



# In the Literature

## JOURNAL OF HEALTH POLITICS, POLICY AND LAW SPECIAL ISSUE: COMPARATIVE PERSPECTIVES ON HEALTH DISPARITIES

Vanessa Northington Gamble,  
M.D., Ph.D.  
Deborah Stone, Ph.D.  
Kala Ladenheim, Ph.D.  
Brian K. Gibbs, Ph.D.  
et al.

*Journal of Health Politics,  
Policy and Law*  
February 2006  
31(1)

Abstracts are available at:  
[http://jhpl.yale.edu/current/  
abstracts311.html](http://jhpl.yale.edu/current/abstracts311.html)

For more information about  
this study, contact:

**Mary Mahon**  
Public Information Officer  
The Commonwealth Fund  
TEL 212-606-3853  
E-MAIL [mm@cmwf.org](mailto:mm@cmwf.org)

This summary was prepared  
by Martha Hostetter and  
Deborah Lorber.

Commonwealth Fund Pub. #921  
April 2006

*In the Literature* presents brief  
summaries of Commonwealth  
Fund-supported research recently  
published in professional journals.

THE COMMONWEALTH FUND  
ONE EAST 75TH STREET  
NEW YORK, NY 10021-2692  
TEL 212.606.3800  
FAX 212.606.3500  
E-MAIL [cmwf@cmwf.org](mailto:cmwf@cmwf.org)  
<http://www.cmwf.org>

Racial and ethnic disparities in health care were the theme of a special issue of the *Journal of Health Politics, Policy and Law* (Feb. 2006), which includes four articles supported by The Commonwealth Fund. Rather than simply describing the problem of racial disparities in health care, the authors attempt to refocus policy discussion on finding solutions, including efforts now under way at the state and local level.

### From Research to Action

Writer and civil rights activist W. E. B. Dubois documented racial inequalities in health as early as 1906. A century later, such disparities still persist. In "[U.S. Policy on Health Inequities: The Interplay of Politics and Research](#)," Vanessa Northington Gamble, M.D., Ph.D., of Tuskegee University, and Deborah Stone, Ph.D., of Dartmouth College, argue that social problems do not become policy priorities just because research demonstrates they exist.

Whether research catalyzes political action depends to some extent on how it is presented. The U.S. Commission on Civil Rights' 1999 report, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination and Ensuring Equality*, framed disparities in terms of discrimination and recommended addressing them through stronger enforcement of existing legislation. The authors note that, while potent, this approach depends on the will of the executive branch.

By comparison, the Institute of Medicine framed its 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in*

*Health Care*, as an objective, scientific inquiry into multiple causes of disparity. The report made general recommendations about restructuring health care delivery without assigning responsibility to specific actors or agencies. Yet, the report carries the imprimatur of scientific evidence and may inspire action within the care delivery system.

The authors conclude that, to maximize impact, researchers should focus on intervention strategies; investigate the controllable causes of disparities, such as institutional rules; target political actors who have the authority to make changes; and be willing to use moral language to fuel political will.

### State Policy Framework

In an additional article in the issue—"[Reframing the Racial Disparities Issue for State Governments](#)"—Stone proposes a way for state policymakers to catalyze political action.

The "story" of racial and ethnic health disparities is complex, she contends. There are disparities in terms of health status, insurance, and medical care, with evidence pointing to complex, interlocking causes. Stone argues that the most compelling way for policymakers to frame the issue is in terms of distributive justice, in which medical care should be distributed according to need. Although health care is often discussed and provided as a market good, many Americans believe that medical treatment is essential to well-being, rather than an optional consumer good.

Framing the issue of racial disparities in this way—that is, as a deviation from medical need, rather than a result of racial and ethnic bias—could defuse some of the explosive energy associated with racial politics, Stone says.

Under the framework of distributive justice, state policymakers could use their power over public health information to reveal patterns of injustice or examine how health care financing policies cause inappropriate distribution of medical services.

### **State Legislative Actions**

In “[State Legislative Activities Related to Elimination of Health Disparities](#),” Kala Ladenheim, Ph.D., and Rachel Groman, M.P.H., of the National Conference of State Legislatures, examine the trends in state legislation related to disparities in care and access and find that the mix of strategies reflects the differing ways that states understand gaps in minority health.

Disease- and population-specific legislation was the earliest type of activity, and continues to be an important approach. Prior to 2001, the creation of an Office of Minority Health was the most common type of legislation aimed at reducing disparities. Other laws in the 1990s focused on making care available and affordable, as well as recruiting minority health care personnel.

During the 2001–02 legislative session, many bills called for studies of disparities and appropriations for specific minority health initiatives. Measures related to cultural competence also were common.

In addition to allocating resources and setting policy, policymakers use state legislatures to educate their peers, health care providers, and the public about racial and ethnic health disparities.

### **Measuring Success**

The variation among states’ efforts to reduce health disparities makes it difficult to compare their effectiveness and

share lessons across the nation. In “[Reducing Racial and Ethnic Health Disparities: Exploring an Outcome-Oriented Agenda for Research and Policy](#),” Brian K. Gibbs, Ph.D., of the Harvard School of Public Health, and colleagues argue that standard variables are needed to measure the efficacy of disparities reduction initiatives.

Specifically, the authors propose the use of a disparity reduction profile (DRP) and a disparity index (DI). They suggest modeling the DRP, intended to measure state efforts to reduce disparities, on the AIDS Program Effort Index. The DRP could take into account organizational structure, policy and planning, the legal and regulatory environment, and monitoring and research.

The DI, a set of 18 health status indicators developed by the Centers for Disease Control and Prevention, could be used to track changes in racial and ethnic health disparities. In pilot tests in California, Massachusetts, Michigan, and Mississippi, use of the index in this way showed considerable promise as well as some limitations.

Such an outcome-oriented approach to addressing racial and ethnic health disparities, the authors argue, would move “beyond ‘doing something’ to ensuring that proposed efforts have an impact on improved health status.”

### **Facts and Figures**

- Racial and ethnic disparities exist in numerous areas of diagnosis, treatment, and preventive care, even when income, insurance status, and other socioeconomic factors are held constant.
- Historically, California, Florida, and Louisiana—all states with substantial minority populations—have been the most active in dealing with minority health issues through statutes.