IHP Kaiser Permanente Institute for Health Policy

Reducing Disparities: Goals, Roles, and Opportunities

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Roundtable Themes and Implications

By Kate Meyers
Kaiser Permanente Institute for Health Policy

A vast published literature documents the existence of disparities in health and health care in the United States. Today, many organizations seeking to reduce disparities are moving beyond documenting the problem to focusing on solutions. Most current nationally prominent initiatives to reduce disparities take place within health care systems and focus on specific conditions, populations, or care settings. Fewer efforts have been made to discern how public and private policy actors and decision-makers can work collectively to address the broader range of interacting factors that impact disparities – including but not limited to the health care system.

Kaiser Permanente's Institute for Health Policy, Kaiser Permanente Community Benefit, and The California Endowment saw an opportunity to bring together 30 experts on health disparities in September 2006 in San Francisco. This roundtable aimed to push the dialogue on health disparities beyond the usual boundaries of health systems and toward notions of multi-sectoral collaboration, stakeholder engagement, and developing policy solutions to address the broad range of underlying influences on health.

Participants and Format

The roundtable included health care providers and insurers as well as participants from federal and state government, foundations, research and policy organizations, advocacy groups, and organized labor.

The meeting was structured as a facilitated discussion focusing on:

- The social and historical context impacting health disparities, with the goal of understanding how trends and conditions affect success;
- A vision of success for 2020, and what intermediate conditions are needed to get there;
- Specific policy/action steps for the near term;
- What participating organizations might do to contribute to these steps;
- Who is missing from the dialogue;
- What steps are most important for progress.

The themes and implications summarized here reflect many of the ideas that were discussed, but they are not intended to represent a consensus of roundtable participants' viewpoints.

Lessons from the Past

An acknowledgment and understanding of the contribution of past events, policies, and initiatives to the current state of health disparities is critical to future progress. The social and historical context of health disparities is broad by nature, given the range of influences on health. Roundtable participants explored this context by developing a timeline of events, trends, and circumstances that have influenced both the existence of health disparities in the United States and attention to the problem. By better understanding how policy and society have both contributed to and ameliorated health disparities, and what conditions enabled or slowed these changes, new efforts to reduce disparities might avoid past pitfalls and build on past successes. Some themes and key conditions for success emerged from the timeline.

1. Activities or conditions that impact health disparities (positively or negatively) are not constant or consistent over time; they ebb and flow. Today's reality of health disparities has origins in an extensive history of economic, legislative, social, cultural, and political events, movements, and environments. This history includes circumstances affecting all aspects of health equality in our society, such as: the legacies of slavery and the Tuskegee Syphilis Study; the civil rights movement, the federal Civil Rights Act, and the integration of hospitals; expansion of health care access through Medicaid, Medicare, and the Economic Opportunity Act, which began the community health center movement; immigration control policies; social movements focused on the rights of minorities, women, and farm workers; actions enabling concentration of school funding in wealthy districts; trends in illegal drug use and crime; and welfare reform.
2. The myriad ways in which public and private policies and socio-cultural movements have influenced health disparities underscores the necessity for a broad set of stakeholders to address the issue from a variety of angles and approaches. In addition, specific leaders – individuals, organizations, collaborative movements – have in the past and can in the future raise the prominence of an issue to catalyze action and significant progress. Conversely, leaders can also stand in the way of such action.
3. Events or trends that contribute to health disparities take place concurrently with events that may reduce disparities. Activities stemming from one sector or affecting one "level" of public or private policy are not necessarily accompanied by complementary actions from other sectors or levels. In addition, events or policies may provoke countervailing actions. This underscores the need for multifaceted, long-term approaches to reducing disparities (such as efforts to improve individual socioeconomic status, to make communities safer, and to improve access to high-quality health care services) from multiple sectors, actors, and levels of influence.
4. While most current disparities-specific work focuses on the health care system, there are growing numbers of actions and trends in other sectors that are not explicitly aimed at reducing disparities but in fact may do so. Increasingly, such actions focus on environmental influences on health, such as legislation to reduce junk food in schools and regulations to add fruits and vegetables to the WIC (Women, Infants, and Children) food package. The emergence and strengthening of this perspective points to a changing, broader framework for health.
5. Some participants noted that success includes not only steps forward, but avoiding steps backward. They cited rejection of efforts to limit growth in Medicaid spending by capping the federal contribution as an example of a success based on what did not happen. Reflection on such "near misses" is needed to understand what messages helped deter potentially negative outcomes and what similar circumstances are likely to arise in the future.

While specific events, such as legislation, have contributed to health disparities in the United States, many broad societal trends have played a more significant role. Although such trends may be more difficult to address than individual actions or events, doing so is essential to understand why health disparities exist – and persist – and what must be done to eliminate them. Roundtable participants raised examples of such trends:

- A general sense of public apathy towards, disconnection from, and lack of awareness and urgency around health disparities, including two major contributors to disparities, concentrated poverty and lack of access to high-quality health care.
- Increasing "medicalization" of many health problems, compounded by the health care industry's focus on technological solutions rather than underlying social problems. For example, medication management of type 2 diabetes often replaces counseling on achieving good nutrition and adequate physical activity.
- Lack of consistent focus on disparities as a core part of the health care industry's improvement efforts. While equity is one of the Institute of Medicine's six aims for quality improvement in the health care system, it often does not receive the same focused, methodical attention as the other five quality aims.
- Inadequate support for efforts to improve diversity and cultural competency of the health care workforce, reflected in limited outreach programs and disparities-related curricula.
- Severe competition for resources in an era of war and resistance to new taxes.
- The belief held by many that an emphasis on personal responsibility is likely to be more effective than governmental action in addressing health disparities and related problems. However, the intractable nature of such problems suggests a different balance is needed.

Vision for the Future

Reflecting on the multi-faceted nature of this historical context, it is clear that future success in reducing (and ultimately eliminating) health disparities will be achieved only through action along a number of paths, by a variety of stakeholders and using a variety of methods. Participants explored the desired future state by discussing the question, "Where do we want to be in 2020?" to understand better where collective action should lead. Four major themes emerged.

1. ***By 2020, a broad set of actors across the spectrum of influences on health will be actively engaged, partnering across formerly "siloed" sectors to achieve the common goal of health equity.***

This will be characterized by:

- A shared understanding and sense of accountability for health disparities as a societal problem – not the problem of a few groups – across multiple sectors and ideologies.
- An understanding of the social determinants of health and the factors that produce inequality, supported by a landmark report summarizing the impact of social determinants and implications for policy. A model could be the United Kingdom's Acheson Report, the result of a government-commissioned independent inquiry into health inequities that summarized the evidence and trends of inequalities in health and identified priority areas for policy development based on "scientific and expert evidence."[1]
- An understanding of the impact of all policy decisions on health, including routine use of Health Impact Assessments, defined as, "a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population."[2]
- Explicit funding and infrastructure to focus and propel national, state, and community-based activity to address disparities, possibly through a federal "National Health Equity Act."

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[1]*Independent inquiry into inequalities in health. London: The Stationery Office, 1998. Available at http://www.archive.official documents.co.uk/document/doh/ih/ih.htm (accessed November 9, 2006).*
[2]*European Centre for Health Policy, WHO Regional Office for Europe. Gothenburg Consensus Paper. Health impact assessment: main concepts and suggested approach. Brussels: WHO, 1999. Available at http://www.who.dk/document/PAE/Gothenburgpaper.pdf (accessed November 9, 2006).*

2. ***By 2020, all Americans will have access to high-quality, patient-centered, culturally appropriate health care for prevention and treatment of illness.***

This will be characterized by:

- Universal coverage for or access to a core set of health care services.
- Routine measurement of quality of care stratified by race/ethnicity and language to understand and address deficiencies and inequities.
- Training of medical/health professionals under established curriculum standards and with defined expectations and measures for providers.
- Trends toward proportionality in the medical workforce flowing from initiatives in elementary schools through colleges that increase the pipeline of nurses, doctors, and other health professionals from diverse backgrounds.

3. ***By 2020, a number of historically underserved communities across the United States will have improved physical, environmental, cultural, and health care factors that impact health, providing models for community-based action to reduce disparities.***

This will be characterized by:

- Implementation of tools and strategies for health care insurers and delivery systems to partner with communities, including robust demonstration projects to identify and address key problems.
- Implementation of a variety of neighborhood-based collaborative interventions focusing on upstream and downstream factors affecting health in communities, reversing past polarization of different populations and making collaboration for community health the norm.
- Achievement of a high level of civic engagement across the country as individuals get involved in identifying and developing solutions for vexing community health problems.

4. ***By 2020, the socioeconomic status of historically disadvantaged groups will be improved compared with 2006.***

This will be characterized by:

- Increasing income equality between racial/ethnic groups.
- High proportions (90% or more) of students from all racial, ethnic, and income backgrounds graduating from high school.

Getting from 2006 to 2020: Policy Opportunities

With an understanding of what success in reducing disparities could look like, roundtable participants voiced a variety of policy opportunities for the near term that would contribute to reaching this vision. Four of these opportunities were prioritized for more focused discussion. While the specifics of these particular policy opportunities are of interest, perhaps most significant is that all four emphasize the need to broaden the framework of influences on disparities and the actors needed to impact the problem. The focus on disparities must shift beyond the limited boundaries of the health care system, to coordinating and bridging work across a great variety of roles and organizations in order to achieve sustained, significant improvement.

1. ***Bridge silos of work that impact health and integrate concerns about health inequities into the broader health policy dialogue.***

This policy opportunity addresses the fact that the issue of health disparities is seen as a niche or special interest, not as an issue that affects and is affected by many aspects of public and private policy. Roundtable participants recognized that the problem of health disparities – as currently framed – is far down the priority list for many health policy leaders in this country. Accordingly, success will require reframing the issue to engage a broader constituency and incite action.

Putting disparities on the radar screen will require a combination of top-down and bottom-up approaches, including developing resonant, relevant public messages and engaging effective leaders to galvanize action and support. The aim would be to help public and private actors recognize the relevance of disparities to the whole population, not just people of color or of lower socioeconomic status, and the need to take action. One aspect would include making the "business case" for reducing disparities by connecting improved health status to national economic productivity and competitiveness. Another aspect would emphasize the ethical and moral imperative of giving all Americans an equal opportunity for health.

Employers and organized labor would be natural constituents to begin increasing action and support to reduce disparities. Because both of these groups pay for health care services, they have a vested interest in ensuring their entire population receives high-quality care for their money. Other natural allies include civil rights organizations that may currently be only peripherally focused on health disparities. Further outreach could be aimed at organizations that do not usually view themselves as responsible for or related to health disparities, such as education, law enforcement, urban planning, and community economic development organizations. To jumpstart this process, Congress could commission the Institute of Medicine or another influential entity to pull together the body of research on the broad determinants of health that lie beyond the health care system to help clarify the roles of these other sectors.

2. ***Develop partnerships between health plans, local government entities, and communities to identify neighborhoods with lower health status and intervene to improve relevant non-medical determinants of health.***

This policy opportunity would entail a place-based focus to improve the health of individuals and communities. The health plan/local government/community partnership would use data from GIS (Geographic Information Systems) mapping tools, health care delivery systems, the Census Bureau, and information from communities themselves to identify areas with the greatest health needs. The partnership would then evaluate the status of underlying social determinants of health in those communities, and would identify non-medical interventions that could support prevention and improved health. The health plans would then work with local government and community groups to plan and fund interventions to address those needs where possible.

3. ***Develop healthy neighborhoods through local interventions and partnerships based on community members' self-identified priorities.***

This opportunity focuses on the role of communities and local governments in improving the physical, cultural, and economic environments of communities. After getting feedback from community members regarding the most pressing needs, local government would target funding and activity to improve neighborhoods. Areas of focus could include affordable housing, support for adequate transportation, well-tended parks, availability of healthy foods, school quality issues, and the local economy. This need not imply a large commitment of new dollars; it might require different use of current dollars and/or attention to relatively low-cost problems with a large impact on safety or quality of life (such as replacing broken streetlights or cleaning up graffiti). The overall goal is to create a broader, multidisciplinary view of health and to take concrete, visible steps toward transformation of a neighborhood or community to improve the health and well-being of residents. The Neighborhood Transformation Initiative in Philadelphia is a possible model.

4. ***Create state commissions to coordinate and develop public/private policies to reduce health disparities.***

This policy opportunity would entail creating large-scale, multi-sectoral partnerships on a state-by-state basis, including business, labor, patient groups, health care leaders, and government leaders. Such state-based commissions would connect public and private resources

and stakeholders to reach a common goal of reducing health inequities in the state. The commissions would capitalize and build on existing political will by bringing new stakeholders into the process, developing common priorities, and identifying policy vehicles to make changes. Each state would have a distinct, self-determined focus and set of initiatives. A national "program office" would convene state-based groups; provide visibility, technical support, and a focal point for lessons learned; lead the evaluation process; and ensure networking and exchange of information between states. The commissions would serve as bridges to local communities and venues for dialogue about community engagement and action – not as barriers to community-level change.

This option would provide a unique opportunity for states to learn from one another about existing successful models so states would not need to start from scratch. The state as a "unit of measure" would be big enough for changes to make a notable difference in the population and to serve as national policy examples, yet small and nimble enough to be practical, specific, responsive, and relevant.

Moving Forward

Conversations between individuals and organizations with diverse perspectives and roles about a highly complex and emerging field can raise more questions than they answer, and this roundtable was no exception. Such dialogue has the potential to influence thinking as individuals contemplate how their piece of work fits into the larger puzzle. Several viewpoints and themes emerged repeatedly during the session and should be considered by all organizations seeking to advance the cause of eliminating health disparities:

- Efforts to reduce health disparities must include – but should not be limited to – activity within the health care system.
- "The choir" must develop a more compelling, more broadly resonant rhetoric around disparities.
- Connections with existing efforts such as health care quality improvement and health reform must be pursued.
- New allies should be engaged to integrate thinking on health disparities in many different sectors of public and private policy.

Roundtable Participants

Anthony Barrueta, JD
Kaiser Permanente

Judith Bell, MPA
PolicyLink

Diana Bonta, RN, DrPH
Kaiser Permanente

Arthur Chen, MD
Alameda Alliance for Health

Rachel Davis, MSW
Prevention Institute

Tekisha Everette, MPA
Service Employees International Union

Alicia Fernandez, MD
UCSF/San Francisco General Hospital

Patricia Hassett, MA
Aetna

Katherine Haynes Sanstad, MBA
Kaiser Permanente

Cindy Hupke, RN, BS, MBA
Institute for Healthcare Improvement

Cara James, PhD
Kaiser Family Foundation

Carole Johnson, MA
Alliance of Community Health Plans

Grantland Johnson
Sacramento Central Labor Council, AFL-CIO

Hemi Kim
Asian & Pacific Islander American Health Forum

Lawrence Kushi, ScD
Division of Research, Kaiser Permanente

Kala Ladenheim, PhD, MSPH
National Conference of State Legislatures

Leandris Liburd, PhD, MPH, MA
Centers for Disease Control and Prevention

Nicole Lurie, MD, MSPH
RAND Corporation

Kate Meyers, MPP
Kaiser Permanente

Faith Mitchell, PhD
Institute of Medicine

Robin Mockenhaupt, PhD
The Robert Wood Johnson Foundation

R. Mauricio Palacio, MSHEd
Colorado Department of Public Health & Environment

Alonzo Plough, PhD
The California Endowment

Murray Ross, PhD
Kaiser Permanente

Marion Standish, JD
The California Endowment

Charles Terrell, EdD
Association of American Medical Colleges

Winston Wong, MD, MS
Kaiser Permanente

Matthew Wynia, MD, MPH
American Medical Association

Facilitator

Beth Goldberg, MPPM, MPH
Organizational Consultant

Staff

Amalia Martino
Kaiser Permanente