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Introduction

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SYMPOSIUM

BRIDGING THE RACIAL DIVIDE IN HEALTH CARE: ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH STATUS

INTRODUCTION

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Why do so many Americans of color die before our time? Sometimes, the answer is as plain as the color of our skin.

For a society that claims to have the finest health care system in the world, disparities in the care provided to Americans of color are unacceptable. This much is generally agreed by health professionals and policy makers of both major political parties. There is far less agreement as to what we, as a nation, must do to correct these failures. The perspectives toward improving minority health care advanced in this edition of the *Journal of Health Care Law & Policy* represent important contributions toward creating the solution-focused policy consensus that is so critical in sustaining effective change.

There is general agreement among health policy professionals with respect to two fundamental elements of the minority health care challenge. First, most leaders now agree that limited and unequal access to affordable, high quality health care—endangering tens of millions of Americans from every racial and ethnic background—is a crisis that requires a heightened sense of national urgency. Statistics confirm that Americans of color are disparately burdened by this failure to assure universal access to quality health care, but minorities are not alone in this tragedy.

Second, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* the Institute of Medicine's 2002 blue ribbon report, confirmed that

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Americans of color tend to receive lower-quality health care than do Caucasians and that this is true even when the patients' incomes and insurance plans are the same. These disparities, the Institute's blue ribbon panel found, contribute to higher minority death rates from heart disease, cancer, diabetes, HIV/AIDS, and other life-endangering conditions.

These two conclusions reflected our general policy consensus about the real-life consequences of minority health disparities in December of 2004, when the *American Journal of Public Health* reported some new, headline-making research findings. A team headed by former United States Surgeon General David Satcher and Professor Stephen H. Woolf, Director of Research at Virginia Commonwealth University's Department of Family Medicine, examined mortality data for the 1990s that they had extracted from the databases of the National Center for Health Statistics. During the last decade, the Satcher-Woolf team concluded, more than 886,000 deaths could have been prevented if African Americans had received the same health care as Caucasians.

Even for policy makers well-versed in the growing body of clinical research about unequal treatment in American health care, the Satcher-Woolf research findings were staggering. What made them so compelling, I believe, was that they quantified the appalling consequences of unequal treatment in concrete terms. An annual death toll of 87,000 African Americans from failures in our health care system is twice the number of deaths that we suffer on our nation's highways each year—and sixteen times the number of Americans murdered during the September 11, 2001, terrorist attacks. We have no reason to believe that other Americans of color are being better served.

Nearly eight years after President Clinton first committed this nation to eliminating racial and ethnic health disparities by the year 2010, the Satcher-Woolf revelations are quite disheartening. However, although the challenges to reform continue to be daunting, there are some reasons to believe that we are beginning to learn how to provide greater racial equity.

This issue of the *Journal* addresses these challenges. The articles that appear in this issue are based on several papers presented at a conference entitled "Bridging the Racial Divide in Health Care: Eliminating Racial and Ethnic Disparities in Health Status," hosted by the University of Maryland School of Law's Law & Health Care Program on March 11, 2005.

Dr. Carolyn M. Clancy, Director of the U.S. Department of Health & Human Services' Agency for Healthcare Research and Quality (AHRQ), cites several of the more effective minority health care initiatives and their results in her article, *Closing the Health Care Disparities Gap: Turning Evidence into Action.* It is important for all policy makers to understand, as Dr. Clancy points out, that if we are to continue making progress in our drive to save lives, we must address both the broader issue of access to health care and the related, but distinct, obstacles to clinical equity. Dr. Clancy observes (quite correctly in my view) that "when a

large proportion of the population cannot access the health care system because of a lack of insurance coverage, large gaps in the quality of care will persist." Likewise, she argues (again with substantial justification) that "the improvement of health care quality in America, as a whole, is inextricably linked to eliminating racial, ethnic, and socioeconomic disparities in health status. Until all Americans have full access to high quality health care, the quality of the overall health care system will be compromised."

The interrelationship between these policy challenges—health care access and equity—underscores the reality that all Americans have a compelling interest in forging an expanded commitment toward achieving a health care system freed of unequal treatment. The research that we are now funding must be expanded, and it must be focused upon identifying and supporting best practices that can be translated rapidly into clinical care across the country. We also must recognize, however, that the impact of this research will be limited unless we are able to achieve a broad consensus about how best to share the costs of health care delivery. I share the point of view that America's employment-based insurance system is broken beyond repair. We must give serious thought to the creation of a nation-wide, single-payer health care system that is publicly financed but provides private care—an expanded and improved Medicare program for Americans of all ages.

However, until we achieve our goal of universal health care, we cannot have a meaningful national debate about access to care and equity without addressing the issues that surround Medicaid, our nation's largest insurer. Professor Sara Rosenbaum's article on Medicaid, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, is an excellent primer on the reasons that our health care funding program for economically disadvantaged and disabled Americans is both essential and surrounded by political controversy.

This "big picture" analysis is balanced, quite effectively, by a revealing, in-depth study into the causes of racial and ethnic health disparities, *Separate and Unequal Care in New York City.* The combined effort of Dr. Neil S. Calman, Maxine Golub, M.P.H., Charmaine Ruddock, M.S., Lan Le, M.P.A., Diane Hauser, M.P.A., and The Action Committee of the Bronx Health REACH Coalition, *Separate and Unequal Care* documents a harsh reality that exists in many, if not most, major population centers of the country: the segregation of care (and, inevitably, of health outcomes) based upon patients' ability to pay.

Thomas E. Perez, Esq., former Director of the Department of Health and Human Services' Office for Civil Rights (and, currently, Assistant Professor at the University of Maryland School of Law), takes on this core issue of health care segregation in *Enhancing Access to Health Care and Eliminating Racial and Ethnic Disparities in Health Status: A Compelling Case for Health Professions Schools to Implement Race-Conscious Admissions Policies.* Grounding his presentation in the well-documented evidence that "physicians of color are more

likely to serve communities of color and more likely to serve low-income, under-represented communities," Professor Perez's article offers a strong argument for affirmative action in the admissions policies of our health professions schools. As Professor Perez acknowledges, the ultimate legal response to this strategy by a newly reconstituted Supreme Court without Justice Sandra Day O'Connor is uncertain. Nevertheless, there is little doubt that saving tens of thousands of lives each year should constitute a compelling state interest worthy of constitutional stature. The challenge will be one of constructing the evidentiary basis for this principle.

Achieving a solution-focused policy consensus about how best to end minority health care disparities is a moral and existential imperative. Despite our failings, we are a moral nation that values human life. We cannot ignore the 886,000 American lives that the Satcher-Woolf research concluded were ended prematurely during the 1990s. Despite our advances, this tragedy continues to take its toll in communities throughout America today.

In *Common Ground: Exploring Policy Approaches to Addressing Racial Disparities from the Left and the Right*, Dr. Michael Gibbons offers a thought-provoking assessment of the conceptual divisions, as well as the commonalities, among conservative and liberal policy-makers that are driving our search for this consensus. Although some might view our disagreements about public health policy as predominantly influenced by differing priorities, Dr. Gibbons' analysis of where we agree is both accurate and helpful.

These areas of policy agreement are critical. Despite all of the progress that we have made, being a minority in America continues to be a medically-dangerous condition, and being both an American of color and poor can be deadly. As a nation, we must build upon our areas of consensus and act far more decisively. The Americans who are suffering and dying while we debate have little time left to waste.