

Confronting Disparities while Reforming Health Care: A Look at Massachusetts

Health Reform in the States

As health care costs and the number of uninsured rise steadily throughout the nation, the lack of a federal solution to this growing crisis has prompted more and more states to take matters into their own hands. Innovative health reform plans have been popping up across the country, from Maine to California. These reform efforts present a unique opportunity to harness the growing political momentum to fix our health care system and to bring attention to the persistent racial and ethnic disparities that plague the system.

It is a common misconception that efforts to provide universal health care will automatically translate into equitable, quality health coverage for all. This is simply not the case: Access alone will not eliminate health disparities.¹ The issue of health disparities must be specifically addressed within health care reform efforts so that inequities can be eliminated.²

In 2006, Massachusetts made national headlines when it passed health reform legislation that extended coverage to nearly all Bay Staters. Health advocates from across the country have looked to Massachusetts as an example of how to successfully enact bold health policy reform. However, Massachusetts can serve as a model for more than its work to expand coverage—recent experience there can also provide guidance in how to address health disparities in the context of health reform.

Massachusetts: A Unique Health Policy History

Massachusetts has a long history of progressive health reform, which has served as a necessary foundation for its most recent expansion.³ In 1985, the state legislature created the Uncompensated Care Pool, which reimburses hospitals and community health centers (CHCs) that provide free care to eligible low-income uninsured people. That same year, the legislature also established a special commission charged with developing a plan for achieving universal health coverage in Massachusetts. A bill based on the commission's plan was signed into law in 1988, and parts of this

legislation are still in place today, including programs that provide coverage for children, pregnant women, uninsured workers, adults with disabilities, and college students.

In 1996, the state undertook a massive reform that reinvented its Medicaid program and created MassHealth, which extended Medicaid coverage to an additional 300,000 residents. That legislation also included expanded coverage for children, limits on the amount of out-of-pocket money seniors were required to pay for prescriptions, as well as assistance for low-wage workers purchasing health insurance.

In 2004, health care advocates in Massachusetts once again saw the opportunity to move forward with new health reforms. Health Care for All (HCFA), a prominent health policy organization in the state, led a diverse coalition of stakeholders in drafting legislation that would expand health coverage to virtually all state residents. The coalition was made up of consumers, patients, community and religious organizations, businesses, labor unions, doctors, hospitals, health plans, and community health centers. It came to be known as the Affordable Care Today (ACT!) Coalition.

ACT! was largely responsible for the passage of the most recent health care reform legislation, commonly known as Chapter 58. Passed in 2006, Chapter 58 was designed to expand health coverage to nearly all Massachusetts residents through several mechanisms, including the creation of the Commonwealth Health Insurance Connector (a program designed to help individuals and small employers purchase affordable insurance more easily), a modest expansion of MassHealth, and an individual mandate.

Racial and Ethnic Health Disparities in Massachusetts

As all of this work to expand health coverage was taking place, momentum was also building around the effort to eliminate health disparities. Soon after the landmark Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Health Disparities in Health Care*, was released in 2002, Boston Mayor Thomas Menino called for city hospitals and community clinics to develop concrete strategies to reduce racial and ethnic health disparities. Menino later established the Mayor's Task Force to Eliminate Racial and Ethnic Disparities and charged it with developing a set of standards and recommendations to help eliminate health disparities in Boston.

In 2005, Menino declared health disparities to be the city's most pressing health care issue and, drawing on recommendations from the task force, launched The Disparities Project to combat health disparities.⁴ The Boston Public Health Commission took the lead and created a "blueprint" that laid out 12 sweeping recommendations designed to eliminate disparities in Boston. Mayor Menino raised more than \$1 million to fund implementation of the blueprint recommendations through contracts with local groups that were already working to eliminate racial and ethnic health disparities.⁵

The effort to eliminate disparities was not limited to Boston. At the state level, a Special Legislative Commission on Racial and Ethnic Health Disparities was investigating health disparities and developing recommendations and an action plan for addressing such disparities statewide. HCFA played a leadership role in writing this commission into state statute.

The key political support of Mayor Menino and the array of disparities reduction campaigns helped move health disparities into the public eye. Suddenly, people who had never heard of health disparities were opening *The Boston Globe* to find stories on The Disparities Project. The strong support of the health research community also helped to make health disparities a serious legislative issue. The general public and, perhaps more importantly, state legislators, were hearing about health disparities around the same time that they were hearing about broader health reform efforts. This timing created a political climate that was favorable to the inclusion of provisions that addressed racial and ethnic health disparities in the new health reform legislation.

Chapter 58 Legislation and Health Disparities

The Chapter 58 legislation contains four provisions that address racial and ethnic health disparities:⁶

1. **Section 160** calls for the creation of an ongoing **Health Disparities Council** that is charged with developing recommendations on several minority health issues, including workforce diversity, disparate disease rates among communities of color, and social determinants of health.
2. **Section 16 L. (a)** calls for the creation of a **Health Care Quality and Cost Council**, which will focus on health care quality issues with the goals of lowering costs, improving health care quality, and reducing disparities.
3. **Section 13B** develops standards for **Hospital Performance and Rate Increases**, with a specific stipulation regarding hospital rate increases being based on quality issues such as reducing racial and ethnic health disparities.
4. **Section 110** requires a **Community Health Worker Study** to be conducted by the Public Health Department to determine the effectiveness of community health workers in reducing racial and ethnic health disparities.

Including these provisions in Chapter 58 was an important and necessary step in beginning to tackle health disparities. However, disparities advocates in Massachusetts recognized that reducing disparities would require more than these provisions. Although these measures created a solid foundation, many advocates working on minority health issues felt it was necessary to build more substantive policy on this foundation.

Expanding Health Disparities Legislation

To build on the disparities provisions in Chapter 58, and to more thoroughly address the host of issues that affect health disparities, a coalition came together to file omnibus legislation whose sole focus was reducing racial and ethnic health disparities. HCFA once again took the lead in bringing the project together, and it was joined by a wide range of individuals, organizations, and institutions, ranging from the Boston Public Health Commission to the local chapter of the Service Employees International Union (SEIU). Others involved in the process included legal associations, research organizations, community health organizations, large health care providers, health policy organizations, as well as multi-issue organizations concerned with equity and justice in health policy. Together, they formed the Disparities Action Network (DAN).^{7,8}

The DAN formally convened for the first time in June 2006 with the goal of drafting omnibus disparities legislation for the 2007-2008 state legislative session. Its work was based partly on recommendations put forth by the Special Legislative Commission on Racial and Ethnic Health Disparities. From there, the group determined what it thought was missing from Chapter 58, drawing upon the collective knowledge of its diverse membership to come up with real policy solutions.

The DAN wrote its legislation using a collaborative work group process, meeting several times throughout the summer and fall of 2006 to write and review the legislation before it was filed. First, the coalition held a brainstorming session to determine what should be included in the legislation, which yielded an exhaustive list of policy recommendations and ideas. The final legislation grew from one key premise, which was the need to create a Health Equity Office. The members of the DAN believed that the abundance of projects, programs, and other efforts to eliminate racial and ethnic health disparities in Massachusetts could be greatly strengthened if they were not so fragmented. A Health Equity Office could serve as a coordinating body for all of the disparities work within the state. Under the guidance of such an office, disparities could be addressed in a systematic, cohesive approach through strategic planning and coordination of efforts on multiple fronts.

These efforts include programs that address both disparities in health and disparities in health care. More specifically, these programs involve developing standards based on best practices from across the state. These standards focus on health literacy, healthy communities initiatives that address environmental and social determinants of health, and workforce diversity (through coordination of existing labor standards). Other programs include support for medical interpreter services, community health workers, wellness education, community-based participatory research, and coordination of racial and ethnic data collection projects across public and private agencies.⁹

Members of the Disparities Action Network (DAN)¹⁰

Action for Boston Community Development
AIDS Action Committee
American Heart/American Stroke Association
American Red Cross of Massachusetts Bay
Association of Haitian Women
Berkshire Area Health Education Center
Boston Center for Community & Justice
Boston Public Health Commission
Boston Urban Asthma Coalition
Cambridge Health Alliance
Caring Health Center
Center for Community Health Education Research and Service (CCHERS)
Community Catalyst
Critical MASS
Greater Lawrence Family Health Center
Haitian Multi-Service Center
Health Care for All
Jewish Alliance for Law and Social Action
Latin American Health Institute
The Lawyers' Committee for Civil Rights under Law of the Boston Bar Association
Mass CONECT, Harvard School of Public Health
Massachusetts Asian and Pacific Islanders for Health
Massachusetts Association of Community Health Workers
Massachusetts General Hospital, Disparities Solutions Center
Massachusetts Hospital Association
Massachusetts League of Community Health Centers
Massachusetts Medical Interpreters Association
Massachusetts Medical Society
Multicultural AIDS Coalition
NAACP Boston Branch
NARAL Pro-Choice Massachusetts
Physicians for Human Rights
Project RIGHT
SEIU 1199
Whittier Street Health Center

The legislation, entitled *An Act Eliminating Racial and Ethnic Health Disparities in the Commonwealth* (H. 2234), was introduced in the Massachusetts legislature on January 9, 2007, by Representative Byron Rushing. In anticipation of the bill's hearing, the DAN formed several committees to build momentum around ending health disparities. This included a grassroots advocacy committee to help bring a community voice to the policy process and to reach out to communities to help them understand more about disparities and why this legislation is important. The organization also formed lobbying and communications workgroups to educate members of the Joint Committee on Public Health both about the bill and about health disparities in general, as well as to gain more publicity in local media to broadly publicize information on disparities and the DAN legislation.¹¹ The bill was heard on May 16, 2007, and it remains in committee. A panel comprised of health care and disparities experts, community members, and the legislative leads for the bill used their testimony as an opportunity to further educate legislators about the importance of addressing health disparities in health reform efforts.

An Act Eliminating Racial and Ethnic Health Disparities in the Commonwealth includes the following provisions:¹²

◆ **Office of Health Equity**

The Office of Health Equity will be housed under the State Executive Office of Health and Human Services and will be advised by the Health Disparities Council that was created by Chapter 58. The Office of Health Equity will be responsible for coordinating all disparities elimination efforts in the state. The office will publish annual disparities impact statements, put out annual disparities report cards on regional progress, set evaluation standards, determine reimbursement rates for medical translation services, and manage programmatic provisions of the legislation.

◆ **Community Agency Grants Program**

The Office of Health Equity will run a grant program to support efforts by community-based health agencies to eliminate disparities in underserved populations.

◆ **Data Collection Coordination**

The Office of Health Equity may choose to publish best standards on data collection. The office will also coordinate the data collection, analysis, and dissemination activities of all parties involved in the collection of data on patient race, ethnicity, and language spoken.

◆ **Community Health Workers**

The Office of Health Equity will run a competitive grant program to provide funds to hospitals, community health centers, and nonprofit community organizations to employ community health workers to better the health of the communities in which they live.

◆ **Community-Based Participatory Research**

The Office of Health Equity will run a competitive grant program to provide funding for research partnerships between community-based organizations and academic researchers focusing on the elimination of health disparities.

◆ **Health Literacy**

The Office of Health Equity will designate and disseminate best practice guidelines for the creation of health-related materials and literature drawing on federal and public health standards. The goal is to make materials widely accessible to patients, including those with limited educational attainment and limited English proficiency

◆ **Workforce Development**

The Office of Health Equity will establish a council to coordinate state, local, and private sector efforts to establish health care workforce diversity and development.

◆ **Environmental Justice**

A statewide community health index will be created to demonstrate which communities suffer from high rates of death and illness based on a weighted set of primary and secondary indicators of health outcomes.

◆ **Chronic Disease Management**

A chronic disease management program will be established in the Department of Public Health to begin wellness education of individuals who suffer from chronic disease.

What about the Social and Environmental Determinants of Health?

Racial and ethnic health disparities are not simply the result of disparities in access to quality health care. Rather, they result from complex social, economic, and environmental factors.

After its initial brainstorming process, the DAN work group realized that many of the provisions it had discussed were focused on the structural and social determinants of health, as opposed to reforms of the health care system itself. For example, there were several provisions that addressed access to healthy grocers, green space, healthy school lunches, and safe places for children to play within communities of color.

These provisions presented a challenge because the legislation was meant to be a “health care bill,” and the group did not want to weaken the bill by spreading its focus too broadly. At the same time, the group did not want to develop a bill that focused solely on health care and ignored the larger environmental determinants of health—such a bill would send the message that policies that improve quality and access in the health

care system are all that is needed to eliminate racial and ethnic health disparities.

Although the majority of the legislation was focused on reforms within the health care system, DAN advocates wanted to acknowledge the deeper roots of health disparities. They therefore included a provision that requires the Office of Health Equity to monitor social and environmental effects on health. The Office of Health Equity will be responsible for addressing these effects by engaging other state agencies, such as the housing and transportation authorities, and by generating annual disparities impact statements on the major initiatives of these agencies. The Boston Public Health Commission, a member of the DAN, also filed smaller-scale legislation on environmental equity issues (this legislation is currently on hold), while the DAN made a concerted effort to emphasize the important role of environmental and social justice in the effort to eliminate disparities.

Lessons Learned

The goals and ideas put forth by the DAN are far from unique. There was already an enormous amount of work going on around the elimination of health disparities prior to the convening of the DAN. Yet there is much to learn from the experiences of minority health advocates in Massachusetts as they move forward with their health disparities legislation.

The DAN showed that by harnessing the political and media attention surrounding health care expansions and reforms, it is possible to successfully elevate a disparities policy agenda to the state level. As more and more states begin to develop their own health care expansion legislation, disparities advocates must be ready to seize any political opportunities that can move the issue of health disparities into the public eye. The DAN advocates were successful because they were able to use all of the public attention surrounding health reform in Massachusetts, as well as the media attention garnered by the mayor's Disparities Project, to successfully raise awareness about health disparities and simultaneously put forth a substantive strategy aimed at eliminating those disparities.

The collaboration among multiple groups coming together to write legislation focused on disparities demonstrated the political power that advocates can wield through collective action. The DAN has been a powerful driving force because it uses the knowledge, skills, resources, and political power that its diverse membership brings to the table. By drawing on these resources and developing a defined agenda, the DAN was well positioned to raise awareness about health disparities and to move its policy agenda forward.

Advocates need to keep in mind that raising awareness around disparities is only part of the battle. Introducing disparities legislation is not easy, which is why collaboration is so crucial. Minority health advocates must look beyond their traditional partners and seek out diverse partners. For instance, advocates who are working to expand health coverage may not be the same advocates who are trying to eliminate disparities and ensure health equity. However, these issues must go hand in hand: Conversations around expanding access are a natural place to discuss efforts to ensure health care equity and reduce disparities. Each of these individual efforts can be strengthened through collaboration.

Another important lesson to be learned from the experiences of the DAN is that policy is a tool that minority health advocates can, and should, use to help eliminate health disparities. Advocates who work on minority health issues often focus on direct service or disease-specific issues in their efforts to reduce disparities in health and health care. Although these efforts are critical, it is important to look beyond these traditional strategies and use policy as a tool to help eliminate health disparities. Health disparities are a systemic problem that calls for systemic answers, and policy can serve as a powerful tool to address inequities. While the

political and historical circumstances in Massachusetts were clearly a unique factor that allowed the disparities legislation to advance, minority health advocates can still look to the state as a model for legislation in their own states.

Finally, although expansions of health coverage can be a useful vehicle from which to address disparities in health care access and quality, because disparities are rooted in many sources, advocates must not limit their work to health care access. Disparities result from a wide range of factors, including social and cultural circumstances, physical environment, and individual socioeconomic status. With so many factors contributing to health disparities, it is unrealistic to believe that disparities can be eradicated by pursuing narrow policies that focus solely on health care access and delivery systems. To combat the complex ways in which health disparities affect minorities, advocates must explore program and policy solutions that can address the environmental and social determinants of disparities as well.

Health disparities are a complex issue. By looking at success stories like that of the DAN, minority health advocates can develop and strengthen tools that will eliminate racial and ethnic health disparities and, ultimately, lead to health equity.

¹ Kate Meyers, *Racial and Ethnic Health Disparities* (Oakland, CA: Kaiser Permanente Institute for Health Policy, 2007), available online at http://www.kpihp.org/publications/docs/disparities_highlights.pdf.

² Jack Geiger, "Race and Health Care – An American Dilemma?" *New England Journal of Medicine* 335 (September 1996): 815-816.

³ ACT! Affordable Care Today, *Previous Health Care Reform Efforts in MA: A Brief Background* (Boston: Health Care for All, 2006), available online at <http://www.hcfama.org/act/reform101.asp>.

⁴ Boston Public Health Commission, *The Disparities Project: Year One Report* (Boston: Boston Public Health Commission, 2007), available online at http://www.bphc.org/reports/pdfs/report_222.pdf.

⁵ Ibid.

⁶ ACT! Affordable Care Today, *Chapter 58 of the Acts of 2006: An Act Providing Access to Affordable, Quality, Accountable Health Care* (Boston: Health Care for All, 2006), available online at <http://www.hcfama.org/act/mahealthreformlaw.asp>.

⁷ Health Care for All, *Disparities Action Network* (Boston: Health Care for All), available online at <http://www.hcfama.org/index.cfm?fuseaction=page.viewPage&pageID=516>.

⁸ Camille Watson, "Policy and Advocacy Efforts to Eliminate Disparities in Massachusetts," presentation at Universal and Equal: Ensuring Health Equity in Health Reform meeting, March 9, 2007.

⁹ Ibid.

¹⁰ Health Care for All, op cit.

¹¹ Ibid.

¹² Health Care for All, *An Act Eliminating Racial and Ethnic Health Disparities in the Commonwealth: Summary* (Boston: Health Care for All, 2006), available online at http://www.hcfama.org/_uploads/documents/live/Dan%20Summary.pdf.

For more information on Families USA's Minority Health Initiatives,
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