In 2009, the Joint Center for Political and Economic Studies ("Joint Center") released a report that made a compelling business case for equity in health services: Health equity saves money. The Joint Center found that between 2003 and 2006, the combined costs of health inequality and premature death in the U.S. were $1.2 trillion. Eliminating health disparities for minorities would have slashed direct medical care spending by nearly $230 billion in that same period.

Although the Joint Center report promoted concerted action to reduce health disparities, state and local health officials still bear the burden of gaining support for health equity initiatives, says Brian Smedley, director of the Joint Center’s Health Policy Institute.

“We need to build the case at the local level of the costs of not moving ahead on health equity,” Smedley says. “Particularly in communities of color, we need to demonstrate the health consequences of everything from lack of quality food choices to environmental pollution and inadequate green space for recreation. Then we need to show that interventions to address such problems yield benefits. All this takes time.”

In a tough economy, when it can be especially difficult to gain political traction for new spending programs generally, public health officials and their staff need to ask themselves if they have the essential tools to articulate the need for health equity strategies, says Sharon Moffatt, MSN, chief of Health Promotion & Disease Prevention at the Association of State and Territorial Health Officials (ASTHO). In her view, those tools should include:

- Solid data on the impact of unequal health services on racial and ethnic minorities, such as high rates of infant mortality, cancer, diabetes, and other health problems. Ideally, the data would drill down to the community or even neighborhood level.
- Building support for action and leveraging resources through strong partnerships with community leaders, businesses, healthcare providers, and insurers.
- Champions willing to take the health equity message before government officials, legislators, and other key decision makers.

To ensure that limited resources are used effectively for health equity initiatives, health department staff also need to research evidence-based programs in areas they are targeting, adds Meenoo Mishra, ASTHO’s senior analyst for Health Equity. One important resource she cites is the Guide to Community Preventive Services, which contains recommendations on evidence-based interventions by a CDC-supported task force.

“With the demand for greater accountability to legislatures, it is especially important for those health equity strategies to carefully consider from the very start the kinds of evaluation techniques they’ll use,” says Mishra. “It shouldn’t be an afterthought.”

Both Mishra and Moffatt emphasize the continuing need to get successful, evidence-based health equity programs reviewed in health professional publications so others can learn from these interventions.
Nadine Gracia, MD, acting director of the federal HHS Office of Minority Health (OMH), points out that state health departments currently face a tough fiscal climate that requires increased collaboration across the public and private sectors to promote effective equity programs. To encourage collaborations, HHS launched the National Partnership for Action to End Health Disparities in April 2011. Among its chief goals:

- Increase awareness of health disparities and their impact on the nation.
- Strengthen and broaden leadership for addressing health disparities.
- Improve healthcare outcomes for underserved populations.
- Build cultural competence and diversity in health professions.
- Enhance data collection, research, and evaluation of health equity programs.

As part of this action plan, the OMH spearheaded a National Stakeholder Strategy, which provides a blueprint for eliminating disparities through cooperative action. Input for this strategy came from a national summit of nearly 2,000 leaders, regional conversations, and focused stakeholder meetings throughout the country.

“The action plan represents the most comprehensive federal commitment to date on the reduction of health disparities,” says Gracia, who also emphasizes the importance of the Affordable Care Act (ACA) in bolstering health equity efforts. According to Gracia, the ACA has already allocated $730 million to community health centers nationwide, which are vital to those who can’t afford healthcare.

The ACA also mandates that all HHS population health surveys must now collect data on ethnicity, sex, primary language, and disability status—valuable information for those planning targeted interventions to reduce disparities.

In the states: Partnerships for progress

In state governments, health department offices charged with promoting health equity go by many names and vary in size, sometimes having only a single staffer or up to as many as 20. Regardless of their differences, the key to their long-term success is the ability to forge partnerships, says Antoniette Holt, director of the OMH in the Indiana State Department of Health and current board president of the National Association of Offices of Minority Health. Holt believes that new local health equity councils established by the National Partnership for Action in all 10 HHS regions could further strengthen these partnerships.

“The idea of the local councils is to ensure that we address the issue of health equity from the ground up, not from the top down,” explains Holt. “So you have involvement not just from health officials and providers, but from community leaders and businesses, all working together to decide what is best for that region. And there is representation from at least one staff OMH in every one of these councils.”

Holt also says it is both necessary and cost-effective to emphasize the importance of including a health equity component throughout state health department programs, such as those dealing with chronic disease prevention, emergency preparedness, or maternal and child health. “Offices of Minority Health
are making progress in ensuring that more resources within state health departments are being earmarked for reducing health disparities,” says Holt. “But it takes planning. You don’t decide to translate disaster plan literature after a tragedy happens.”

In the spirit of addressing the social determinants of health, many experts agree that state health departments need to do more to influence other sectors within government, such as housing, transportation, and economic development. “That would be a very effective strategy in reducing health disparities,” says Paula Braveman, MD, MPH, director of the Center on Social Disparities in Health at the University of California at San Francisco. “But this can be an uphill battle, because of the silo mentality that often exists within state government. If people are healthier because of a greater supply of safe, affordable housing, will the housing department get credit for it?”

Braveman contends that the barriers to health equity in the U.S. are primarily political and ideological. In her view, the United States falls behind Western Europe in fulfilling a social contract to help those in need. “Sometimes, it just costs more to do the right thing,” she observes.

Still, there is evidence that state health departments are developing a raft of creative solutions to advance the cause of health equity, despite limited resources. The six case studies found in this report provide a glimpse at the many approaches being tried nationwide. To cite just a few examples of collaborative efforts involving state health departments:

- The Maryland Community Health Resources Commission, a quasi-independent body within the Department of Health and Mental Hygiene, helps support 16 federally-funded community health centers, as well as free clinics that serve as the safety net for low-income individuals. Its funds come from insurance premiums paid to nonprofit insurance carrier CareFirst, a unit of Blue Cross Blue Shield. The state also plans to launch Health Enterprise Zones, allowing community organizations to apply for funds to improve health in areas shown to have high rates of chronic disease or inadequate access to care.

- Alaska’s Department of Health and Social Services teams with the Alaska Mental Health Trust Authority on a variety of programs, including “Bring the Kids Home,” which focuses on early detection and treatment of mental illness in children and adolescents in community settings, rather than in distant institutions. The Trust is financed from sales and leases of Alaska’s rich land, timber, and mineral resources.

- Since 2001, the Minnesota Department of Health has administered an Eliminating Health Disparities Initiative (EHDI) to fund community grants in eight priority areas: infant mortality, adult and child immunizations, breast and cervical cancer, HIV/AIDS and sexually transmitted diseases, diabetes, cardiovascular disease, unintentional injuries and violence, and teen pregnancy. Grant applicants must research other state and community efforts to avoid duplication and to leverage resources. For example, UCare, a nonprofit health plan for people enrolled in government healthcare programs, awards supplementary grants to EHDI projects.
Oregon is undergoing a massive overhaul of the healthcare system that could reduce spending by more than $3 billion over the next five years. Relying on community-based coordinated care organizations, the new plan primarily targets about 600,000 people who receive Medicaid benefits. Healthcare equity was well-represented in the authorizing legislation for the new system, which includes a growing role for culturally competent community health workers.

Texas and Louisiana have authorized their state health departments to administer aggressive new programs to reduce infant mortality and premature births—health concerns that occur much more frequently in the minority population. These programs promote healthier birth outcomes and curb soaring Medicaid costs by working closely with a wide range of stakeholders, including businesses, insurers, hospitals, and doctors.

Beyond these examples, many states are moving ahead resolutely to establish new insurance exchanges, as mandated by the ACA, which collectively could make affordable health insurance available to some 30 million uninsured Americans. The U.S. Supreme Court ruling on the constitutionality of the ACA’s mandate that all Americans must buy health insurance signifies a significant change in our nation’s approach to healthcare. Health experts believe that the wheels of a national health reform movement will continue to turn as a result of a rising demand for better healthcare at more reasonable costs for a wider swath of the population. In more states, traditionally underserved minority populations are growing at a much faster rate than that of whites, making preventive care a major priority.

“The health reform movement in the United States provides a continuing opportunity for our country to recognize the inequities that still exist in the distribution of health services,” says Moffatt of ASTHO. “We have the opportunity to focus especially on access to healthcare, promotion of healthier lifestyles, and the importance of early screening. All these measures combine to prevent diseases that can erode the quality of life for millions and add to soaring medical costs.”

Learn more about the economic issues surrounding health equity:

The Economic Burdens of Health Inequality in the United States
http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf

The Guide to Community Preventive Services
http://www.thecommunityguide.org/index.html

HHS Action Plan to Reduce Racial and Ethnic Disparities

National Stakeholder Strategy for Achieving Health Equity
http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

CDC Morbidity and Mortality Report (Jan. 2011)
http://www.cdc.gov/mmwr/pdf/other/su6001.pdf
Health Reform at the Crossroads