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Riots and Rebirth: The Role of Policy Sciences in Addressing Disparities in Health Care

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“Of all forms of inequality, injustice in health care is the most shocking and inhumane”
Martin Luther King, Jr.

**Introduction**

Among African Americans, health and health care disparities are exacerbated by the complexity of the U.S. health care system and the design of policy models used to craft health policy. Health policy analysis plays a central role in the health care delivery system because it serves as the mechanism through which public resources are allocated, which in turn determines the priorities of medical research, the supply of health care providers, and the distribution of medical care.

In the United States, the government plays an important role in planning, directing, and financing health care services. Public programs account for nearly 40 percent of the nation’s personal health expenditures. Over 50 percent of all health and research development funds are provided by the government through programs such as Medicare and Medicaid. With this being said, the government finances the training of most physicians and other health care personnel, and most community-based and university hospitals rely on government expenditures for a significant share of their revenues.¹

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The current cadre of health policies and programs of the U.S. government evolved incrementally in response to clearly defined market imperfections that resulted in unmet needs. In the health delivery system, the role of government has historically been one of support to the private sector, rather than that of a direct provider of health care services. This role presents an interesting puzzle, which has baffled health policy analysts over the years. As a result, the United States has not pursued a comprehensive resolution to the national crisis that has emerged due to the rising costs of health care, racial and ethnic disparities in health and health care, or the issues surrounding the quality of health care.

This paper examines the origins of health disparities in the United States and the persistence of racial disparities in health care. It begins with a descriptive review of the health care of African Americans as it compares to that of Anglo Americans. This section is followed with a discussion of the dimension of policy development in health. The next section discusses more specific policies and programs that developed or expanded over the past thirty years, which were aimed at health inequalities. The fourth and final section offers suggestions for improving policies to eliminate racial disparities in health care.

The challenge with contemporary health public policy is that it has strayed too far from the original aims of the field of policy sciences. This aim was fastened on a broader socioeconomic approach to multi-faceted problem solving.\(^2\) Instead, in the past 40 years we have witnessed the crowning of the rationality theorem as articulated in the discipline of economics.

Traditional policy analysis in health is dominated by the proposition that we can resolve health care controversies in the health care sphere through traditional economic reasoning. Under classic welfare economics, it is argued that the systematic rationalization of medical and health-policy decision making is possible when medical services are valued and weighed against the enhancement of

biological functioning so as to maximize society’s collective welfare. This view has been intensively criticized and its efficacy has been challenged on the grounds of effectiveness and policy direction.

The traditional policy analysis approach, with its emphasis on the welfare economics model and its positivist foundations, is inadequate to improve policy decisions that address health care disparities. This framework lacks the tools to analyze this problem because of its complexity. The classic welfare economics framework is designed to identify efficient solutions at the expense of fairness and human dignity. Brown has argued that such models are incapable of incorporating the full complexity of people’s thoughts about health policy issues. For example, as a society we lack a consensus on how to value benefits and harms of therapeutic intervention. There are vast differences over what types of benefits and harms should be factored into a cost/benefit calculation. It remains unclear how such costs and benefits should be measured, and how society’s competing demands for social welfare should be mediated (i.e., how do we balance the maximization of social welfare and provide the level of health care that individuals desire without regard to cost?). As a result, the model envisioned by classic welfare economics is beyond our cognitive and moral reach.

The traditional policy analysis approach is argued to be antiquated because it does not accurately reflect the contemporary practice of medicine. We know little about the efficacy of most of medicine, and the complexity and variability of patients’ illnesses make large advances in this knowledge unlikely in the foreseeable future. In light of this medical uncertainty, the cognitive constraints of individual physicians, the emotional needs of individual patients, and the persistent moral disagreements about the value of medical interventions make policy analysts question whether the model is robust enough to capture the complexities involved in the practice of medicine. Traditional policy analysis approach reflects a Newtonian/positivist worldview with a focus on

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4 Steven Brown, Political Subjectivity: Applications of Q-Methodology in Political Science (New Haven, CT: Yale University Press, 1980).
This view has been discredited by research in the fields of quantum mechanics, chaos theory, and cognitive science. Fischer has made a similar argument and suggested that policy analysis in general needs to take into account the new realities of science.

The weight of the evidence of racial health care disparities in the medical literature is overwhelming. There are health care disparities in both preventive services and therapeutic treatment. In studies where researchers control for income, education, and health insurance status, significant differences are found in the preventative services and therapeutic treatment that African Americans and white Americans receive for life threatening diseases such as breast cancer, heart disease, HIV-AIDS, liver disease, and lung cancer. Even more troubling is the fact that there is

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a substantial body of literature that reports significant racial disparities in the general treatment of pain.  

Causes and Explanations for Racial Disparities in Health Care

The previous section of this article detailed the fact that race is closely associated with the provision of health care in the United States. On almost every major health access measure (mortality, morbidity, and disability), African Americans have less access to health care than their white counterparts. According to the Center for Health Equity Research and Promotion, disparities in health and health care often result from four factors: social and environmental factors, system and policy factors, individual factors, and provider factors; however, provider factors, such as the knowledge, attitudes, practice patterns, communication and the cultural competence of doctors, nurses and treatment staff affect the major health access measures and functional status. Further widening the gap, the lack of health insurance coverage is often cited as a reason for the racial disparity in access to care. Data from the National Health Interview Survey show that African Americans are more likely to be uninsured than Anglo Americans.

A second potential explanation for disparities in utilization of health care is the type of insurance. Given the propensity of managed care to restrict access to care through utilization management techniques, some African-American health care advocates have been concerned. The

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15 Morehouse Medical Treatment and Effectiveness Center, “A Synthesis of the Literature.”


concern is that as the nation moved toward the adoption of managed care as the solution to the health care cost crisis, African-American health consumers would be disproportionately harmed. Others have argued just the opposite, that HMOs and managed care plans are better for African-American health consumers because they are more inclined to promote health and disease prevention through preventive services.\textsuperscript{18} The fact remains that regardless of the type of health insurance, African Americans experience differences in the level and type of health care they receive.

Third, there are some studies that attempt to show that biological/genetic differences between black and white persons could explain most of the disparities found in health and health care. According to Gornick, when six major risk factors are studied—smoking, systolic blood pressure, cholesterol level, body-mass index, alcohol intake, and diabetes—only 31 percent of the excess mortality between black and white adults could be explained; another 38 percent was explained by income differences.\textsuperscript{19} This analysis leaves almost one-third of the excess mortality unexplained.

A fourth explanation for the continued disparities in health and health care can be traced to race-based discrimination in health care. Given that integration in the provision of health services is a relatively recent event in the United States, it should come as no surprise that systematic discrimination still exists in some pockets of the health care system. Some of the current levels of racial disparities can be explained by personal discrimination on the part of providers; however, the vast majority of the race-based discrimination in health care takes place at the societal level.\textsuperscript{20}

According to Williams and Rucker, societal discrimination has changed over time from the in your


\textsuperscript{19} Marian E. Gornick, \textit{Vulnerable Populations and Medicare Services}. 2000.

face “Jim Crow Racism” to the more faint “laissez-faire racism.” Smedley et al., found that racial and ethnic minorities tend to receive low quality health care when compared to non-minorities. This is true even when access-related factors, such as a patient’s insurance status and income, are the same or similar. Provider prejudice and stereotyping often affect clinical decision making, particularly because some physicians still view minority consumers, African-Americans in particular, as “less intelligent, less educated, less likely to comply with their advice, and more likely to have problems with alcohol and drugs.” Clinical encounters that involve stereotyping, biases, and uncertainty, on the part of health care providers, contribute to the health care gap between racial/ethnic groups in the United States. The link between provider care and patient outcomes among racial/ethnic groups continues to be a significant one.

The various causes of racial disparities in health and health care provide insight into the possible solutions or policy options to address this persistent issue. The more knowledge that can be brought to bear in the policymaking process, the more refined and informed the resulting public policy will be. The next section frames the problem of racial disparity as one of bias in clinical judgments as it relates to similarly situated patients who differ by race in an attempt to offer some insight into how health policy can be developed to address the fourth explanation described above.

There is some promising research in the discipline of psychology, which helps to shed some light on the attempt to account for the reported racial disparities in medical treatment. These studies have identified the influences of the internal psychological factors of patient and doctor attitudes. It is

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21 Ibid.


conceivable that some racial disparities in health care might result in part from differences in patient preferences: minority patients might receive certain medical treatments less frequently because they choose not to accept the treatment. Oddone provides some evidence that suggests that African-American patients generally are more averse to surgery than are white patients.  

However, the mindset of patients is a less significant factor in the medical care equation than clinical discretion of physicians. The attitudes of health care providers may play a crucial role in producing disparate treatment decisions because their clinical discretion has remained unconstrained.  

In an attempt to account for the shift in the practice and patterns of racial cognitive bias in recent years, researchers have increasingly focused their attention on individual-centered psychological variables. The question of whether (and to what extent has) the attitudes and beliefs of caregivers influenced medical decision-making is the focus of this work.  

One recent study served as the “triggering event” to frame the issue of health care disparities as a cognitive bias issue and to place the matter of racial disparities in medical care on the American public policy agenda. In 1999, Kevin Schulman and his colleagues reported significant differences in physician responses to identical heart disease symptoms presented by black and white actors portraying patients. In this study of 720 physician-subjects, patients were matched on sex, stratified by race, and controlled for dress, insurance, occupation, and for the presentation of their clinical symptoms according to a standard script. Using videotaped interviews of hypothetical patients and given additional clinical information, the physicians were asked to provide clinical recommendations for cardiac catheterization, a costly, state of the art diagnostic measure. After controlling for the


27 Ibid.
physicians’ subjective impression of disease likelihood and severity, this study showed that the physicians referred lower proportions of black than white patients for cardiac catheterization.

While there are hundreds of studies, which provide evidence of racial disparities in health and health care, the findings of this study seemed to ring clear to the media and policymakers alike. The result was a general acceptance of the conclusion that one significant cause of racial disparities in medical care is racial bias on the part of the medical caregiver. As Schulman and his colleagues observed, this bias likely resides beyond the reach of our current policy analytical frameworks: "Bias may represent overt prejudice on the part of physicians or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts." 28 This new understanding of racial bias on the part of the medical caregiver has fueled research, which connects racial disparities to interventions in healthcare.

Since the civil rights movement of the 1960s, it has become socially unacceptable to express overt racial prejudice. As a result, there has been a marked decrease in reporting overt prejudice against racial and ethnic groups among Anglo Americans. 29 In fact, when asked in the form of a survey, Anglo Americans are more likely to endorse social equity goals in schools, housing, employment, and politics 30 Nevertheless, contemporary theorists of psychology have failed to dismiss the notion that prejudice is a thing of the past. Instead, they have developed new models of prejudice to uncover the new form in which racial prejudice now appears. One group of researchers observes:

28 Ibid., 624-625.


A cornerstone of many recent models of prejudice is the assumption that, in response to normative expectations, there have been fundamental changes in the nature of people's attitudes. Specifically, people's attitudes have shifted from predominantly reflecting negativity to being more mixed or ambivalent in nature. A theme common in contemporary theories of prejudice is that whites experience a conflict between two competing tendencies in their reaction towards blacks. One tendency encourages positive or non-prejudiced responses; the other encourages negative or prejudiced responses. In some cases, theorists argue that, in response to normative prescriptions against overt bias, prejudice has gone underground or that it has been transformed into subtle and increasingly covert expressions of prejudice.31

In light of the fact that current law and custom has eliminated many of the overt forms of prejudice, contemporary prejudice models have distinguished explicit, overt forms of prejudice from subtle, implicit forms. As a result of this new research focus, there have been substantial empirical findings indicating that implicit prejudice remains widespread even in individuals who, on an explicit level, are genuinely unprejudiced.32 According to Devine, implicit prejudice can be found principally within two main cognitive domains: attitudes and stereotypes.33

Greenwald and Banaji define attitudes as positive or negative dispositions toward objects in one's social environment. While pre-civil rights movement researchers have traditionally focused on attitudes that are consciously accessible, more recently there is a growing recognition that attitudes can be implicit as well as explicit. Implicit attitudes can be thought of as "introspectively unidentified (or inaccurately identified) traces of past experience that mediate favorable or unfavorable feeling, thought, or action toward social objects."34 Thus, implicit attitudes, by explanation, are unconscious. Moreover, they are activated habitually by the mere presence of the attitude object.

32 Ibid.
33 Ibid.
Implicit stereotypes, though related to implicit attitudes, are theoretically, a distinct subset of implicit bias.\textsuperscript{35} As reflected above, attitudes are dispositions toward social objects; stereotypes, on the other hand, are beliefs about particular groups.\textsuperscript{36} Greenwald and Banaji define implicit stereotypes as “the introspectively unidentified (or inaccurately identified) traces of past experience that mediate attributions of qualities of a social category.”\textsuperscript{37} Kunda describes implicit stereotypes as subconscious mental representations of social categories-representations, which involve knowledge, beliefs, and expectations about social groups.\textsuperscript{38}

When one considers the substantial amount of clinical discretion available to physicians in the practice of medicine in conjunction with the prevalence of implicit cognitive bias, it seems more likely than not that racial disparity in clinical judgment will endure. Van Ryan and Burke provide evidence in support of the claim that implicit stereotypes are pervasive within the medical community. Using a focus group discussion survey, Van Ryan and Burke reported the following examples of racial and ethnic stereotypes from hospital administrators: “Asians won’t discuss complaints;” “obtaining medical history information from immigrants is impossible;” “Native Americans don’t show emotion;” and “Hispanics and African Americans won’t lose weight or eat healthy diets.”\textsuperscript{39} Kunda found that some physicians were inclined to believe that African-American patients are less like to

\textsuperscript{35} Patricia G. Devine, “Classic and Contemporary Analysis of Racial Prejudice,” 201.

\textsuperscript{36} Ibid.


\textsuperscript{38} Ziva Kunda, Social Cognition: Making Sense of People (Boston: MIT Press, 1999).

\textsuperscript{39} Michelle Van Ryan and Jane Burke, “The Effect of Patient Race and Socioeconomic Status on Physician’s Perceptions of Patients,” Social Science and Medicine 50, no. 6 (March 2000): 813-828.
comply with treatment and more like to engage in unhealthy behaviors (such as substance abuse) that interfere with medical treatment.\(^{40}\)

In as much as health and healthcare disparities are pervasive in our health care system, the National Health Care Disparities Report suggests that these differences in provider treatment and patient outcomes represent a national crisis for the United States of America. Health care disparities carry a significant “personal and societal price,” including loss productivity, needless disability, and early death.\(^{41}\) The National Healthcare Disparities Report indicated that health care disparities for minorities were worsening when compared to whites. Specifically, the National Health Care Disparities Report data showed worsening quality of health care for African Americans and Hispanics that needed substance abuse care.\(^{42}\) When quality of care was examined in relation to issues of cultural competence, the data showed higher proportions of African American and Hispanic parents/guardians of adolescent clients reported that health care providers “sometimes or never” listened carefully to them, “sometimes or never” explained things clearly to them, “sometimes or never” respected what the adult had to say, and “sometimes or never” spent enough time with them. One clear explanation for disparate outcomes in medical treatment is a situation where a physician exercises the discretion to withhold care because of a belief that the patient would not comply with treatment recommendations.\(^{43}\)


One challenge to eliminating disparities in access to and provision of quality of health care is the ethical dilemma posed by the expectations placed upon the current health care delivery system. Williams and Rucker argue that the current health care inequalities go against the American egalitarian principles, which dictate that all health care consumers be treated equally. While this may be true, it does not reflect this society’s commitment to individual liberties. The fact is that there is no single overriding social value that is superior to all other values. Consumers may have rights, but providers have rights too. We as a nation have not decided whether the rights of one group are subordinate to the rights of another.

In searching for an enduring theory of justice, health economists like Uwe Reinhard pose the question, “To what extent should the individual liberties of health care providers be curtailed in the name of justice within the realm of health care?” The answer to such a question would make it possible to rank alternative ways to distribute economic privileges such as health care.

Dimension of Policy Development in Health

The current U.S. health care system is the only system in the western industrialized nation that attempts to pursue an egalitarian distribution of health care from a libertarian system of delivery. Reinhardt reminds us that libertarian philosophers argue that individual liberty is the overriding social value to which all other values are subordinate. Hence, in the libertarian credo, health care providers have the right to determine whom to serve and whom not to serve, and what price should be charged for providing services.

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44 Uwe Reinhardt, “Uncompensated Hospital Care,” In Uncompensated Hospital Care: Rights and Responsibilities, ed. Frank Sloan, James F. Blumstein and James Perrin (Baltimore: Johns Hopkins Press, 1986), 7.

45 Ibid.
At the opposite end of the extreme are the various theories of distributive justice, championed by egalitarian philosophers. These philosophers argue that “equal respect for individuals” or “equality of opportunity” should serve as the overriding values of a just society, and that individual liberty should be subordinate. This philosophical view requires that at the very minimum, all members of a society should have equal access to certain basic commodities such as health care.

The dilemma posed by the attempt to accommodate simultaneously both the egalitarian and libertarian theories of justice is partially responsible for the failure to develop strategies to eradicate inequities in medical care. The ethical confusion generated by the extreme opposing views of justice prevents the development of policy on any level to address the racial disparity issue in health care. At some point, America will have to decide whether it wants a health care system which distributes health care as a business, or one which distributes it via some other more socially oriented mechanism.

A second dimension of the public policy process that contributes to the challenges of eliminating the race disparities in health is the distribution of authority within a federal system of government. The concept of federalism has evolved since the founding of the United States more than two centuries ago. In its infancy, federalism was a legal concept that defined the balance of power between the federal government and the states as outlined in the constitution. This division initially stressed the independence of each level of government from the other, while integrating the notion that some functions, such as national defense, were the exclusive territory of central government, while other functions, such as education, police protection, and health care were the responsibility of state and local governments.

As the concept of federalism has evolved, the responsibilities assigned to each level of government have shifted. Lee and Benjamin suggest that such shifts do not pose a serious problem for health policy, provided two conditions are met: (1) regulatory boundaries and fiscal accountability are
compatible, and (2) the various levels of government possess the administrative infrastructures, management techniques, and capabilities to assume the responsibilities assigned to them.\(^{46}\)

The prime example of the shared relationship between the federal government and the states in the realm of health policy is the Medicaid program. Medicaid is ostensibly the public program designed to address the health care needs of the poor. As such, it does not directly address the issue of race disparities in health because it targets income and not race as its eligibility criteria. Beyond this particular issue, are the dysfunctional outcomes produced by the multiple, yet uncoordinated, federal-state programs and, the corresponding impacts of the failure of one level of government to meet the conditions, as outlined by Lee and Benjamin.\(^{47}\) They offer the example of the case where Medicaid cutbacks at the state level leave the federal government paralyzed in its attempts to shield the poor from the adverse effects on access to care. Such situations has led to the argument that what matters most in the structure of the relationship within federalism is not so much the distribution of power, but the relationships among levels of government.\(^ {48}\)

A third dimension to eliminating racial disparities through public policy is the politics of interest groups, which influence the function of democratic governments. Political theorists argue that the number and diversity of interest groups prevent any one group from having undue influence on the political system. This view has been heavily criticized by well-recognized political scientist such as Bachrach\(^ {49}\) and Schattschneider.\(^ {50}\) If the interest group model works as effectively as some political theorist argue, then there should be no racial disparities in health because the appropriate interest


\(^{47}\) Ibid.


group (NAACP, Urban League, etc.) would have influenced both federal and state laws to effectively address this issue.

Instead, many have come to realize what Ginzberg has identified as the four power centers in the health care industry that influence the environment of health care and the function of government: (1) physicians, (2) large insurance organizations, (3) hospitals, and (4) a highly diversified group of participants in the profit-making activities within the health care arena.  

It comes as no surprise that while the interest of big business tends to be well served by health policy in the United States, the interest of minority consumers are too often ignored. Medical politics is the term often used by Silver and Marmor, Whittman & Heagy to describe the imbalanced market, where some participants have unequal power; and those with the lion’s share of power have the greatest investment in the effects of policy. As a result, cost containment has dominated the health care policy debates for the last 40 years while access issues have received less attention than it deserved.

The fourth dimension to eliminating racial disparities in health at this level is policy implementation. It has been persuasively argued that the nature of the health care system is determined by the balance of power among political actors, and also by the relationships of such interest groups to government actors. Public policy observers recognized that policy making travels through at least three stages: (1) agenda setting-the fluid process through which issues are debated in public and subsequently placed on the agenda for government action; (2) policy adoption-the process of compromise and trade-offs required of legislatures, executives, and bureaucracies to define broad

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outlines of policy from the alternatives available for consideration; and (3) policy implementation—the process by which agency administrators develop policy by addressing the issues required to carry out policy adopted by legislation.\(^5\)

Over the past 20 years, there have been a few policies adopted by Congress to address the racial health disparities issue. The challenge with much of this legislation is not unlike that of most legislation: statutory ambiguity. Creative evolution is fostered in the implementation phase of the policy process when Congress fails to draft its legislation in a fashion that provides clear direction to the agencies charged with implementing a specific law.

The context of health policy implementation is influenced to a great extent by the technological changes in the provision of health care. It becomes more difficult to design specific statutes to address the health disparity issue when the practice of medicine changes at a rapid pace. For example, knowledge of which specific health care procedures produce quality outcomes is in a constant state of flux. Therefore, a health care law that precisely establishes a minimal level of access to a specific type of care would be destined for rapid obsolescence.

The end result is that regulatory agencies tend to have a great deal of discretion in implementing laws promulgated by the Congress, particularly when the bureaucracy faces an environment relatively free of interest groups in opposition to the program; to the extent that the interests of the minority are not represented by senior administrators within governmental structures, then we can not expect issues, such as racial disparities in health, to receive the attention it deserves at the policy implementation stage. For example, while there may be laws against discrimination on the basis of race in the provision of health care, in the absence of regulatory enforcement, health care providers are more likely to go unpunished for failing to provide equal access to services.

Incrementalism poses yet another challenge to eliminating health disparities. The nature of the public policy process in American government is such that many small steps are preferred to one large step. This process is best described by Lindblom as the incremental decision model. In its most basic form, this model posits that policy is made in small increments and that policy is rarely modified in significant ways. Policymakers prefer reform in incremental steps because the consequences of policy change are difficult to model, and such unpredictability makes for uncalculated risk in the political market.

The implication of the incremental process to policy development and adoption for the racial health disparities issue is that a complete solution should not be expected in a given policy term. Rather, one should expect that any change should emerge over time in a series of small steps. This approach is not without critics. Researchers such as Estes have examined the institutional and class basis of public policy. This research lends some support to the view that defects such as racial health disparities are rooted deeply in the structure of a class society, and that the only appropriate solution is a radical transformation in the current health care system, creating a national health service. Those who hold this view are not convinced that tinkering with the health care system itself will achieve outcomes such as the elimination of health disparities.

Given a policy process characterized by limited government roles, federalism, pluralism, administrative bargaining, and incrementalism, prospects remain relatively dim for a public policy solution to the racial health disparity problem. Given the current state of racial politics in the United States, a race-based policy option is completely beyond the consideration of policymakers.

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Policies and Programs Aimed at Addressing Health Inequalities

One of the most straightforward remedies to the racial health disparity issue is to renew the government’s commitment to enforcing existing legal mandates and federal regulations, which deal with discrimination in medicine. Smith reminds us, given the history of overt discrimination in medical care, it is clear that such mandates and regulations were ineffective until the institutional commitment and capacity to enforce them was created. Legal scholars, such as Noah, argue that existing statutes such as Title VI of the Civil Rights Act of 1964 offers promise, but is not currently being enforced. Title VI prohibits health care institutions that receive Federal financial assistance from discriminating on the basis of race in providing goods or services. Given that Medicare and Medicaid are forms of federal financial assistance, this law and the corresponding regulations extends to nearly all hospitals, nursing homes, and other health care facilities in the United States. According to Noah, the courts have held that Title VI prohibits both intentional and disproportionate adverse impact, thereby making the documentation of adverse impact a powerful strategy for addressing and correcting discrimination in health care.

At the federal level, the Office of Minority Health (OMH) has been instrumental in keeping the nation focused on reducing health disparities by facilitating conversations with health care organizations to embrace holistic approaches like cultural competence as a standard for health care. The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care emphasize the importance of cultural competence in health care. However, the CLAS standards fall

58 Ibid.


60 Ibid.

short in that the organizations are only mandated to provide language access services – demanding culturally competent care for all citizens and requiring organizational support for cultural competence are suggested to providers in the form of guidelines and recommendations that managed care organizations are encouraged to adopt.

One would be remiss to avoid the unique role that judicial activism could bring to bear in resolving the challenges of the racial disparities in health. This is a form of public policy where the third arm of government, the judicial branch, has asserted itself in a position to address the problems of disadvantaged groups. Some examples include the Supreme Court’s 1954 *Brown v. Topeka Board of Education* Decision, which reversed the governmentally sanctioned “separate but equal” discrimination embodied in Jim Crow Laws; and the 1989 *Richmond v. Croson* decision, where the Supreme Court struck down a municipal affirmative action system for construction contracts. Some of the more extreme forms of judicial activism include instances where lower courts have effectively taken over the day-to-day operations of schools, prisons and hospitals in the name of racial representation.

To date, the courts have not asserted their power in the policy arena to address the racial health disparity issue. There are relatively very few discrimination cases pursued in the courts under Title VI of the Civil Rights Act of 1964. Most of the cases heard by the courts have centered on the potential adverse impacts of hospital closures on communities of color, and not on cases involving individual patients and providers. The lack of lawsuits in this arena is most likely the result of the exemption of individual providers from the anti-discrimination policy embodied in Title VI of the Civil Rights Act of 1964. This is clearly a case where the individual rights of physicians, who choose patients in the interest of their business, supersedes the individual rights of citizens to be seen by the physician of their choice.
Discrimination in health care has been a constant for African-Americans. The segregation/integration dichotomy has not offered the insight needed to eliminate disparities in health and health care. African Americans ultimately need better health and better access to health care when appropriate. Whether this care is provided by white physicians, in integrated facilities, or black providers, in segregated ones, is irrelevant. To the extent that the courts can assume a more active role in addressing the issues involved in eliminating racial disparities in health and health care, their participation should be embraced.

A second remedy needed to eliminate racial disparities in health and health care is intensive educational campaigns about the problem. The medical community is the appropriate place to start, although the general public and other professional communities should be included in such efforts. As with any successful campaign or program, such an effort should begin with research aimed at identifying the most effective ways to raise awareness of, and increase sensitivity to, the issues of race in the practice of medicine. For example, in the case of increasing the awareness of the benefits of the flu shot among elderly African-American Medicare beneficiaries, the Health Care Financing Administration found that involving church leadership in educational campaigns proved to be most effective.62 In the case of raising sensitivity towards race issues, medical school curriculums should clearly be targeted.63 Researchers such as Geiger have called for educating every physician about the “... dilemmas associated with race and health care...”64 State mandates, which require physicians to demonstrate formal (recent) training in cultural competency prior to receiving a medical license,

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62 Health Care Financing Administration, Evidence Report and Evidence-Based Recommendations: Interventions that Increase the Utilization of Medicare-Funded Preventive Services for Persons Age 65 and Older, Publication No. HCFA-02151 (Prepared by Southern California Evidence-based Practice Center/RAND, 1999).


64 Ibid, 816.
would be an innovative approach that could be implemented to ensure that racial/ethnic health and healthcare disparities would be reduced.

Another educational and training goal needed to ensure that progress is made toward the elimination of racial disparities in health and healthcare access is to increase African-American health professionals. Research has informed us that African-American physicians are significantly more likely than other physicians to care for vulnerable patient populations such as African-Americans. In their recent research findings, Libby, Zhou, and Kindig reported that in order to reach racial and ethnic population parity, with the supply of physicians, the United States needs to triple the number of Native-American residents and double the number of African-American and Hispanic residents.

From a policy perspective, it is important to mention that affirmative action programs in the medical school admission processes have been successful in recruiting and retaining physicians from disadvantaged backgrounds. Nickens and Cohen have defended such affirmative action programs on multiple grounds, including societal obligations to ensure that the health needs of all citizens are met. Other reports provide estimates that indicate that affirmative action is responsible for nearly 40 percent of all U.S.-trained physicians from disadvantaged backgrounds.

**Improving Policies to Eliminate Racial Disparities**

Williams and Rucker point out that society’s efforts to address racial bias in the medical arena require systematic and routine analysis based on racial/ethnic group. They cite differences among

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groups of Hispanics, as a particular example of how socioeconomic status serves as an intervening variable when the influences of ethnicity are examined among Mexicans, mainland Puerto Ricans, and Cubans.\textsuperscript{69}

Given the widespread nature of discrimination in health care, it is clear that racial data are needed for every medical encounter. The collection of data on racial differences could also aid in the efforts to enforce civil rights laws. Such data could also assist medical facilities such as hospitals, nursing homes, and home health agencies in designing unique programs to address disparities at the provider level.

Report Cards and Monitoring the Behavior of Providers

Smith argues that as a result of structural changes in the organization of health care, there are new opportunities to monitor the way in which medical care is delivered. As a result, there has been a shift in power from individual providers to large health plans and major purchasers of care.\textsuperscript{70} These changes were coupled with a shift in the methods of payment from fee-for-service arrangements to managed care and risk-sharing agreements, thereby resulting in a greater need for external monitoring of provider behavior. As individual providers responded to these changes, physicians, hospitals, and other service providers began to standardize and integrate their clinical and financial information. Herein lies the opportunity for a new type of monitoring called “report cards,” which could be used to enhance civil rights monitoring of health care delivery system.\textsuperscript{71}

Smith indicates that a modification of the existing data systems with the Office of Management and Budget’s (OMB) common racial classification scheme would facilitate report cards that could be used


\textsuperscript{71} Ibid.
to monitor disparities in health plans, health care institutions, and communities. Some examples include broadly accepted indicators of health and health care delivery (such as breast cancer death rates and specific preventive measures) that have evolved from the efforts of private-public professional partnerships over several decades.

Multi-disciplinary Models in Health Policy

The traditional policy analysis, with its positivist perspective, has long served as the lodestar for health policy in the United States. The challenge with using this rational approach to health policy is that it is incongruent with the practice of medicine that results in the health care disparities. To start, we have demonstrated in the review and analysis above that discretion plays a significant role as a source of disparities in health care. The evidence in support of the claim that a scientific model is at work in the practice of medicine is weak, as most medical decision are not empirically based. There is an astonishing amount of clinical practice variation around the multiple diagnostic and therapeutic procedures.72 There is a lack of consensus among medical providers about the appropriateness of diagnostic and therapeutic measures primarily because of the lack of scientific evidence. The dearth of scientific support for most medical decisions results in such wide variability in clinical practice so as to render the notion of reaching evidenced-based conclusions about the appropriateness of practice variations beyond our current human capacity. The result is a practice of medicine that is more idiosyncratic because of the heavy reliance on physician discretion. In other words, in far too many cases, the practice of medicine relies on the kind of art like qualities of intuition and insight, which leaves physicians unable to rationally justify their medical decisions.73 At best, it can be considered to

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be a blend of scientific elements with trial and error, as are other science-based professional bodies of knowledge.\textsuperscript{74} If the practice of medicine, as we know it, does not proceed solely from rationalistic assumptions, should our public policies, which are designed to regulate this activity, emanate from these assumptions?

It seems evident that the highly analytic character of health policy making, with its over-reliance on the assumptions of economics, proves to be unrealistic in the search for empiricism.\textsuperscript{75} The major difficulty here is the over-reliance on one discipline to address the complexity of an issue such as health care disparities. Economics, as a discipline, tends to side step the muddy issues that arise when political, social, and psychic factors are considered. Such factors do not lend themselves to the kind of quantitative analysis demanded in the quest for mathematical elegance in the field of economics.

If we are to develop more sound health policies to address health care disparities, we need to go back to the original aims of the discipline as outlined by Lasswell. He envisioned three main characteristics of the policy sciences: multidisciplinary, problem oriented, and contextual working in concert to promote democracy.\textsuperscript{76}

Lasswell argued that all disciplines—social and physical sciences—were needed in the field of policy sciences to help resolve the current issues of a global society. This multidisciplinary perspective


was demonstrated with his selection of a sociologist, an anthropologist, and an economist as contributors to his book, the *Policy Sciences*.\(^{77}\)

In his conceptualization of policy sciences, Lasswell proposed that it should be policy-relevant as opposed to theory when advancing a particular discipline. As such, the aim of this field was to permit the state-of-the-art of usable knowledge to be brought to bear on world issues. He wrote:

> The basic emphasis of the policy approach…is upon the fundamental problems of man in society rather than topical issues of the moment…The point is that all the resources of our expanding social science need to be directed toward the basic conflicts in our civilization which are so vividly described by the application of the scientific method to the study of personality and culture.\(^{78}\)

Lasswell was clearing his belief that policy issues needed to be situated in specific contexts, and that policy sciences should provide usable knowledge on issues with respect to time and location. This view is in contrast to the hypothesis testing of propositions to advance social and political theory. Instead, he suggested that “[t]he policy frame of reference makes it necessary to take into account the entire context of significant events (past, present, and prospective) in which the scientist is living.”\(^{79}\)

At the highest level, Lasswell expected that policy sciences would be used to promote democracy. He envisioned that the usable knowledge function of this field would lead to the development of policies that promoted human dignity “in theory and fact.” Towards that end he wrote the following:

> The dominant American Tradition affirms the dignity of man, not the superiority of one set of men. Hence it is to be foreseen that the emphasis will be upon the development of knowledge pertinent to the fuller realization of human dignity. Let us for convenience call this the evolution of the “policy sciences of democracy.”\(^{80}\)

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\(^{77}\) Ibid.

\(^{78}\) Ibid, 8.

\(^{79}\) Ibid, 14.

\(^{80}\) Ibid, 10.
The ability of physicians, nurses, and treatment providers to provide effective treatment to racial/ethnic minorities is multidimensional and complex, even when cultural and linguistic barriers do not exist. Health care providers must possess the knowledge, skills, and abilities, which are essential to providing effective health care.\textsuperscript{81} In addition, health care providers must be able to communicate effectively with patients by developing a rapport and trust, by demonstrating that they have the ability to assess relevant cultural factors within the patients’ health history (socioeconomic influences, educational attainment, family structure and dynamics, cultural beliefs and practices, ethnic origin and identification, and language preferences), by understanding the patient’s perspective on their health problems, and by recognizing any cultural misunderstandings.\textsuperscript{82}

\section*{Conclusion}

This paper presents a positive trend in access to care for African Americans over the decade of the 1990s. The federal government is perhaps responsible for the lion’s share of this improvement with the implementation of a broad range of health policies across a number of agencies, including the U.S. Department of Health and Human Services, the Civil Rights Division of the Department of Justice, and several innovative, proactive states such as Washington State. In spite of these gains, racial disparities on the major indicators of health status and access to care persist. These disparities are greatest for African Americans who are very young, uninsured, low income, and aged. The U.S. health care system is comprised of fragmented, non-comprehensive programs, duplicative and confusing administrative structures, and uncoordinated multiple programs, serving similar populations. These

\textsuperscript{81} Miguel D. Tirado, Monitoring the Managed Care of Culturally Linguistically Diverse Populations (Washington, DC: Center for Managed Care, Health Resources and Services Administration, 1998).

characteristics foster the development of independent interest groups that may impede the implementation of a comprehensive solution to the problem of racial disparities in health.

The federal government has responded to the persistent racial disparities in health and health care with a number of policies and initiatives ranging from programs that target specific segments of the African-American population (such as Medicare and Medicaid beneficiaries) to an increase in funding for research and education activities. While it is perhaps premature to assess the impact of many of these initiatives, there have been some notable gains reported by the National Center for Health Statistics. Keppel and colleagues reported that all racial and ethnic groups experienced improvements for 10 (including prenatal care, infant mortality, teen births, death rates for heart disease, homicide, motor vehicle crashes, and work-related injuries, tuberculosis case rate, syphilis case rate, and poor air quality) of 17 health status indicators developed as an objective of Healthy People 2000. These indicators provide a means to quantify and assess the progress of the Healthy People 2010 objective to eliminate disparities in health among population groups. The indicators reflect various aspects of health and include infant mortality, teen births, prenatal care, as well as death rates for all causes. It also includes indicators for heart disease, stroke, lung and breast cancer, suicide, and work-related injuries.

There is still a great deal more that needs to be done to eliminate racial disparities in health and health care. We need the courageous and moral leadership of both public and private actors. The United States health care system is a complex arrangement of individuals and institutions from the private sector. It is time for private-sector actors to meet at the table with public-sector actors to work in partnership to achieve the goals of Healthy People 2010. Smith reminds us that we have the

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technological capacity to address the racial disparities in health issues, now all we need is a commitment from both the public and private sectors to make the possibility a reality.  

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Bibliography


Tirado, Miguel D. *Monitoring the Managed Care of Culturally Linguistically Diverse Populations.* Washington, DC: Center for Managed Care, Health Resources and Services Administration, 1998.


