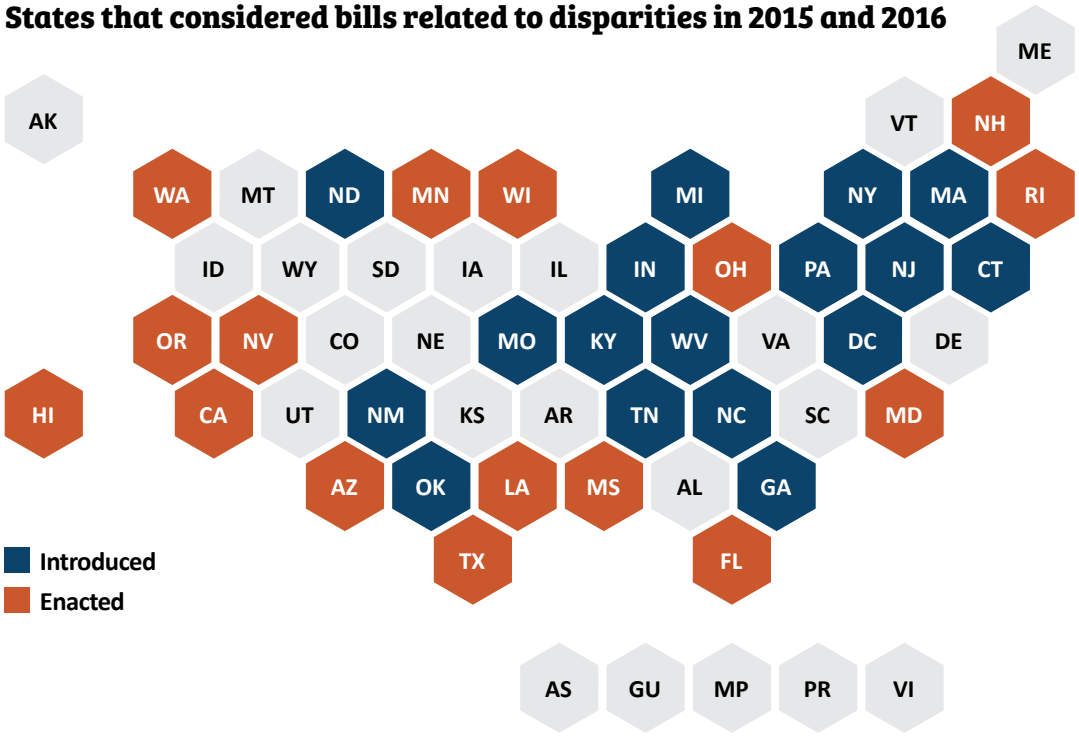


Types of providers or services may also be a consideration in addressing specific needs in underserved areas through these incentives. For example, Arizona in 2015 enacted legislation to include pharmacists, advanced practice providers (i.e., physician assistants and registered nurse practitioners) and behavioral health providers in its Primary Care Provider Loan Repayment Program and the Rural Private Primary Care Provider Loan Repayment Program. Non-physician health professionals, such as physician assistants and nurse practitioners, can offer primary care services and are more likely to practice in rural and underserved areas.[19, 20]

In addition, a number of states have pipeline or pathway programs that recruit young students to participate in programs that introduce them to health careers and encourage or support them in pursuing those career paths. These programs often seek students from backgrounds historically underrepresented in health care, such as racial and ethnic minorities, to promote workforce diversity. Pipeline programs exist across the country, and legislation has supported these programs in states such as Arkansas and Virginia.

State lawmakers are also considering cultural competence—the ability of providers and health care systems to provide services and interact with patients in ways that are appropriate and aligned with patients' social, cultural and linguistic needs. The cultural context and language needs of patients can affect how they receive and perceive information, the degree to which they adhere to treatment and, ultimately, affect their health. As of 2013, more than 20 states had enacted legislation to improve cultural competency in their health care workforces.[21] In a 2015 bill, Maryland legislators required the Office of Minority Health and Health Disparities to provide certain health occupations boards with a list of recommended courses. They include cultural and linguistic competency, health disparities and health literacy, and are publicly accessible and provided to health care professionals at the time of license renewal.

## States that considered bills related to disparities in 2015 and 2016



## Cost of Disparities

The health-related costs of health disparities are clear, such as in the burden of disease, disability, or premature death. These issues have obvious implications for direct health care costs and the health care system. For instance, chronic disease accounts for the majority of health care spending in the U.S., and lack of health insurance can lead to expensive emergency room visits. Poor health and health disparities can also affect employment, productivity and other societal contributions.

Addressing health disparities may also be important from a financial standpoint, particularly as the country seeks to rein in rising health care costs. According the Joint Center for Political and Economic Studies, health disparities cost $1.24 trillion in direct medical and indirect costs between 2003 and 2006. In those same years, the authors calculated that approximately 30 percent of direct medical expenditures were excess costs for racial and ethnic minorities. In addition to the direct medical costs, health disparities' indirect costs include lost worker productivity and losses from premature death. The authors estimated that if health disparities were eliminated, indirect costs would be lowered by more than $1 trillion.

Multiple reports and articles concur that eliminating disparities aligns equity and financial considerations—in other words, many argue that addressing disparities is the "right thing to do" for individuals and the population, and is also financially beneficial.

*Sources: Association of State and Territorial Health Officials, 2016. Centers for Disease Control and Prevention, 2016. LaVeist, T.A., Gaskin, D.J., and Richard, P., 2009.*

### DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH

In addition to leveraging the health care workforce to address disparities, state legislators have considered legislation that specifically seeks to examine health disparities or address certain dimensions of the issue. Bills introduced and enacted in 2015 and 2016 addressed topics like task forces, grant programs and social determinants of health.

Task forces or study groups on issues like health disparities have been suggested or created to better understand the problem and devise solutions or recommendations. Legislation typically includes criteria or responsibility for study group membership, duties and reporting requirements. In 2015, Louisiana created two separate groups to evaluate health care delivery in the state, including access barriers encountered by people of different incomes and demographics. A task force focused on the Baton Rouge area and policies that could expand clinics' capacity to serve medically underserved populations. In 2016, the Legislature adopted a resolution to continue the task force. Louisiana's second group, a study committee, was tasked with looking at the health care delivery system across the state. Both groups were required to submit a report and recommendations.

Hawaii focused on workforce issues and established the Hawaii Healthcare Workforce Advisory Board in 2015. The board's objectives included prioritizing programs, services and activities that address social determinants of health and reduce health disparities.

State funding or support can also help create or sustain new programs implemented by state agencies or other entities. Florida's Closing the Gap grant program was amended in 2015 to include racial and ethnic disparities in morbidity and mortality rates relating to sickle cell disease among the topics that project proposals could address. This is in addition to the existing areas addressed, such as racial and ethnic disparities in infant mortality rates, cancer, cardiovascular disease and diabetes.

Minnesota passed multiple bills in 2015 and in 2016 relating to health disparities and the social determinants of health. A 2015 budget bill included various stipulations designed to decrease racial and ethnic disparities.

### National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare

The National CLAS Standards, first created in 2000, provide guidance and a framework for health care providers to address cultural competency. The standards are divided into four primary themes, including one principal standard related to providing quality care and services that are responsive to patients' needs.

States are engaged in efforts to promote these standards. At least 21 states have considered or enacted CLAS training legislation, and have implemented CLAS-related activities supported by the states.

*Source: U.S. Department of Health and Human Services.*

### Integrating Health in All Policies

"Health in all policies" (HiAP) is an approach that considers potential health implications of policies across sectors, such as transportation, education and housing. HiAP involves collaboration and stakeholder input to incorporate health considerations in decision-making processes. Health Impact Assessments (HIAs) are more structured tools, with a six-step process, that can be used to support an overall HiAP approach. HIAs have been used widely across the globe in different communities, and states like California, Massachusetts, Washington and Vermont have implemented HIAs or HiAP at the state level.

*Source: Blackman, K., and Shinkle, D., 2016.*

Among other provisions, the enacted legislation:

- appropriated Temporary Assistance for Needy Families (TANF) funds for decreasing racial and ethnic disparities in infant mortality rates;
- required that data on health care quality be examined based on race, ethnicity and other sociodemographic factors that are correlated with health disparities, and that data collection methods be developed in consultation with communities affected by health disparities using culturally appropriate principles and methods;
- established a task force related to health care financing and Medicaid, enumerating its duties, which include "assessing the impact of options for innovation on their potential to reduce health disparities";
- required development of a methodology to pay higher rates to providers and services that take into consideration patients and populations experiencing health disparities.

Minnesota's 2016 legislation included a provision establishing a "good food access program" to increase the availability of and access to affordable, nutritious and culturally appropriate food for underserved communities in low- and moderate-income areas. Louisiana also adopted a resolution in 2015 including social determinants of health among the guiding principles in a request to develop the Louisiana Health and Wellness Innovation Plan.

In addition to the legislative examples listed above that explicitly address health disparities and social determinants of health, other policy options exist that can leverage improvements in health, such as those described below.

## State Policy Options

Given the various determinants of health and interactions among the factors at work in health disparities, no single policy solution exists to address or eliminate them all. Experts recommend pursuing multiple angles, including policies both in and outside of the health care arena, and considering a combination of policies and strategies to address various determinants. Policymakers seeking to address health disparities may wish to consider the following strategies to determine the most appropriate policies for their states.

**Assess barriers in access to care.** Examine drivers of disparities in access to care, such as lack of insurance coverage and challenges navigating the health care system. Consider strategies to remove barriers or test new models of paying for and delivering care that address disparities. These state strategies may include supporting community health centers or other facilities reaching underserved communities, using telehealth as a way to improve access and extend providers' reach, and promoting the use of community health workers or navigators to support patients. In addition, patient-centered medical homes, which aim to improve coordination of care, may help address the social determinants of health.[22]

**Examine health care workforce needs and consider ways to develop the workforce.** Evaluate backgrounds and languages spoken among the existing health care workforce, and how that aligns with the communities being served. In addition to the health care workforce (whose members typically serve individuals), consider public health workers (those who focus on community and population health, such as

health screenings or immunizations). Assess other gaps in the workforce, such as geographic distribution or number of Medicaid providers. Look at ways to address gaps and strategies that may fit the state's needs, such as cultural and linguistic competency standards, recruitment and retention efforts, and pipeline programs for students from underserved communities. The federal Office of Minority Health's 2016 compendium highlights states' implementation of the National CLAS Standards (see box) and includes examples of how states promote cultural and linguistic competency.[23]

**Support data collection efforts and use data to analyze needs.** Work with other state officials, such as public health officials, minority health, rural health, and Medicaid offices, to learn more about existing data collection efforts and data needs. Consider ways the state can support data collection around gaps in health care, health care workforce shortages, and disparities experienced by specific populations (for example, racial and ethnic minorities and rural communities). Use existing data to focus state efforts and resources. Maryland, for example, requires the state Commission on Health Care to compile data on minority health and health disparities and publish its findings in the "Health Care Disparities Policy Report Card."

**Convene stakeholders and support partnerships across sectors.** Collaborate with other state officials to discuss health disparities in the state, current activities, and ways to leverage efforts and existing funding. Involve non-governmental groups, community- and faith-based organizations, and others, and include sectors outside of health to promote innovative solutions. Reach out to people who are experiencing the greatest health disparities to ask about their barriers and challenges and involve them in discussions about strategies. Connecticut, for example, established the Connecticut Multicultural Health Partnership in 2008, as a collaboration between the state Department of Public Health and public and private partners to identify and address health disparities.

> **"Policy has often focused on health care rather than health, with a significant lack of emphasis on prevention … [although] the multilevel promotion and adoption of healthy behaviors stands to reap the most 'bang' for our health care 'buck.' … However, addressing even the few determinants that are thought to be most responsible for good health requires policymakers to work across all sectors, public and private, and at the federal, state, and local level."**
>
> *—McGovern, L., Miller, G., and Hughes-Cromwick, P., 2014.*

**Consider health disparities using a social determinants of health lens.** Analyze the external factors in the social, economic and environmental landscape that may affect health and health disparities in the state. For example, look at health disparities that exist within the context of other factors like education and income. Consider policies that may address social determinants as a way to improve health for communities experiencing disparities. Colorado's Office of Health Equity, for example, is charged with implementing strategies to address the varying causes of health disparities, including the economic, physical and social environment.

## Conclusion

Health disparities are the result of a complex array of factors and determinants, including social, economic and environmental conditions. The policy environment is a key part of the context that affects health disparities, and state legislators can play an active role in addressing this stubborn issue. Lawmakers are paying attention—state policymakers have responded by introducing between 50 and 80 bills each year over the past few years to address health disparities.

The health care environment has traditionally served as the primary avenue for solutions, such as ensuring access to care and promoting culturally competent providers, and continues to play an important role in addressing health disparities. The social determinants of health offer a different way for legislators to think about and approach the problem, providing a multitude of avenues that can improve health and other important issues—such as poverty, education, housing and transportation—for constituents. Eliminating health disparities will likely require leveraging multiple strategies and policies, but successful efforts have the potential to save states millions of dollars in health care spending and lost productivity in the future.

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