

Introduction

Health equity is an economic issue as well as a social justice issue. Significant inequities and disparities exist between different racial/ethnic groups, socioeconomic classes, and geographical location; in key health indicators such as infant mortality rates, life expectancy, and rates of preventable disease; in key risk factors such as smoking rates, access to care, nutrition, and physical activity; and in social determinants of health such as poverty, education, inadequate housing, and unsafe working conditions. Health disparities that have their roots in social determinants of health are referred to as health inequities and are a reflection of the persistent inequities that exist in American society. Health and healthcare inequities result in lower quality of healthcare, worse health outcomes for minority racial/ethnic populations and people with low socioeconomic status, increased direct and indirect healthcare costs, decreased productivity, and an overall disparate use of corporate healthcare dollars.

Approximately \$230 billion in direct medical care expenditures and more than \$1 trillion in indirect costs associated with illness and premature death for the years 2003-2006¹ would have been saved by eliminating health disparities for racial/ethnic minority groups. A comprehensive health equity strategy with robust federal and state offices of minority health/health equity will improve productivity and control large annual increases in healthcare costs that consume a significant percentage of corporate profits.

This issue brief will discuss the return on investment offered by prevention efforts, the increased costs caused by inequities in health and healthcare, the decreased productivity and disparate use of corporate healthcare dollars caused by those same inequities, the rationale for and benefits of a comprehensive health equity strategy, and recommendations for steps employers can take to reduce health inequity.

Investing in Prevention Is Worth It

Inequities in health and healthcare lead to lower quality care and worse health outcomes. Racial and ethnic minorities (defined as African Americans, Hispanic Americans, American Indians and Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders) currently represent one-third of the U.S. population. According to the Pew Research Center, racial and ethnic minorities will become a majority in the United States by 2050,² but research shows that they tend to have worse health outcomes than whites.

- Racial and ethnic minorities have higher morbidity and mortality rates.³
- Infant mortality among African Americans in 2000 occurred at a rate of 14.1 deaths per 1,000 live births, which is more than twice the national average of 6.9 deaths per 1,000 live births.⁴
- African American men are more likely to die from heart disease than white men.⁵
- African American adults are more likely to have a stroke compared with white adults.⁶

- African American women have higher death rates from heart disease, breast and lung cancer, and stroke.⁷
- Native Americans have diabetes rates more than two times the white rate.⁸
- Mexican Americans are two times more likely than whites to be diagnosed with diabetes.⁹
- Asian/Pacific Islanders are three times more likely to develop liver cancer.¹⁰

People with low socioeconomic status and people living in rural and frontier environments also have worse health outcomes.

- Low socioeconomic status is associated with higher mortality and morbidity.¹¹
- Rates for incidence and morbidity from cardiovascular disease are high for people with low socioeconomic status.¹²
- Cancer outcomes and treatment differ greatly for people with low socioeconomic status.¹³
- One-third of all motor vehicle accidents occur in rural areas, and two-thirds of the deaths attributed to these accidents occur on rural roads.¹⁴
- The suicide rate for men living in rural areas is significantly higher than for men living in urban areas.¹⁵

Moreover, the Prevention Institute has found that economically segregated neighborhoods are more likely to have limited economic opportunities, unhealthy options for food and physical activity, environmental hazards, substandard housing, lower performing schools, and higher rates of crime and incarceration.¹⁶

Disparities in health and healthcare exist, even among employees with equal benefits. As Brian Smedley states in his article “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” “Even when they have the same health insurance benefits and socioeconomic status, and when comorbidities, stage of presentation, and other confounding variables are controlled for, members of racial and ethnic minority groups in the United States often receive lower quality health care than do their white counterparts.”¹⁷ Examples include: Whites with congestive heart failure were more likely to receive appropriate cardiac care such as angioplasty and bypass surgery than racial and ethnic minorities with the same conditions.¹⁸

- Racial and ethnic differences exist in cancer screening, diagnosis, and treatment.¹⁹
- African American diabetics are more than three times more likely to receive limb amputation than white diabetics.²⁰
- African American children with asthma are three to four times more likely than white children with asthma to be hospitalized, suggesting that they do not receive appropriate treatment and monitoring of their condition.²¹

- African Americans, Asian Americans, Hispanics, and Native Americans are less likely to receive sophisticated treatments such as kidney transplantation or advanced drug therapy for HIV/AIDS.²²
- African Americans, Hispanics, Asian Americans, and people with low socioeconomic status are less likely to have a regular source of healthcare.²³

The inability to understand a patient’s language or cultural background contributes to the lower quality of care provided to racial and ethnic minorities. It is important to note that one in five people in the United States speaks a language other than English in the home. A patient’s inability to understand and process medical information often results in worse health outcomes.

In addition, racial and ethnic minority healthcare professionals—who are more likely to serve minority populations—are grossly underrepresented in the workforce. Between 1978 and 2008, 75 percent of all medical school graduates practicing medicine were White, while Blacks or African Americans, American Indians/Alaska Natives, and Hispanics or Latinos comprised a combined 12.3 percent of the U.S. physician workforce.²⁴

Investing in disease and injury prevention and public health not only saves lives, but also yields a significant return on investment. Prevention programs help our nation address the exploding growth in healthcare treatment costs in Medicaid, Medicare, and private healthcare. As the table shows, prevention saves money.

For every \$1 spent on:	We save:
Water fluoridation	\$38 in dental treatment costs ²⁵
Preconception care programs for women with diabetes	\$5.19 by preventing costly complications in both mothers and babies ²⁶
School-based HIV/STD and pregnancy prevention programs	\$2.65 in medical and social costs ²⁷

Additionally, investing in arthritis self-management for 10,000 individuals, reducing their pain by 18 percent and increasing their productivity and quality of life, could save more than \$2.5 million.²⁸ Implementing clinical smoking cessation interventions costs an estimated \$2,587 for each year of life saved, the most cost effective of all clinical preventative services.²⁹

Increased Direct and Indirect Health Care Costs

Data clearly reflect the serious gaps in health outcomes by race, ethnicity, socioeconomic class, geographical location, education, and other social determinants of health. Between 2003 and 2006 the combined costs of health inequalities and premature death in the United States were \$1.24 trillion.³⁰

Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than \$1 trillion during this same time period.

Rising healthcare costs are also a growing burden for businesses. A Kauffman Foundation report revealed that companies with 25 or fewer employees saw their healthcare costs rise 30 percent between 2000 and 2005.³¹ For example, treating chronic conditions in African Americans and Hispanics cost the US health care system \$24 billion in 2009.³² These increased healthcare costs erode profits, threaten the ability of businesses to offer health benefits to their employees, and may also force some companies to raise prices for their products. GM estimated that providing health insurance for its employees and retirees added \$1,400 to the cost of every vehicle built in the United States in 2004.³³ According to a report by Goetz et al., rising healthcare costs erode corporate profits and leave less money for businesses to invest in new equipment, better facilities, research or expansion.³⁴

Decreased Productivity and Disparate Use of Corporate Healthcare Dollars

Employees who receive inadequate healthcare services have increased rates of absenteeism and presenteeism (lost productivity as a result of employees presenting to work sick or injured) and decreased productivity.³⁵ Employees with chronic health conditions are more likely to leave the workforce either short term, extended term, or permanently. Medical costs, disability benefits, the cost of hiring and training new employees, and added stress on remaining employees result.

Health inequities result in employers investing healthcare dollars in a system that does not administer services equally to diverse workforces. Employers' dollars are not paying for the same healthcare for all of their employees. In many cases they are paying for inappropriate or inadequate care. As a result, some employees may be underserved while others are overserved.³⁶

Beyond Healthcare: Recommendations for the Social Determinants of Health

Disparities in medical care only partly explain health disparities by racial and ethnic group, education, or income. Deeper root causes of health inequities such as inadequate education, poor living conditions, unsafe neighborhoods, and institutional racism/discrimination affect health. Health disparities are unlikely to be eliminated without addressing these root causes. Promoting healthy living and well-being through community interventions is critical to achieve improvement of social, economic, and environmental factors.³⁷

The social determinants of health need to be addressed within the larger public health infrastructure. The state health agencies and state offices of minority health, health disparities, and health equity must work in collaboration with the federal Office of Minority Health to provide leadership and executive-level awareness of the economic impact of health inequities and disparities. All levels of the public health infrastructure should:

- Ensure integration of health equity into all programs, priorities, and policies.
- Provide leadership and financial and administrative support for information and analysis on underrepresented population groups.
- Evaluate and promote successful state and territorial health equity promotion practices at the national level.
- Lead all state/territorial government agencies in evaluating and optimizing the impact that agencies' policies and programs have on population health status and ensure interagency collaboration to end health inequities.
- Engage all sectors of state, territorial, tribal, and federal executive government in health equity promotion efforts, including the application of solutions that directly address the social determinants of health.³⁸

Rationale for and Benefits of a Comprehensive Health Equity Strategy

Gaps in health outcomes between populations can be addressed through improvement of quality of care, increased cultural competency, and a comprehensive health equity strategy. Two out of every three Americans with health insurance receive their insurance from large employers.³⁹ Large employers are poised to leverage their healthcare dollars to ensure that the marketplace makes necessary changes to improve the quality of healthcare services. According to the CDC, 65 percent of the adult population can be reached through worksites, an ideal setting for wellness initiatives. Eighty-one percent of American businesses with 50 or more employers have some type of health promotion program.⁴⁰

According to the Wellness Councils of America, for every dollar spent in worksite wellness programs, the employer saves more than a dollar.⁴¹ At DuPont, each dollar spent in workplace health promotion yielded \$1.42 over two years in lower absenteeism costs. At the Travelers Companies, each dollar invested in workplace health promotion yielded \$3.40 in savings for total corporate savings of \$146 million. Unnecessary doctor's and emergency room visits were also reduced. And at Union Pacific Railroad, where healthcare costs totaled \$6,000 per employee (about two times the national average), worksite health promotion yielded savings of \$1.26 million. Employees also lowered their risk of high blood pressure by 45 percent and high cholesterol by 34 percent; twenty-one percent stopped smoking.⁴²

In addition to reduced medical costs, benefits to employers working to reduce the burden of chronic health conditions among employees include:

- Reduced disability benefits.
- Avoiding the cost of hiring and training new employees.
- Avoiding added stress on remaining workforce.⁴³

Recommendations

Employers can leverage their resources as purchasers to ensure that diverse populations receive the highest quality healthcare by selecting health plans that offer cultural competency training to their providers and employees. This is critical to reduce racial/ethnic stereotyping and ensure the equitable administration of healthcare services to all populations.

Healthcare organizations can employ a more diverse workforce of healthcare providers, as racial/ethnic minorities are grossly underrepresented as health care professionals. Racial/ethnic minorities are often more comfortable seeing a provider of a similar racial/ethnic background as the provider more likely to be culturally competent and communication between patient and provider may be improved, thereby strengthening the patient-provider relationship. Biased care, stereotypes, and assumptions are less likely. Healthcare and public health organizations can systematically collect and use data on race, ethnicity, and primary language to improve the quality of care for diverse populations as well as identify specific health needs of specific populations and help plan targeted interventions.

Health facilities should follow the federal Office of Minority Health Standards for Culturally and Linguistically Appropriate Services (CLAS), including sufficient language assistance services (i.e. bilingual staff and interpreters) for patients with limited English proficiency.⁴⁴ Additionally, employers can support these standards by launching culturally and linguistically competent health awareness initiatives such as health fairs and provision of health information to employees. Employers can ensure that all employees know that reducing racial and ethnic health disparities is a priority.

Health plans and insurance companies can reduce health disparities by using innovative and wide-ranging strategies. The National Health Plan Collaborative⁴⁵ brought together 11 leading health plans, including Aetna, Kaiser Permanente, Humana, and UnitedHealth Group among others, to create a toolkit that combined case studies, sample tools, policies, and other resources to help reduce health disparities within their memberships.⁴⁶ One example is using geographic information system mapping to identify the most optimal census tract areas for targeted interventions. This tool can make it possible to closely examine social and health factors at the neighborhood level, which can help with analyzing the health plan market area for specific health conditions, such as people with diabetes who have not received recommended care in a particular neighborhood.⁴⁷ Other recommendations from the National Health Plan Collaborative included language access, data collection on members' race/ethnicity and language, and calculating a return on investment for improving quality and addressing disparities.

Conclusion

Eliminating health inequities is a core public health principle. Addressing them is the right thing to do, but this analysis shows that equity in health can also have economic benefits to society. A comprehensive health equity strategy will reduce indirect and direct healthcare costs by using a two-

pronged approach: addressing health inequities in the clinical setting and through the social determinants of health. Improving the quality of care through clinical settings as well as public health settings, ensuring cultural and linguistic competence in those settings, and providing access to high performing hospitals are strategies to reducing disparities in healthcare.

Employee wellness programs can have a significant impact on the U.S. population, as much of the population can be reached through their employee-owned health plan. The cost savings of employee wellness plans have been well-documented and are a relatively obvious way of reaching all socioeconomic levels through the various employees of a company.

The U.S. Department of Health and Human Services (HHS) acknowledged the central importance of addressing health inequities and disparities to achieve overall improved health when it established “a renewed focus on identifying, measuring, tracking, and reducing health disparities through a determinants of health approach” as one of two overarching goals of Healthy People 2020, the national blueprint for public health.⁴⁸ The goals and mission of federal initiatives such as HHS’s *National Stakeholder Strategy to Achieve Health Equity* and *Action Plan to Reduce Racial and Ethnic Health Disparities* stress the commitment to achieving health equity for the nation from the highest levels of the government and provide a flexible road map for public- and private-sector partnerships to collaborate on initiatives and programs to achieve health equity. In addition, health reform provides opportunities to achieve health equity through the Affordable Care Act and the National Prevention Strategy.⁴⁹ It is clear that if we are to achieve health equity, it will require the integration of business and health strategies working together towards this critically important goal.

Health begins in the environments in which we are born, live, work, study, and play. Engaging with the social determinants of health is a critical component of any comprehensive health equity strategy to reduce healthcare costs and improve the health of everyone in the nation. Improving community environments by supporting programs and policies that address social determinants of health ensures that the root causes of health inequities are addressed.

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