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# Promoting Racial Equity in Health Care: Access and Quality Initiatives at the State Level

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National studies demonstrate that a patient's race, ethnicity, and socioeconomic status seriously impact when and if an individual can get into a doctor's office. These factors also impact what happens once the door opens. States have a role in changing this situation. Unfortunately, it is not entirely clear what array of legislative, regulatory, and fiscal interventions can most effectively attack these problems.

National studies demonstrate that a patient's race, ethnicity and socioeconomic status seriously impact when and if an individual can get into a doctor's office.

The National Healthcare Disparities Report for 2005 documents the inequities that continue to plague our health care system. Minorities and the poor generally suffer higher mortality and morbidity rates that do whites. Minorities and the poor receive lower quality care. They are also less able to access the services that are available. For racial minorities, the "quality gap" is significant even though it has diminished slightly in recent years. For Hispanics, the disparity in health care quality continues to worsen. The same appears to be true of health care access measurements. African-Americans and other racial minorities report slightly better access in recent years; Hispanics report increasing barriers to the health care system.[1]

## I. State Efforts to Promote Equity in the Health Care System

Two years ago, Maryland's General Assembly adopted legislation aimed at attacking these disparities.[2] This initiative gave rise to the "Maryland Plan to Eliminate Health Care Disparities," which offers a preliminary roadmap for coordinating policy efforts in the field. The Maryland Plan seeks to identify the nature and extent of existing disparities, understand their causes, and design interventions to eliminate these differences.[3]

At the state level, three factors will continue to influence the rise and fall of health disparity trends. First, will underserved communities have reasonable access to public health prevention programs? Second, to what extent will these communities be better able to access needed health care? Finally, at the individual practitioner level, will strategies emerge to eliminate unexplained deviations from accepted clinical norms?

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Legal considerations are likely to influence each of these racial equity elements. Statutes, regulations, and grants will need to be drafted. Licenses, contracts, and certificates of need will be awarded. Licensing and disciplinary actions will be prosecuted. The law certainly will not solve this problem, but legal strategies can strengthen the movement to build a more equitable health care system.

## II. Prevention as the First Order of Business

Public health prevention is a sound investment. This is especially true in the field of chronic disease prevention. The U.S. Department of Health and Human Services estimated in 2000 than 46.7 percent of all U.S. deaths were attributable to modifiable health behaviors such as smoking, poor diet, and alcohol use.[4] Chronic disease treatment is the primary driver of health care costs. Researchers believe that nearly 75 percent of health expenditures are related to preventable chronic disease treatments involving conditions such as diabetes, hypertension, and obesity.[5]

To the extent that racial and ethnic minorities shoulder a higher disease burden than other communities, preventive health programs can have a significant impact on individual health outcomes. The design and implementation of these prevention programs can be enhanced through the effective use of legal analyses and strategies.

*Mandatory Vaccination Laws:* In a series of legal reviews conducted for the Centers for Disease Control & Prevention (CDC), Professor Sara Rosenbaum highlighted significant differences in state immunization laws.[6] These studies demonstrate that the manner in which governing statutes reference clinical standards, define personal exemptions, and formulate due process protections can impact childhood immunization rates. A public health program that increases vaccinations for African-American and Hispanic children who previously lacked access to routine medical care clearly promotes a more equitable health care system.

*Lead Paint Remediation Programs:* For children, lead paint exposure may cause a range of adverse health consequences including reduced IQ, attention deficit disorders, impaired hearing, and kidney damage. At

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high levels of exposure, a child may become mentally retarded, fall into a coma, and even die from lead poisoning.[7] Like many states, Maryland adopted statutes designed to enhance lead paint remediation programs.[8] These programs also provide funding for community outreach and case management services.[9] Again, to the extent that a minority population suffers from increased exposure to adverse environmental conditions, prevention and abatement programs that reduce this exposure lower the overall disease burden and help reduce future health disparities caused by this exposure.

*Tobacco Litigation and Prevention:* Perhaps the most significant public health campaign over the last quarter century focused on the tobacco industry. Over time, individual damage actions gave rise to state Medicaid recovery claims. Subsequent settlement agreements imposed advertising restrictions on the industry and provided states with funding to support a range of health promotion efforts.[10] Maryland reserved some of these funds to support prevention programs in minority communities adversely affected by cigarette marketing strategies.[11] A properly framed litigation strategy can assist underserved populations in securing better access to needed care. For example, California's Public Health Trust has used class action and *cy pres* recoveries to support improvements in heath care services for a number of special populations.[12]

## III. Access

At the heart of the health care access debate lies an unresolved policy question: Does this nation consider assuring access to a reasonable measure of health care services a personal right, an individual obligation, or a mere privilege to be meted out as finances permit? On balance, the nation continues to treat health care access as something of a privilege and not a right. Racial equity in the health care system cannot be achieved if large segments of the population lack the financial means to access medical services.

The debate concerning access to health care insurance is again taking center stage in many state legislatures. While this broad debate continues to play out, it is worth noting the ways in which incremental progress can still occur. At the national level, the Clinton Administration's effort to expand the Children's Health Insurance Program was a key incremental gain. Similar efforts are possible at the state level.

*Expanded Access to Community Clinics:* Recent Maryland legislation created a funding pool aimed at supporting the growth of local health care services.[13] The Commission administering these funds seeks to identify underserved areas and enhance the ability of underserved populations to access health care.

*Increasing the Number of "Historic Providers:"* As health care reform proceeds, licensed providers based in a minority community will face new economic challenges. Maryland addressed this problem in the context of moving its Medicaid population into a managed care program. State legislation encouraged newly created managed care organizations to include practitioners who "historically have served the community" in their provider panels.[14] While this helps preserve the limited physician practices that have historical roots in underserved communities, additional emphasis and funding is needed to make specialty services available to many minority communities. [15]

## IV. State Efforts to Reduce Health Care Disparities

As noted in the National Healthcare Disparities Report for 2005, there is a statistically significant gap in the overall quality of healthcare services provided to racial minorities in America:

[D]isparities related to race, ethnicity, and socioeconomic status still pervade the American health care system. While varying in magnitude by condition and population, disparities are observed in almost all aspects of health care, including:

Does this nation consider assuring access to a reasonable measure of health care services a personal right, an individual obligation, or a mere privilege to be meted out as finances permit?

- Across all dimensions of quality of health care including effectiveness, patient safety, timeliness, and patient centeredness.
- Across all dimensions of access to care including facilitators and barriers to care and health care utilization.
- Across many levels and types of care including preventive care, treatment of acute conditions, and management of chronic disease.
- Across many clinical conditions including cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health and substance abuse, and respiratory diseases.
- Across many care settings including primary care, dental care, home health care, emergency departments, hospitals, and nursing homes.
- Within many subpopulations including women, children, elderly, residents of rural areas, and individuals with disabilities and other special health care needs.[16]

These deficits cannot be explained by differences in age, sex, geography, lifestyles, diet, or a myriad of other factors.

There is clearly an argument that expanding access to high quality health care services can remedy some portion of the racial and ethnic disparities problem, but there is also more to be done. The following types of initiatives may prove beneficial in bringing racial and ethnic equality to the health care system.

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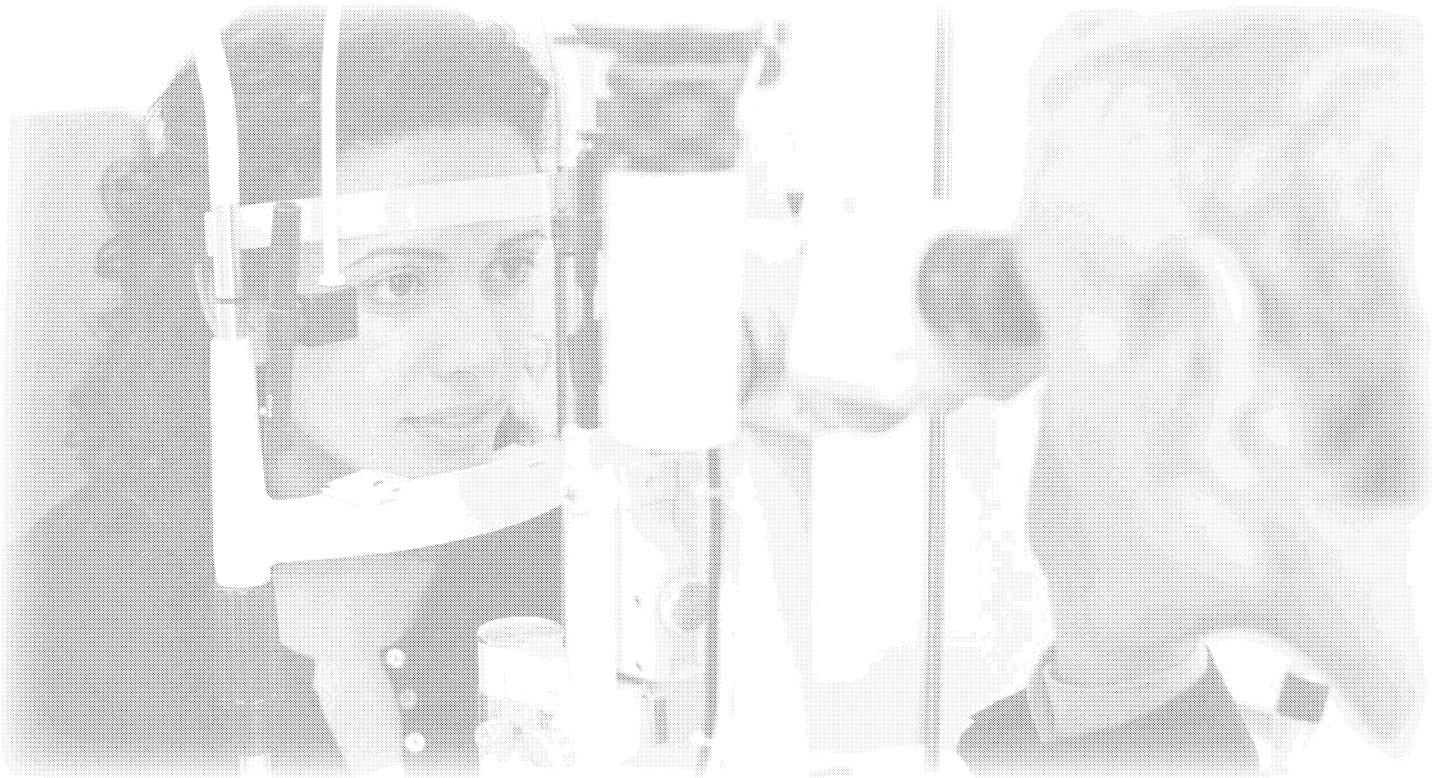
*"Report Cards" and Quality Measurements:* An important milestone in the effort to address health care disparities is creating an awareness that these differences exist. Knowledgeable patients may be able to advocate for more equitable treatment. As more disparities data becomes available, "report cards" can be used to alert consumers and payors about the comparative ability of different providers to achieve quality goals. The Maryland Medicaid Program now tracks certain quality indicators and has created financial incentives to improve provider performance.

*Workforce Diversity and Cultural Competence:* Minorities are seriously underrepresented in many of the health care professions. Under-representation in the provider ranks exacerbates access and cultural competency problems in the overall health care setting. Means exist to address these issues. Professional schools retain the ability to increase minority enrollment and to focus all students' attention on the prevalence of health care disparities. Later, health care licensing boards may impose continuing education requirements on licensees after graduation. All of these efforts could be combined with private sector initiatives to improve access to bilingual health care services such as those provided by CASA of Maryland, Inc.[17]

*Economic Incentives to improve Health Care Quality and Consumer Participation:* State health programs have begun to incorporate financial incentives into the design of health care programs for underserved populations. While not without controversy, West Virginia's Medicaid program has moved to condition a patient's continued receipt of certain Medicaid benefits on compliance with an established plan of care.[18] Overall, the impact of these incentives to secure long-term individual improvements in clinical outcomes is uncertain.[19] Nevertheless, efforts to eliminate disparities at the practitioner level are unlikely to be achieved solely through provider education and regulatory enforcement actions. The active involvement of the patient in achieving this goal is also important.



## V. Conclusion

It is simple enough to assert that health care disparities exist. The more difficult question is determining which specific communities are affected and why. There has been some progress in answering these questions. A still more difficult task is to formulate strategies to eliminate these differences. States clearly have the epidemiological tools needed to frame the debate. They also have the regulatory and fiscal power to encourage providers, health insurers, and even patients to move the debate into forceful action.

1 *See* Agency For Healthcare Research & Quality, U.S. Dept. Of Health And Human Services, Pub. No. 06-0017, National Healthcare Disparities Rep. 5 (2005), *available at* http://www.ahrq.gov/qual/nhdr05/nhdr05.pdf (last visited Feb. 11, 2007) [herinafter Disparities Rep.].
2 *See* Md. Health-Gen. Code Ann. § 20-1004 (2006).
3 *See* Maryland Plan to Eliminate Health Disparities, *available at* http://www.dhmh.state.md.us/hd/pdf/MDPlantoEliminateHealth Disparities Preliminary2006.pdf (last visited Feb. 11, 2007).
4 *See* Ali H. Mokdad et al., *Actual Causes of Death in the U.S.*, 291 JAMA 1238, 1238-41 (2004).
5 *See* National Business Group on Health, The Role of Clinical Preventable Services in Disease Prevention and Early Detection 26, *available at* http://www.businessgrouphealth.org/ prevention/purchasers/guide/part1.pdf (last visited Feb. 11, 2007).
6 *See* Sara Rosenbaum & Alexandra Stewart, George Washington University Medical Center, *Translating CDC Immunization Guidelines into Practice: State Laws Related to the Use of Standing Orders Covering Immunization Practice* (2006), *available at* http://cdc.confex.com/cdc/nic2006/techprogram/P10022.HTM (last visited Feb. 21, 2007).
7 *See* National Safety Council, Lead Poisoning (2004), http://www.nsc.org/library/facts/lead.htm (last visited Feb. 11, 2007).
8 *See* Md. Env't. Code Ann., §§ 6-801, 6-848 (2006).
9 *See id.* at § 6-848 (2) (2006).
10 *See* Md. Health-Gen. Code Ann. §§ 13-1101, 13-1119 (Supp. 2006).
11 *See id.* at §§ 13-1115 (Supp. 2006).
12 *See* Public Health Trust, Linking Settlement Funds to Community Needs, http://www.publichealthtrust.org/settlements/index.html (last visited Feb. 11, 2007).
13 *See* Md. Health-Gen. Code Ann. § 19-2101 *et seq.* (Supp. 2006).
14 *See id.* at § 19-2111(b)(2) (Supp. 2006).
15 *See id.* at § 19-2111 (Supp. 2006).
16 *See* Disparities Rep., *supra* note 1, at 2.
17 *See* CASA of Maryland's Health Program- Bilingual Health Hotline, http://www.casademaryland.org/Health_md.htm (last visited Feb. 11, 2007).
18 *See* Gene Bishop and Amy C. Brodkey, *Personal Responsibility and Physician Responsibility – West Virginia's Medicaid Plan*, 355 New Eng. J. Med. 756, 756 (2006).
19 *See* Agency For Healthcare Research & Quality, No. 101, Economic Incentives For Preventative Care 3 (2004), *available at* http://www.ahrq.gov/clinic/epcsums/ecincsum.pdf (last visited Feb. 11, 2007).

*Endnotes continued from page 9*

60 *See* Personal Responsibility, Work Opportunity and Medicaid Restructuring Act of 1996, Pub. L. No. 104-193, §§ 401-3, *available at* http://www.libertynet.org/edcivic/welfbill.html (last visited Jan. 29, 2007).
61 *See* Mary Otto, *State to Restore Some Coverage to Immigrants*, Wash. Post, Oct. 20, 2006, at B06; Wendy Zimmermann & Karen C. Tumlin, *Patchwork Policies: State Assistance for Immigrants Under Welfare Reform*, 64 Tbl. 8 (Urban Inst., Occasional Paper No. 24, 1999), *available at* http://www.urban.org/UploadedPDF/occ24.pdf (last visited Jan. 29, 2007); Karen C. Tumlin, Wendy Zimmermann & Jason Ost, *State Snapshots of Public Benefits for Immigrants: A Supplement Report to "Patchwork Policies,"* 17 (Urban Inst., Occasional Paper No. 24, 2004), http://www.urban.org/UploadedPDF/occa24_sup.pdf (last visited Jan. 29, 2007).
62 *See* Mary Otto, *State to Restore Some Coverage to Immigrants*, Wash. Post, Oct. 20, 2006, at B06.
63 *See* the Mental Health Parity Act of 1996, P.L. 104-204.
64 *See* Md. Code Ann., Ins. § 15-802 (1994).
65 *See* Timothy's Law (2006) New York Senate Bill 8482; Ohio Sen. Bill 116, 126th Gen. Assem. (2006), *available at* http://www.legislature.state.oh.us/bills.cfm?ID=126_SB_116 (last visited Jan. 29, 2007).
66 *See* Margaret Mead, The Changing Significance of Territoriality in Human Societies, Presentation at the National Institutes of Health (Oct. 17, 1973).