Health Policy, Health Disparities, and Immigrant Health: There is More to Health Than Health Care

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Immigrant Health Care

Immigrants to the United States have always been essential to the country's growth, health, and economic well-being.

How Do Immigrants receive Health Care?

- The majority of Naturalized citizens have employer or other private insurance
- Although non-citizens are as likely as citizens to work, non-citizens are often in jobs and industries that do not offer insurance coverage
- Safety-Net providers-clinics and health centers

Source: Henry J Kaiser Family Foundation Commission on Medicaid & The Uninsured

Immigrant Health Needs

- Access to Services
- Payment Issues
- Clinical Guidelines

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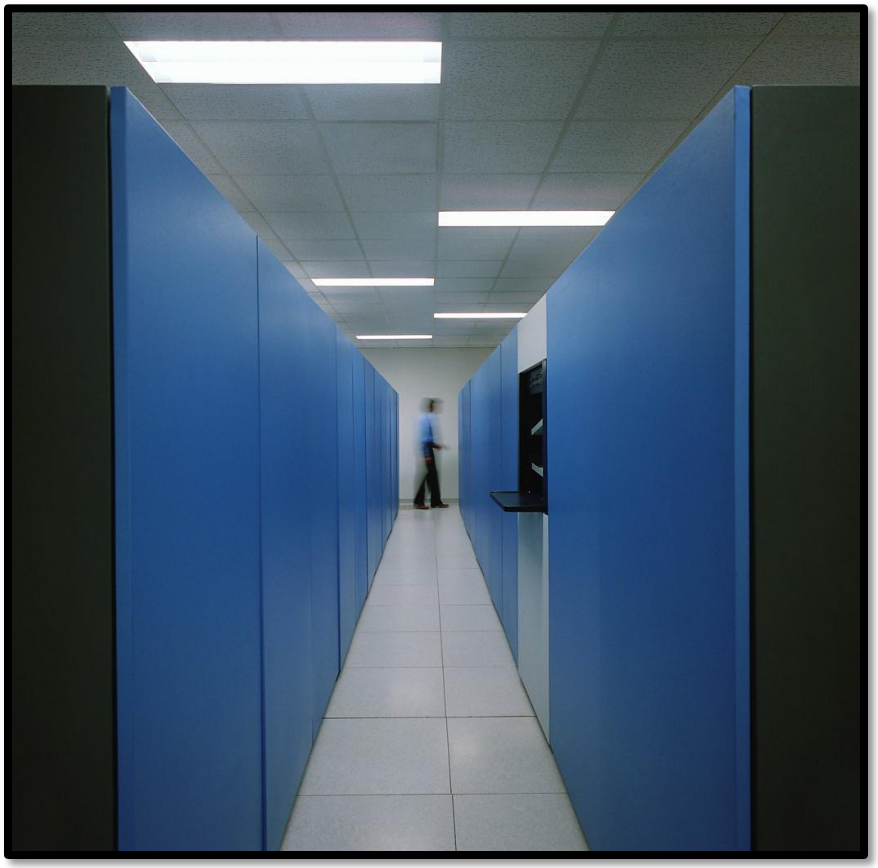
Data Needs



- Current Data on Immigrant Health is Inadequate

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Health Care Spending

- The U.S. spends more than any other nation in the world on health care-in 2009 we spent 2.5 trillion

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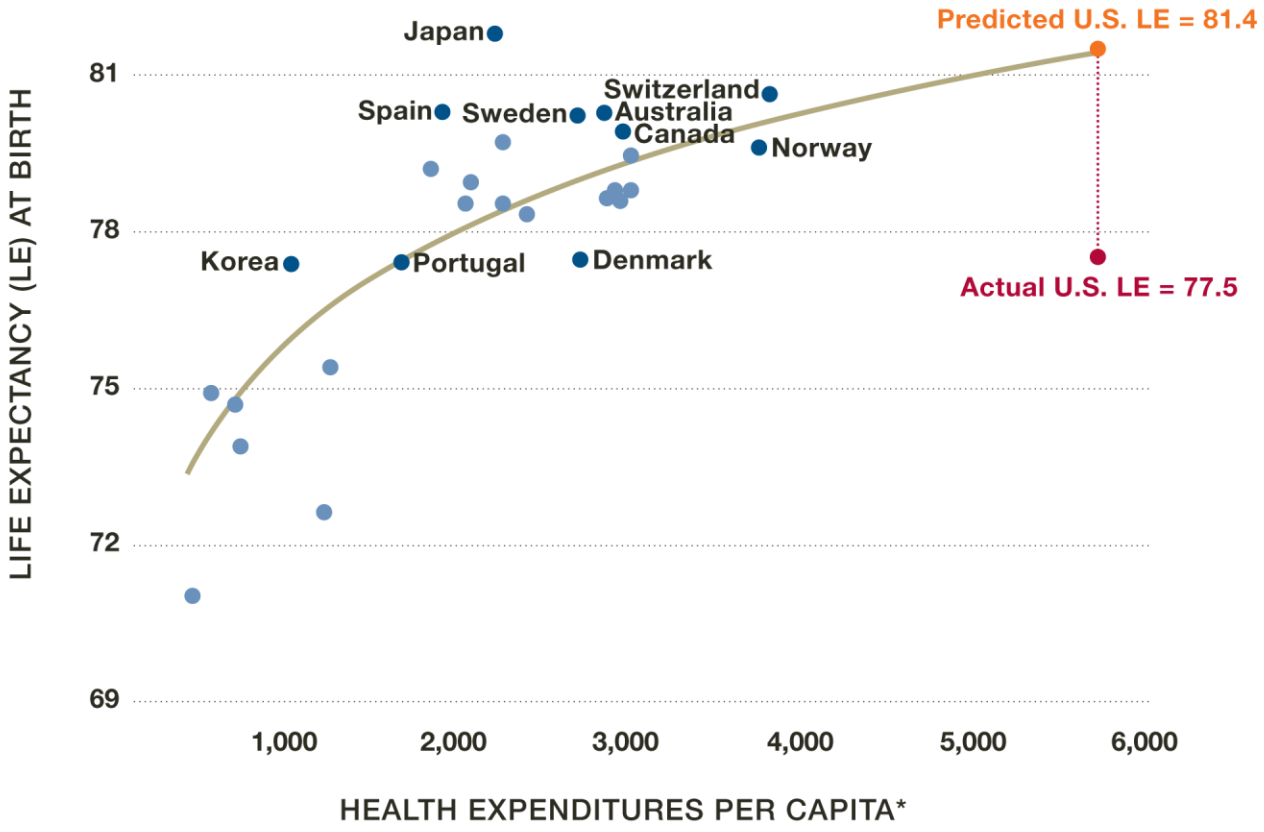
America Is Not Getting Good Value for Its Health Dollar

The U.S. spends more money per person on health than any other country, but our lives are shorter—by nearly four years—than expected based on health expenditures.



Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Sources: OECD Health Data 2007.
Does not include countries with populations smaller than 500,000. Data are for 2003.
*Per capita health expenditures in 2003 U.S. dollars, purchasing power parity

www.commissiononhealth.org

Losing Ground in Health: Life Expectancy

In 1980, the U.S. ranked 14th among industrialized countries in life expectancy (LE) at birth. By 2003, we had slipped to 23rd place.

1980	Rank	2003
LE = 76.7 Iceland	1	Japan LE = 81.8
Switzerland	2	Iceland
Japan	3	Spain
Netherlands	4	Switzerland
Norway	5	Australia
Sweden	6	Sweden
Spain	7	Italy
Canada	8	Canada
Australia	9	Norway
Greece	10	France
Denmark	11	New Zealand
France	12	Austria
Italy	13	Netherlands
LE = 73.7 United States	14	Finland
Belgium	15	United Kingdom
Finland	16	Germany
New Zealand	17	Luxembourg
United Kingdom	18	Belgium
Germany	19	Greece
Ireland	20	Ireland
Austria	21	Portugal
Luxembourg	22	Denmark
Portugal	23	United States LE = 77.2
Slovak Republic	24	Korea
Czech Republic	25	Czech Republic
Poland	26	Mexico
Hungary	27	Poland
Mexico	28	Slovak Republic
Korea	29	Hungary
Turkey	30	Turkey

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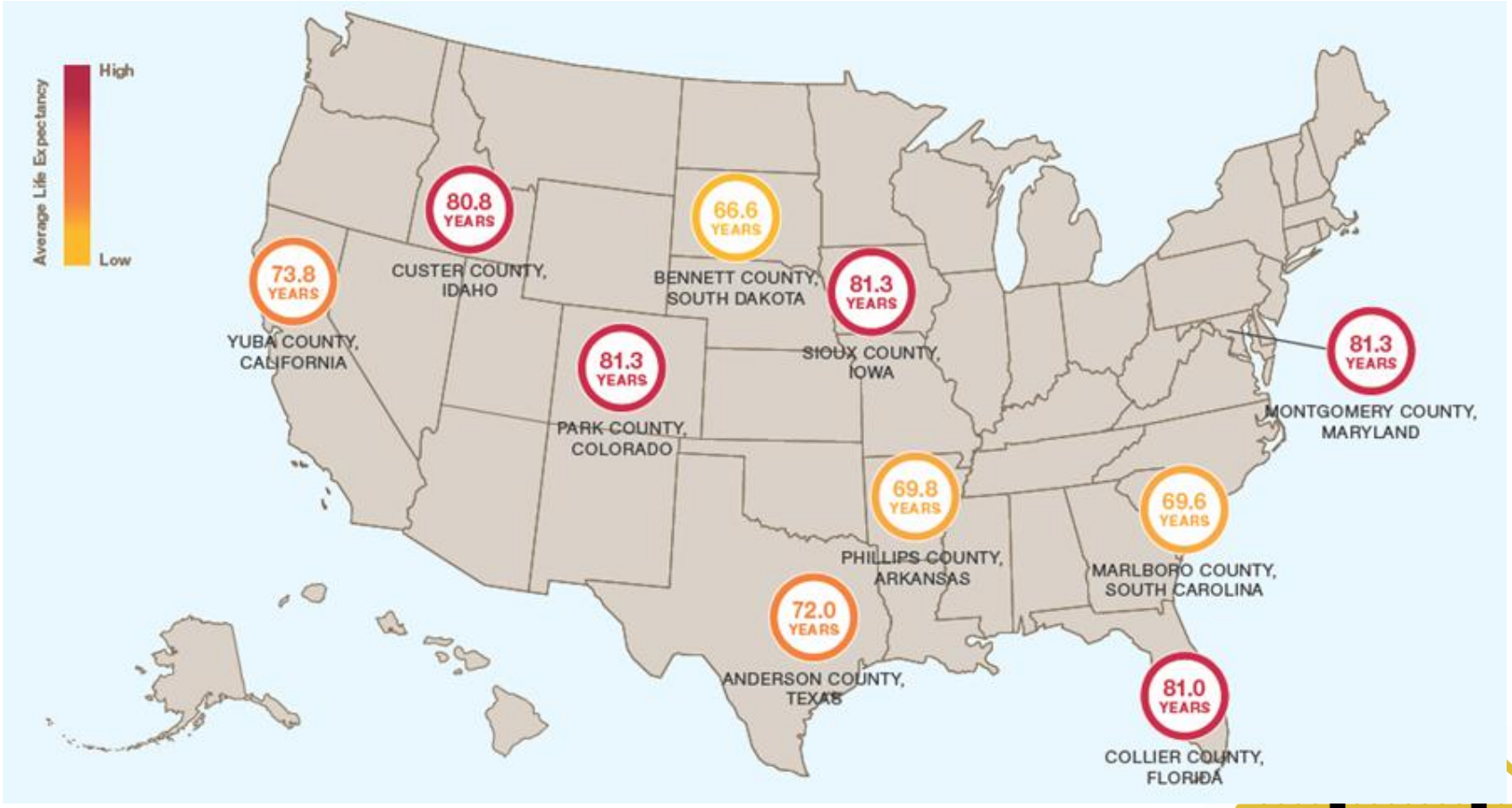
Source: OECD Health Data 2007.

www.commissiononhealth.org

Robert Wood Johnson Foundation Commission to Build A Healthier America

Across America, Differences in How Long and How Well We Live



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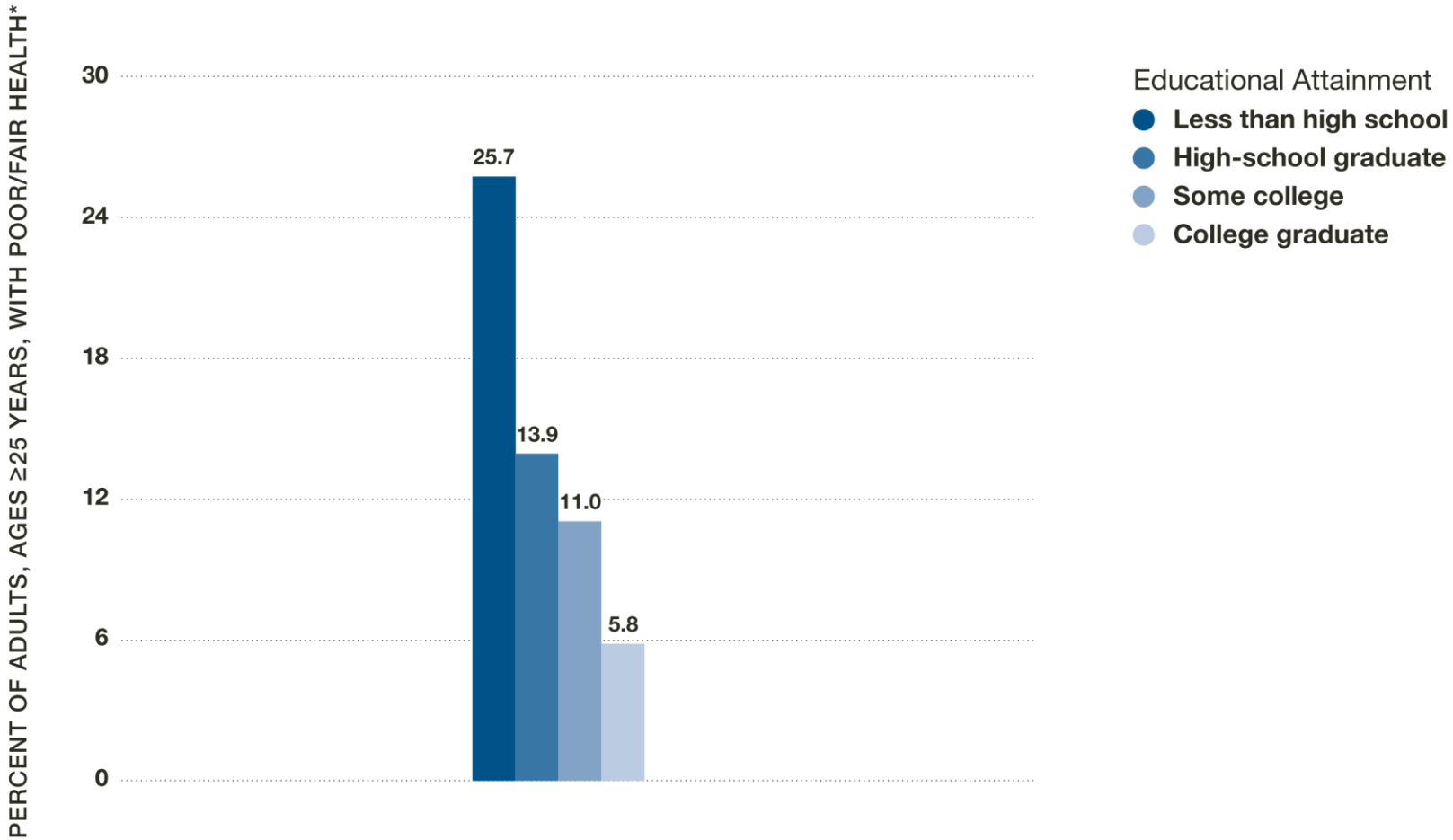
Health Disparities

- The socioeconomic circumstances of persons and the places where they live and work strongly influence their health. In the United States, as elsewhere, the risk for mortality, morbidity, unhealthy behaviors, reduced access to health care, and poor quality of care increases with decreasing socioeconomic circumstances

Less Education, Worse Health

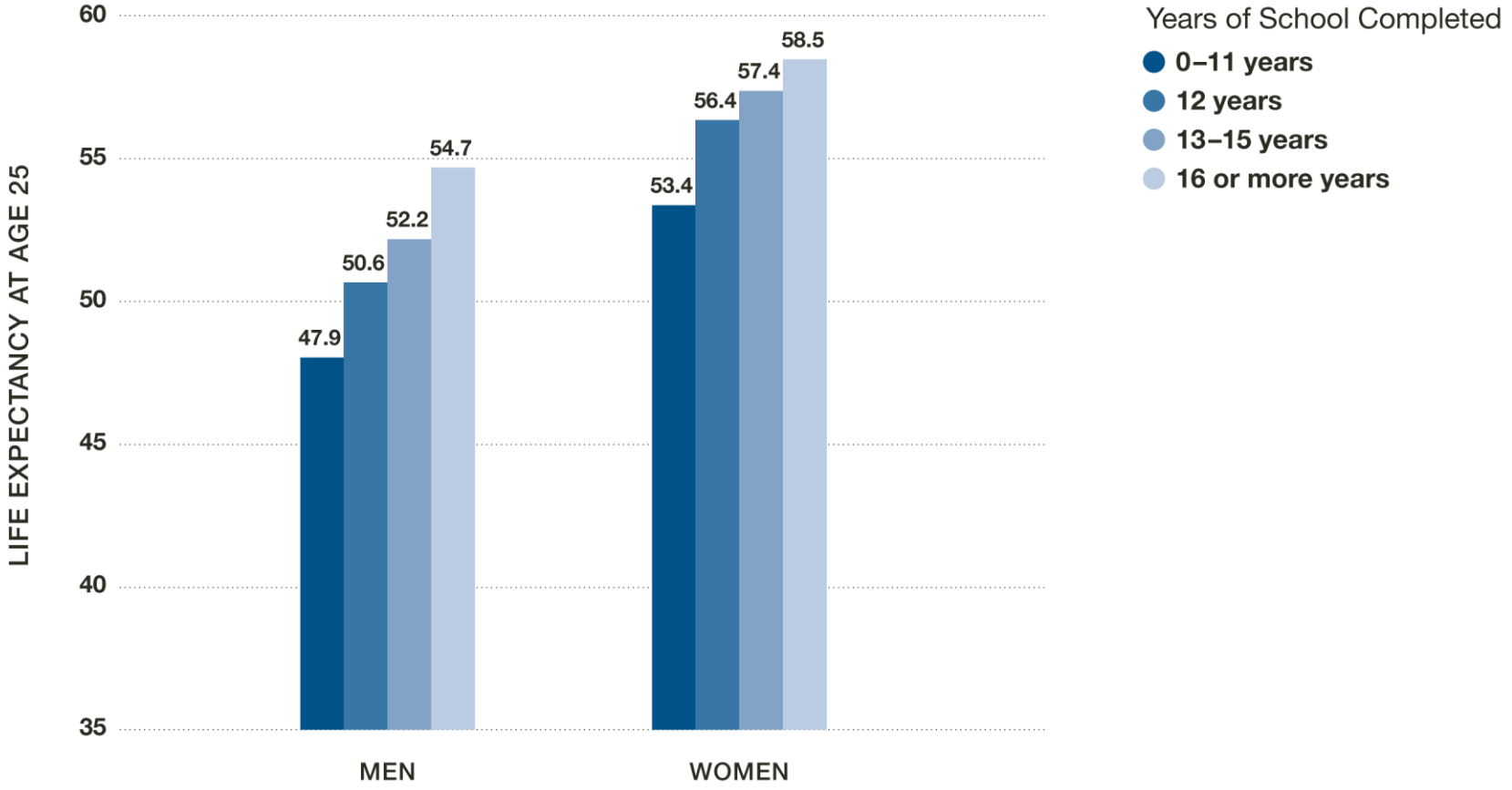
Less education is linked with worse health. Compared with college graduates, adults who have not finished high school are more than four times as likely to be in poor or fair health.



Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: National Health Interview Survey, 2001–2005.
*Age-adjusted

More Education, Longer Life

For both men and women, more education often means longer life.*
College graduates can expect to live at least five years longer than individuals who have not finished high school.



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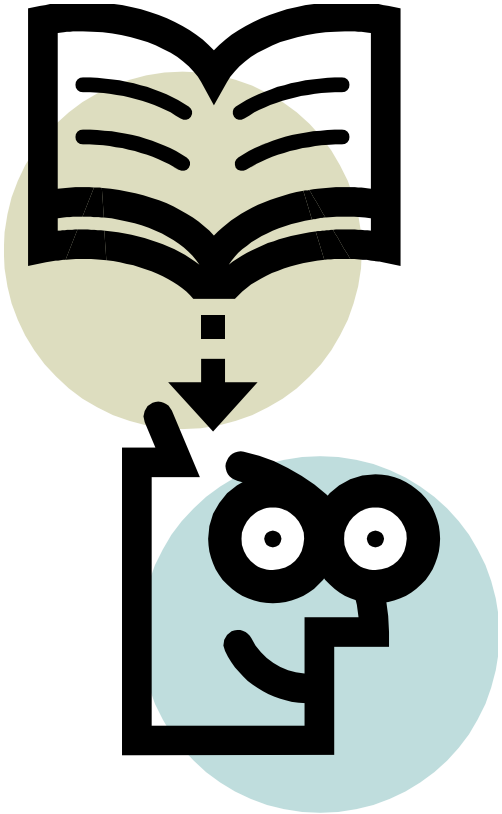
*This chart describes the number of years that adults in different education groups can expect to live *beyond age 25*. For example, a 25-year-old man with 12 years of schooling can expect to live 50.6 more years and reach an age of 75.6 years.

Source: National Longitudinal Mortality Study, 1988–1998.

Education Can Shape Health Behaviors

- Health Knowledge
- Health Literacy
- Capacity to problem solve
- Coping skills



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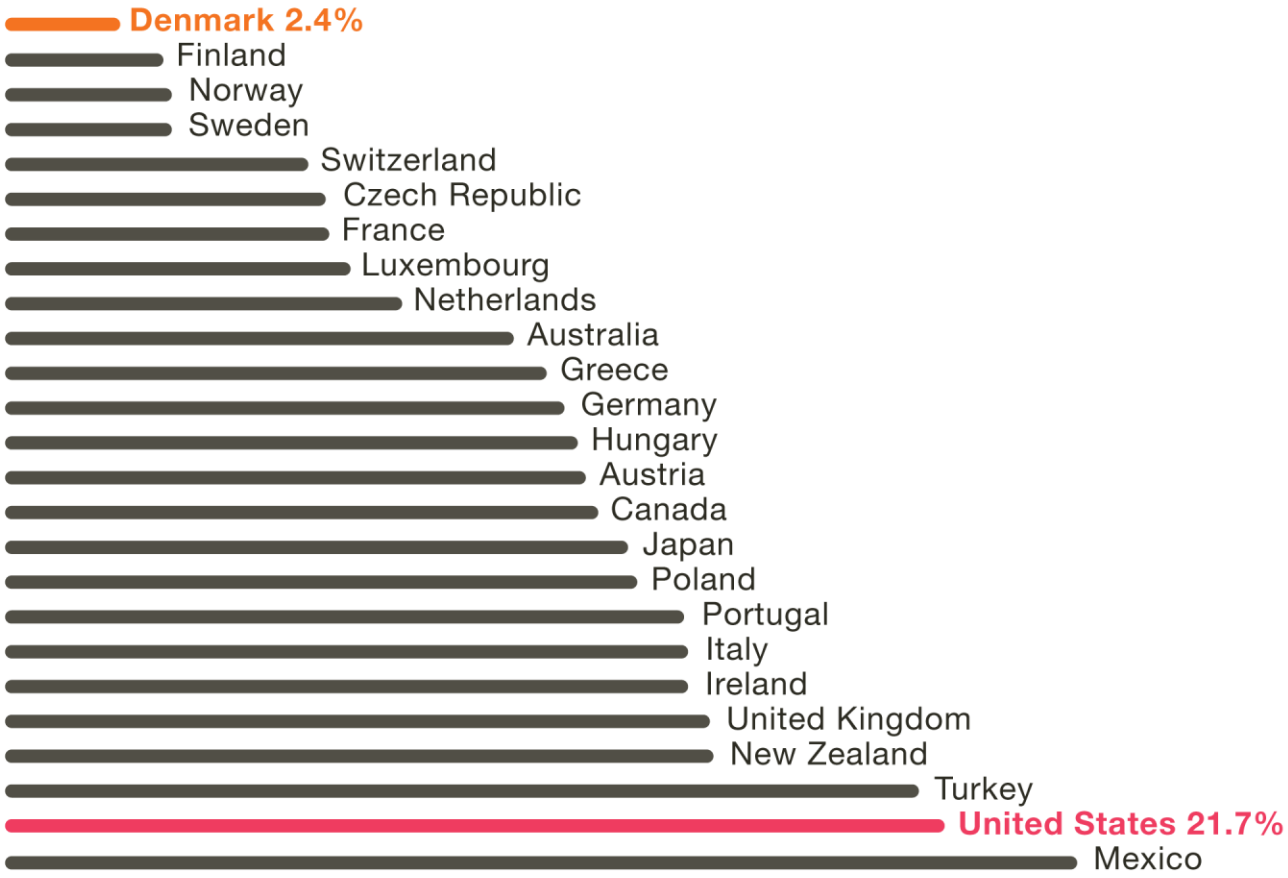
More Child Poverty in America

The U.S. has higher rates of child poverty* than many other countries. In 2000, one-fifth of American children were poor—a proportion that was nine times higher than in Denmark.



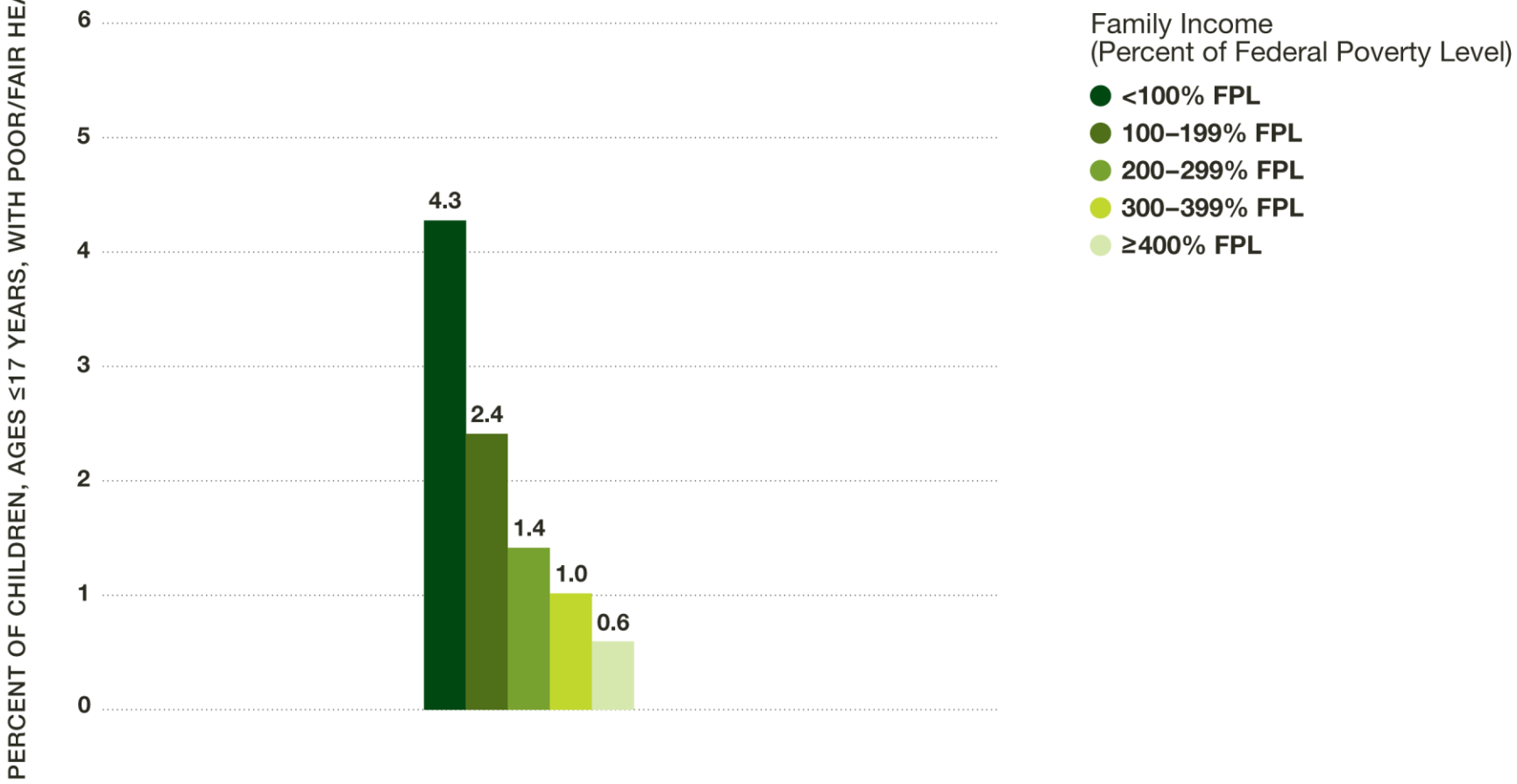
Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.

*Percent of children 17 years and younger living in households with equivalised disposable income less than 50 percent of median income.

Source: Förster M and Mira d'Ercole M. *Income Distribution and Poverty in OECD Countries in the Second Half of the 1990s*. OECD Social, Employment and Migration Working Papers, No. 22. Paris: OECD Publishing, 2005.

Parents' Income, A Child's Chances for Health

Children in poor families are about seven times as likely to be in poor or fair health as children in the highest-income families.



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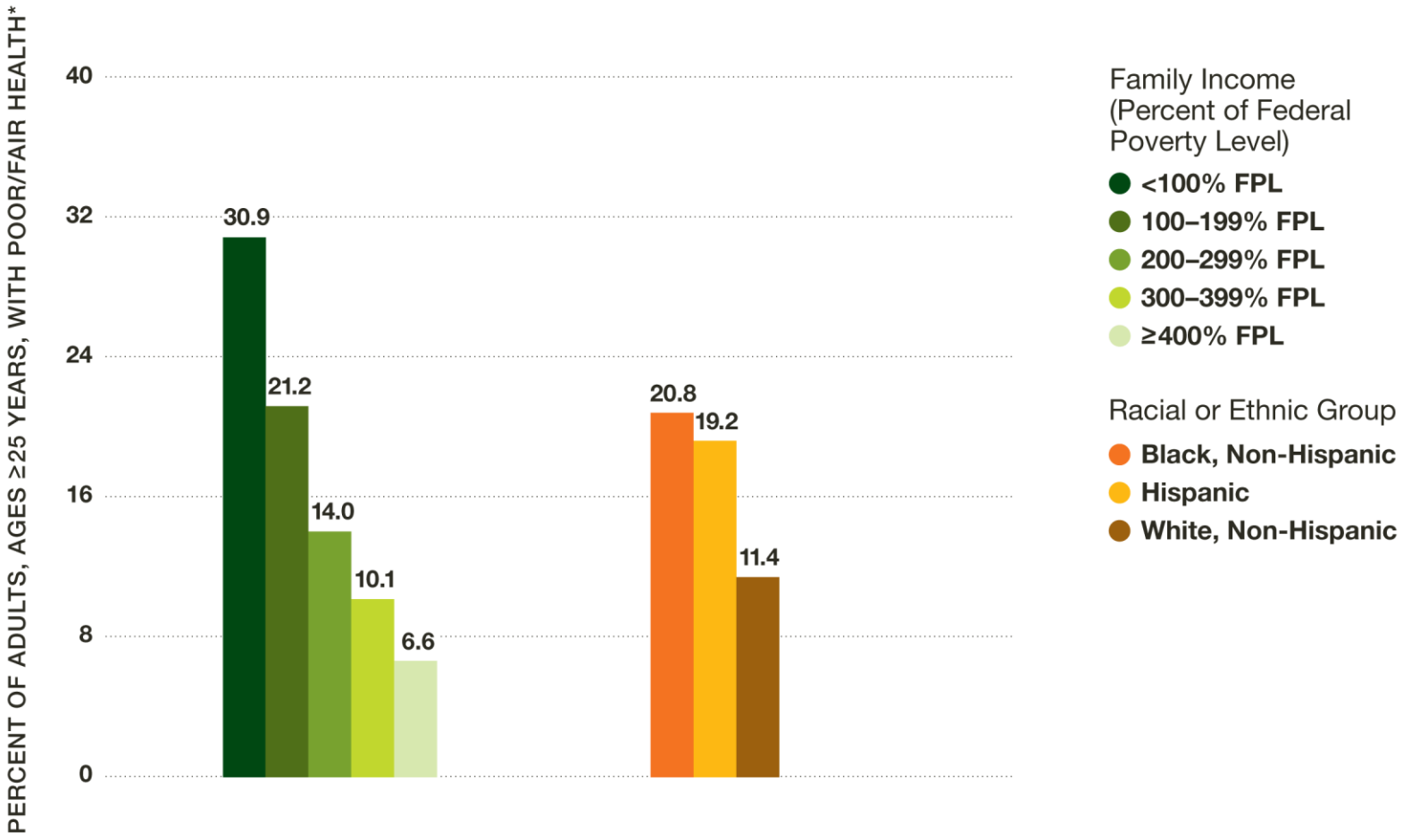
Source: National Health Interview Survey, 2001–2005.

*Age-adjusted

Health Varies by Income and Across Racial or Ethnic Groups

Lower income generally means worse health. Racial or ethnic differences in health status are also evident: Poor or fair health is much more common among black and Hispanic adults than among white adults.



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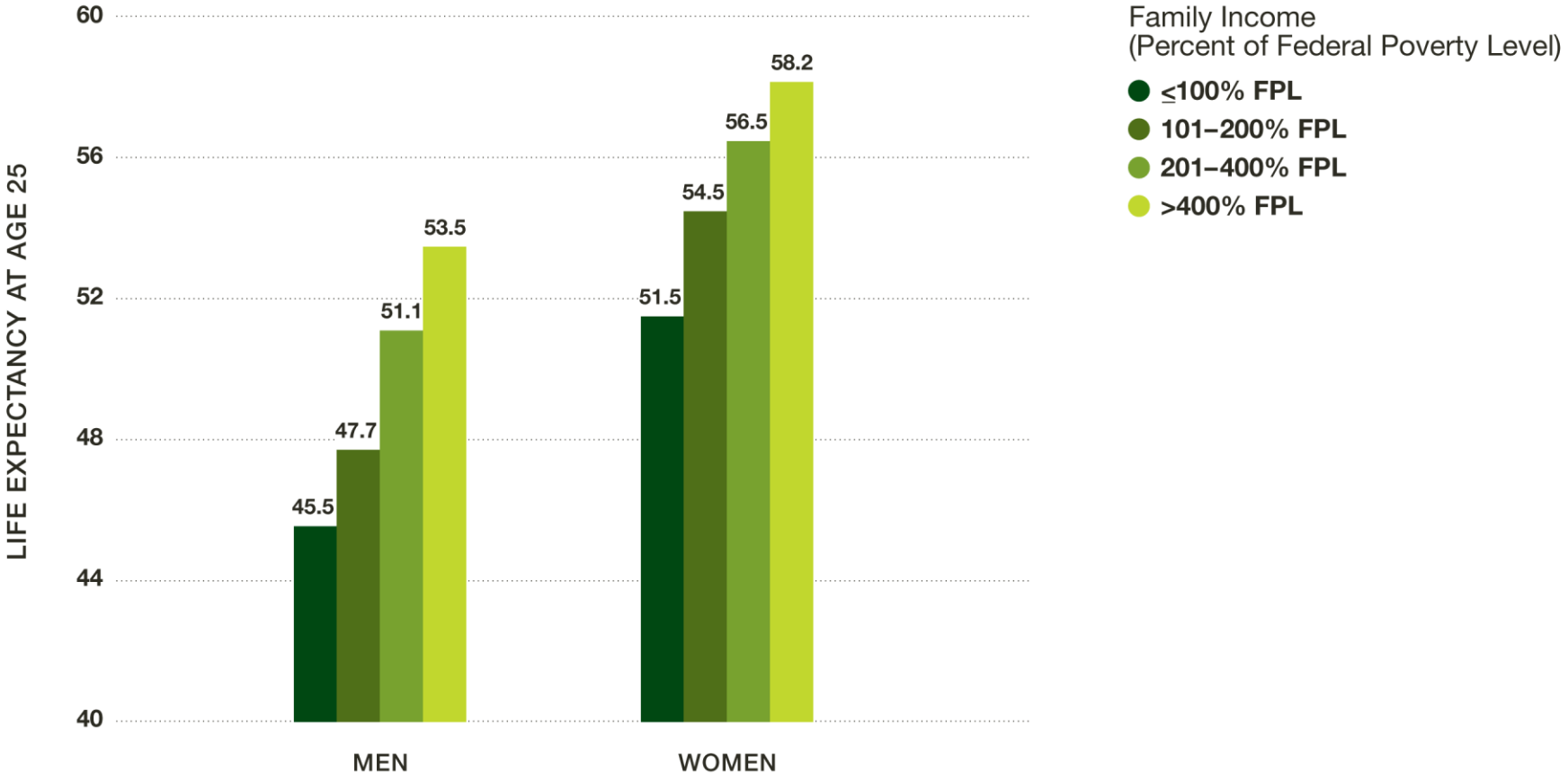
Source: National Health Interview Survey, 2001–2005.
*Age-adjusted

Higher Income, Longer Life

Adult life expectancy* increases with increasing income. Men and women in the highest-income group can expect to live at least six and a half years longer than poor men and women.



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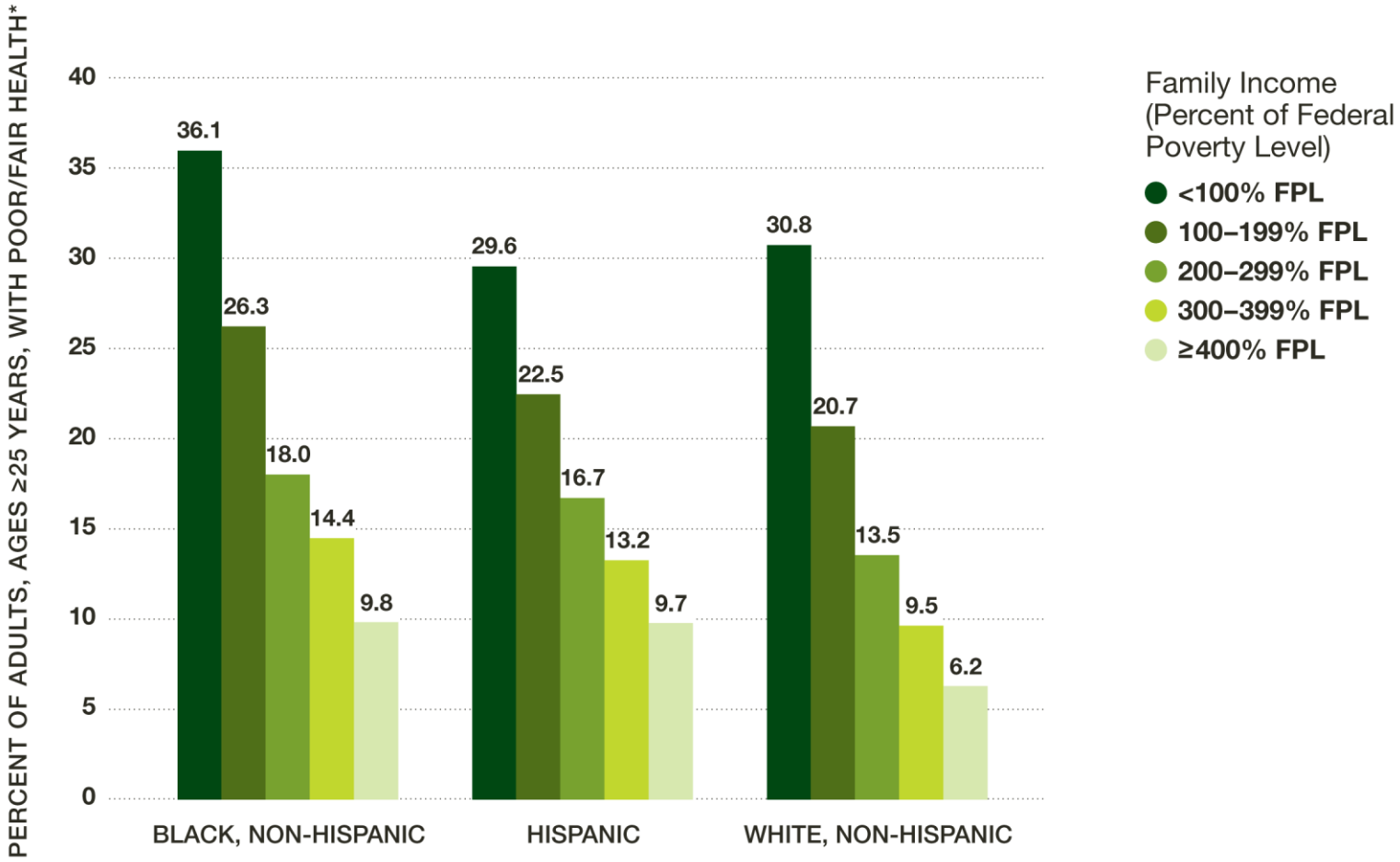
Source: National Longitudinal Mortality Study, 1988–1998.

*This chart describes the number of years that adults in different income groups can expect to live *beyond age 25*. For example, a 25-year-old woman whose family income is at or below 100 percent of the Federal Poverty Level can expect to live 51.5 more years and reach an age of 76.5 years.

Income Is Linked With Health Regardless of Racial or Ethnic Group

Differences in health status by income do not simply reflect differences by race or ethnicity; differences in health can be seen within each racial or ethnic group. Both income and racial or ethnic group matter.



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Source: National Health Interview Survey, 2001–2005.
*Age-adjusted

How could income affect health?

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Income affects neighborhood options

- Safe places to exercise
- Access to healthy food
- Targeted advertising of alcohol and tobacco
- Social Networks and support
- Norms, role models, peer pressure
- Fear, anxiety, stress, despair
- Quality of schools

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Demographic projections

- The U.S. continues to become more and more racially and ethnically diverse.
  - By 2042, minorities will become the majority
    - 54% by 2050
  - The Hispanic/Latino population will nearly triple by 2050 and make up one in three U.S. residents
  - The African American population will increase to 15%

U.S. Census

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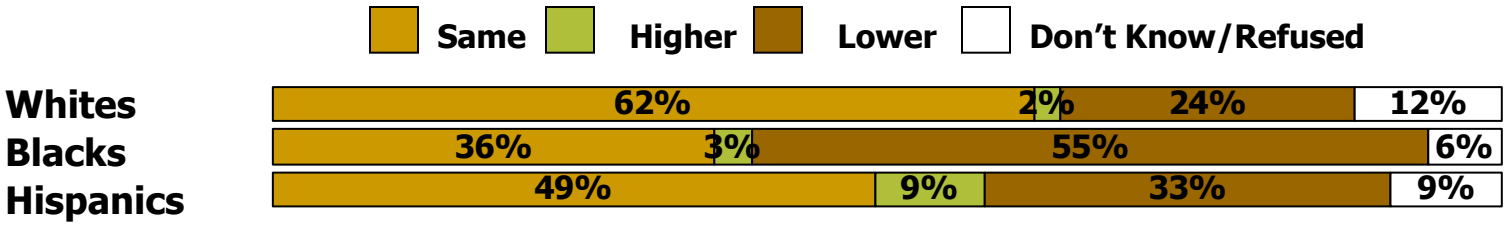
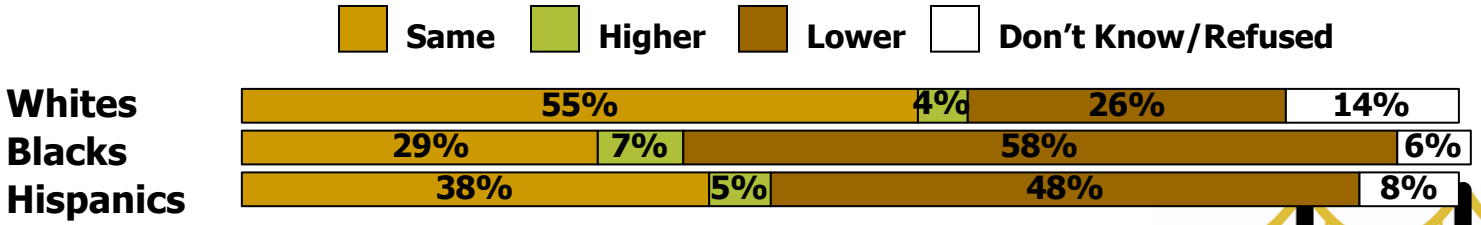
Perceptions of Disparities in Health Care

When going to a doctor or health clinic for health care services, do you think most African Americans receive the same quality of health care as whites, higher quality of care or lower quality of health care as most whites?



When going to a doctor or health clinic for health care services, do you think most Latinos receive the same quality of health care as whites, higher quality of care or lower quality of health care as most whites?



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SOURCE: Kaiser Family Foundation, *March/April 2006 Kaiser Health Poll Report Survey*, April 2006 (Conducted April 2006)

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Current and Future Realities That Impact Health Disparities

- Emphasis on Prevention and the Social Determinants of Health
- Growing Racial and Ethnic Minorities
- Broader Minority Health Constituency
- Increasing Access for Persons with Disabilities
- Growing Awareness of Conditions Impacting Rural Health

Current and Future Realities That Impact Health Disparities

- Challenges to Urban Health
- Increasing Knowledge of Health Concerns for LGBT Populations
- Expectations for Improved Data Collection, Reporting, and Diffusion
- Major Advances in Technology

Cost of Health Disparities

- Study commissioned by The Joint Center for Political and Economic Studies:
  - More than 30 percent of direct medical costs faced by African Americans, Hispanics and Asian Americans were excess costs due to health inequities-more that $230 billion over a three year period;
  - When you add the indirect costs of these inequities over the same time period, the tab comes to $1.24 trillion.

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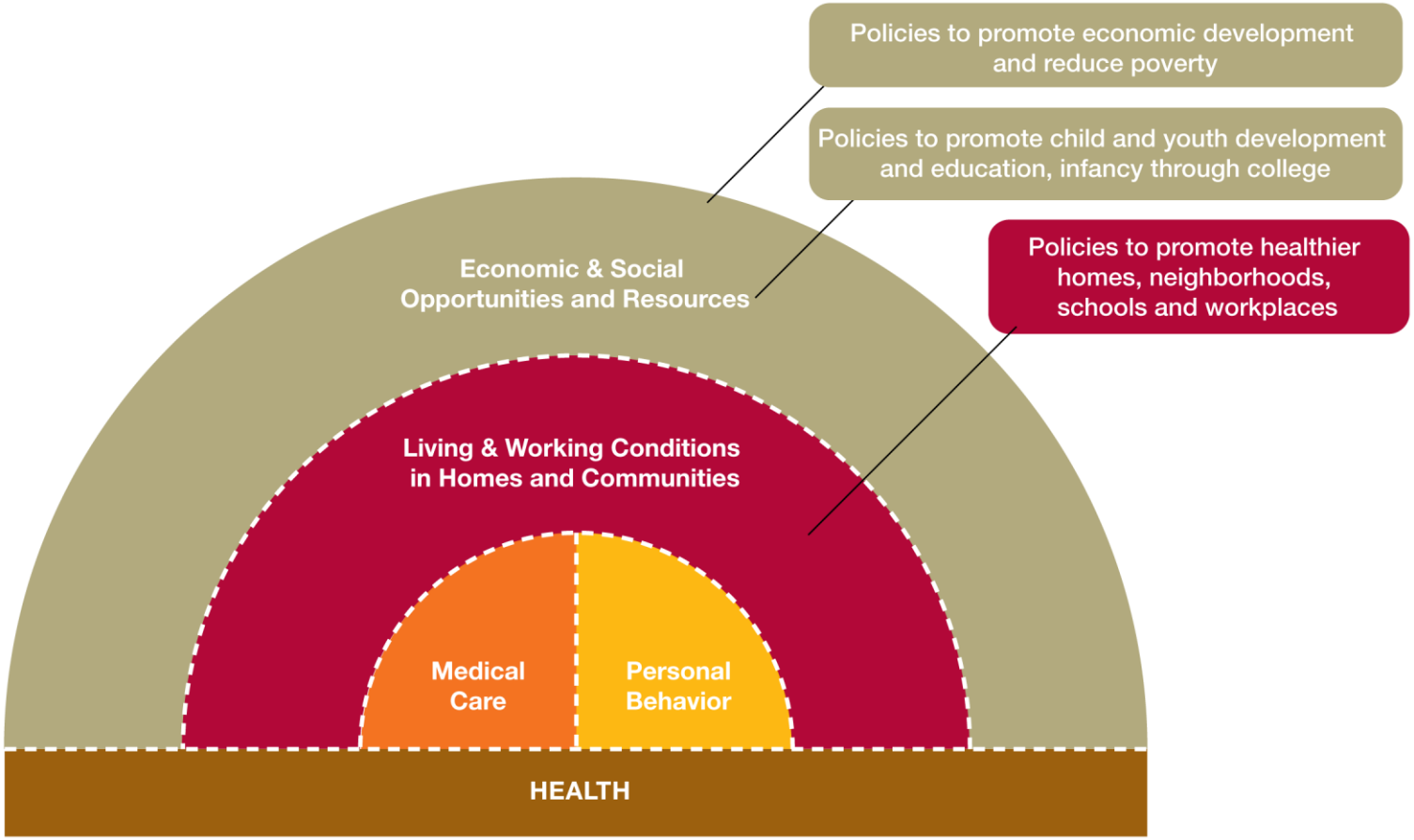
Influences on Health: Broadening the Focus

Health is shaped by many influences, including age, sex, genetic make-up, medical care, individual behaviors and other factors not shown in this diagram. Behaviors, as well as receipt of medical care, are shaped by living and working conditions, which in turn are shaped by economic and social opportunities and resources.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.

Reducing Health Disparities: Broadening the Focus

Medical care and personal responsibility for behaviors are important. But finding promising strategies to reduce disparities will require broadening the focus to include the social and economic contexts in which Americans live.



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Health Disparities and the Affordable Care Act

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Health Reform and Communities of Color

- Racial and Ethnic groups have much to gain form health reform. They represent one-third of the total U.S. population but comprise over 50 percent of the uninsured.

How ACA will help reduce disparities

Prevention

- Section 4102 –National Oral Health Campaign with Emphasis on Disparities
- Section 3507-Standardized Drug Labeling on Risks & Benefits
- Section 2951- Maternal & Child Home Visiting Programs
- Section 3506-Culturally Appropriate Patient-Decision Aids
- Section 2953- Culturally Appropriate Personal Responsibility Education
- Section 10221- Support for Preventative Programs for American Indians and Alaskan Natives

Cultural Competence Education and Organizational Support

- Section 5307- Develop & Evaluate Model CC Curricula
- Section 5307- Disseminate CC Curricula Through Online Clearinghouse
- Section 5301-CC Training for Primary Care Providers
- Section 5507-CC Training for Home Care Aides
- Section 5307-Curricula for CC in Working With Individuals with Disabilities
- Section 5203-Loan Repayment Preference for Experience in CC

Access to Care

- Section 10503-Support for Community Health Centers
- Section 5208-Nurse-Managed Health Centers
- Section 3502-Community Health Teams
- Section 4101-School-based Health Centers

Insurance Reforms

- Section 2001-Expanded Medicaid coverage to 133% FPL
- Section 1513-Employer requirement to cover
- Section 1421-Small business tax credits
- Section 1311- State-based Health Insurance Exchanges

Data Collection and Reporting

- Requires the DHHS Secretary to establish data collection standards
  - Section 4302-Reuires that population surveys collect and report data on race, ethnicity and primary language
  - Section 4302-Collect/Report data in Medicaid and CHIP
  - Section 4302-Monitor health disparities trends in federally-funded programs.

Legal and Regulatory Landscape

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Regulations

-Title VII of the Civil Rights Act of 1964-

- Prohibits discrimination by employer because of:
  - Gender
  - Race/Ethnicity
  - National Origin
  - Religion

- Failure to provide language access services for Limited English Proficiency persons may be a form of discrimination based on national origin.

Regulatory landscape

- The US Dept of Health and Human Services, Office for Civil Rights issued
  - "Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency" in February, 2002
- Department of Health and Human Services regulations require all recipients of federal financial assistance from HHS to provide **meaningful access to LEP persons**

- HHS utilizes a four factor analysis for recipients (of federal funds)

1. The number or proportion of LEP persons eligible to be served by the program or grantee;
2. The frequency with which LEP individuals come into contact with the program;
3. The nature and importance of the service provided by the recipient to its beneficiaries; and
4. The resources available to the grantee/recipient and the costs of interpretation/translation services.

Key point:

What is considered “reasonable” for one recipient may not be reasonable for another.

Non-compliance

- The Office for Civil Rights will investigate complaints that are made, notifying the recipient of noncompliance and outlining corrective action when necessary.

- Remedies include – revocation of federal funding or further enforcement action through the U.S. Department of Justice.

2009 was an active year

- National Committee for Quality Assurance – measures released in 2009
- National Quality Forum
  - Developed cultural competence quality measures in 2009
- National Business Group on Health
  - Major effort to educate employers about disparities, brief released 2009

DHHS Office of Minority Health–CLAS standards

- 14 standards directed at health care organizations
- Should be integrated throughout an organization
- Undertaken in partnership with communities being served

CLAS Standards

- Three types – mandates, guidelines, and recommendations
- Three themes
  - Culturally Competent Care (1-3)
  - Language Access services (4-7)
  - Organizational supports for cultural competence (8-14)

The Joint Commission

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Issues to Address

- Effective Communication
  - Identification of patient communication needs
  - Provision of language services
- Data collections and use
  - Collection of patient-level demographic data
  - Use of population-level demographic data for service planning & performance improvement
- Addressing specific patient needs
  - Cultural, religious, spiritual needs & beliefs
  - Patient and family involved in care

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Regulations

Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

- Standards
  - Hospitals *should* train on cultural sensitivity.
  - Hospitals *should* provide education and training on how to use available communication tools, language access services, auxiliary aids and plain language.

Regulations

Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

- Proposed Standards
  - The hospital *should* provide patient education and training based on each patient's needs and abilities.
  - *Should* address health literacy needs and barriers to communication.

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Standard. The hospital effectively communicates with patients when providing care, treatment, and services.

Elements of performance:

1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care.
Note 1: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.

2. The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

<u>Standard</u>: The medical record contains information that reflects the patient's care, treatment, and services.

Elements of performance:

The medical record contains the following demographic information:

1. The patient's name, address, date of birth, and the name of any legally authorized representative
2. The patient's sex
3. The legal status of any patient receiving behavioral health care services
4. The patient's communication needs, including preferred language for discussing health care
5. **The medical record contains the patient's race and ethnicity.**

<u>Standard</u>: The hospital respects, protects, and promotes patient rights.

Elements of performance:

1. The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.
2. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

<u>Standard</u>: The hospital respects the patient's right to receive information in a manner he or she understands.

Elements of performance:

1. The hospital provides language interpreting and translation services.

   Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.

2. The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.

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Successful Implementation

- Requires support from all levels
  - Senior management
  - Doctors
  - Nurses
  - Patient staff
  - Administrative staff

Achieving Better Health for Immigrants

- Equal Access
- Better data collection
- Diversify health care workforce
- Use community health workers
- Better use of interpreters
- Cultural Competence

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Thank You

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