

**RACIAL AND ETHNIC HEALTH INEQUITIES: ECONOMIC IMPACTS &
POLICY SOLUTIONS**

COURTNEY LAWLER

Grand Valley State University

ABSTRACT

This study examines alternative approaches to framing the topic of racial and ethnic health disparities as an economic issue and the exploration of REHD policy at the State level to explore federal program expansion. The analysis explores how the gap between research and policy (action) can be bridged for racial and ethnic health disparities in the United States to achieve health equity. A literature review on the economic impact of REHD is presented to take an alternative approach to framing the issue, which is then followed by an exploration of policy barriers and options, concluding with recommendations for action.

INTRODUCTION

As early as 1899, W.E.B Dubois (1899) observed the existence of Racial and Ethnic Health Disparities (REHDs). In his social study of Blacks in Philadelphia he interpreted statistical data about their health and drew several conclusions that are similar to today. He identified the expected higher death rate of blacks compared to whites, which he expected because of the different living conditions (environmental factors, social degradation) of the two groups (Du Bois, 1899). Also, Du Bois acknowledged the flawed health data collection in Philadelphia that sacrificed the accuracy of statistical analysis. Similar to present day, a multi-causal diagnosis for health disparities was recognized and recommendations were made in 1899. Unfortunately, more than a century later the goal of racial and ethnic health parity in the United States has yet to be realized.

Despite the many decades of recognition there has not been a significant reduction in the inequities of health or health care in the United States. The significant differences in life expectancy, infant mortality, and disease incidence between non-minority and minority populations are just some of the documented disparities in health (Suthers, 2008). Several examples are displayed in Table 1 to show the prevalence of health disparities among all racial and ethnic minority populations. Although the individual groups have diverse health issues, they share the common bond of a *collective history*, “marked by struggle; multiple forms of inequality; and social political, economic, and cultural divides” (Centers for Disease Control and Prevention, 2007).

Racial and ethnic inequities in the delivery of health care have been the focus of over eighty studies between the years of 1984 and 2004. Disparities in cardiac care were identified in sixty-eight out of eighty studies for at least one racial and ethnic minority group, further contributing to the growing body of literature that recognizes the existence of racial and ethnic inequities in health and health care (National Business Group on Health, 2003).

The Institute of Medicine’s 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* marked a key moment in the fight against Racial and Ethnic Health disparities by providing national visibility to the initiative and encouraging the development of academic, health industry, and community discussions/ projects on the topic. The purpose of the report, requested by Congress was “to assess the extent of racial and ethnic differences in the quality of health care received by patients, not attributable to known factors such as access to care, ability to pay, or insurance coverage; evaluate potential sources of these disparities, including the role of bias, discrimination, and stereotyping at the provider, patient, institutional, and health system level” (Nelson, 2002). The existence of racial and ethnic health disparities is well supported by the literature, but the ability to eliminate or significantly reduce the inequalities has not been accomplished.

Minority Group	Racial and Ethnic Disparities in Health
African Americans	<ul style="list-style-type: none"> • Though breast cancer is diagnosed 10% less frequently in African American women than in white women, African American women are 34% more likely to die of the disease. • African American adults are 1.9 times more likely to have a diagnosis of diabetes than non-Hispanic white adults. • African Americans had asthma-related emergency room visits 4.5 times more often than whites in 2004. • Non-Hispanic blacks were 70% more likely to die of viral hepatitis than whites in 2006.
American Indians and Alaska Natives	<ul style="list-style-type: none"> • American Indian and Alaska Native adults are 2.3 times more likely than white adults to receive a diagnosis of diabetes. • American Indian women are 1.7 times more likely to die of cervical cancer than white women. • Infant Mortality rates are 1.4 times higher among American Indians/ Alaska Natives than among non-Hispanic whites.
Asian Americans	<ul style="list-style-type: none"> • Rates of cervical cancer are higher among Vietnamese American women than among any other racial or ethnic group in the United States. The rates are 5 times higher than the rates among non-Hispanic white women. • Even though the rates of asthma are generally lower among Asian Americans than among whites, asthma related deaths were 50% higher among Asian Americans in 2003.
Hispanics/ Latinos	<ul style="list-style-type: none"> • Hispanics were 1.6 times more likely to die of diabetes than non-Hispanic whites in 2005. • Hispanic women were twice as likely as non-Hispanic white women to have a diagnosis of cervical cancer
Native Hawaiians/ Pacific Islanders	<ul style="list-style-type: none"> • In Hawaii, the rate of diabetes among Native Hawaiians is more than twice the rate among whites. • Native Hawaiians are 5.7 times more likely to die of diabetes than whites living in Hawaii.

Table 1: Racial and Ethnic Disparities in Health compiled in the Centers for Disease Control and Prevention *At A Glance 2010* report.

The topics covered in this study are dedicated to alternative approaches to framing the topic of racial and ethnic health disparities as an economic issue and the exploration of REHD policy at the State level to explore federal program expansion. The purpose of the study is to determine how the gap between research and policy (action) can be bridged for racial and ethnic health disparities in the United States to achieve health equity. First, a literature review on the economic impact of REHD is presented to take an alternative approach to framing the issue, which is then followed by an exploration of policy barriers and options, concluding with recommendations for action.

AN ALTERNATIVE ARGUMENT FOR ADDRESSING REHD

Although there is an obvious social justice argument for addressing racial and ethnic health disparities, there is also an emerging and compelling economic affect on all Americans. Various public and private entities have begun to research and estimate the current costs of health disparities, and the future consequences of allowing the trends to continue. This literature review will identify the economic implications of racial and ethnic health disparities at the individual, business, and societal level through both direct and indirect costs. Racial and ethnic health disparities cost the United States a considerable amount in excess costs and addressing the problem could result in significant savings by all.

Method for Selecting Literature

The selected papers were identified from two major sources. The first type of source was a computerized bibliographic database search. The general health science databases searched included: PubMed, CINAHL, and Medline. The general economic database searched was Academic Search Premier. The final computerized database searched was Google-Scholar. The search terms included: racial and ethnic; health disparities; economic impact, expenditures, costs. The full reports and papers were downloaded or requested from Grand Valley State University- Document Delivery then reviewed for appropriateness and relevancy. The secondary source for literature was a review of the bibliographies from the originally selected articles. The same search terms were used to identify related literature that was not captured by the computerized bibliographic database search. The new items were retrieved electronically or via document delivery and reviewed for applicability.

Exclusion Criteria

Literature that did not specifically address *racial* and *ethnic* disparities was excluded. Several of the original articles contained disparities related to disabilities and socio-economic status, which made them ineligible. Also, papers that did not address the economic implications or cost relation for the individual, business, or society were excluded for lack of relation to review requirements.

The Medical Expenditure Panel Survey (MEPS) is a nationally representative survey of the non-institutionalized civilian population that collects detailed information on health care utilization and spending (Le Cook & Manning, 2009) (Waidmann, 2009). This survey was used as the direct source for data analysis in three of the studies (Table 2).

However, the years of MEPS data varied: 2003-2005 (Waidmann, 2009), 2002-2006 (LaVeist, Gaskin, & Richard, 2009), 2001-2005 (Le Cook & Manning, 2009).

Direct medical costs refer to the out-of-pocket health care costs to the individual, business, and public health programs. Indirect costs result from loss of revenue from reduced on-the-job productivity due to poor health or illness, and total loss of productivity from increased rates of absenteeism (National Business Group on Health, 2003) (Suthers, 2008). Three of the papers directly addressed the case of direct and indirect costs associated with racial and ethnic health disparities (Table 2).

Characteristics of Selected Papers	1	2	3	4	5	6	7	8
Source - Medical Expenditure Panel Survey				✓		✓		✓
Direct Medical Costs & Indirect Costs	✓						✓	✓
Estimated Dollar Figures	✓			✓	✓		✓	✓
Individual Level Assessment						✓	✓	
Business Level Assessment (Business Case)	✓	✓	✓				✓	
Society Level Assessment			✓	✓			✓	✓
Specific Disease Assessment (i.e. cost of diabetes, obesity, cardio-vascular disease)	✓			✓	✓			

Table 2: Characteristics of papers selected. 1 (National Business Group on Health, 2003); 2 (Bovbjerg, Hatry, & Morley, 2009); 3 (Lurie, Somers, Fremont, Angeles, Murphy, & Hamblin, 2008); 4 (Waidmann, 2009); 5 (Colorado Department of Public Health and Environment, 2005); 6 (Le Cook & Manning, 2009); 7 (Suthers, 2008); 8 (LaVeist, Gaskin, & Richard, 2009)

An estimated dollar figure refers to actual dollar amounts presented in the paper that were related to health disparities. Five of the papers presented estimated dollar figures within their analysis of the economic impact of health disparities (Table 2). All of the papers provided a cost analysis at the individual, business, or societal level; some of the papers presented more than one view (Table 2). The business case was presented in the affirmative for all of the studies; however, one study did provide an in-depth presentation of the opposing argument to the business case (Lurie et al., 2008). Lastly, three of the papers focused their cost analyses on specific diseases within racial and ethnic populations, rather than only general health costs (Table 2).

The Economic Impact of Racial and Ethnic Disparities

Studies show that minority Americans experience less than average health outcomes from birth to death (LaVeist, Gaskin, & Richard, 2009). The myth that the existence of these inequities is exclusive to the low-income minority population has been dispelled by evidence that reveals racial and ethnic health disparities at every income level (Suthers, 2008). These health inequities have been found to carry a price tag of more than \$230 billion over a three year period (2003-2006) in excess direct costs (LaVeist, Gaskin, & Richard, 2009). The excess costs were paid out by individuals, families, communities, health care organizations, employers, health plans, and government agencies. Although the social-justice issue of providing equitable health care opportunities to minority groups is apparent and relevant to those directly affected, the economic burden that society carries makes the motivation to address the issue even greater.

According to LaVeist et al. the elimination of health disparities between the years of 2003 and 2006 would have reduced direct health care expenditures by \$229.4 billion and indirect costs of health inequalities and premature death by \$1.24 trillion (2009). The economic impact of health disparities is egregious and will only intensify as the diversity of the population increases. As the government looks for places to reduce expenditures and opportunities to fund health reform, the elimination of racial and ethnic health disparities to achieve health equity appears to be a logical and fiscally responsible place to begin. The following sections will go into depth about the individual, business, and societal direct and indirect costs of health disparities.

Economic Impact on Individuals

Lower Quality Care. As mentioned before, the evidence of disparities in the area of cardiac care have been observed by numerous studies. The observation of cardiac care not only has implications for the health of the patient, but also the employer because coronary heart disease and heart disease risk factors are the leading cost drivers for employers yearly (National Business Group on Health, 2003). The treatment and outcomes have been studied and compared for blacks and whites with comparable symptoms, finding that blacks receive lower rates of cardiac catheterization, coronary angioplasty, and bypass surgery (Le Cook & Manning, 2009) (National Business Group on Health, 2003). The lower quality of care provided to minorities in this instance results in poorer health outcomes for the individual and the potential of higher future health care costs, despite having the same health insurance coverage and disease severity (Suthers, 2008) (Le Cook & Manning, 2009) (National Business Group on Health, 2003).

Similarly, disparities exist among cancer patients in both screening and treatment; this type of care is in the upper tail of medical expenditures (Le Cook & Manning, 2009) (National Business Group on Health, 2003). As in the case of cardiac care despite equal insurance, the screening rates for racial and ethnic minorities is less than whites, which places them at a greater risk due to the late-detection of cancer (National Business Group on Health, 2003). Furthermore, treatment disparities among patients with breast, colorectal, lung, and prostate cancers have not improved between 1992 and 2002, with black cancer patients being 23 percent less likely than whites to receive radiation and surgery. (Le Cook & Manning, 2009) (National Business Group on Health, 2003). Insufficient cancer screenings and diagnostic services in the minority population can drive up health costs for the individual and others because the treatment options for late

stage cancer are less cost-effective than early-stage cancer treatments and have decreased survival odds (National Business Group on Health, 2003).

Lost Income and Labor Productivity. The disproportionate burden of disease in the minority community negatively impacts their work force participation. The economic impact on the individual results from increased absenteeism and decreased rates of productivity, which decreases the individual’s earning power (Suthers, 2008). The outcomes also pose an indirect cost on employers by costs related to disability benefits, the hiring and training of new employees, and lost or reduced productivity (National Business Group on Health, 2003). There is a possibility of decreased indirect costs for business organizations to address racial and ethnic health disparities, which is a financial incentive (National Business Group on Health, 2003).

THE ECONOMIC IMPACT OF HEALTH DISPARITIES: THE BUSINESS CASE

The Definition of a Business Case:

A business case for health care improvement intervention exists if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame, using a reasonable rate of discounting. This may be realized as “bankable dollars” (profit), a reduction in losses for a given program or population, or avoided costs. In addition, a business case may exist if the investing entity believes that a positive indirect effect on organizational function and sustainability will accrue within a reasonable time frame. (Leatherman et al., 2003)

The elements of a business case for the elimination of health disparities are the potential reduction in losses or avoided costs, and the positive indirect effect on organizational function and sustainability.

The Impact on Large Employers

Two out of three Americans with health insurance coverage receive it as a benefit from a large employer, identifying them as a major stakeholder in the health care marketplace (National Business Group on Health, 2003). Employers are under the belief that every employee is receiving the same opportunity and quality of health care; however in many instances as previously described this is not the case.



While employers attempt to maintain quality, while restraining the increasing cost of health care benefits, the reduction of health disparities experienced by racial/ethnic minority employees may be an appropriate intervention point. The diagram (Figure 1) illustrates that the negative effects of the problem on the employee may have a direct negative consequence on the employer as well as additional costs and lost revenue. This problem only stands to be exacerbated by the changing demographics of the workforce, which is projected to be made up of 41.5% racial/ethnic minorities by 2015, according to the U.S Bureau of Labor Statistics (United States Bureau of Labor Statistics, 2008).

Impact of Direct and Indirect Costs on Employers

In the case of coronary heart disease that is disparately treated in the racial and ethnic minority community, large employers collectively assumed over \$325 billion in direct and indirect costs in 2002 (National Business Group on Health, 2003) (Suthers, 2008). Employers have a great financial incentive to participate actively in the reduction of health disparities. As a key stakeholder in the health care market, large employers have the leverage to collectively address the delivery of health care services, particularly in the areas of preventative, diagnostic, and treatment (National Business Group on Health, 2003) (Suthers, 2008). The elimination of racial and ethnic health disparities could reduce the annual health care expenditures of employers, which is an opportunity to reduce losses or avoid costs. Also, addressing the issue indirectly affects the organization's function and sustainability by improving the quality of employee health care and increasing the opportunity for better health outcomes and productivity (National Business Group on Health, 2003). A business case exists for large employers to acknowledge and address the problem of racial and ethnic health disparities.

Challenges to the Business Case for Addressing Health Disparities

Although the business case exists for large employers, would the return on investment (ROI) of addressing health disparities be equally beneficial for health care organizations? The argument presented by Lurie et al. focused on the many challenges to using a business case for health care organizations (2008). The common challenges that were identified included: lag-time in ROI, disconnect between investor and the realized beneficiary.

The ROI for health disparity interventions are not immediately realized, especially in the case of chronic disease treatment, because it may be several years before financial investments are recovered (Lurie et al., 2008). There is also the possibility that the return may be realized by an unrelated party rather than the original investor, because of the lag-time and the transient nature of patients and health plans or practices (Lurie et al., 2008). In addition, the fear exists that addressing health disparities will positively impact one entity, while negatively impacting another. For example, an aggressive health plan initiative to reduce emergency department visits for coronary heart disease issues will decrease the emergency department and inpatient care for congestive heart failure (Lurie et al., 2008) (Bovbjerg, Hatry, & Morley, 2009). However, the use of partnerships between multiple health organizations to address the problem can reduce the individual intervention cost, and provide the opportunity to create cost sharing mechanisms to share the benefit of the investment (Lurie et al., 2008). Moreover, the potential cost savings to

individuals, businesses, and society by addressing racial and ethnic disparities is a collective benefit shared by all.

THE ECONOMIC IMPACT OF HEALTH DISPARITIES ON SOCIETY

The societal economic impacts of racial and ethnic disparities have been implicated throughout the previous sections on the individual and business costs. As noted by the Healthy People 2010 initiative: *The Health of the Individual is almost inseparable from the health of the larger community and...the health of every community in every State and territory determines the overall health status of the Nation (Suthers, 2008)*. The relationship between the health of the individual and the community does not stop at a health assessment, but it continues to hold true for a financial assessment. The cost savings of eliminating racial and ethnic health disparities, where the disease incidents were equal between all racial and ethnic groups, would be realized on a societal level.

Cost of Ethnic and Racial Disparities on Medicare and Medicaid

The State of Colorado explored the potential cost savings in Medicaid payments for their state by the elimination of health disparities for three specific diseases. The study revealed that the elimination of health disparities between groups could result in diabetes care savings of \$80 million annually to tax payers, obesity related savings on \$40 million, and HIV/AIDS related savings of \$7.6 million annually (Colorado Department of Public Health and Environment, 2005). This represents the amount of money that could have either been saved or re-allocated to other areas if racial and ethnic disparities did not exist in the State of Colorado (Colorado Department of Public Health and Environment, 2005) (Suthers, 2008).

The combined excess costs as a result of health disparities for the Medicare and Medicaid program were estimated at \$12 billion for African Americans and \$5 billion for Hispanics, according to the study performed by Waidmann (2009). As mentioned on the individual level, the societal economic impact will be further aggravated as the minority population and age increases, and racial/ethnic health disparities remain constant or worsen.

Implications

The economic impact of racial and ethnic health disparities is broad and un-restricted to a group, geographic region, industry, or socio-economic status. The costs at the individual, business, and societal level both directly and indirectly have been well documented. As long as the problem goes unaddressed, the economic implications and consequences that have been presented by the literature will only worsen, and the potential benefits to eliminating disparities will continue to go unrealized to all. As LaVeist, Gaskin, & Richard stated “Usually we think of change as coming with costs, that doing something will cost more than doing what we are accustomed to doing. But in the case of health inequalities, doing nothing has a cost we should not continue to bear.” (2009)

HISTORY OF POLICY ACTIONS

The history of political actions fueled by research reports has not resulted in the effective legislative behavior needed to address disparity issues.

Heckler Report

Although the problem of REHD has existed and been documented for over a century, one of the first formal acknowledgements of the issue was documented in January 1984. Margaret Heckler, the secretary of health and human services during the presidency of Ronald Reagan released *Health, United States, 1983*, a report card regarding the health status of Americans (Gamble & Stone, 2006). Within this report it was noted that “there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation’s populations as a whole” (Gamble & Stone, 2006). The report led to the development of the Secretary’s Task Force on Black and Minority Health in an effort to examine these disparities. Among many things the task force realized were that the underlying factors that caused the disparity were “complex and defying simplistic solutions” (Gamble & Stone, 2006). The observation of the multifaceted causal relationship to REHD made it immediately difficult to frame as a policy issue or gain political will, which is evident in the recommendations that were decided upon by the task force. The recommendations excluded political action, but focused on improved information strategies (education, research, data, and communications interagency). Some critics criticized the report as over simplifying the problem and the solution (Gamble & Stone, 2006). However, supporters acknowledge the Heckler report as a fundamental facilitator of federal and state initiatives to address the issue, which included the development of the Office of Minority Health (federal), related state offices, data collection, and research efforts (Stone, 2006). Unfortunately, it still was not considered a political issue deserving of political action (legislation).

The Health Care Challenge vs. Unequal Treatment

Two government sponsored reports released by different agencies illustrates two of the barriers that will be addressed in the following section. *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination and Ensuring Equality* was authored by the U.S. Commission on Civil Rights (CCR) in 1999, as authorized by Congress to pursue investigations about deficiencies of civil rights (Gamble & Stone, 2006). The report utilized the civil rights framework to examine REHD, this placed discrimination as an essential root cause and a critical component to address to fully eradicate the problem (Perez, 2003). The aim of the report was to evaluate particular offices and agencies that related to the enforcement of civil rights law in health care, which provided a specific purpose and audience to whom the information is directed (Gamble & Stone, 2006). This resulted in a targeted report that identified specific behavioral changes of agencies and offices to combat REHD. The Institute of Medicine (IOM) released a report in 2002 that was titled *Unequal Treatment*. The aim of this study was much different than the CCR report. Congress requested that the IOM fulfill three requests which included:

- Assess the extent of racial and ethnic disparities in health care that are not otherwise attributable to known factors such as access to care.
- Evaluate potential sources of racial and ethnic disparities in health care, including the role of bias, discrimination, and stereotyping at the individual level.
- Provide recommendations regarding interventions to eliminate healthcare disparities (Gamble & Stone, 2006).

The framework utilized by the IOM was very scientific and the expectations of the study were broader than that of the CCR report. Therefore, the IOM did not directly indicate *who* should carry out the recommended actions and as acknowledged by Gamble and Stone, “commands uttered to no one in particular will likely not fall on *any* ears, let alone deaf ones” (2006). The IOM report contains strong scientific evidence that could support political action if present, but it does not solely incite political will. Conversely, the CCR report provoked political action by the framing of the issue, unfortunately the political climate swiftly changed as President Bush took office (Gamble & Stone, 2006).

Barriers

The existence of a social problem does not guarantee transformation to a policy issue, even if it is strongly recognized by scientific research. As illustrated by the three reports in the previous section the absence of political will and a fertile political environment can be a major barrier to addressing social issues. What are the barriers to converting REHD to political issues?

DISPARITY VS. INEQUITY

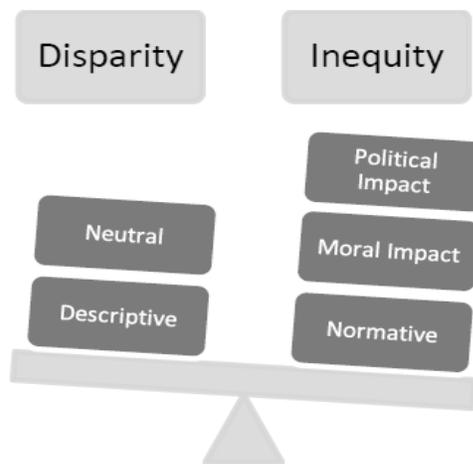


Figure 2: Framing the issue of REHD with terminology (Gamble & Stone, 2006).

The term disparity is a descriptive, politically neutral term. It simply described the difference between the population’s health status or access, while failing to indicate a

right or a wrong. Inequity is a normative term, meaning it acknowledges a preferred behavior. The term categorizes the difference in population's health as "unfair, unjust, or morally wrong" (Gamble & Stone, 2006).

Both terms can be used as a political strategy, to either charge up the base or make the information more neutral and spectator-friendly/scientifically-unbiased. The accepted terminology in the United States is *disparity*, however inequity is commonly used internationally (Pittman, 2006). The use of *disparity* in the U.S. can be considered a barrier to aggressive political discourse and action related to REHD, because it fails to frame the existence of differences as wrong.

Opposing Political Agendas

The congressionally mandated report *National Health Care Disparities Report* was released in 2003 with the assumed responsibility of delivering objective and truthful research to Congress for policy and budgetary decisions (U.S. Department of Health and Human Services, 2003). Instead, Tommy Thompson, the secretary of health and human services, published a report that was grossly inaccurate and had a heavy political agenda to remove REHD as a political issue. The original report was generated by the Agency for Health Care Quality and Research and was stripped of the following characteristics/items:

- Eliminated researchers' conclusion that national disparities are "national problems"
- Traded a discussion on the social costs of disparities with a list of the "successes"
- Exchanged examples of very significant health disparities with milder examples.
- Eliminated the term "disparities" and exchanged it for "difference" (Gamble & Stone, 2006)

The revised version was in direct contradiction of more than one hundred years of research on the topic and was obviously inaccurate. As a result of guerrilla activity by staff members of the DHHS the original report was leaked, forcing the secretary to retract the *revised* version (Gamble & Stone, 2006). The political climate of the Bush Administration was not in support of addressing REHD and therefore, took action and liberties over research findings to create a new agenda and eliminate the concern and funding of REHD issues.

Misconceptions & Misdirection of Political Leaders

A 2006 study indicated that lawmakers may view the issue of REHD as a fairly new topic; however, the literature has supported its existence for more than a century (Ladenheim & Groman, 2006). This indicates disconnect between the history and existence of the issue and the policy makers that can foster political will to bring about legislation. Additionally, some legislatures believe that it is the responsibility of other agencies to address the problem and there are more pressing issues to deal with. Lastly, some legislatures are not comfortable addressing health along the lines of racial categories, but would rather focus on poverty or rural lines as suggested by one Arizona senator (Ladenheim & Groman, 2006). Although health disparity issues can be identified socioeconomically and geographically, the health disparity experienced by minorities in

the U.S. cannot be sufficiently addressed by re-focusing the initiatives to other more politically acceptable areas.

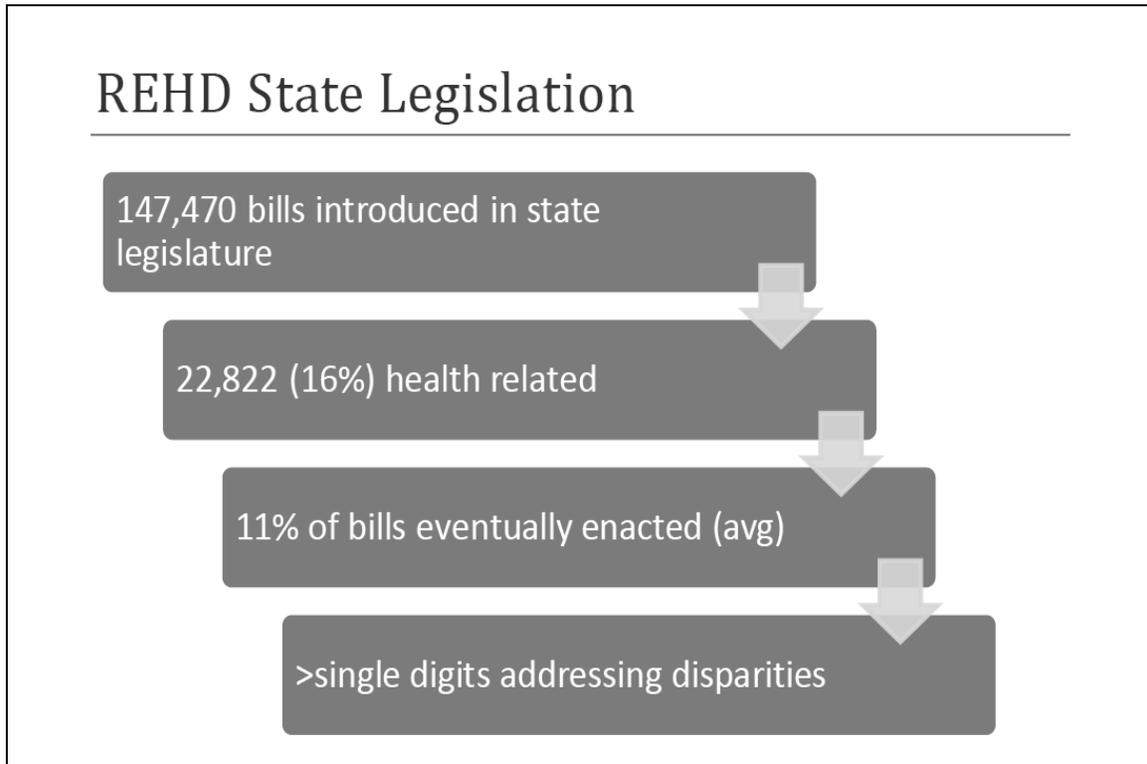


Figure 3: During the 2001 legislative session the trend of bills introduced, health-related, enacted, and related to disparities (Ladenheim & Groman, 2006)

State legislative action as it relates to health disparities is not as strong as indicated by Figure 3. The less than single digits' representation of bills indicates that REHD is not a relevant policy issue. However, when policies are introduced and sometimes passed there have been certain trends nationally and then unique to specific states.

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Office of Minority Health

A popular type of REHD state legislation (prior to 2001) was the development of an Office of Minority Health, which has been established by thirty-six states as indicated by Figure 4. (Ladenheim & Groman, 2006). In addition to establishing an OMH, some states developed a permanent fund in their treasury that is dedicated to minority health research and education.

Race-Specific and Disease-Specific

Since 1974 there have been state laws that address sickle-cell anemia (disease specific), which disproportionately affects African-Americans (Ladenheim & Groman, 2006). The long history of legislation that includes 12 states as of 2001 makes disease/population-

specific lawmaking one of the earliest consistent state legislative activities related to REHD. In the last decade many of the disease specific legislation was focused on the *Healthy People 2010* targets.

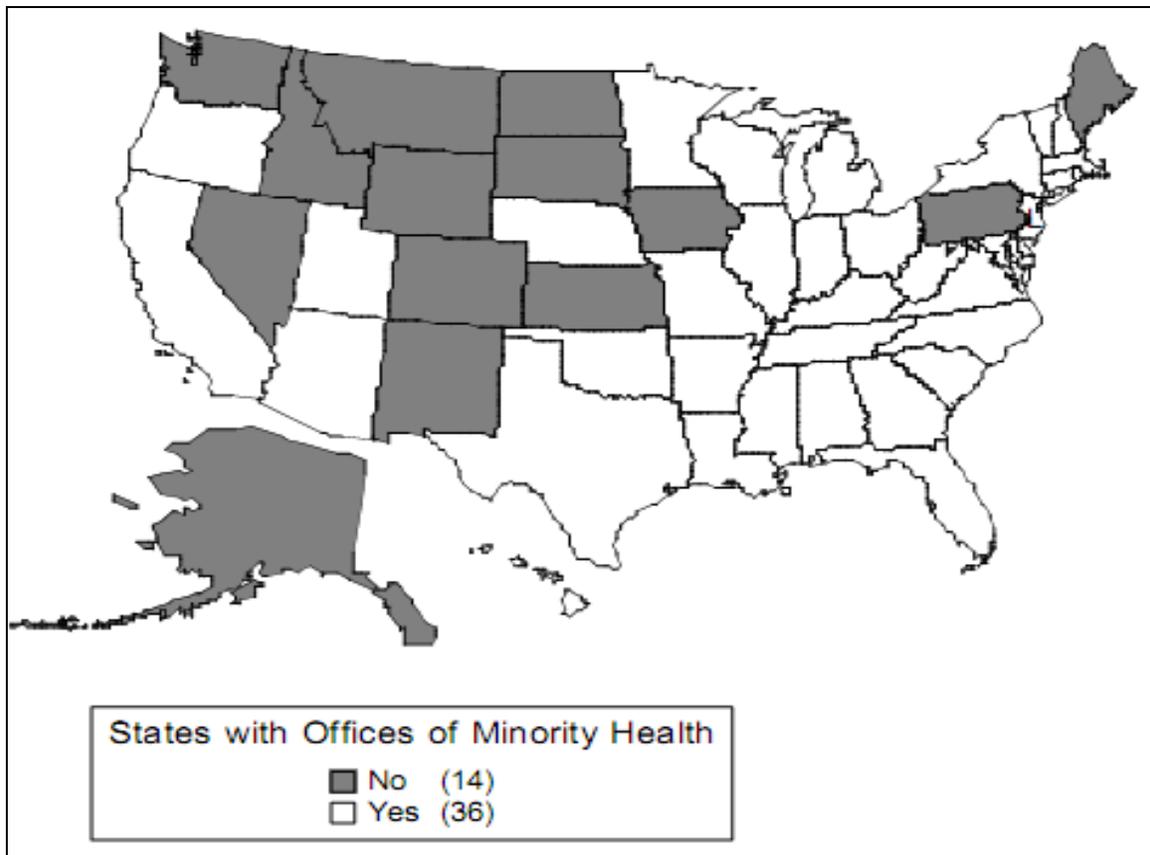


Figure 4: State Offices of Minority Health 2002

Minority Health Care Professionals

The third highest rank of state legislative action was in the area of minority health care professionals, focusing on both recruitment of minority students in health professions and encouraging the placement of health providers in medically underserved areas (Ladenheim & Groman, 2006). From 1996-2001, nine states legislated 12 laws related to minority health care professionals. One of the more aggressive approaches was in Florida, where “any entity contracting with the Agency for Health Care Administration to provide health care services to Medicaid recipients must submit a plan demonstrating the entity’s ability to recruit and retain minority health care providers” (Ladenheim & Groman, 2006). Although there has not been an overwhelming amount of state legislation concerning REHD, there have been trends in widely used policies and creative adjustments to the norm.

FROM RESEARCH TO ACTION

The following recommendations should be considered to bridge the gap between research and demonstration projects and larger action to address REHD.

Expansion of Florida Minority Health Care Professionals Program

The existing program in Florida as indicated in the earlier section takes a unique and aggressive approach to recruit, place, and retain minority health care providers. The program should not only target health care services that are recipients of Medicaid dollars, but Medicare dollars as well; this will expand the affected institutions to include all of those receiving government funding. The program should have strong evaluation and oversight components that guarantee compliance and measure success. After the adoption of more stringent regulation in Florida, the program should be expanded nationally if successful. This would require all hospitals that receive federal funding to develop and submit a plan that exhibits their ability to recruit and retain minority health care providers. This would create a commitment to increasing the minority population of health professionals, which could have a positive effect on provider patient interactions and overall cultural competency of the health care service. Furthermore, this would have the potential to foster industry interest in facilitating minority health education recruitment at the University level.

Re-Framing of REHD Issue

As presented earlier, the use of *disparity* as opposed to *inequality* weakens the framing of the issue of racial and ethnic health disparities. There should be a concerted effort to standardize the use of *inequality* instead of *disparity* because of the stronger moral and political implications. The use of language to fully express the intensity and nature of the problem is important in developing consensus on how to address it. The use of *inequality* allows for truer dialogue about REHD. Additionally, some politicians believe the use of the word *minority* is not relevant for legislation and that will make bills more successful by removing that term (Ladenheim & Groman, 2006). Although the broad approach of *disparities* may gain more political support, it far from addresses the completeness of the issue. It would be a step in the wrong direction to deny an essential part of the description and the issue, which is minority health.

CONCLUSION

As previously indicated, the literature strongly supports the existence of racial and ethnic health disparities. By framing the issue using the economic impact it presents at the individual, business, and societal level the effects are more widely shared and realized by the non-minority population. By providing an alternative approach to understanding the problem it creates an additional opportunity to build greater consensus about the urgency in addressing the issue of REHD. In addition, when discussing the issue it is important to use more morally/politically charged language to convey the urgency of the problem that can be universalized by a discussion of the economic impact. Lastly, by using re-framing and political will to bridge the gap between established research and

political action, the issue of racial and ethnic health disparities can be addressed legislatively.

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