Eliminating Health Disparities

A Cornerstone for Solving Colorado's Health Care Crisis

Monograph No. 1

Health Disparities as a Cornerstone of Colorado's Health Care Reform

Colorado Interagency Health Disparities Leadership Council

Providing leadership, education and resources to comprehensively eliminate health disparities in Colorado through collaboration, consultation, research and inclusion

http://www.cdphe.state.co.us/ohd/

A Monograph of the Interagency Health Disparities Leadership Council

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I. INTRODUCTION

Health care reform in Colorado and nationally is often focused on the issues of *access*, *affordability* and *quality*. In this regard, the health care models of reform emphasize affordability, insurance coverage and/or universal care, such as those explored by the Blue Ribbon Commission on Health Care Reform and Governor Bill Ritter's Colorado Health Plan.

One additional important aspect to emphasize in health care reform is the issue of health disparities, which is a leading factor in the high cost of health care. A comprehensive approach to addressing health disparities can improve the quality of life for citizens and reduced health care costs for those living in the State of Colorado.

The Interagency Health Disparities Leadership Council, in partnership with the Colorado Department of Public Health and Environment's Office of Health Disparities and the Minority Health Advisory Commission, is a resource available to Colorado's leaders as they seek to improve health and health care in Colorado.

Formed in January 2006, the Leadership Council met as an independent advisory council composed of 51 participating members representing federal and state agencies, universities, community providers and foundations. Senate Bill 242 passed in 2007 by the Colorado General Assembly, placed the Leadership Council in statute. The mission of the council is to provide leadership, education and resources to comprehensively eliminate health disparities in Colorado through collaboration, consultation, research and inclusion.

What are health disparities?

Health disparities are persistent differences in health outcomes (i.e. access, disease, disability and death) across many areas of health over time because of social factors such as race, ethnicity, gender, sexual orientation, lifestyle, geography, environment, workplace, education or socioeconomic status. Many health disparities are avoidable.

Although ensuring every Coloradan has access to quality care is an important part of reforming the health care system, it will not address many of the most pressing problems leading to poor health outcomes. Overcoming health disparities requires a commitment both to health equity and cultural sensitivity, providing the same best practices to everyone for the same physical illnesses, chronic diseases and mental health concerns, and at the same time utilizing cultural sensitivity in how services are delivered. Access to health care is affected by income, cultural and linguistic factors. The role of variables such as culture, language and social class in health disparities has been actively researched.

While these variables are interrelated, they play independent roles in health disparities. What they share is a common causal pathway, such as discrimination and lack of opportunity. Research has documented the following findings:

- Individuals with limited English proficiency may be unable to access care regardless of financial considerations, if health care providers — an individual or group of individuals (or an institution) who provide health care services to beneficiaries — (Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs, 2006) do not speak the same language and written information about health care and treatment is not in a language they understand.
- Individuals with distinct cultural needs are affected by provider bias. Studies show that health care providers often display biases in their treatment of culturally different patients. For example, providers fail to offer care options to patients based on biases and presumptions about what might be acceptable. Provider biases might be tied to race or ethnicity, national origin, sexual orientation, gender, socioeconomic statuses, geographical differences or a variety of other social differences.
- Low income families and individuals are more likely to have decreased access to high quality, continuous health care. Lower-income adults, minorities and non-citizens consistently have worse access and utilization than do people with none of these characteristics. The factors of culture, income and language overlap to a large extent. However, each exerts its own independent effect on access and utilization.

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

— Dr. Martin Luther King, Jr.

Maya Leon-Meis from "Los Secretos de Maya/ Maya's Secrets" presents a cooking demonstration at a health festival in Commerce City.

The drivers of health disparities are only partially economic, and even when they are economic they are only partially addressed by increasing the affordability of health care. For example, groups experiencing health disparities due to socioeconomic status experience a lack of access to affordable care, but they also may have limited health literacy. Health literacy is the constellation of skills that constitute the ability to perform basic reading and numerical tasks for functioning in the health care environment and acting on health care information. Low educational attainment is one contributor to limited health literacy (Berkman et al., 2006). Citizens experiencing health disparities also may work and live in hazardous environments with increased stress. They may experience increased financial stress due to a lack of accumulation of wealth. All of these lead to worse health outcomes, regardless of health care access.

For a health care reform effort to address health disparities, it must recognize how social factors interact to limit access to quality care, result in undertreatment, and result in prevalence of a wide variety of illnesses. Reform efforts also must recognize that the health care system by itself cannot address health disparities, but rather must be reformed in concert with improvements to housing, transportation, education and other public systems. Failure to address the integrated nature of health disparities will be felt by all Coloradans, as the costs of health disparities continue to require public resources. Overall, focusing on health disparities improves the quality of life for citizens and reduces health care costs for those living in our state.

"When you teach a child, you teach that child's child." - Unknown

II. HOW DO HEALTH DISPARITIES AFFECT THE CITIZENS OF COLORADO?

In Colorado, there are differences between racial and ethnic groups in the incidence and prevalence of chronic health conditions, injury and rates of death. According to the Colorado Department of Public Health and Environment 2005 Racial and Ethnic Health Disparities Report:

⇒ *Latinos*, especially women, have comparatively lower death rates of many chronic diseases, including heart disease, cancer, Alzheimer's disease, and cerebrovascular disease (which leads to stroke). Comparatively, however, Latino populations have the highest death rates of diabetes, chronic liver disease, cervical cancer and injuries related to motor vehicle crashes.

⇒ *African Americans* have the highest rates of death from heart disease, cerebrovascular disease, HIV/AIDS, infant mortality, homicide/legal intervention, kidney disease, septicemia (infection of the blood), perinatal period conditions leading to death (occurring near the time of birth) and cancer (overall), plus cancers of the lung, breast, colon and prostate.

⇒ *American Indian* populations, with approximately 35 different tribal nations in Colorado, have relatively higher rates of diabetes, chronic liver disease/cirrhosis, and motor vehicle crashes. Suicide and homicide are leading causes of death in Colorado and nationally.

⇒ *Asian American and Pacific Islanders (AAPI)* include people from 30 Asian nations and 25 Pacific Island nations. Overall, the population of AAPI has many positive health indicators. Vietnamese American women, however, have the highest rate of cervical cancer in Colorado. Both nationally and in Colorado, tuberculosis rates are highest among members of the AAPI group.

⇒ Health disparities for the Asian American Pacific Islanders population are intimately tied into their status as immigrants and refugees, where language and culture significantly impact health care status.

Does having health insurance eliminate racial and ethnic disparities in health?

⇒ African Americans/blacks are two times and Hispanics/Latinos are three times as likely as non-Hispanic whites to be uninsured. Health insurance facilitates access to preventive services, a regular source of care and better quality care, *although it does not erase all disparities in morbidity and mortality*. Studies show, for example, that health insurance lessens disparities in access to cardiovascular procedures such as angiography and revascularization (Committee on the Consequences of Uninsurance, 2003).

⇒ "Two and a half years ago my son died from a stroke and he was 28. He knew that he had high blood pressure. I knew it too. But we didn't know it would kill him . . .So many young African American males are dying young." (Sandy Douglas, Community Advocate, 2005).

"In our every deliberation, we must consider the impact of our decisions on the next seven generations."

From the Great Law of the Iroquois Confederacy

What are the current demographic shifts in the population in Colorado that affect future health care needs?

⇒ Demographic shifts are taking place locally and nationally. In Colorado, two population groups at risk for poor health outcomes are growing, *notably the elderly population and people of Latino descent.*

⇒ The Colorado population age 65 and older is expected to increase almost 50 percent by 2020. Distinct differences exist between elderly Coloradans residing in rural or urban settings. People tend to use more services as they get older. Medical services for elderly citizens may range from two to three times the cost of non-elderly citizens. Conversely, however, in Latino populations, elderly people may use fewer services and have lower costs when compared with blacks and whites. Health disparities are more likely to occur among Latino individuals under 65 years of age.

This zumba exercise class at a Greeley area recreation center is part of the Diabetes Disparities Project, a grant project of the Weld County Department of Public Health and Environment.

"In many ways, Americans of all ages and in every race and ethnic group have better health today than a decade ago yet considerable disparities remain. We should commit our nation to eliminate disparities in the next decade, for through prevention we can improve the health of all Americans."

- David Satcher, U.S. Surgeon General (1998-2002) and Assistant Secretary for Health (1998-2001)

What are the estimated costs of health disparities in Colorado?

Chronic health diseases such as diabetes are costly for Colorado's citizens. It is estimated that 6,056 individuals are diabetic and receive Medicaid or are uninsured. The estimated annual cost for treatment for this population is $80,196,146 calculated using 2002 dollars among adult minorities.

Low birth weight is significantly higher among infants born to African American/black mothers than among other racial and ethnic groups. It is estimated that an infant born with very low birth weight (VLBW <1500 g.) will cost about $175,302, an infant with low birth weight (LBW <2500 g.) about $43,713, and an infant with normal weight about $2,119. In Colorado, reducing low birth weight and very low birth weight will significantly reduce hospital costs. Working to reduce disparities in maternal and child programs will help to reduce cost and disability among children (Schmitt, Sneed, & Phibbs, 2006).

Health care emergencies can increase the cost of publicly funded health care services for citizens.

⇒ When citizens do not have continuous health insurance, they may wait longer to seek treatment. Not having preventive and regular health care often means that they opt for treatment of serious health care conditions in the emergency departments of Colorado hospitals.

⇒ Rates for potentially avoidable hospitalizations are higher in communities that include proportionally more lower-income and uninsured residents, indicating both access problems and greater severity of illness.

⇒ In Colorado, the cost of Medicaid and emergency Medicaid has grown significantly. The costs for emergency Medicaid have gone up 57 percent in the past six years. Medicaid takes care of poor adults, children and people with disabilities, with a 50-50 split between the federal government and states. Federally mandated programs pay for emergency room care for anyone who would qualify for Medicaid based on income but can't prove citizenship or five years of legal residency. Emergency Medicaid costs in Colorado rose from $39.4 million in 2001-2002 to $61.9 million in 2006 (Brand & Ramirez, 2006).

III. HOW CAN WE ADDRESS HEALTH DISPARITIES?

With the Blue Ribbon Commission on Health Care Reform and Gov. Ritter's Colorado Health Plan, Colorado is in a good position to address health care reform and health disparities. The following seven key issues serve as the outline of a state strategic plan to help guide leaders on state actions for addressing health disparities:

1. Workforce Diversity in Health Professions/Cultural Competence
2. Community Involvement/Community Partnerships
3. Health Disparities Research
4. Addressing the Determinants of Health
5. Policy and Legislation
6. Sustainability

The Interagency Health Disparities Leadership Council, a recently formed statutory council, working in conjunction with the Office of Health Disparities within the Colorado Department of Public Health and Environment, has the expertise to look for systemic solutions to the underlying causes of health disparities in Colorado.

"Health is more than absence of disease; it is about economics, education, environment, empowerment, and community. The health and well being of the people is critically dependent upon the health system that serves them. It must provide the best possible health with the least disparities and respond equally well to everyone."

- Joycelyn Elders, U.S. Surgeon General (1993-1994)

The Interagency Health Disparities Leadership Council is excited about the goals and strategies outlined in Gov. Ritter's Colorado Health Plan because the council has considered many of the same issues. Here is a short summary of the types of challenges identified by the Interagency Health Disparities Leadership Council that align with the Colorado Health Plan:

1. ***Workforce diversity in the health professions*** increases access of communities experiencing high rates of health disparities, especially ethnic and racial groups. **Linguistic access** is the most obvious need, and it extends beyond Spanish. More challenging are the **cultural barriers**. To be effective and accessible, **health care delivery must support the consumers' traditions** or risk patient non compliance and returning for follow up visits.

2. ***Attracting rural health care providers,*** including dental providers, is a persistent problem underlying rural health disparities. Creating incentives to bring providers to small towns is part of the answer. The other is to **provide health care training in rural areas** through a coordinated educational system using community colleges, the new School of Public Health, and university distance education programs. Instead of trying to attract new people to the community, developing the skills and knowledge of rural residents can be a highly effective strategy to lessen the provider shortage.

3. ***Providing child health care and maternity care*** for **all residents is the foundation for a healthy society.** Health disparities in childhood disease and birth outcomes are found in ethnic and racial populations, which will be increasingly difficult to reach with the passage of HB06-1023, "Restrictions on Defined Public Benefits." Although all children are eligible for health care regardless of the immigration status of their parent(s), family members will be wary of bringing their child into a system that could expose their status or the status of an extended family member.

4. ***Tracking population trends through a common set of health indicators*** throughout Colorado is important for understanding where health outcome improvements are being made and where gaps continue. Important to this data collection effort is to **go beyond state collected data and work with all agencies, health research disciplines and communities in the design of the tracking system, development of measures and collection of data.** Statewide data, while good at providing a broad picture of health status in Colorado, will miss important health outcomes of sub populations. And the unintended consequences of HB06-1023 will impede the collection of statewide and community-level data on populations at high risk of poor health outcomes.

"(We) cannot wait for time to solve our racial problems or leave it to future generations, because racism belongs to us, not to our future generations."

— Derald Wing Sue

IV. WHO CAN HELP IN ADDRESSING HEALTH DISPARITIES?

As the discussion above demonstrates, the issue of health disparities relates to many different types of policy, not just health care. The Interagency Health Disparities Leadership Council is well placed to address the need for integration of policy solutions due to its ability to reach broad segments of the community by fostering a more inclusive approach with all of the stakeholders. One of the more persistent criticisms of government is its inability to collaborate, and share information and resources. The council can address this shortcoming by providing information and resources that promote access to health care for all Coloradans, thereby fulfilling the spirit and intent of the Colorado Promise.

In 2006, the Office of Health Disparities, working in partnership with its sister organizations, the Minority Health Forum and the Minority Health Commission, completed a project that identified organizations and groups that are already working on health disparities issues in the state of Colorado and the collected information on the nature of the work each entity has undertaken. This analysis was done as a preliminary step for the perceived need to conduct a full-scale, comprehensive needs assessment. The results of this needs assessment will identify a combination of community and provider strengths and gaps for planning how to best use existing resources and complement them with new resources that can be used in the most effective manner. There are many examples of engaging communities in meaningful participatory research and these communities reaching out to other communities to share their knowledge and insights.

Interagency Health Disparities Leadership Council Participants

Providing leadership, education and resources to comprehensively eliminate health disparities in Colorado through collaboration, consultation, research and inclusion.

- Asian Pacific Development Center
- Center for Systems Integration
- Colorado Asian Health Education and Promotion
- Colorado Community Health Network
- Colorado Consumer Health Initiative
- Colorado Department of Corrections
- Colorado Department of Education
- Colorado Department of Human Services
- Colorado Department of Public Safety
- Colorado Department of Public Health and Environment
- Colorado Department of Transportation
- Colorado Developmental Disabilities Council/ Multicultural Committee
- Colorado Division of Human Rights
- Colorado Institute of Public Policy-Colorado State University
- Colorado Multi-Ethnic/Cultural Consortium
- Colorado Prevention Leadership Council
- Colorado Progressive Coalition
- Denver Health
- Denver Regional Council of Governments
- Kaiser Permanente
- Minority Health Advisory Commission
- OneGiving
- Protektmark LLC
- The Colorado Neurological Institute
- The Colorado Trust
- University of Colorado Health Science Center, Addiction Research Treatment Services, America on the Move, American Indian and Alaska Native Programs
- University of Northern Colorado/Community Health
- U.S. Department of Health & Human Services, Public Health Service Region VIII

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V: WHAT CAN STATE LEADERSHIP DO TO ADDRESS HEALTH DISPARITIES?

Colorado can begin to comprehensively address health disparities by ensuring current health care reform efforts are inclusive of strategies to reduce or eliminate heath disparities. This can be accomplished by

- ⇒ expansion of the dialogue on health care reform to include issues of utilization and determinants of health;
- ⇒ expansion of the health dialogue beyond health care reform, to recognize the role that education, employment, transportation, housing and other factors play in health outcomes; and
- ⇒ informing cabinet members, policy analysts, legislators and other policymakers about health disparity issues and strategies that are specific to the state of Colorado.

The Interagency Health Disparities Leadership Council, in partnership with the Office of Health Disparities and the Minority Health Advisory Commission, is a resource available to Colorado's leaders as they seek to address health disparities as part of broader efforts to improve health and health care in Colorado.

VI. REFERENCES

Berkman, N. D., DeWalt, D. A., Pigone, M. P., Sheridan, S. L., Lohr, K. N., Lux, L., et al. (2006). *Literacy and Health Outcomes*. Rockville, MD: Agency for Health Care Research and Quality.

Brand, R., & Ramirez, R. (2006, August 28). Hospital, Medicaid numbers tell immigration tale. *Rocky Mountain News*.

Committee on the Consequences of Uninsurance. (2003). *A shared destiny: Effect of uninsurance on individuals, families, and communities*. Washington, D.C.: National Academy of Sciences.

Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs. (2006). *Medicare's Quality Improvement Organization Program: Maximizing Potential (Series: Pathways to Quality Health Care).* Board of Health Care Services (HCS) and Institute of Medicine (IOM).

Hunsaker, J., Krause, E. M. S., Carrington, J. M., & Hester, N. M. (2005). *Racial and Ethnic Health Disparities in Colorado 2005*. Denver, CO: Colorado Department of Public Health and Environment.

Schmitt, Sneed, & Phibbs. (2006). Costs of Newborn Care in California: A Population-Based Study. *Pediatrics, 117* (1).

Interagency Health Disparities Leadership Council
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