Culturally Competent Health Care
A Plan for Employers to Improve Employee Health and Medical Plan Efficiency by Eliminating Disparities in Care

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We use the term “Culturally Competent Health Care” to describe an approach to health care that offers all participants equal access and opportunity to receive quality care and medical purchasing efficiency through elimination of structural barriers and respect for the cultural context of each individual.
Executive Summary

Employers have become increasingly aware of disparities in health care attributable to race, ethnicity, and socioeconomic status. Research confirms that we find these disparities in both uninsured groups and employer-sponsored plans.

Health care disparities are due to a number of factors: systemic/structural sources as well as the lens—or cultural context—through which the individual views his or her health and interactions with medical providers.

A recent study by the Johns Hopkins Center for Health Disparities Solutions calculated the direct and indirect costs of racial and ethnic disparities in health care in the United States. The estimated cost for the period 2003 through 2006 was $229.6 billion.¹

Employers are now in a position to analyze their own health care data to identify and reduce costly disparities and strive for a more equitable health care system. We use the term “Culturally Competent Health Care” to describe an approach to health care that offers all participants equal access and opportunity to receive quality care and medical purchasing efficiency through elimination of structural barriers and respect for the cultural context of each individual. Cultural context refers to race, language, age, gender, lifestyle, ethnicity, faith, location, and/or socioeconomic status, which influence individual decisions about health and medical care.

This approach provides employers with an opportunity to improve quality, reduce short- and long-term medical costs, and improve workplace productivity. Employers who are willing to demonstrate leadership in this area stand to gain competitive advantage.

Culturally Competent Health Care is not a new diversity program. Rather, it is a prism for employers and their health plan partners to look through to better promote employee health and medical purchasing efficiency in an increasingly multicultural society.

This paper provides background on Culturally Competent Health Care and includes steps that employers can take to phase it into their existing health care programs.
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Employers have become increasingly aware of health care disparities attributable to race, ethnicity, and socioeconomic status. However, they have been slow to address these disparities and are often hindered by measurement challenges and even debate about the return on investment associated with programs that explicitly recognize workforce diversity.²

Actions to reduce or eliminate health care disparities share the same social justice argument as all diversity programs—i.e., they are the right thing to do. But when it comes to health care programs, reducing health care disparities offers employers an added benefit: a tangible and measurable way to lower medical plan spend and improve worker productivity.

Disparities Defined

There is an abundance of literature on the subject of racial, ethnic, and socioeconomic disparities in health care. The data are very clear: compared to the majority white population, minorities have a different, and often inferior, experience with—and outcomes from—the health care system. Although the definition of a disparity itself has been a topic of discussion,³ a useful working definition for employer-sponsored health plans is:

A health care disparity is substandard access, treatment, or outcomes based on racial, ethnic, or socioeconomic factors.

Health care disparities affect both the insured and uninsured. Minorities experience lower rates of many preventive services, higher incidence of disease, and often substandard treatment. The National Business Group on Health⁴ identifies the most common health care disparities for minorities as:

- **Access to care** - System structural and financial barriers prevent minorities from receiving high-quality care.
- **Safe care** - Minorities experience more medical errors with great clinical consequences.
- **Evidence-based care** - Minorities receive less evidence-based care and are less likely to receive preventive health services.
- **Timely care** - Minorities are more likely to wait for the same procedure.
- **Efficient care** - Minorities often have higher rates of emergency room utilization and hospital admissions as well as longer inpatient stays.
Causes of Disparities

Contrary to misconceptions, the presence of a health care disparity does not necessarily imply that someone or some group is consciously acting in a discriminatory manner. In fact, in its landmark 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* the Institute of Medicine (IOM) identified three sources of health care disparities: system-level variables, care process-level variables, and patient-level variables.

Our analysis indicates that these three sources of disparities should be expanded in employer-sponsored health "plans to include a fourth type: health plan inequalities affected by the employee-employer relationship, or employment structure-level variables."

**Expanded Institute of Medicine (IOM) Health Care Disparity Sources**

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<th>Health care system-level</th>
<th>Care process-level</th>
<th>Patient-level</th>
<th>Employment structure-level</th>
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**Health care system-level** - Factors that make it difficult for individuals to navigate the system, reducing the chance that they receive the highest quality care. These include a medical care system that is at times confusing and expensive, geographic location of providers, as well as the lack of minority providers.

**Care process-level** - Factors that contribute to disparities at the individual provider level. These include clinical uncertainty, the implicit nature of stereotyping, and simple provider prejudice.

**Patient-level** - Individual characteristics that contribute to health care disparities. These include language barriers, poor health literacy, cultural norms and beliefs, as well as medical or other types of debt that form a barrier to seeking care.

**Employment structure-level** - Our addition to the IOM model, these aspects of the employment relationship are a barrier to improving health or receiving medical care at the highest level. Examples include limited availability or pricing of nutritious food at the workplace (vending machines and cafeteria), rigid work schedules that prevent receiving care in a timely manner, awareness and participation in company-provided wellness and health promotion programs (e.g., programs are only available at certain locations), and plan design limitations (e.g., complexity of coverage features, cost-sharing provisions that discourage low-wage employees from seeking timely primary and preventive care, and provider networks that are geographically inconvenient or not accessible during weekends or evenings).
The Cost of Disparities

Employers who are committed to the goals of diversity and inclusion have a powerful social justice argument for addressing health care disparities (i.e., all participants in the health plan should have equal access and opportunity to receive quality, efficient care).

They also have a strong financial argument. A recent study by the Johns Hopkins Center for Health Disparities Solutions, commissioned by the Joint Center for Political and Economic Studies, used econometric modeling to calculate the direct and indirect costs of racial and ethnic disparities in health care in the United States. It estimated the cost for the period 2003 through 2006 to be $229.6 billion.\(^6\)

Health care disparities also act as an unseen tax on employee productivity and an accelerator of medical plan costs. Although the science is new and the financial impact varies significantly by employer, the same study found that 30.6 percent of the direct costs of medical care for blacks, Asians, and Hispanics was attributable to health care disparities—and this is not inclusive of the cost of lost productivity.\(^7\)

In a recent study of disparities for an employer-sponsored program by Aon Consulting, we found that the impact of disease burden and related purchasing efficiency varied across racial/ethnic groups. The data for four major diagnostic groups studied (asthma, back pain, coronary artery disease, and diabetes) indicated a clear pattern of blacks and Hispanics underutilizing physician office visits while being associated with significantly higher rates of emergency room utilization and inpatient admissions. For example, data for coronary artery disease and diabetes showed physician office visit utilization by blacks to be 7 to 12 percent below whites. Costly emergency room and inpatient admissions ranged from 38 percent to 70 percent higher for blacks as compared with whites.\(^8\)

When looking at disparities and calculating productivity loss and added medical costs, employers should examine such factors as size and cultural diversity of the workforce, relative pay level of employees, turnover, and geographic location.

It is important to note that whether addressing disparities directly or through other quality initiatives, improving the quality of care can increase certain short-term costs. In many cases, this cost increase is offset by lower short-term costs in other areas. For example, increasing participation in an employer’s healthy baby program will marginally increase per-participant enrollment costs in the program. However, avoiding just one premature birth from fuller program participation will more than offset any increase in short-term costs. A careful analysis of employer-specific data is required to assess the interplay of short- and long-term costs.

Left unattended, the cost of health plan disparities to individual employers and society as a whole will continue to grow. Each generation of U.S. workers is more diverse than preceding generations. Due to the relative homogeneity of the baby boomers, today about one-third of the U.S. workforce is comprised of non-white workers. By 2040, that number will reach 50 percent of the U.S. workforce.\(^9\)
Employers Have Been Slow to Act

Even with more than a decade of literature exposing health care disparities, most employers have not taken action. A 2008 survey by the Harvard School of Public Health of 609 large public and private employers and 252 health plans showed that nearly all health plans (90 percent) and most employers (58 percent, with the percentage increasing with size of employer) cite health care disparities. However, only 3 percent of employer respondents analyzed differences in health plan performance by race and ethnicity or chose plans that addressed racial and ethnic disparities.

With so many moving parts to employee health plans, employers have been slow to recognize and tackle disparities. Their reasons include:

- Absence of information on health care disparities in general or a belief that the problem is largely confined to the uninsured.

- Difficulties in collecting racial and ethnic data from vendors. Race and ethnicity data can be complex and nuanced. Most health plans today use indirect surname and geocoding analysis, which is useful at the aggregate, but not individual, level. Most health plans also have not modified their IT structure to capture diversity information directly.

- The perception that disparities are the result of language barriers that could largely be eliminated through multilingual print materials, language-appropriate call center support/coaching, and existing health plan services.

- Trepidation by corporate benefit administrators that recognizing disparities in the employer-sponsored health plan may be tantamount to admitting a flaw in the program, or worse, a tacit admission of discrimination on the company’s part.

To date, corrective action has been more common when it comes to socioeconomic health care disparities. Pay-based premiums for medical insurance have long been a vehicle employers use to improve coverage access for lower wage workers. Also, employers and their health plan network partners routinely review provider coverage areas to ensure that employees of all socioeconomic groups have good access to quality providers.

More recently, employers have recognized that health plan affordability impacts not just the employee’s ability to purchase health insurance, but also patient decisions about compliance and prescribed therapies. Value-based plan designs have been effective in increasing patient compliance with condition management programs. Although results are not uniformly conclusive, the literature suggests that value-based programs can help avoid more costly inpatient episodes by facilitating patient adherence with drug regimes.

Health plans have been somewhat more forward-thinking in response to health care disparities. A recent informal survey of vendor-based programs conducted by Aon Consulting shows that all of the major health plan vendors are aware of the issue of disparities and are in various stages of developing solutions to address them.
Achieving Culturally Competent Health Care

For an organization to achieve Culturally Competent Health Care, it must address the employer’s role as plan sponsor as well as the role of the health care system (and medical providers), and the interconnected role of community and family.

Culturally Competent Health Care is not a new diversity program. Rather, it is a new way to view the various roles and activities of the stakeholders within and around the health care system. With the individual at the center, the broad context of Culturally Competent Health Care includes the employer, health care providers/system, and the community/family. The employer has an important role in all three areas.

- **Employer** - The employer can control development of the plan design and financing structure, creating access points to care, allocating work scheduling, etc.

- **Health care providers/system** - The employer can influence the health plan’s selection of network providers, quality standards, results monitoring, and execution of health promotion and condition management programs. If the employer does not feel it can influence the health plan/vendor towards Culturally Competent Health Care, it can select other vendor partners to manage this aspect of the employee health and medical care program.

- **Community/family** - The employer can reach into the community to find and then support programs that promote culturally appropriate patient self-management, social networks, recreational programs for children, and address environmental factors like neighborhood immunization programs and condition support groups.
Getting Started:  
Six Steps for Employers to Achieve Culturally Competent Health Care

Employers can take a variety of actions to address health care disparities and deliver Culturally Competent Health Care to employees and covered dependents. Steps include:

Educate the senior leadership team and ask for their active participation. Without leadership, Culturally Competent Health Care may be trivialized as the “initiative of the month.” Make sure your leadership team understands what is at stake for your workforce and the overall financial success of the organization. Visible engagement by the leadership team can mean the difference between success and failure.

Expand the benefits team to include expertise in cross-cultural issues. Add someone from the office of the Chief Diversity Officer to your benefits team, or get input from an external source. Reach out to employees directly, including leveraging your organization’s existing diversity and inclusion programs through focus groups and/or surveys. Instead of confining your questions to the mechanics of the health plan, ask about job structure and location issues to gain insights into employment structure-level variables. Employees will know the problems and might even offer solutions.

Collect data on health care disparities. Uncover data with your vendors (direct and indirect sources) or by appropriately matching EEOC data with program participation, outcomes, and utilization results. Review recent health plan data to determine your primary cost drivers. This could lead to disease-specific initiatives (e.g., increasing minority participation in diabetes management programs) or working with your health plan to improve the cultural competence of their programs (e.g., auditing the program to collect baseline data and then working with the pharmacy benefit manager to implement programs to improve minority adherence to specific therapeutic regimes).

Learn what programs your vendors already have in place to uncover disparities, and consider an audit of current programs and vendor performance. Vendors are anxious to improve their cultural competence, and employers who show leadership in this area will have the opportunity to help shape vendor programs.

Look into your communities. Review community initiatives in areas of heavy employee concentration. Many states and localities already have programs in place. With a little research, you may be able to help your employees get connected to needed services.

Build a multi-year plan to eliminate disparities. As part of your overall employee health and medical care strategy, build a set of actions targeted to access, participation, and outcome disparities. Recognize that some disparities will be easier to address than others, and a multi-year action plan is required.

Execute your plan. Make use of all available levers, going beyond the direct actions you can take as an employer. First, address the disparities of greatest impact to your organization, including what your health plan providers/system (vendors) can do to address structural issues and provider disparities. Leverage the strengths of the community and family by improving awareness and access to initiatives. Build smarter rules around job and location to incent healthy behaviors. Finally, make an investment in society by participating in local, regional, and national programs to build standards and practices to eliminate health care disparities overall.
Conclusion

Health care disparities either directly or indirectly impact every person in the United States. As health plan sponsors, employers have a unique opportunity to address the blight of disparities in employee health. The path is now clear for employers to take a leadership position—moving forward to reduce and eliminate disparities—to improve the quality of life for employees while at the same time boosting productivity and lowering medical plan costs.

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Sources


12. Telephone survey of four national health plans conducted by Aon Consulting, January 2010.
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