



Commission to End Racial and Ethnic Health Disparities



FINAL REPORT

Rep. Peter J. Koutoujian, House Chair

Sen. Dianne Wilkerson, Senate Chair



AUGUST 2007

PREFACE

We are pleased to present the final report of the Commission to End Racial and Ethnic Health Disparities. This report is the result of an effort that started over three years ago, involving community members, health care advocates, policy experts and legislators. It is grounded in three fundamental understandings:

- 1) Health disparities stem from social arrangements historically rooted in interpersonal and institutional racism. These arrangements have an active legacy in the present.
- 2) There are multiple causes of health disparities. Single sector approaches, whether aimed at larger social conditions, health care services, or patient education and behavior, will not suffice. Only a comprehensive approach can lead to the elimination of health disparities.
- 3) Eliminating health disparities requires political will and coordinated oversight to ensure that gains are both substantive and sustainable.

It is our belief that this document provides an analytical framework and a blueprint for the elimination of health disparities. Upon its release, Massachusetts moves to the national forefront once again, leading the country in the area of health. We urge leaders in government, the private sector, non-profits, and local communities to join together to address racial and ethnic health disparities, an injustice that has rightly been called by the late Dr. Martin Luther King, Jr. as the “most shocking and inhumane civil rights issue”.

Representative Peter J. Koutoujian

Senator Dianne Wilkerson

Commission Co-Chairs

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ACKNOWLEDGEMENTS

The establishment of this Commission would not have been possible without the foresight and leadership of former Speaker Thomas Finneran and Senate President Robert Travaglini. The continued support from House Speaker Salvatore DiMasi and Senate President Therese Murray has allowed this Commission to finish the work of the people and shine a spotlight on this growing health crisis.

The Co-chairs would like to thank the dedicated membership of this Commission. We are truly appreciative of the commitment and resolve they have demonstrated throughout this process. Without them, this report would not have been possible. We would like to extend our deep appreciation to the Massachusetts Health Council and the Harvard Pilgrim Health Care Foundation which were instrumental in the printing and dissemination of this report.

The Commission would finally like to acknowledge the efforts of all those who provided testimony at our public hearings and in written form. Personalizing the everyday reality of health disparities, not only informed our findings, it provided the impetus to see this project through as we move forward toward the implementation of these recommendations.

ABOUT THE COMMISSION

In Massachusetts, there has been a growing understanding among political leaders and policy makers that the existence of health disparities is unacceptable, yet there has been little consensus about the role of the Commonwealth in a comprehensive response. In the General Court, Representative Peter J. Koutoujian and Senator Dianne Wilkerson recognized the serious public health implications for minority communities and for all Massachusetts residents of maintaining the current piecemeal approach to disparities reduction.

Under the leadership of these two legislators the Commission to End Racial and Ethnic Health Disparities was established in Chapter 65 of the Acts of 2004. A 29-member Commission was appointed, consisting of legislators, community members, and experts in health and health care. The Commission's charge was to examine the racial, ethnic and linguistic disparities in health and provide an action plan for the state to address these disparities.

The work of the Commission is unique in that it is the first attempt to develop a statewide, comprehensive approach to eliminate racial and ethnic health disparities led by the very policy makers who are in positions to make the plan a reality. Most interventions at the federal and state level to address racial and ethnic health disparities have been limited by concentration on a single focus instead of on the full range of factors that contribute to health disparities. In addition they have not accounted for the need to develop political and policy strategies that are so important in determining the eventual success or failure of any initiative.

Eliminating health disparities requires a more comprehensive approach that examines factors both inside and outside of the health care setting and specific treatment modalities. Disproportionate mortality and morbidity from diseases like diabetes, hypertension and cancer are large and must be specifically addressed. However limiting interventions to disease specific interventions is likely to yield only limited results. Similarly, any effective response must move beyond purely academic assessments and consider the political and policy resources that should be brought to bear on the problem.

This report represents the findings and recommendations of the Commission with specific recommendations for state policy initiatives to: (1) address the social factors that contribute to disparities; (2) design, implement, and improve new or existing health programs and services; (3) propose appropriate regulatory and statutory changes to reduce disparities in access to care and quality of care; and (4) determine initiatives to increase the diversity of the health care workforce.

Commission Membership by Appointment (Initial Appointments)

House Appointments

House Members:

**Representative Peter J. Koutoujian
(co-chair)**

- Representative Gloria Fox
- Representative William Lantigua
- Representative Jeffrey Sanchez

*Community members
disproportionately affected by
health disparities:*

- Rosalin Acosta Sayre, Sovereign Bank
- Dr. Azzie Young, Mattapan Community Health Center
- E. Keith Johnson, Massachusetts State House

Senate Appointments

Senate members:

**Senator Dianne Wilkerson
(co-chair)**

- Senator Richard Moore
- Former Senator Jarrett Barrios

*Community members
disproportionately affected by
health disparities:*

- Harold Cox, Cambridge Public Health Department
- Sylvia Saavedra – Keber, Concilio Hispano
- Reverend Martin McLee, Union United Methodist Church
- Daniel Delaney, Union of Minority Neighborhoods

Legislative Appointments

- Secretary of Health and Human Services, Paul Cote
- Commissioner of Department of Public Health, Christine Ferguson
- Commissioner of Department of Medical Assistance, Beth Waldman
- American Cancer Society (MA), Stephanie Harriston-Diggs
- American Heart Association (NE), Dr. Paula Johnson
- Massachusetts General Hospital, Dr. Joseph Betancourt
- Brigham & Women's Hospital, Dr. JudyAnn Bigby
- Massachusetts League of Community Health Centers, Dr. Paul Mendis
- Massachusetts Medical Society, Dr. Alice Coombs
- Boston Public Health Commission, John Auerbach
- Springfield Health Department, Helen Caulton – Harris
- Massachusetts Nurses Association, Mary Crotty
- Massachusetts Association of Health Plans, Ralph Fuccillo
- Program to Eliminate Disparities at Harvard School of Public Health, Dr. Brian Gibbs
- Boston Medical Center, Dr. Lauren Smith

COMMISSION PROCESS

The Commission met to review data, policies and programs from national, state and local initiatives to identify short-, medium-, and long-term goals across multiple sectors to eliminate racial and ethnic disparities in health. The Commission heard testimony on a wide range of issues from scientific and program experts. In April 2005, the Commission sponsored a public hearing to gather input and ideas for the elimination of disparities.

Commission members organized their work around four overlapping intervention points to address racial and ethnic health disparities. Four sub-committees were established to explore these areas:

- (1) The social context of health
- (2) Access to health care
- (3) Health care quality and delivery
- (4) Workforce development and diversity

Description of Sub-committees:

1. Social Context of Health

The sub-committee focused on the social factors, outside the health domain, that influence health and the social circumstances which produce and sustain racial and ethnic health disparities. The sub-committee examined factors such as employment, housing and education that lead to inequities and to limiting healthy life options, as well as the barriers that prevent effective health promotion.

2. Access to Health Care

The sub-committee focused on impediments to consumer access to health care such as inequities in public and private insurance coverage, licensure of providers and regulation of facilities. This committee recognized five key aspects of meaningful access: affordability, availability, accessibility, accommodation, and acceptability of health care.

3. Health Care Quality and Delivery

The sub-committee focused on barriers to the delivery of optimal health care services to all patients, regardless of racial, ethnic or linguistic background. The sub-committee focused on the content and quality of health care once individuals access the health care system and considered the roles quality improvement and cultural and linguistic competency in delivering equitable health care.

4. Workforce Development and Diversity

Workforce development and diversity are interrelated strategies to address disparities. The sub-committee considered ways to increase diversity among health care providers by focusing on areas such as improving existing pipelines of minority students into the health professions, and improving the retention of minority physicians, nurses and other allied health professionals. This subcommittee also considered the issue of workforce development, including enhanced cultural competence.

Based on the presentations from state and national experts, on testimony from the public, and on existing research, each sub-committee developed recommendations that were reviewed and prioritized by the Commission. The recommendations in this report reflect a synthesis of ideas and concepts expressed during this process.

INTRODUCTION

Racial and ethnic disparities in health have been documented for well over three decades. Former Surgeon General Dr. David Satcher raised awareness of the existence of the widespread nature of this problem and challenged the U.S. to eliminate health disparities by the year 2010. Health disparities exist in measures of health status such as life expectancy, mortality rates, disease incidence, and self-report of health status. Disparities exist in regards to access to care as evidenced by rates of uninsuredness, representation in public plans like Medicaid, and problems racial and ethnic minorities report in seeing specialists or finding a usual source of care. In addition many studies document disparities in the quality of health care minorities receive compared to the care Whites receive.

A broad range of research, such as documented in the Institute of Medicine's 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, provides evidence that racial and ethnic health disparities occur across health conditions and can not be solely attributed to insurance status or socioeconomic position. African American, American Indian, Latino, and some Asian American populations disproportionately experience the burden of death, disease and disability. The IOM report defines *racial and ethnic health disparities* as differences in health status among racial and ethnic groups, *health care disparities* as differences that are "not due to clinical needs, patient preferences or appropriateness" (IOM 2003).

Massachusetts, like the rest of the nation, demonstrates significant health disparities as documented by reports from the Massachusetts Department of Public Health and other health departments and research from Massachusetts hospitals and medical schools. The following describes some of the disparities that have been documented in Massachusetts.

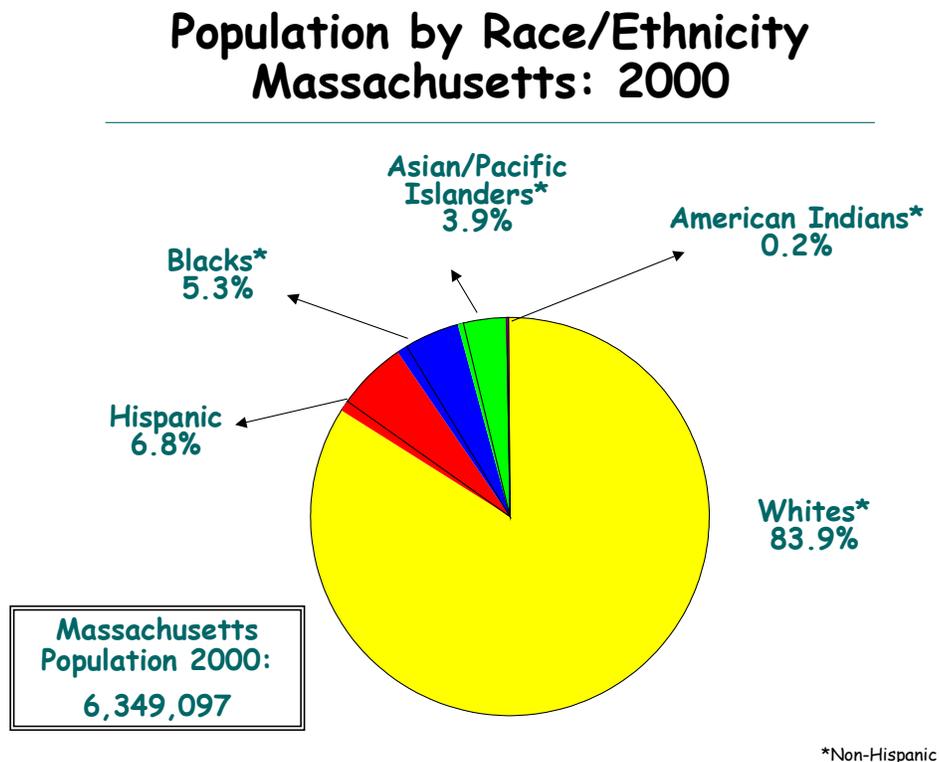
- Reproductive health outcomes –In 1999 black infants were nearly three times more likely to die before their first birthday compared to white infants; only about 67% of black and Hispanic women receive adequate prenatal care compared to 83% of white women; teen birth rates are 5 to 10 times higher among black and Hispanic teens than among white teens (2001 Massachusetts Department of Public Health report *Massachusetts Health Status indicators by Race and Hispanic Ethnicity*).
- Mortality – Blacks have a 35% higher age-adjusted mortality rate compared to Whites and nearly twice the rate of Hispanics and Asians; blacks have higher age-adjusted death rates for heart disease, cancer, stroke, diabetes, HIV/AIDS, homicide, MVAs and other injuries (2001 Massachusetts Department of Public Health report *Massachusetts Health Status indicators by Race and Hispanic Ethnicity*).
- Hospital Discharges – Blacks have higher hospital discharge rates for hypertension, stroke, and cardiovascular disease; Blacks and Hispanics have three to four times higher rates for asthma discharges compared to Whites (2001

Massachusetts Department of Public Health report *Massachusetts Health Status indicators by Race and Hispanic Ethnicity*).

- Diabetes care – In one health care setting Blacks with diabetes were less likely to be prescribed cholesterol lowering drugs when indicated compared to Whites with diabetes and were less likely to have their diabetes well controlled (Sequist TD et. al Arch Intern Med 2006;166:675-81)

As the population of Massachusetts becomes more diverse, the implications of health disparities become more compelling for policy makers, public health officials, health care providers, business leaders, educators, and the broader public. The increasing diversity of the population of Massachusetts is reflected in remarkable demographic changes over the past several decades. Compared to 1990 when minorities made up 11.2% of the population, in 2000 17.3% of the population, in 2000 there were 6.3 million residents in the Commonwealth with Whites representing largest racial group (84%) and Hispanics comprising the largest ethnic group (6.8%), Blacks comprising 5%, Asians represent 4% and American Indians are less than 1%. (See Figure 1.) We must ensure that present and future citizens of the Commonwealth are healthy to ensure economic growth and security, educational attainment and competition and for the quality of life for all in Massachusetts.

Figure 1.



Racial and ethnic health disparities, while manifested in clinical outcomes, are rooted in broader social conditions. The evidence indicates that disparities are not simply explained by differing access to health care insurance, socioeconomic status, or health behaviors. The historical accumulation of social and economic discrimination based on race and ethnicity has an enduring influence on current disparities.

Development and Perpetuation of Health and Health Care Disparities

Despite an increased focus by researchers and some policymakers, few comprehensive public policy approaches have been implemented to eliminate existing health disparities. Most of the interventions at the federal and state level to address racial and ethnic health disparities have been limited by a focus on single causes, diseases, or sectors. The Commission recognized the need for a comprehensive approach that incorporated the complex interconnection of factors contributing to health and health care disparities. The Commission recognizes four broad domains that must be addressed in an inter-sectoral manner to effectively eliminate health disparities:

- The social context of health and health disparities;
- Access to health care;
- The role of the health care system, including quality, delivery of care; and
- Health care workforce diversity and development

In this section of the report, we present data gathered during the Commission’s work, illustrating the importance of these domains. It is beyond the scope of this report to summarize the extensive literature on health disparities. Rather, we summarize highlights that informed the recommendations presented in the following section.

The Social Context of Health and Health Disparities

The Commission heard testimony and examined data concerning four important components of the social context of health: (1) ***racism and discrimination***, (2) ***socioeconomic factors***, including income, employment and education, (3) ***healthy housing and neighborhoods*** and (4) ***environmental exposures***.

A. Racism and discrimination

It is critical, when considering health disparities broadly, to directly address the role of racism within and outside of the health care system. Health care providers are not immune from broader social forces and messages that reinforce and perpetuate biased care and disparate outcomes. In a landmark issue of the *American Journal of Public Health*, Dr. Sherman James (2003) noted,

“Because racism, operating through varied interpersonal and institutional pathways, is a fundamental cause of racial/ethnic health disparities, the elimination of these disparities—the

magnificently democratic goal of Healthy People 2010- cannot be achieved without first *undoing* racism” (p. 189).

Policy efforts focused on cultural competency, public health programs, and improvements in health care system must do more than try to be race or ethnicity “neutral” or “sensitive”. They must be implemented with the understanding that all these efforts take place within institutions that have been historically tolerant of racial bias. Segregation, redlining, patient dumping and discrimination have all left legacies to be overcome if we hope to eliminate health disparities.

Research demonstrates that racism and discrimination continue to be manifested within the dynamics of interpersonal relations and social institutions in ways that limit opportunities for minorities through a complex interplay of factors. Within the health care system, research shows that bias, whether conscious or unconscious, influences healthcare providers in their diagnostic and treatment decisions. The Institute of Medicine report, *Unequal Treatment*, notes that although most healthcare providers find prejudice morally abhorrent, “...healthcare providers, like other members of society, may not recognize manifestations of prejudice in their own behavior.”^{vi} (Burgess et al, 2004; Van Ryn citations).

For example, a study in which identical resumes with different names were submitted in response to employment postings in newspapers in Boston and Chicago revealed that applicants with a ‘White-sounding’ name were 50% more likely to be called in for a job interview than those with a ‘Black-sounding’ name. Furthermore, as the credential levels of the applicants rose, the racial gap in job interview offers actually increased (Bertrand & Mullainathan, 2004).

Exposure to discrimination has been shown to independently contribute to poorer physical and mental health outcomes. A review of scientific studies on discrimination found evidence of an association between perceived discrimination and both mental and physical health indicators (Williams, Neighbors, & Jackson, 2003). For example, perceived severity of exposure to racism has been linked with hypertension in Black males (Steffen, McNeilly, Anderson, and Sherwood, 2003). Another study revealed that African American women who reported higher levels of discrimination were found to have higher degrees of coronary artery calcification, which is associated with atherosclerosis (Everson-Rose et al., 2005). Researchers at Harvard have demonstrated a link between exposure to racism and elevated cortisol levels, a marker of stress. Cortisol patterns in subjects exposed to high levels of discrimination are similar to those of Holocaust survivors and war veterans (Bennett, 2005).

B. Socioeconomic factors – employment, income and education

The unequal distribution of resources is evident in employment, income, and education. This distribution contributes to health disparities because of the well-documented relationship between lower socioeconomic status and health. Individuals with lower income, less education and less desirable occupations consistently have worse health outcomes across all racial and ethnic groups.ⁱⁱ

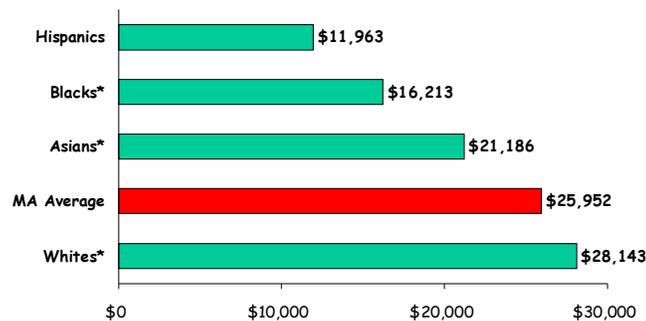
In the United States, people of color are disproportionately represented among the impoverished and unemployed in comparison to White populations. In 2001, of the 11.7% of families with incomes below the federal poverty level, Blacks comprised 22.7% compared to Whites who made up only 7.8%.^{i,iii}

Employment is an issue not only as it relates to income but also as it relates to obtaining health insurance. Minorities have higher rates of uninsurance due to higher rates of unemployment and to employment in jobs that either offer no health insurance or high premium health insurance. However, even people of color with insurance have worse health status than others.

In Massachusetts, the coverage per capita income of all residents was approximately \$26,000, but differed substantially by racial and ethnic group. The average per capita income of White residents is 73% higher than that of Blacks, more than twice that of Hispanics and 33% more than that of Asians of the Commonwealth (See Figure 2).

Figure 2.

Per Capita Income by Race/Ethnicity Massachusetts: 1999



Source: 2000 Census

*Non-Hispanic

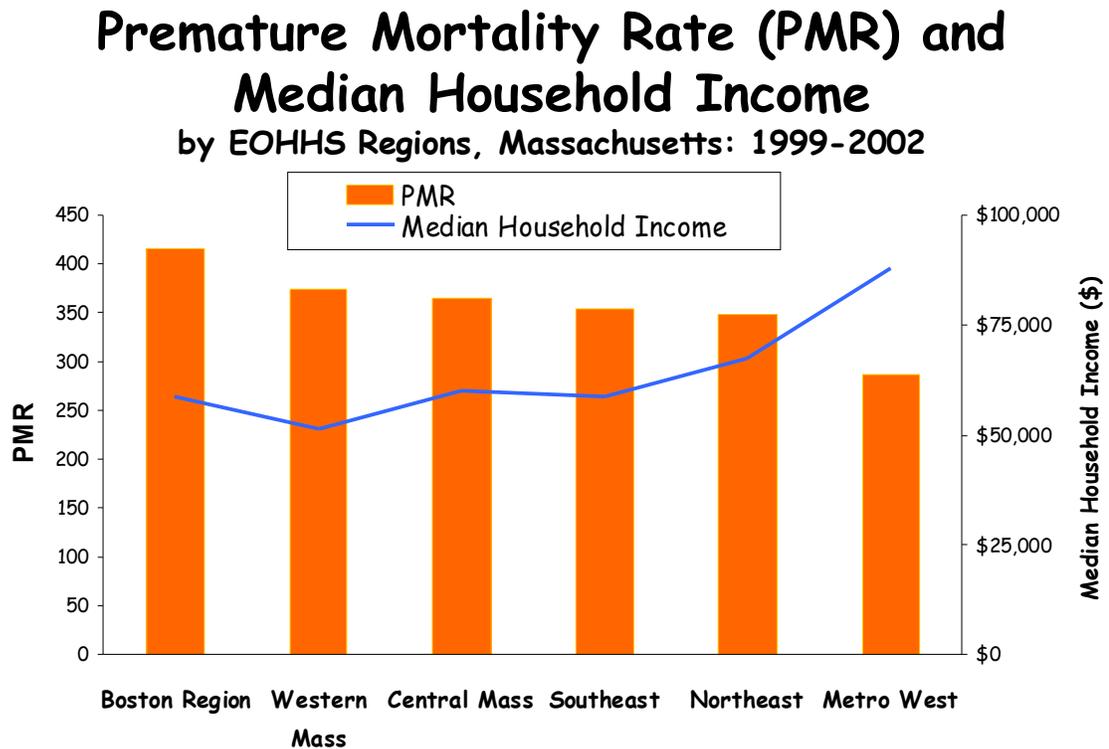
The disparity in income is compounded by racial and ethnic disparities in wealth. At equivalent income levels, Blacks and Hispanics have lower net worths than Whites, which includes property holdings as well as financial assets. These differences in wealth are important because wealth serves to buffer individuals from adverse health consequences of environmental and other risks. Even if two families have the same income, if one has a car and a small amount of savings that makes a critical difference. The importance of such resources was demonstrated by the differing capacity of people to flee from Hurricane Katrina.

Poor minorities are more likely to live in segregated neighborhoods with fewer resources than poor whites. They are also more likely to live in areas of concentrated

poverty rather than more economically diverse communities. Racial and economic segregation, as well as differences in income and net worth, result in differential exposures to factors contributing to poor health, such as poor quality and unsafe housing, (including older housing stock, lead paint, pest infestation, lack of safe parks, fewer supermarkets, lack of access to fresh produce, dangerous neighborhoods.)

The unequal distribution of income is relevant to health disparities because most health indicators, including measures of mortality and morbidity are influenced by income. Figure 3 illustrates this pattern of higher income and better health outcomes. According to Massachusetts Executive Office of Health and Human Services data, the Metro West region of Massachusetts has the highest median household income and the lowest premature mortality rate.

Figure 3.



Rates are per 100,000 persons under 75 years of age, age-adjusted to the 2000 US standard population
State Median Household Income: \$66,365

C. Healthy housing and neighborhoods

The Commission heard ample evidence connecting housing quality and affordability and neighborhood conditions with health outcomes. The lack of affordable housing and the social and geographic isolation of the poor and minorities result in differential patterns of health risks (Hynes & Lopez, 2003). Research shows that this is associated with both infant and adult mortality in Blacks (Acevedo-Garcia et al., 2003).

Furthermore, sociological research shows that this segregation is not primarily due to the preferences of minority groups. Numerous studies show that Blacks and Hispanics continue to face discrimination in housing and mortgage applications. Research also shows that race plays a larger role in residential segregation than income (Acevedo-Garcia et al., 2003).

Racial segregation is an important public health concern. When health promoting factors and health harming factor are unequally distributed across racially segregated neighborhoods health outcomes are significantly influenced. The association of residential segregation with poor health outcomes is due to several causes, such as: unhealthy neighborhood conditions, inadequate resources and infrastructure, decreased access to transportation and insufficient supply of employment. For example, residential segregation is associated with both infant and adult mortality in Blacks (Acevedo-Garcia et al., 2003; Williams reference). Recent research findings on playground safety in Boston reveal that playground safety scores are strongly related to the percentage of non-white residents in a neighborhood. As the percentage of minority residents increases, the playground safety score drops significantly. (AJPH article)

As an example of neighborhood level exposures, minorities experience disproportionate marketing of both legal and illegal substances. An analysis of liquor store distribution revealed more liquor stores in Black neighborhoods regardless of median income levels. Minority neighborhoods were also found to have higher numbers of tobacco advertisements and significantly higher numbers of fast food restaurants. (Bennett, 2005). Conversely, White neighborhoods have four times as many supermarkets as Black neighborhoods. The availability of nutritious, affordable food is a significant factor related to healthy food intake. Fruit and vegetable intake by Blacks has been found to increase by 32% for each additional supermarket in the neighborhood.

Neighborhood segregation also affects health by imposing barriers to regular physical activity, which is another important component of health promotion. Lack of access to safe areas for outdoor activity presents a barrier to physical exercise. The residents of minority neighborhoods are less likely to report feeling safe in their neighborhoods.(Rich, 2005) This perception of being unsafe is supported by the data showing that minorities face a much higher risk of being a victim of assaults (Rich, 2005). In Boston, for example, the four neighborhoods with the highest percentage of nonwhite residents had the highest incidence of assaults. Research findings on playground safety in Boston reveal that as the percentage of non-white residents in a neighborhood increases, the mean playground safety score drops significantly. ^{iv}

D. Environmental exposures

It is well documented that exposures in the physical environment are associated with numerous health conditions, including lead poisoning, cancer and asthma. Dr. John Rich (2005) notes that some of the environmental indicators affecting health disparities include external factors such as air pollution and toxins.

Residential segregation poses health risks

Due to residential segregation, blacks and Hispanics face increased toxic environmental exposures, which place them at higher risk of disease. These exposures include proximity to toxic waste dumps, landfills and polluting power plants.

- In Massachusetts, a study revealed that communities whose minority population was 25% or more faced *nine times* the exposure to environmental hazards in comparison to communities with a minority population of 5% or below (Faber & Krieg, 2001).

Air pollution is of particular concern for minorities living in urban areas such as Roxbury, which has a history of high levels of emissions from diesel trucks and bus exhaust (Rich, 2005). There are documented connections between air pollution and many respiratory conditions, including asthma and emphysema. The American Heart Association (2004) issued an official statement linking air pollution to heart disease and stroke. Prolonged exposure to elevated particulate pollution levels reduces overall life expectancy between 1.8 and 3.1 years. Even short-term exposure to air pollution is associated with a higher death rate from cardiovascular events.

Access to Health Care

Massachusetts is implementing landmark health care reform that has the potential to substantially change rates of uninsurance in the Commonwealth. In April 2006, the General Court passed an historic health insurance reform package structured to ensure that virtual universal health care within three years. A number of measures were included in this legislative package to specifically address the issue of racial and ethnic health disparities, including the continuation of the commission, and initiatives to address disparities through pay for performance standards for MassHealth providers.

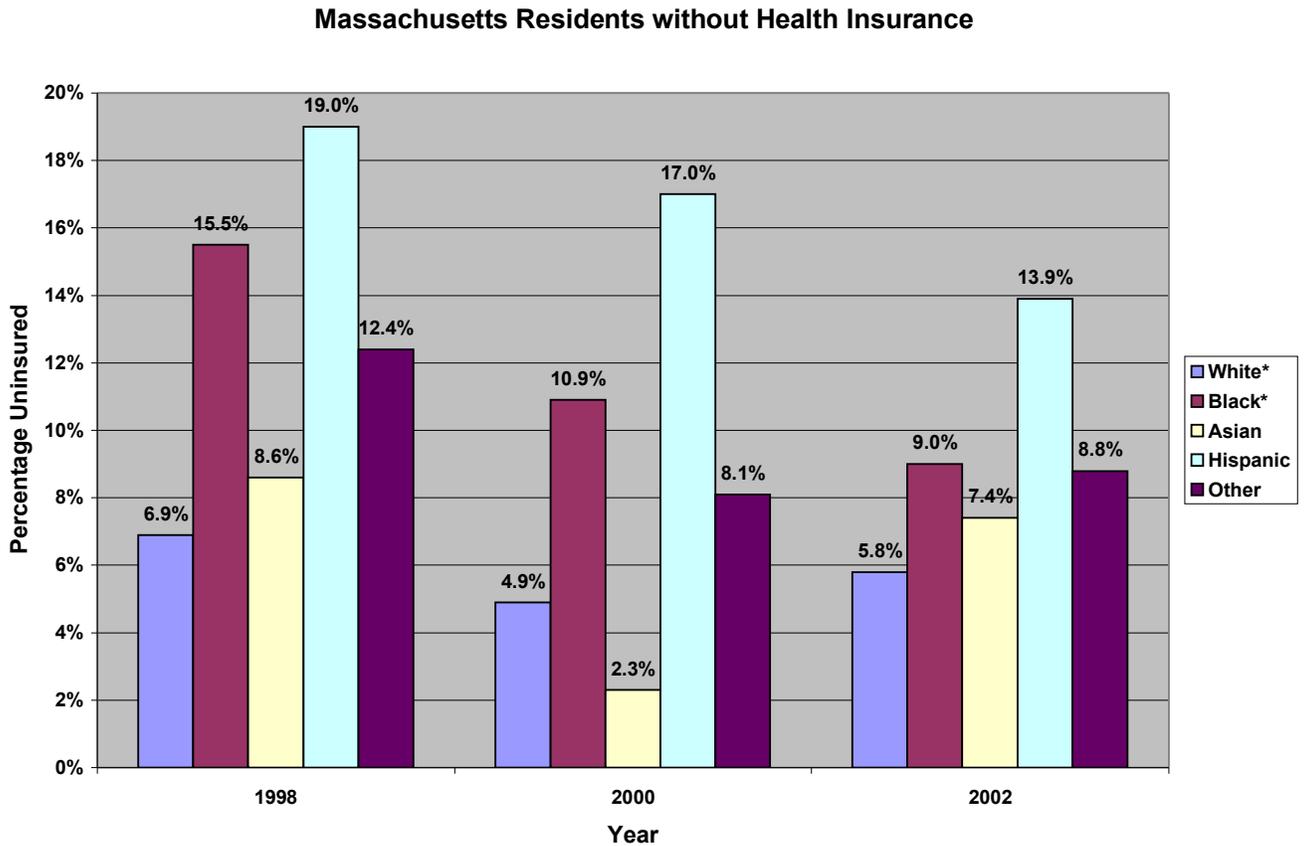
The commitment of the state of Massachusetts and of the legislature presents a tremendous opportunity to eliminate health disparities based on differences in access to care. It may also pose significant risks to minority communities if poorly implemented. An implementation approach that is not sensitive to the specific barriers to access facing different minority populations could very well lock in harmful policies.

The Commission believes that affordable health insurance coverage is a necessary part of health care access, but is not sufficient. The Commission defines health care access as five inter-related components: *affordability*, *availability*, *accessibility*, *accommodation* and *acceptability*.^v Affordability refers to how provider's charges relate to the client's ability and willingness to pay for services. Availability refers to the degree to which the provider has the personnel and technology resources to meet the client's

needs. Accessibility refers to the ease or difficulty the client has in reaching the provider’s location. Accommodation refers to the extent to which the provider’s services are organized to meet client preferences. Finally, acceptability refers to the extent to which the client and provider are comfortable with each other’s immutable characteristics such as age, sex, social class and ethnicity.

There is ample evidence documenting racial and ethnic disparities in each of the above components. For example, the insurance coverage rates in Massachusetts vary substantially by race/ethnicity, as shown in Figure 4.

Figure 4.



In Massachusetts, African Americans and Hispanics are much more likely to receive their health care through Medicaid than whites. In Massachusetts, 8.2% of whites rely on Medicaid, compared to 24% of African Americans and 37.6% of Hispanics.^{vi} Persons from racial and ethnic minority groups are also over represented among the users of the Uncompensated Care Pool. However, evidence presented to the Commission clearly indicated that even where insurance and affordability issues were not problems, racial and ethnic minorities still faced significant barriers to accessing quality care.

Health Care System

Quality and Organization

Substantial data and research reveals that minorities receive lower quality health care, even when controlling for insurance status and socioeconomic position. These data are compelling across a variety of clinical services and in all health care settings. The evidence for disparities in health care quality has been documented for more than two decades and is summarized in the Institute of Medicine Report *Unequal Treatment*. This report documents racial and ethnic differences in cardiovascular care and cardiovascular procedures, in receipt of cancer diagnostic tests, immunizations, diabetes care, treatment for end stage kidney disease, HIV/AIDS care, and use of pain medication among cancer patients and patients with acute long bone fractures. Despite the presence of numerous world renowned hospitals and research institutions in the Commonwealth, Blacks and Hispanics generally receive lower quality care than other groups do.

Limited English proficiency acts as an important barrier to equal quality health care.^{vii} Estimates in Massachusetts indicate that almost 20% of people over the age of 5 years speak a language other than English at home. Of these, 45% state they speak English less than “very well”, totaling over 500,000 people.^{viii} Studies show that patients with limited English proficiency that have access to interpreter services visit their physicians more often, use more preventive services, receive more prescriptions, and are more satisfied with their care than patients without these services.^{ix x xi xii} There are also data revealing that the lack of trained interpreters results in increased medical errors and lower quality health care for non-English speakers. Incorrect diagnosis and treatment lead to increased morbidity or even mortality when providers are not able to effectively communicate with their patients with limited English skills.

Many populations find the health care system difficult to navigate, even when they have health insurance, are well educated and knowledgeable about health care. A lack of familiarity and discomfort with the complexity of the health care system can lead to under utilization of health services, particularly primary care and preventative services. Minority patients are more likely to refuse recommended services^{xiii}, adhere poorly to treatment regimens, and delay seeking care.^{xiv} This has been attributed to a lack of knowledge about how to best use the health care system. For example, minority women screened for breast cancer are less likely to follow up abnormal results. The Commission heard testimony that patient navigators and outreach workers can be examples of effective resources for increasing access to care when health care systems barriers exist because they help minority populations better utilize primary care and preventive resources.

Workforce Development and Diversity

The importance of workforce development and diversity in addressing disparities was emphasized in data and testimony presented to the Commission.

The elimination of health care disparities requires a workforce that is responsive to and representative of an increasingly diverse population. Two recent reports, In the Nations Compelling Interest, by the Institute of Medicine and Missing Persons: Minorities in the Health Professions, by the Sullivan Commission have outlined the issues and presented a comprehensive roadmap to diversifying the healthcare workforce. Both reports showed that African Americans, Latinos, and American Indian/Alaskan Native make up 25% of population but only 9% nursing, 6% physicians, and 5% dentists. Minority representation within faculties of health professional schools is also low, comprising less than 10% of nursing faculty, 8% of dental school faculty, and only 4% of medical school faculty. In Massachusetts, despite having some of the nation's most highly ranked medical institutions, the situation is not much different. Recent data indicate that although Blacks, Latinos, and Native Americans make up 14 % of the population, they comprise only 3% of the physician workforce.^{xv}

As the Massachusetts population becomes more racially and ethnically diverse, health care providers increasingly serve patients who are racially, ethnically, and culturally different from themselves. The differences in the racial and ethnic make up of the population and the health care workforce presents unique challenges to ensuring consistent high quality health care for all populations. The Commission heard testimony supporting cultural competence training for all health providers, regardless of racial background to enhance provider knowledge, attitudes, and skills^{xvi} and cultural awareness, potentially essential skills for providing quality health care to a diverse patient populations.^{xvii}

Conceptual Policy Framework

Because racial and ethnic health disparities, and the dynamics that foster them, have existed for a long time, undoing these inequities will require significant commitment from multiple sources. Government agencies, private industry, organized healthcare including teaching hospitals, community health centers (CHCs), and community-based organizations acting independently will not alleviate this enormous problem. Instead, partnerships among these entities and others are required to build the necessary capacity and infrastructure to eliminate racial and ethnic health disparities.

It is critical, when considering health disparities broadly, to forthrightly address the role of racism. Health care providers are not immune from broader social forces and messages that reinforce and perpetuate biased care and outcomes. Policy efforts related to cultural competence, public health programs, and improvements in the health care system must do more than attempt to be race or ethnicity “neutral” or “sensitive”. They must be implemented with the understanding that all these efforts take place within

institutions that have been historically tolerant of racial bias. Segregation, redlining, patient dumping and discrimination have all left legacies to be overcome if we hope to eliminate health disparities.

A comprehensive policy approach is needed to move this issue forward. To be effective, such an approach must use a conceptual framework that is based on scientific evidence. It should include targeted interventions and a political strategy reflecting the realities of our contemporary social and political context.

RECOMMENDATIONS OF THE SPECIAL COMMISSION

I. ESTABLISH STATE CENTER FOR THE ELIMINATION OF HEALTH DISPARITIES

Given the broad range of factors that contribute to health disparities and the magnitude of the task of eliminating these disparities the Commission strongly recommends the establishment of a Center for the Elimination of Health Disparities at the state level. Such an office should engage with the community in an active way and oversee the implementation of the recommendations of the Commission in a sustained effort to eliminate health disparities.

The Center should have adequate resources and authority to monitor, assess and address the social determinants of disparities in health across executive branch departments, including barriers to health care services, quality of health care, and diversity in the healthcare workforce. It should be situated to allow for effective exercise of oversight and to allow sufficient independence. Functions of the Center include, but are not limited to the following:

A. Program and Policy Development, Implementation and Oversight

- Establish and coordinate the efforts of a working advisory group made up of representatives of key agencies and health disparities populations (similar to current commission but also add representatives from key domains, such as housing). The working group will work to maximize state resources, research, and technical assistance to ensure health disparities issues are evaluated and addressed in each of the agencies' jurisdiction and programs;
- Develop and implement a health disparities oversight process which will monitor, evaluate and report on the efforts of all state agencies.
- Coordinate with other state agencies to monitor data to ensure consistent and appropriate measurement of key health disparities indicators;
- Convene key stakeholders and obtain their commitment to addressing workforce development and diversity.

- Finance demonstration projects in geographic areas across the state to examine the effectiveness of interventions to decrease disparities in access to health care services. Initial demonstration projects should include an assessment of navigators, outreach workers, case managers, and/or health educators to improve access to care and the quality of care for health disparities populations.

B. Training and Technical Assistance

- Provide a health disparities training program for legislative and executive branch staff to ensure that committees regularly consider the impact of proposed policies on health disparities, especially when such policies fall outside the traditional realms of health care and public health.
- Raise public awareness through collaborative efforts with legislators, media, academia, and community advocacy groups.
- Coordinate with the accrediting and licensing bodies for health care in the state of Massachusetts to enforce the adherence of diversity related efforts.

C. Data Collection and Analysis

- Assess status of existing data collection efforts across state agencies regarding health disparities, discrimination, and environmental justice;
- Collect data and publish analyses, including report cards that measure and compare health care institutions' workforce diversity efforts and progress toward identifying and eliminating health care disparities.

D. Community Engagement

- Increase awareness of racial, ethnic and social disparities in health through public education campaigns;
- Establish regional outreach and partner with non-profit agencies, faith-based organizations, and grassroots organizations to provide education and implement new efforts;
- Engage the community through open dialogue and communication to participate in disparities elimination initiatives.

E. Evaluation

- The **Center for the Elimination of Health Disparities** shall oversee the evaluation of the effectiveness of disparities elimination initiatives. The Center will not necessarily perform these evaluations, but will be responsible for ensuring that evaluations are ongoing and results are incorporated in future initiatives.

II. EXPAND ACCESS TO QUALITY HEALTH CARE

Massachusetts has already passed landmark health care reform, which has the potential to decrease health disparities. Massachusetts state government and the private sector should collaborate to ensure that affordable, comprehensive health care services are available to racial and ethnic minorities in the Commonwealth.

Expand access to health insurance

- The Center should actively monitor the implementation of the health care reform law to ensure that all populations within the Commonwealth are experiencing the benefit of increased health care coverage. The Center will pay particular attention to the issues of affordability and quality of coverage to ensure that health insurance expansion is truly accessible to racial and ethnic minority populations.
- There should be a targeted outreach, enrollment and retention campaign aimed at racial and ethnic minorities eligible for MassHealth and the Connector insurance coverage products.

Expand access to quality services

- The Department of Public Health, in collaboration with health care institutions and insurers, should finance demonstration projects in multiple regions across the state to examine the effectiveness of strategies to decrease disparities.
- Expand access to public health and prevention. Public health and prevention initiatives should be targeted to populations most at-risk among racial and ethnic minorities. These initiatives should be accessible in diverse locations within the communities targeted. There are important differences within and among minority populations that must be considered as initiatives are developed, implemented and prioritized.
- Promote health education and health literacy through targeted and culturally sensitive approaches. Health education and literacy programs must be designed to provide information and skills that health care consumers can use to effectively advocate for high quality care.
- Uniform standards for delivering interpreter services are necessary in all health care settings. These standards should be modeled after the national standards developed through the National Council on Interpreting in Health Care.
- Develop and implement procedures for reimbursement for interpreter services by all payers, public and private. The Department of Public Health should review the procedures used in other states including the model programs in the states of Maine and Washington and make recommendations for implementing programs in Massachusetts.

III. IMPROVE WORKFORCE DEVELOPMENT AND DIVERSITY

- Convene a panel of experts to recommend basic knowledge and skills required for health care professionals to practice culturally competent health care and care that embodies behaviors, which support the elimination of health disparities.
- Require health care professionals licensing boards to develop regulations for ensuring that licensed health care professionals receive training and education in these basic knowledge and skills. Successful qualification, credentialing and licensure of health professionals should be linked to the demonstration of specific cultural competencies and understanding of health disparities.
- Encourage health professions schools to recruit, retain, and graduate students from racial and ethnic minority groups. These efforts should also include strategies to increase the pipeline of qualified students for graduate health training, as well as financial assistance and support.
- Develop grant incentive programs for state colleges and universities to work in partnership with public schools to increase nursing, medical and other health related professionals from diverse backgrounds.
- Encourage the Governor and legislature to insure diversity in appointments under the Health Care Reform Law.

IV. TRACKING AND IMPROVING QUALITY OF CARE

Health care organizations, local and state government and regulatory agencies should collaborate to monitor and improve the quality of health care delivered to racial and ethnic minority populations.

- Health care institutions, insurers and the Department of Public Health should routinely collect race, ethnicity, language and insurance status data. At a minimum, the race and ethnicity data should include the federal OMB categories. Data collection strategies should ensure that individuals have the opportunity to self-identify their race and ethnicity.
- Department of Public Health and other regulatory bodies should require that health care institutions, health plans and health insurers collect and report quality of care data by race and ethnicity, insurance status, language ability and educational attainment. These institutions should also develop strategies for addressing any disparities detected.

- The Department of Public Health should issue all reports of health outcomes stratified by race and ethnicity and socioeconomic status (such as educational level, income, and insurance status), age and gender.

V. PROMOTING SOCIAL CONDITIONS THAT ENHANCE HEALTH AND REDUCE DISPARITIES

The Commission acknowledges the substantial influence social factors that are outside the realm of health care have on generating and perpetuating racial and ethnic health disparities. Addressing the social determinants of health will require the engaged participation of policy makers across departments in the executive and legislative branches of state government.

- Require the Executive Office of Health and Human Services to provide an annual health disparities report card to the legislature on the current status and progress in reducing health disparities, including promotion of best practices and prioritized interventions and evaluation of the impact of state funded disparity initiatives. This should be coordinated through Center for the Elimination of Health Disparities.
- Require appropriate state agencies to track indicators of social determinants of health, such as the experience of discrimination in the multiple domains of daily life (employment, education, health care, housing recreation, financial lending,) etc.
- Provide funding for community-based prevention and health promotion programs that address environmental and societal factors demonstrated to influence health outcomes, such as targeted marketing and sale of legal and illegal products (alcohol, tobacco, fast food) in low-income and minority neighborhoods.
- Enhance environmental justice efforts to prevent disproportionate effects of environmental hazards on low-income and minority communities by requiring the inclusion of assessment of differential impacts on health in environmental impact statements. In addition, the Commonwealth should strengthen the Executive Office of Environmental Affairs' environmental justice initiatives by codifying its environmental justice policy as state law.
- Increase enforcement of existing anti-discrimination statutes (e.g., in housing, employment, education, health care, etc.) by the Attorney General and the Massachusetts Commission Against Discrimination.
- Encourage the Legislature to establish a statewide family economic self-sufficiency or living wage standard and have the state annually report on this standard for different regions.

- Tax credits for de-leading and pest extermination.

Conclusion

The Special Commission to End Racial and Ethnic Health Disparities represents a seminal moment in health and racial justice for Massachusetts. The Commission is the first concerted attempt to bring political will, policy expertise and scientific data to bear on a problem which harms the public health, burdens the state economy, and goes against the moral purpose of the Commonwealth. As such, we hope that it will serve as a model for other state-level and national initiatives.

The Commission found that the social determinants of health disparities are strikingly widespread and deeply embedded. There was an early consensus and firm commitment to move beyond the piecemeal and single-sector solutions. This will have a limited impact on addressing health disparities. The Commission calls for a state center for the elimination health disparities. The center will provide an opportunity for sustained and structured engagement across areas such as health care, housing, education, and the workplace.

This report, while significant, is neither the sole, nor most important, outcome of the Commission. The Commission's work has already led to a number of legislative advances, including critical components of the Health Reform Act of 2006. Furthermore, the Commission has developed and solidified a high level cadre of policy experts, political leaders and health care providers whose collaboration has already sparked a number of initiatives in the advocacy, policy, education, and public health arenas.

The Commission's work is not yet complete but has only just begun. Commission members who have put countless hours into addressing health disparities, both collectively and individually, must work to broaden and deepen partnerships and efforts to end health disparities. The General Court must act to provide the statutory and budgetary resources needed to promote integrated initiatives and programs. The Executive Branch must design and implement programs in a way that is cognizant of the disparities related implications. The private sector, both for-profit and non-profit, must strive to recognize the costs and forgone opportunities related to the perpetuation of disparities.

The members of the Commission hope that this report serves as both a first step and a call to action to those who would work towards a society where race and ethnicity is as irrelevant to health outcomes as eye color. This work will be a generational endeavor, but we strongly believe that the Commission has made a solid and historic step in this direction. We cannot ignore race in our economic, social, educational, health, and work arena.

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