



ROOSEVELT HOUSE

PUBLIC POLICY INSTITUTE
AT HUNTER COLLEGE

National Health Reform and Eliminating Racial and Ethnic Disparities in Health & Health Care

Summary of Roosevelt House Symposium

December 3, 2010

“Racial and ethnic health inequities literally exist from the cradle to the grave. Whether we’re talking about higher rates of infant mortality all the way through a greater burden of chronic disease and disability. You name the disease area, we see higher rates among many populations of color and a tremendous toll in terms of the human and economic toll of these disparities for these populations.”

With these words, Brian D. Smedley, Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies, launched a symposium on “National Health Reform and Eliminating Racial and Ethnic Disparities in Health and Health Care,” held December 3, 2010 at Hunter College’s Roosevelt House Public Policy Institute in New York City. Smedley, who served as lead editor of *Unequal Treatment*, the Institute of Medicine’s landmark 2002 report on health disparities in the U.S., delivered the symposium’s opening keynote address.

Genesis of the symposium: Making an impact on health disparities

The symposium grew from a year-long faculty seminar by John E. McDonough, a health policy expert, former Massachusetts state legislator, and former Senior Advisor to the U.S. Senate Committee on Health, Education, Labor and Pensions. McDonough led the seminar while serving as the inaugural Joan H. Tisch Distinguished Fellow in Public Health at Roosevelt House. The seminar attracted faculty from throughout Hunter—from nursing, public health, social work, economics, sociology, and other fields—to study issues in health policy relating to federal health reform. Participants planned the symposium to go beyond study and seminar discussions and to focus on the potential impact of health reform in reducing racial and ethnic disparities in health. Darrell P. Wheeler, then

Associate Dean of Hunter’s School of Social Work, spearheaded this effort along with McDonough. The invitational symposium, which was supported by the Aetna Foundation with additional funding by the Charina Endowment Fund, drew an audience of over 100 health professionals, academics, community activists, students and others.

Smedley: Focus on determinants of health

Symposium participants were welcomed by Jennifer Raab, President of Hunter College. Kristine Gebbie, then Dean of Hunter’s School of Nursing, introduced Smedley. In his keynote address, Smedley outlined features of the Affordable Care Act (ACA)—the federal health reform law enacted in 2010—that may contribute to reducing racial and ethnic disparities in the U.S. The ACA will enhance access to health insurance coverage for millions of uninsured Americans. Smedley pointed to the potential impact of the ACA’s expansion in Medicaid eligibility—beginning in 2014, Medicaid eligibility will be extended to include all U.S. citizens and legally-residing aliens with incomes below 133% of the Federal Poverty Line (FPL). The law will also support an expansion of the health care workforce and provide incentives to improve the distribution of that workforce to address the needs of underserved communities.

Smedley also emphasized the law’s requirements for improved data collection methods as an important way to provide specific and meaningful information on the health of racial and ethnic groups that are most often described by broad, aggregate categories.

In particular, Smedley declared that the law’s creation of a new Prevention and Public Health Fund—funded at \$15 billion through the year 2015—is potentially “one of the most important provisions for ensuring that all population groups have the

opportunity to be healthy.” Smedley sees a need for a broad view of prevention—one that considers the social, economic and environmental factors that influence health—as a critical component of any effective response to ongoing health disparities. He pointed to the impact of structural racism on health inequality, in particular residential segregation that occurs — not by law but, as Smedley explained, “by common practice.” Segregation, he explained, shapes health behaviors, concentrates poverty, and limits opportunities. Smedley noted that many Black and Latino neighborhoods in the U.S. are “food deserts,” lacking ready access to sources of fresh fruits, vegetables and other healthy foods.

In its 2008 report, the World Health Organization’s Commission on the Social Determinants of Health declared that “inequities in health arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.” Quoting this statement, Smedley concluded by noting that “the point is that we didn’t get here by accident...[W]e need to work with other sectors to ensure that we consciously ensure that in all policies and practices, equity is a key consideration.”

Koh: Extending the federal commitment to reducing disparities

After an introduction by Kenneth Olden, Dean of the City University of New York (CUNY) School of Public Health at Hunter College, Howard K. Koh focused his remarks on the Obama Administration’s efforts to eliminate racial and ethnic disparities. Koh, Assistant Secretary for Health in the U.S. Department of Health & Human Services, recounted how his experiences—as a Korean-American child of immigrant parents, as a practicing physician, a Massachusetts state health commissioner, academic, and now as a federal health official—have informed his perspectives on health disparities as part of what he termed (quoting the late Rev. William Sloane Coffin) the “monstrosity of inequality.”

Koh noted that just the day before, on behalf of the Obama Administration, he had unveiled *Healthy People 2020*, the latest iteration of a national health agenda for the U.S. Among the overarching goals of *Healthy People 2020* is to achieve health equity, eliminate disparities, and improve the health of all groups. Describing its main aim as providing a “public health roadmap,” Koh emphasized that “as a country . . . we can’t be truly healthy unless each person reaches their highest attainable standard of health... we are all interdependent.”

Focusing on the ACA, Koh noted the importance of expanding access to health care coverage in reducing health disparities. He discussed the large-scale changes approaching in 2014, especially the creation of state health insurance exchanges to provide uninsured individuals and families with access to health care coverage. He also cited many of the interim steps being rolled out between now and 2014.

Koh emphasized that the ACA brings “new opportunities to build real systems of prevention.” He explained that this is particularly important because “so many of the disparities that we are seeing now are preventable. So many [of them are] because the people just don’t have access to proven services.” The ACA, he explained, removes many of the cost barriers to high-value preventive services in private insurance and in Medicare—which, along with other steps, will “help prevention come alive.” The ACA also includes a focus on population health that will be important in tackling health disparities. It provides funding for health workforce expansions that will target increasing diversity and providing services to underserved populations. ACA and Recovery Act funding will make it possible “to literally double the 19,000,000 people served by community health centers over the next five years.”

Koh also discussed the importance of improved data collection—to overcome the presumption by many policy-makers that if “there’s no data, then there’s no problem.” The ACA requires population surveys to collect data on race, ethnicity and primary language in more “granular” means. The Administration is also looking at collecting data related to other dimensions of disparities, including LGBT populations. Koh emphasized that the Administration’s focus on health is motivated by the goal of “mak[ing] sure that every person reaches their highest attainable standard of health and it’s to make sure that even though we are a diverse society, we are one nation and one community working for this single overriding goal.”

Panel: Focusing on health disparities in NY

Participants heard from a panel of four speakers who focused on efforts to reduce health disparities in New York: Alan D. Aviles, President of the New York City Health and Hospitals Corporation; Louise Cohen, Deputy Commissioner for the Division of Health Care Access and Improvement of the New York City Department of Health and Mental Hygiene (DOHMH); Charmaine Ruddock, Director of Bronx Health REACH Coalition at the Institute for Family Health; and David M. Keepnews of the

Hunter-Bellevue School of Nursing at Hunter College. Darrell Wheeler served as moderator.

Alan Aviles: Ensuring a strong safety net

Aviles discussed the role of the New York City Health & Hospitals Corporation (HHC)—the largest public hospital system in the nation—as a safety net for underserved populations, including new immigrant communities. He pointed out that HHC has sought to embrace new models of care, such as primary care medical homes, that emphasize primary care, coordination and continuity of care, emphasizing the importance of addressing chronic illness as essential to reducing health disparities. Aviles also pointed to HHC’s successes in quality improvement as an important development in reducing disparities, since the “vast majority” of patients served by HHC are people of color.

Like Smedley and Koh, Aviles also noted that the ACA’s expansion of access to coverage will particularly benefit minority patients. He explained that the state health insurance exchanges will provide subsidies to people below 400% of poverty level, and “80% of African Americans and Hispanics are below 400% of federal poverty level.” Aviles also cited the importance of funding for piloting models of care that can incentivize care coordination and integrated approaches to care delivery.

At the same time, with the expansion of Medicaid may come new challenges for safety net providers if Medicaid payment rates for providers are not adequate. Moreover, the new law will reduce Medicare and Medicaid Disproportionate Share Hospital (DSH) payments – which currently help to compensate for care to uninsured patients -- since so many uninsured patients will soon have access to health care coverage as a result of the ACA. However, Aviles explained, 300,000 of the 450,000 currently uninsured patients HHC treats are undocumented immigrants, who are excluded from the ACA’s coverage expansions. So the DSH reductions will create new financial burdens on HHC and other safety net providers that serve large numbers of undocumented patients.

Cohen: Sharpening New York’s focus on eliminating disparities

Louise Cohen of the New York City Department of Health & Mental Hygiene (DOHMH) explained that “The Affordable Care Act sets a stage for us to think about the way that we address and potentially eliminate health disparities, but implementation of the ACA requires purposeful intent to address the

question of disparities,” but it also “has the potential for exacerbating disparities,” citing the exclusion of undocumented immigrants from health exchanges as an example. She also explained that expanding the health care workforce requires developing a workforce that is “culturally competent, and located in the right neighborhoods to address the right populations at the right time.”

Cohen identified NYC DOHMH initiatives that illustrate its approach to reducing health disparities. Take Care New York was initiated in 2004 to focus on factors that contribute to morbidity and mortality in New York. The program addressed target areas for improvement—for example, increasing colon cancer screening—but did not set specific goals for reducing health disparities in these areas. Colon cancer screening rates increased, and racial/ethnic disparities in screening for people over age 50 virtually disappeared. Overall colorectal cancer deaths decreased as well—but not for minority New Yorkers, who experienced an increase. Take Care New York 2012, the current version of this program, now includes goals that include reducing disparities. So it not only targets a 12% decrease in colorectal cancer deaths over four years, but also a reduction in differences in those deaths between African Americans and whites.

Referring to initiatives to provide financial incentives for quality improvement, Cohen noted that “unless pay-for-performance . . . is done in a way that takes disparities into account, it can actually exacerbate the health disparities instead of reducing them.” In developing an electronic health records system, the department targeted primary care providers in minority communities and others who serve a large Medicaid population. DOHMH also initiated a program called Healthy Hearts, which provides incentives for providers to achieve improvements in focusing on improvement in the use of basic interventions such as blood pressure and cholesterol screening. Those incentives, Cohen explained, increase for Medicaid patients and patients with comorbidities such as diabetes.

Ruddock: Community-driven initiatives to target disparities

Charmaine Ruddock discussed the work of Bronx Health REACH (Racial and Ethnic Approach to Community Health), a community coalition that is a CDC National Center of Excellence in the Elimination of Disparities. The coalition is located in the southwest Bronx, a community with high levels of poverty and significant disparities in health status. Ruddock explained that when their program started,

the coalition conducted focus groups in the community and found a “widespread distrust of the health care system. People felt undervalued and disrespected in their encounters with the system.” They reported difficulties in communication with health care providers and many expressed reluctance to seek care from nearby providers based on the presumption that good providers leave to practice in other areas.

Initially, Bronx Health REACH focused on discreet programs—diabetes education, primary prevention, nutrition, fitness. But community members pressed for a sharper focus on institutional and organizational change. The coalition initiated on a “culinary initiative,” working with local churches to improve their nutritional offerings. School programs focused on providing healthier foods to children and educating parents. Bronx Health REACH then added a focus on working with local supermarkets and restaurants to make healthy food choices more accessible.

Ruddock pointed to expanded access to coverage and care as key improvements promised by health care reform. But she also posed the challenge of confronting what she termed “separate but unequal medical apartheid” in New York City. She stated that, in some large academic medical centers, privately insured outpatients are referred to private faculty practices while assigning uninsured and Medicaid patients to resident-staffed clinics, with less continuity of care and limited access to off-hours contact with providers.

Keepnews: Nursing diversity and distribution

David Keepnews discussed diversity among health care professionals, particularly nurses, in New York City. Lack of diversity is widely cited as having an adverse impact on quality of services to minority patients. Although its impact has been less widely studied in nursing than in medicine, Keepnews also pointed to workforce diversity as a social justice issue—one of providing minority populations with access into the health professions.

Nationally, 16.8% of RNs in 2008 came from racial or ethnic minorities, while in New York City about 40-50% of RNs are from racial or ethnic minorities, including large numbers of immigrants. But overall figures on minority nurses in New York City do not reflect the composition of the city’s residents: for example, only 7-8% of NYC RNs are Latino in a city that is 27% Latino. Within the city, the distribution of minority nurses appears skewed.

Keepnews related that a meeting of minority nurse leaders had strongly emphasized that “minority and immigrant nurses know which institutions they are welcome in and which they are not, and where the opportunities for advancement are and where they are not.” Keepnews discussed raw data that suggests that minority and white nurses are each concentrated into hospitals in specific communities. There is also a marked difference in the demographic composition of the RN workforce in public and private hospitals. He noted that workforce funding in the ACA can help increase diversity and distribution of health professionals. He also pointed to more nuanced data collection as potentially improving our understanding of the composition of the nursing workforce. Beyond this, he pointed out, there is a need to directly address concerns about discrimination and to identify and generalize best practices in improving workforce diversity.

Ng’andu: Address health care needs of immigrant populations

Jennifer Ng’andu, Deputy Director of the Health Policy Project at the National Council of La Raza, discussed the growing presence of immigrants in the U.S. and their important role in the diversification of the U.S. She noted that the ACA will have a positive impact for many immigrants: “. . . [H]ealth care reform provides a pathway to coverage for all U.S. citizens and legal immigrants. All lawfully present immigrants are treated equitably to citizens in a new insurance marketplace, the state [health insurance] exchanges.” She also pointed to strong consumer protections and improved data collection as features of the law that will contribute to reducing health inequities for most immigrants.

However, Ng’andu expressed concerns about aspects of the law, including the fact that undocumented immigrants are excluded from purchasing insurance through the health insurance exchanges. In addition, as a result of federal legislation enacted in 1996, documented immigrants are barred from receiving Medicaid for their first five years in the U.S. While that bar remains in place in the ACA, beginning in 2014, documented immigrants will be able to obtain coverage through the new state-based health insurance exchanges. Still, many documented immigrants—and all undocumented immigrants—will continue to be excluded from Medicaid.

Breakout Workshops

Conference participants divided into three breakout workshops to focus on specific issues related to eliminating health disparities.

A workshop on **Race and Health Care Reform**, facilitated by Jesse Daniels of the CUNY School of Public Health, emphasized the need to be more active and organized in educating the public about the ACA and its provisions. Some participants expressed concerns about the possibility that health care reform will not resolve the dichotomy of care, in which uninsured and Medicaid patients receive care from different providers than privately insured and Medicare patients. The workshop also focused on issues related to care for immigrant populations, noting that some public programs in New York State serve immigrants—documented and undocumented—without proof of immigration status and without the five-year waiting period required for federal programs. But many immigrants may not be aware of this, and undocumented immigrants may be hesitant to seek services at all.

A workshop on **Mental Health Issues**, led by Neal Cohen of the CUNY School of Public Health and Darrell Wheeler of the Hunter School of Social Work, identified disparities in prevalence of mental health problems, diagnosis and access to treatment. Increasing numbers of patients receive antidepressant medication from primary care providers, but there is evidence that these clinicians tend not to medicate minority patients at the same levels as white patients. In many minority communities, the stigma attached to mental illness and mental health treatment prevents many people from seeking needed care, as does a lack of trust in providers.

Participants identified a need for more evidence-based practices to address the needs of underserved communities—noting that current models of care are based on serving primarily white and middle-class patients. Better, more nuanced data are needed to guide both treatment and prevention efforts that will be more effective in addressing the needs of minority communities.

Another workshop focused on **Separate and Unequal Care in New York**. Charmaine Ruddock of Bronx Health REACH facilitated the workshop along with Diana Mason of Hunter's School of Nursing and its Center for Health, Media and Policy. Ruddock discussed efforts to address disparate treatment by some large, private teaching hospitals in New York, including referring privately insured outpatients to be seen by private faculty practices while referring uninsured and Medicaid patients to resident-staffed clinics. Participants also addressed assumptions made by many health professionals about minority patients—for example, that minority

patients do not adhere to treatment plans and medical advice. Other participants discussed the need for a more diverse and culturally competent health care workforce.

Historical precedent: Medicare and segregated care

During a closing reception for symposium participants, Barbara Berney of the CUNY School of Public Health at Hunter College discussed her current work on a documentary addressing Medicare's role in ending segregated health care in the South. Medicare was enacted in 1965—a year after the Civil Rights Act was first passed. The Medicare statute had the effect of requiring all acute care hospitals in the U.S., and especially those in southern racially segregated states, to desegregate their facilities in order to qualify for Medicare payment. It was one of the most dramatic improvements in racial justice in the era and largely unremembered.

RECURRING THEMES:

Throughout the day's events—in speaker and panel presentations, workshops and audience questions—some consistent themes emerged.

Prevention is critical, and must include a focus on social and economic determinants of health. A prominent message was that prevention is critical to eliminating health disparities. The ACA offers important opportunities to launch and sustain large-scale initiatives prioritize prevention. In order for prevention-focused efforts to be effective in reducing health disparities, however, they must include a sharp focus on social, environmental and economic determinants of health.

The U.S. needs a more diverse and culturally competent workforce. The ACA creates new resources for expanding the nation's health care workforce. This is an important goal—in particular, a larger primary care workforce will be critical to meeting an expanded need for health care services among newly insured patients. It is also crucial to ensure achieve a more racially and ethnically diverse health care workforce. Cultural competence must be an integral part of all health professionals' education from the start. A more equitable distribution of the health care workforce is also needed to improve access to care for underserved communities. The ACA provides mechanisms to achieve these objectives; it will be important to ensure their timely and effective implementation.

Expanded health care coverage is an important step to improving health care for racial and ethnic minority populations.

Minority communities represent more than half of the nation's uninsured. Greater access to health care coverage—through health insurance exchanges and Medicaid expansion—will help to rectify this inequity in health care coverage, an essential step in eliminating disparities.

Other disparities still need to be addressed.

Disparities in care, referral patterns and quality must still be addressed—these problems will not be resolved by increased access to coverage alone. In addition, there are some important potential, unintended consequences of health reform. Medicaid expansion is important, but disparate treatment of Medicaid and privately insured patients is an ongoing source of concern. Inadequate Medicaid payment rates to providers may serve to weaken the health care safety net. And eliminating Medicare DSH payments will place new burdens on safety-net institutions that serve large numbers of undocumented immigrants.

Better, more nuanced data collection is needed to support efforts to reduce health disparities.

Expanded and improved data collection is a necessary precedent to identifying and replicating evidence-based approaches to reducing health disparities. In addition, the widespread use of broad, aggregate categories of racial and ethnic minorities greatly limits the helpfulness of health care data in identifying disparity-related issues, setting priorities for reducing disparities and measuring progress. The ACA mandates improvements in collecting data on minority health, and the Administration has indicated its strong commitment to this goal.

Immigrant health care remains an important but unaddressed concern.

The exclusion of undocumented immigrants from participating in health insurance exchanges leaves many people without health care coverage and may also harm those providers, especially safety net institutions, who serve large numbers of undocumented immigrants. Many documented immigrants continue to be excluded from Medicaid for their first five years in the U.S. These remain important concerns in providing coverage to underserved populations and to making progress in reducing health disparities.

Overall, the Affordable Care Act provides important resources for reducing health disparities.

Despite whatever concerns may exist regarding specific aspects of the ACA, this law represents an important and historic milestone in reforming health

care in the U.S. and a critical step forward in efforts to eliminate health disparities. For all those who share a commitment to reducing disparities, defending the ACA against attempts to repeal, defund or otherwise undermine implementation of the ACA should be a major priority.

UPDATE FROM THE FIELD:

HHS Action Plan & Nati'l Stakeholder Strategy

In April 2011, HHS announced the release of two action plans aimed at reducing and eliminating health disparities. The HHS *Action Plan to Reduce Racial and Ethnic Health Disparities* outlines that department's strategic plan to address health inequities, building on existing efforts and incorporating new initiatives under the ACA. It focuses on five areas: Transforming health care; Strengthening the nation's Health and Human Services infrastructure and workforce; Advancing the health, safety, and well-being of the American people; Advancing scientific knowledge and innovation; and Increasing the efficiency, transparency, and accountability of HHS programs. (The Action Plan is available at http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf).

Concurrently with the release of the HHS Action Plan, the National Partnership for Action to End Health Disparities (NPA), launched by the HHS Office of Minority Health, released a National Stakeholder Strategy for Achieving Health Equity (National Stakeholder Strategy) to "provide[] an overarching roadmap for eliminating health disparities through cooperative and strategic actions" among the public and private sectors and partnerships. (The National Stakeholder Strategy is available at <http://minorityhealth.hhs.gov/npa>.)

Health Reform Implementation

In the time since the symposium was held in December 2010, implementation of the ACA has continued in several areas relevant to health disparities. Among these: The U.S. Department of Health & Human Services (HHS) has awarded Community Transformation Grants to thirty-five grantees, focusing on local community efforts to reduce health disparities. The HHS Centers for Medicare and Medicaid Services (CMS) has launched a Comprehensive Primary Care Initiative that seeks to expand availability of comprehensive, coordinated primary care services and to pilot new payment models for those services. Proposed new data standards require collecting more specific

information on race, ethnicity, primary language and disability status. HHS has provided funding to state and local health departments to expand preventive services and new rules also expand preventive services available to Medicare beneficiaries.

Threats to health reform

At the same time as implementation of many ACA provisions continue apace, several threats to health reform have emerged. The November 2010 elections resulted in political gains for opponents of health reform. In January 2011, the U.S. House of Representatives passed a bill calling for repeal of the ACA—a proposal that was quickly defeated in the Senate, but which displayed the intensity of opposition to the ACA by some policy-makers. The political environment surrounding the ACA remains turbulent and will be further shaped by the outcome of the 2012 presidential and congressional elections.

Federal legal challenges to the ACA—focusing on the constitutionality of the law’s mandate for individuals to purchase health insurance—have met with conflicting results in the courts that have ruled on them thus far. These conflicts will not be settled until the U.S. Supreme Court considers and rules on the issues raised by the ACA and the individual mandate.

While attempts to withhold funding from the ACA have been unsuccessful thus far, national debate on long-term deficit reduction may result in reduced funding for some of ACA’s programs. Republican proposals, for example, would (among other things) transform Medicaid into a program of state-operated block grants. President Obama’s deficit reduction proposal would reinforce some of the ACA’s provisions but would also cut \$3.5 billion from the ACA’s Prevention and Public Health Fund.