

Beyond Equal Care: How Health Systems Can Impact Racial and Ethnic Health Disparities

By Kate Meyers, MPP

Much has been written on the existence of racial and ethnic differences in health status and health care access and quality in the US. Researchers, think tanks, government entities, and advocacy organizations have worked to summarize many of the root causes, environmental and behavioral influences, and health system factors that play a role. Yet sustained and significant change has been elusive.

Many of the initiatives and efforts aimed at reducing health disparities have focused on the role of the health care system. In this context, potential solutions usually include approaches such as cultural competency training, access to linguistically appropriate care, expansion of insurance coverage, and support for consistent delivery of known best care practices to all patients.

However, factors outside traditional health care delivery—including community-based social determinants of health such as environmental pollution, job opportunities, education, income, and support for healthy lifestyles—play an equally if not more important role in disparities. Whereas at first blush it may seem that these factors are beyond the purview of health care organizations, there are in fact many ways in which they can influence—for better or for worse—these factors. Although equal care is a critical goal, if health care organizations' efforts to reduce disparities focus only on this goal, they will have limited impact on reducing overall differences in health status and outcomes.

What Are Health Disparities?

A voluminous literature, including the landmark 2003 Institute of Medicine report, "Unequal Treatment,"¹ documents the existence of disparities between whites and nonwhites in many different measures of health care access, quality, health status, and outcomes. Despite this attention, consensus is lacking on the definition, existence, or extent of the problem, let alone the causes and potential solutions.

Health disparities are generally described as differences in health care processes or health outcomes between different groups,^{2,3} but more specific criteria sometimes include whether those differences are avoidable or un-

just.⁴ Population groups are often defined by race and ethnicity, but can also be based on socioeconomic status (SES), sex, age, language preference, country of origin, or other characteristics. Some researchers describe SES (usually characterized by education, income, occupation, and/or wealth) as the most important determinant of racial and ethnic health disparities,⁵⁻⁸ and some have found that health differences between socioeconomic groups are often greater than differences between racial groups.^{6,9-11} At the same time, the majority of studies find that measured disparities between races are reduced but not eliminated after controlling for SES.¹ Whether disparities are an issue of race or of socioeconomic status is a false choice—there are disparities by race; there are disparities by SES; and these factors are intertwined but also likely play distinct, independent roles.

While the term "disparities" is frequently used in the US, many European countries refer to "inequities," a term that places greater emphasis on issues of morality and fairness. Though debate over the use of the term continues, this paper uses "disparities" for consistency with the bulk of work in the US.

Reducing Disparities: Influences and Arenas for Action

Disparities in health status and health care have been well documented, but solutions for reducing them are less clear. One reason is that the landscape of influences on health disparities is complex. The adapted version of the "ecological model"¹² presented here provides a framework for understanding that landscape, showing how individuals exist within, influence, and are influenced by their surrounding networks and environments (Figure 1). The model highlights the following key arenas for policy action, each with ample research connecting it to health:¹³

1. **Individual socioeconomic circumstances**—such as education, income, wealth, and occupation
2. **Physical and cultural community environment**—such as pollution, the built environment, public safety, access to services that support health, and social capital

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- 3. **Personal management of health**—such as health behaviors, resources, and beliefs
- 4. **Health care financing and delivery**—such as geographic location of services, insurance status and type, provider payment rates, linguistic and cultural competency, provider bias, and adherence to known care standards.

A broad variety of actors have roles to play in addressing each of the four arenas. Because the first three arenas sit outside of traditional health care boundaries, health systems and providers may naturally gravitate toward addressing issues in Arena 4, health care financing and delivery. While there are critical equity deficiencies in the delivery of health care that do need to be addressed, health systems and providers also have important roles to play in impacting socioeconomic circumstances (Arena 1), the physical environment (Arena 2), and their patients' personal management of health (Arena 3) through their roles as employers, educators, community members, and health leaders. Health care delivery organizations, health insurers, and individual clinicians must move beyond current thinking that attention to health disparities means focusing only on care processes that patients do (or do not) receive and into a broader perspective on how their actions and decisions impact health more generally.

Investing in Communities

Health care organizations and providers have clear potential to impact health disparities beyond the usual realm of care processes by investing in the communities they serve. Such investment can take many forms, including providing insurance dues subsidies for low-income community members; providing no-cost screening and treatment services through specialized health fairs or clinics; developing community health worker programs that bring health education to the community and provide meaningful volunteer or job opportunities to the health workers themselves; supporting and partnering with local safety net institutions; and providing longer-term investments in communities to address their most pressing health needs. Some examples of how Kaiser Permanente (KP) has approached these investments follow:

- For more than a decade, KP has partnered with community health centers to “improve the quality and cost-effectiveness of care, to help build effective clinic management infrastructure, and to collaborate on projects that reduce health disparities and promote a community-based system of disease prevention and management.”¹⁴ These safety net partnerships are being strengthened by more recent work with local health departments and public hospitals. Current areas of support include investment

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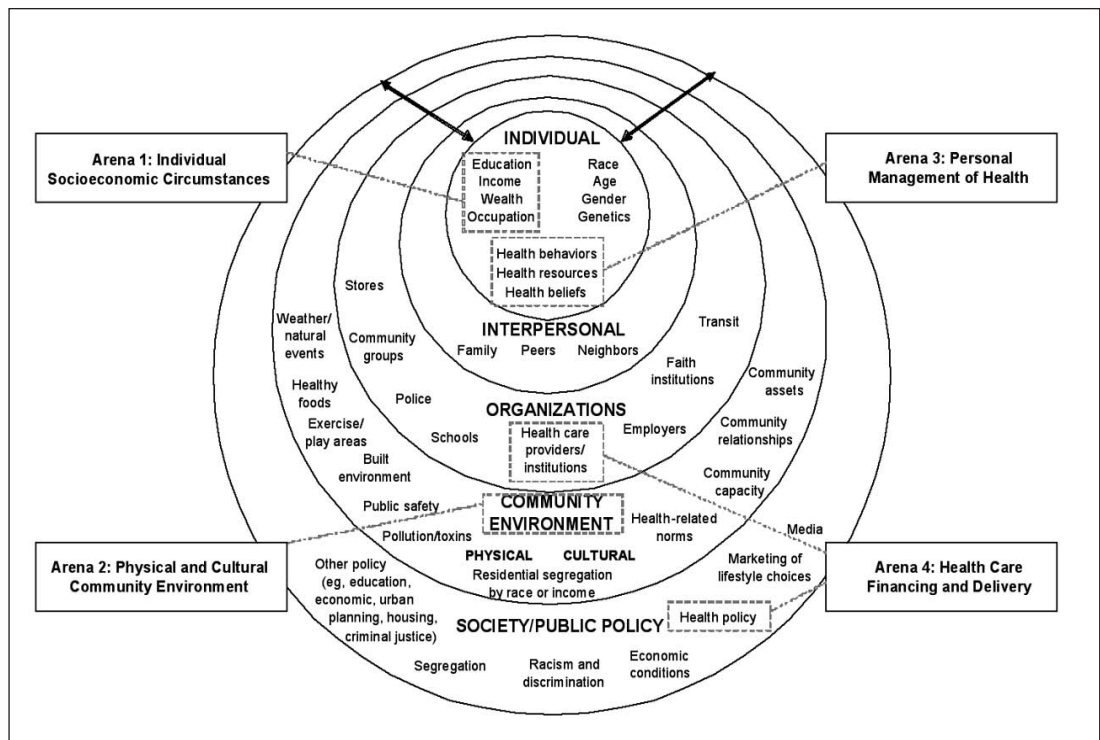


Figure 1: Landscape of influences on health disparities and arenas for policy action.

in health information technology; implementation of evidence-based treatment protocols for common chronic conditions; enabling KP physicians to deliver care and technical assistance in safety net settings; and connecting safety net health care teams to training in quality improvement processes through the Institute for Healthcare Improvement.¹⁵

- KP is developing Community Health Initiatives (CHIs) across its eight regions “by linking an evidence-based and prevention-oriented approach to medicine with community activism and proven public health interventions.” The focus of these CHIs is “Healthy Eating/Active Living” (HEAL) and the various health issues that can result from poor nutrition and inactivity. Some areas of emphasis within the CHIs are: focusing on small, defined geographic areas, working for change at multiple levels (eg, individuals, schools, workplaces, environment, policy); focusing on racial and ethnic disparities; committing to long-term partnerships (seven- to ten-year timeframe); and leveraging assets and strengths of the communities.¹⁶

Building Healthy Places

Despite advances in telemedicine, e-mail access to clinicians, and home care, the vast majority of health care delivery takes place within health care facilities such as hospitals, physicians’ offices or clinics, and nursing homes. The continued dominance of “bricks and mortar” in health care means that opportunities abound to use more environmentally friendly practices in the materials and processes used in these medical and administrative facilities.

As capital investment in renovating and building health care facilities has increased in recent years, opportunities to use more environmentally friendly construction and design choices have grown. The *Green Guide for Health Care*, an educational resource for sustainable planning, design, construction, operations and maintenance of health care facilities, has helped provide health care systems with the tools they need to improve the health and impact of their buildings and practices.¹⁷ In recognition of some of the field’s “early adopters” and innovators, National Geographic’s *The Green Guide* newsletter has recognized America’s top green hospitals based on 12 criteria: **siting** (locating facilities with consideration of impact on transportation, redevelopment, the surrounding environment); **water efficiency** (including landscaping, water use reduction, and waste water use); **energy use and air pollution**; **materials and resources** (using recycled or local building materials); **indoor environmental quality** (including ventilation,

use of toxics, and lighting); **healthy hospital food** (fresh, local, and organic options); **green education** (staff training); **procurement** (efficient and green products); **contaminants** (reducing toxins); **green cleaning** (use of cleaning products that do not release hazardous chemicals); **waste reduction**; and **healing gardens** (gardens, green roofs, low-water landscaping).¹⁸ These criteria demonstrate the variety of ways in which the decisions of health care providers impact their patients, the communities where they exist, and larger environmental and conservation concerns.

KP has been one of the leaders in such efforts to build healthier hospitals, medical office buildings, and administrative offices. The vision of its Environmental Stewardship initiative is, “to provide health care services in a manner that protects and enhances the environment and the health of communities now and for future generations.”¹⁹ To fulfill this vision, KP has focused on programs across the spectrum of environmentally responsible purchasing, green building, sustainable operations, chemical policies, and healthy foods. Some examples follow:

- For several years KP has been working to eliminate use of PVC (polyvinyl chloride) in its hospitals, due to the carcinogens created both in the production and incineration of this chemical. One major source of PVC is the backing used in carpeting, so when KP set out in 2002 to find PVC-free carpeting for its facilities, it used its purchasing power to encourage carpet manufacturers to pay attention to the contents of their carpets and how waste was disposed.²⁰ The national contracts were awarded to the vendor who was most responsive to KP’s inquiries and requests, which ultimately led to the creation of PVC-free carpeting that is now being used across KP’s facilities.²¹
- KP Colorado received the 2006 National Environmental Leadership award from Hospitals for a Healthy Environment for its work related to recycling, energy and water efficiency, reducing waste, and reducing the use of hazardous chemicals. Between 2002 and 2006, KP Colorado recycled more than 25,000 mercury-containing florescent lamps; recycled more than 1900 tons of paper and cardboard and 52 tons of plastic, and decreased the use and disposal of photo-processing chemicals by 70% by converting radiology to digital imaging in almost all cases.²²
- Starting with a pilot program in 1990, KP has implemented the use of reusable plastic totes instead of disposable cardboard boxes for distribution of medical supplies from its central supply ware-

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houses to each hospital and medical office building. Because cardboard and other paper materials make up almost half of a typical hospital's solid waste, KP's efforts to decrease the use of cardboard and minimizing the use of packing supplies (by having several sizes of plastic totes available) can serve as a model for similar programs in other health systems.²³

- In KP's renovation and construction of hospitals and medical office buildings, it is pilot testing innovative designs such as permeable paving and "green" roofs; reducing water use through landscaping design and use of urinals and toilets with lower water use; choosing nontoxic or less toxic building materials and cleaning products, and researching hazardous chemicals and working with vendors to identify suitable, safer alternatives.²⁴
- KP is also working to improve air quality in its communities by using more environmentally friendly fuels. For example, KP Northern California is in the process of switching from regular diesel fuel to biodiesel fuel (made from vegetable oil) for many of its supply transportation and courier trucks, aiming to reduce fossil-fuel emissions and air pollution. In addition, KP is now specifying cleaner thermal fluid boilers for its new facilities rather than smaller, more polluting "California specials" that have been a mainstay of the low-pressure boiler world for years.

These and other efforts to reduce air pollution, conserve resources, and reduce waste can provide broad benefit to the community and the environment. They

also have the potential to help reduce health disparities related to physical environmental factors such as pollution, toxins, or other harmful substances in the air and water, as people of color more have a much higher likelihood of living and working around such harmful substances compared to whites.²⁵ As health care organizations and providers conduct capital expansions and renovations, attention to the negative impact on their immediate (and the more global) environment and efforts to reduce that impact are important ways they can approach health disparities reduction beyond the financing and delivery of care itself.

Making it Easier to Eat Right

Media attention regarding what Americans eat and how that contributes to today's high rates of obesity is at an all-time high. Access to healthy foods clearly impacts health, and differences in access by race make this an important factor in health disparities. The greater prevalence of fast food outlets and liquor stores and lower prevalence of healthy food outlets in predominantly nonwhite or low-income neighborhoods have been documented repeatedly,²⁶ and are logical factors in greater overweight and obesity in those communities.

These differences in access to healthy foods can be addressed in part by actions and policies of health care organizations. For example:

- Since 2003, KP has established about 30 weekly farmers' markets at its hospitals and medical office buildings across the country.²⁷ As described by sponsor KP

Reaching Beyond the Clinic Walls to Address Obesity

By Jon Stewart, Health Policy Editor

Kaiser Permanente's (KP's) historic mission to serve not only its members, but the communities in which those members live, means that the organization has always looked for ways to reach beyond the medical setting and beyond clinical care to promote healthier communities. That has often meant working in the community to address health disparities related to minorities and socioeconomic status.

In Northern California, KP's Community Benefit program, for instance, is investing more than \$6 million to promote changes in public policy and community infrastructure related to the epidemic of childhood obesity in three lower-income, heavily minority communities in the Region. They include the predominantly Latino agricultural community of Modesto; the

heavily African-American city of Richmond, in the Bay Area; and the mainly Latino neighborhoods of south Santa Rosa. Called the Healthy Eating Active Living Community Health Initiative (HEAL-CHI), these five-year, \$1.5 million grants (plus additional funds for evaluation) are focused on promoting changes in four critical sectors in each community: schools, neighborhoods, workplaces, and health care.

Dana Williamson, KP project manager for the Santa Rosa grant, explains that the HEAL-CHI grants are specifically aimed at encouraging long-term, sustainable, and community-based strategies that go far beyond "merely educating people that they should eat more fruits and vegetables." To qualify for the grants, she says, community collaboratives were expected to

develop strategies to "make sure that those types of foods are available, affordable, and accessible in the communities. Similarly, it's not enough to tell people they have to get more exercise. Projects have to make sure that there are places in their community that provide and allow for safe physical activity."

The Santa Rosa collaborative provides a good example of how communities are taking advantage of the grants in this first year of funding. Led by the Community Activity and Nutrition Coalition of Sonoma County and the Prevention and Planning Division of Sonoma County Department of Health Services, the collaborative has developed a detailed action plan that targets specific activities in all four sectors throughout the south fringe of the city,

Community Benefit, the markets were "... developed in collaboration with local health departments and community-based organizations ... to improve access to fresh, local foods for members, employees, and communities, and to provide a venue for health education and social marketing."²⁸

- KP has also focused on improving the health profile of food served in its facilities to patients, to employees, and to visitors, through catering, cafeterias, and vending machines. In addition to simply making more healthy options available and to revamping recipes to make them healthier, KP is piloting programs to serve more fresh, locally grown fruits and vegetables in its facilities. In Northern California, this focuses on small farms run primarily by ethnic minorities.²⁹

By helping to improve access to healthy foods—for patients, for employees, and for surrounding communities—health care organizations can help impact one of the critical aspects of personal management of health (Arena 2 in the model presented here).

Additional Opportunities

Although it is beyond the scope of this paper to explore in depth several other important opportunities for health care organizations to help reduce health disparities through the "nonhealth care arenas," they do warrant consideration. These include: employee wellness programs that encourage and support healthy behaviors and appropriate health-seeking behaviors; employee development programs that enable staff to learn new skills,

attain higher educational degrees, and potentially earn higher incomes in the future; and investing in internship or mentoring programs for students of color to help them learn about careers in the health fields.

Take-Aways

The complex nature of disparities means paying attention to only one policy arena is insufficient. Long-term solutions demand action to address factors in all of these arenas. The potential policy actors who could act to impact these arenas represent a broad swath of organizations and individuals, many of whom are already committed to working to address disparities—but who may have greater opportunities to address arenas currently seen as peripheral or beyond their scope.

Continued progress in the elimination of racial and ethnic disparities in health and health care will require integrated, interdisciplinary action from the affected communities and from the vast variety of organizations whose policies and actions impact their health and well-being. As health care organizations examine their current or future strategies, consideration of how they can positively impact the broad landscape of influences on disparities is essential to accomplish sustained, significant change. ❖

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which is a checkerboard of incorporated and unincorporated neighborhoods, most of which have major infrastructure gaps.

Already, funds have been allocated for two community garden projects and hiring a consultant to work with local restaurants and other food outlets to increase the availability of healthy food options. Project staff are also working with local residents on a "Photovoice" project—a social action strategy imported from China. Residents are given cameras and sent out to photograph what's working and what's not working in their communities, in terms of physical activity and access to healthy foods. They then share their pictures of things like streets with no sidewalks or crosswalks and stop signs, bike and pedestrian paths with poor or no lighting, and the shelves

of local mom-and-pop stores stocked with little more than canned goods, junk food, and alcohol. They pick several photos that they agree illustrate the most pressing needs, which they use as advocacy and communication tools in meetings with community leaders.

The project is also working in 11 local schools to implement nutrition and physical activity programs, including adding salad bars in five schools, starting three school garden programs, and training teachers to incorporate physical activity into their classroom curriculums. Worksite projects include working with two major employers in the area to pilot a worksite wellness program, and working with restaurants near major worksites to improve their menu choices. In the health care sector, the focus will be on

educating community physicians about BMI screening and training in communicating with families about obesity.

Anthony Taylor, a project coordinator with the Santa Rosa collaborative, says the involved residents there have already learned something important about how to maximize the impact of the KP grants. "We've discovered that there are a lot of people out there who are trying to do some of the same things we're doing, but for different reasons. They want more parks, they want community gardens, they want to fix the infrastructure. But they may be approaching these issues from very different directions and for different reasons—crime, personal security, recreation. But the end result is still the same—healthier communities." ❖

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Resources

- Kaiser Permanente Institute for Health Policy: www.kpihp.org/issueareas/improving/disparities.html
- Kaiser Family Foundation: www.kff.org/minorityhealth/disparities.cfm
- The Commonwealth Fund: www.cmwf.org/topics/topics.htm?attrib_id=12024
- Joint Center Health Policy Institute: www.jointcenter.org/new_site/index.htm
- RAND Center for Population Health and Health Disparities: www.rand.org/health/centers/pophealth/index.html
- PolicyLink: www.policylink.org/HealthAndPlace/default.html
- Prevention Institute: www.preventioninstitute.org/healthdis.html