Improving the Odds

Dozens of states aim to help minorities and low-income residents receive better medical care and live healthier lives.

BY MELISSA HANSEN

When it comes to health and health care, not all people are created equal.

Your race, ethnicity, income, occupation, education, insurance and even where you live can have a significant impact on your health and the quality of care you receive. As the nation focuses on health care reform, these differences—referred to as health disparities—are beginning to get more attention from lawmakers.

Some of the differences are striking. Native American women, for example, are nearly twice as likely to die from cervical cancer compared with white women. African Americans are one and a half times as likely as whites to have high blood pressure.

Given the wide range of factors than can lead to disparities, including people's own behaviors, lawmakers are looking at a broad array of policies, including ones that will improve access to care, strengthen family finances and improve the overall health of communities. And across the country, dozens of states already have taken actions that range from improving access to healthy food to lowering the cost of health coverage.

"One of the greatest public health challenges facing our nation is the elimination of health disparities, that disproportionately effect the lives and well-being of racial/ethnic minority populations," says Barbara Pullen-Smith, president of the National Association of State Offices of Minority Health.

"A comprehensive approach is needed, which includes national, state and local level policies and practices."

INSURANCE COVERAGE

Lack of health insurance is probably the most widely recognized dividing line between health "haves" and 'have nots." About 45.7 million Americans—17.1 percent of the population under age 65—lacked health insurance in 2007, according to the Census Bureau. Breaking those numbers down, however, shows that minorities are far less likely than whites to be covered: About 33 percent of Hispanics and Native Americans and 21 percent of African Americans are uninsured compared with 12 percent of whites. People who lack health insurance are in poorer health than those with coverage, often delay seeking services and may not receive proper care.

Hispanics are much less likely to have a regular primary care physician, and African Americans are twice as likely to use a hospital emergency room than white Americans.

Most uninsured people report the cost of premiums as the biggest barrier to coverage, so states have expanded public programs and made private coverage more affordable.

From 2005 to 2008, more than half the states passed laws to cover more kids, and at least 12 increased coverage for parents. Expanding access can help reduce racial and ethnic health disparities, but it will not eliminate them.

SOCIAL FACTORS

Income, education, occupation, where people live and what sort of resources are available in their neighborhoods also have an effect on health and care, according to the Centers for Disease Control and Prevention.

Not surprisingly, as personsal income rises health improves. Some states are evaluating programs to help poor families build financial assets to break the cycle of poverty. Three states—Delaware, Pennsylvania and New Mexico—have state-level commissions, and 11 others have statewide nonprofits with the same mission.

Where you live affects your health, too. Places to exercise, close-by grocery stores or farmers' markets, and places to plant a vegetable garden can all play a role in a person's health. Obesity—a major risk factor for diabetes and some cancers—remains much higher among minorities than among whites. In fact, 70 percent of African-American adults are overweight or obese.

Twenty-four states passed legislation to increase access to healthy food or opportunities for physical activity in 2008, including programs to bring fresh produce into communities and schools, build bicycle and walking paths, and develop grocery stores where none exist.

Lawmakers have paid special attention to helping kids stay healthy. In 2008, at least 23 states considered some type of school nutrition legislation, and six made changes to food and beverage options.

GAPS IN QUALITY

Not all health disparities, however, can be explained by income, lack of health insurance or the community where people live. Racial and ethnic minorities are less likely to receive recommended care, such as diagnostic tests or referrals to specialists even when they are insured, research indicates.

This may be the result of a confusing health care system, or a lack of coordination among primary care providers, specialists, pharmacists, the patient and administrators. As well, not all doctors, hospitals and other health care providers deliver the same quality of care, a problem magnified for patients who do not speak English well.

"Improving cultural competency within the health system is the only way you can eliminate health disparities," says Maryland Delegate Shirley Nathan-Pulliam. "Policies have to address the many causes—biological and social—that cause health disparities."

Melissa Hansen, works on primary care, rural health, and disparities in health for NCSL.

DELEGATE
SHIRLEY
NATHAN-PULLIAM
MARYLAND

REPRESENTATIVE
OMERIA SCOTT
MISSISSIPPI

CULTURE BARRIERS

"Some communities are afraid to go to the doctor," says Mississippi Representative Omeria Scott. "There is a real fear of the institution of medicine. To improve the quality of care for minorities, the health care system really needs providers who understand how culture interacts with health."

This means encouraging more minorities to become health care workers, Scott says. Studies show that minority physicians are more likely to practice in underserved areas serving the poor, people of color and those enrolled in Medicaid. West Virginia, New Mexico and Tennessee have passed laws that encourage minority youth to pursue a career in health.

West Virginia's Legislature created a math and science program for middle and high school students that helps prepare minority and disadvantaged students for health-care jobs. Of the 2,500 students who have participated since 1994, 95 percent who graduated went to college and 59 percent majored in health-related fields.

OTHER OPTIONS

Some states also have focused on a patient-centered care model, what is referred to as a medical home, to try to reduce disparities.

The aim is to better coordinate care and focus on primary and preventive services, education and family involvement. While definitions vary, a medical home usually includes an ongoing relationship with personal physician; medical practices that address the whole person—physical, mental, emotional health; coordinated care across the health system; high quality and safe care; access to care when needed, including off business hours; and a payment system that recognizes the value of these services.

Legislators play an important role in creating and supporting this model, especially in the policy areas of health information technology and provider payment reform. From January 2007 through August 2008, 132 bills to improve information technology were enacted in 44 states and the District of Columbia. Iowa and Minnesota passed laws to change the way doctors and hospitals are reimbursed as an incentive to increase prevention and primary care and create medical homes.

Community health centers, which serve more than 18 million uninsured and low-income people, also play a role in reducing disparities. Research indicates minority patients of health centers—and 63 percent of the patients are minorities—have fewer disparities in health than their counterparts who are not health center patients.

Supporters of the centers suggest this is, in part, because they are located in underserved areas, governed by community members, and cannot turn people away regardless of ability to pay. Lawmakers in 35 states and the District of Columbia have increased funding to a total of $590 million in 2008.

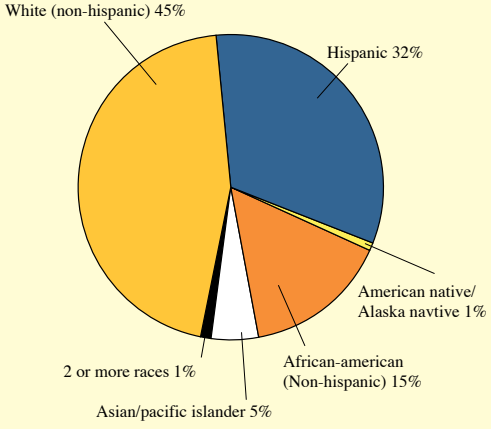
TAKING RESPONSIBILITY

The best health care program, of course, is one that helps people stay healthy in the first place. State policies aimed at preventing obesity, diabetes, heart disease and other ailments are common. In addition, lawmakers and the insurance industry are encouraging people to take responsibility for their health with incentives and consequences. Programs help people stop smoking, eat a healthy diet, exercise, take their medications as prescribed, and test their blood glucose levels.

"Communities and states should encourage citizens to be more aware of healthy lifestyles, recognizing that not everything requires a government plan or an appropriation," says North Dakota Senator Judy Lee.

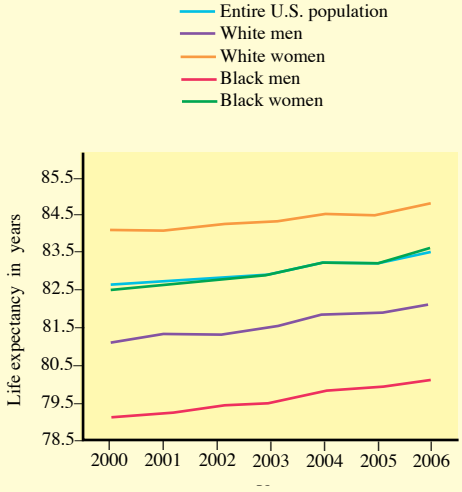
WHO'S UNINSURED

Breakdown by race of the approximately 45 million people who are not insured.



Note: American Indian group includes Aleutian Eskimos.
Source: Urbane Institute and Kaiser Commission on Medicaid.

LIFE EXPECTANCY BASED ON RACE AND GENDER



Source: Urbane Institute and Kaiser Commission on Medicaid.

"People can put a tomato plant and herbs in a patio pot, as well as in a flower bed or community garden. We can walk and bike through our neighborhoods."

West Virginia and South Carolina have reformed their state Medicaid programs to enhance beneficiaries' involvement and responsibility. West Virginia will provide additional health care services to members who agree to go to a medical home for check-up, arrive on time for appointments and use the emergency room for emergencies only.

Other states—Colorado, Minnesota and Oregon for example—are looking to improve transparency in the health care system so that patients can be more informed consumers. States also have invested in smoking cessation programs and workplace-based wellness programs.

CREATING A PLAN

Since 2005, 35 states have adopted statewide comprehensive plans to reduce health disparities among minorities.

The Massachusetts legislature, for example, created the Commission to End Racial and Ethnic Health Disparities in 2004. Its 50 policy suggestions led to the creation of the Massachusetts Health Disparities Council, the Health Care Cost and Quality Council, and a $250,000 grant program directed at community organizations.

This also has been discussed on Capitol Hill. Members of the Asian, Black and Hispanic caucuses in Congress in June promised to include language addressing disparities in any health reform. They want more funds for community health centers, expansion of the National Institutes of Health's focus on minority health concerns, efforts to diversify the health care workforce and better data on the health status of minorities.

The Obama administration would welcome legislation that included a focus on reducing health disparities, says Health and Human Services Secretary Kathleen Sebelius.

"Minority Americans not only are more likely to be uninsured, but are less likely to have quality care when they come to seek the care that they need," she says.

Even in this recession, health reform will remain on both the national agenda and that of many state legislatures.

REPRESENTATIVE
JEFFERY SANCHEZ
MASSACHUSETTS

"The crisis of health disparities has many faces, and for that reason we need many different approaches to properly address them," says Massachusetts Representative Jeffery Sanchez. "We cannot let our current economic situation distract us from addressing the inequities in health and from achieving access to affordable, quality and accountable health care for every resident."

CHECK OUT more about the steps states are taking to address health disparities and see a 50-state map showing the 35 states that have created statewide strategic plans to address the problem at www.ncsl.org/magazine.