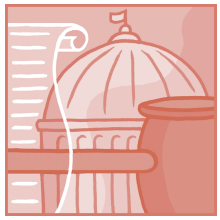

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Review of State Legislative Approaches to Eliminating Racial and Ethnic Health Disparities, 2002–2011

Jessica L. Young, PhD, MS, Keshia Pollack, PhD, MPH, and Lainie Rutkow, JD, PhD, MPH

We conducted a legal mapping study of state bills related to racial/ethnic health disparities in all 50 states between 2002 and 2011.

Forty-five states introduced at least 1 bill that specifically targeted racial/ethnic health disparities; we analyzed 607 total bills. Of these 607 bills, 330 were passed into law (54.4%). These bills approached eliminating racial/ethnic health disparities by developing governmental infrastructure, providing appropriations, and focusing on specific diseases and data collection. In addition, states tackled emerging topics that were previously lacking laws, particularly Hispanic health.

Legislation is an important policy tool for states to advance the elimination of racial/ethnic health disparities. (*Am J Public Health.* 2015;105:S388–S394. doi:10.2105/AJPH.2015.302590)

DESPITE DECADES OF research and awareness,[1–3] and increasing federal attention and action,[4–7] racial/ethnic health disparities persist throughout US society. It is well documented that some racial/ethnic groups are more likely to live shorter and sicker lives.[8–10] Health disparities also vary geographically. For example, research suggests that there are more severe racial/ethnic health disparities among rural populations compared with urban dwelling populations.[11] These health disparities are the result of myriad social, individual, and political factors, including health behaviors, housing, education, income, and access to health care.[12–15] Because of the complex nature of the drivers of health disparities, eliminating racial/ethnic health disparities requires integrating science, practice, and policy at all levels of government.[16]

States are well positioned to use their policymaking powers toward eliminating racial/ethnic health disparities, and have done so in the past.[17] State legislative activities related to racial/ethnic health disparities have focused on developing governmental infrastructure focused on racial/ethnic health disparities, disease-specific approaches (e.g., lupus task forces), race-specific activities (e.g., African American oral health programs), and increasing awareness of health disparities through special commissions.[17]

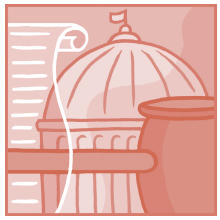
Few researchers have devoted attention to mapping state legislative activity regarding racial/ethnic health disparities. By not doing so, we miss opportunities to further our understanding of how states have used legislation to eliminate racial/ethnic health disparities, and to support advocacy and monitoring efforts related to racial/ethnic health disparities. To our knowledge, Ladenheim and Groman published the first study in this area, by reviewing state legislation that specifically targeted racial/ethnic disparities in health care and access from 1975 to 2001.[17] We furthered the understanding of the recent state legislative environment related to eliminating racial/ethnic health disparities. Our analysis examined proposed and enacted state legislation from 2002 to 2011 to identify legislative approaches to eliminating racial/ethnic health disparities. Our research, which considered state bills that were proposed and failed along with those that were passed into law, offered insights into states' legislative agendas related to health disparities, including emerging trends and challenges.

METHODS

We conducted a legal mapping study of proposed and enacted legislation related to racial/ethnic health disparities in all 50 states between 2002 and 2011.[18] We examined state-level bills that were introduced and failed, and those that were introduced and ultimately became law.

Data Collection

We used a systematic and structured keyword search of introduced



bills at the state level from January 1, 2002, to December 31, 2011, to identify relevant proposed and enacted legislation. We used LexisNexis State Capital (Reed Elsevier, Oxford, UK), an electronic legal database, to search for bills from all 50 US states that addressed racial/ethnic health disparities using 30 keywords. We initially selected some keywords based on the keywords used in the Ladenheim and Groman study,[17] and we identified others identified using keywords from the current health disparities literature.[19] This allowed us to identify the language used to describe health disparities that might have been recently introduced or increased in usage since the 2006 publication of the Ladenheim and Groman study (e.g., the trend toward favoring "health equity" over "health disparities"). Bills were collected and analyzed from December 2012 to June 2013.

Because we focused on state-based initiatives to eliminate racial/ethnic health disparities, bills related to Medicaid, a federally initiated program, were deemed outside the study's scope, and thus excluded.

Bill Identification, Coding, and Categorization

We collected and read the full text of each identified bill. We initially identified a total of 909 bills for inclusion in the study. We only retained the most recent version of the bill for analysis for bills with multiple versions. We also excluded some bills after a second read, if we determined that the bill did not clearly address racial/ethnic health disparities. Following these inclusion and exclusion criteria, our final data set included 607 bills. We then compared the data set with the publically available collection of state health disparities bills from the National Conference of State Legislatures (NCSL), which includes tracking for bills introduced in 2010 and 2011[20] and the NCSL collection of state health disparities laws, which began in 2005.[21] If a discrepancy was noted, further research was conducted, such as examining the text of a bill or law to determine if its language differed from keywords in our list or if the subject of a bill in the NCSL collection was beyond the scope of this study (e.g., bills focused on health disparities other than racial/ethnic health disparities).

We coded the bill as falling under a specific topic area if the language in the bill text indicated a presence of that characterization. We selected these topic areas based on previous categorizations of health disparities policies in the extant literature, including those used in the Ladenheim and Groman study, and factors that could influence state policy decisions, such as state demographics. Topical coding was not mutually exclusive. Bills often addressed multiple policy domains, thus we coded them for multiple topic areas. We coded the identified bills into 11 health disparities topic areas, several population-based variables from the US Census Bureau, and state political characteristics (see the box on this page).

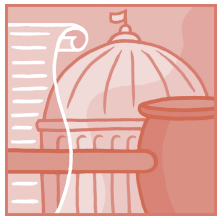
Bill Coding Variables: State Legislative Approaches to Eliminating Racial and Ethnic Health Disparities, United States, 2002–2011

- Legislative session (year)
- Lead sponsor (sponsor's last name)
- Pass status (yes/no)
- Topic areas (yes/no)
- Appropriations
- Disease-specific
- Data collection/reporting/planning
- Cultural competency
- Infrastructure
  - Offices of Minority Health
  - Task force/committee
  - Representation
- Race-specific
- Recognition/awareness
- Research study
- Workforce
- Non-White, non-Hispanic population (%)
- Hispanic population (%)
- State median income ($)
- No. of democratically controlled years in the state legislature, 2002–2011
- No. of years of Democratic governor, 2002–2011
- Census region and subregion

Data Analysis

We included descriptive statistics in our data analysis to summarize state characteristics (e.g., state demographic characteristics) and included the legislative year in which a bill was introduced. We also collected population demographic characteristics from the US Census, including racial/ethnic population percentages (non-White non-Hispanic minority population and non-White Hispanic population) and median income for each state. Using Census population estimates, we collected these population-based data for each year of the study (2002–2011),[22] and we also averaged the data across the time period. Political factors that were analyzed included bills introduced in Democratic-controlled legislatures and under Democratic governorships. We determined party control of the state legislatures for each year from the US Census Bureau, and we referenced the statistical abstract of the US party control of the governorships from the Council of State Governments "Book of the States."[23]

We used Microsoft Excel 2013 (Microsoft, Redmond, WA) for data analysis. We analyzed bills by state, year (and across years), and geographic region, as determined by the US Census Bureau. For both cross-sectional and longitudinal analyses, we analyzed bills for trends by topic,



state, geographic region, passage rates, minority population, and median household income. We generated summary statistics, including frequencies, means, and percentages. When relevant, we also compared average state demographic data to national estimates over the study period.

RESULTS

We analyzed 607 bills. Forty-five states introduced at least 1 bill that specifically targeted racial/ethnic health disparities between 2002 and 2011. No bills were identified from Idaho, Montana, North Dakota, South Dakota, and Wyoming. Of the 607 analyzed bills, 330 bills were passed into law (54.4%), although 7 were ultimately vetoed by the respective state's governor.

Characteristics of States Included in Analysis

States that introduced at least 1 health disparities bill during the study period varied in geography, demographics, and political variables. The non-White, non-Hispanic population of these states averaged approximately 19.0% (compared with 20.4% nationally). Between 2002 and 2011, the Hispanic population for these states averaged 10.2% (compared with 10.8% nationally). In addition, Republicans controlled the legislature in most states for most of the study period, whereas Democrats tended to control the governor's office.

Bills were classified into 11 health disparities topic areas (Table 1). On average, states addressed approximately 6 different topic areas (range = 1–11 topics). Table 2 shows the topics addressed by year. Bills addressing infrastructure accounted for the highest proportion of bills introduced (43.2%). This category included 3 subcategories, which were Offices of Minority Health (OMH), task forces or committees, and representation. Appropriations bills (41.2%) were the second most common bills, followed by disease-specific bills (25.0%). Only 2 states introduced bills that touched on all 11 topics (FL, MD).

The number of states introducing bills in each topic area also varied. Among the most common topic areas, 43 states introduced bills related to infrastructure in general. Under infrastructure, 32 states addressed OMHs, 35 states addressed task forces or committees, and 19 states used bills to require OMH representation (such as the OMH director) on a state task force or committee. Thirty-two states had at least 1 bill that appropriated funds for health disparities activities. Twenty-eight states introduced bills for data

TABLE 1—Category and Topics of State Health Disparities: State Legislative Approaches to Eliminating Racial and Ethnic Health Disparities, United States, 2002–2011

Category	% of Total Bills (n = 607)	No. of States
Infrastructure	43.2	43
OMH	24.0[a]	32
Task force/committee	21.9[b]	35
Representation	7.6[c]	19
Appropriations	41.2	32
Disease-specific	25.0	27
Data collection/reporting/planning	16.5	28
Cultural competency	14.2	26
Workforce	11.2	21
Recognition/awareness	9.6	22
Race-specific	8.9	24
Research study	4.8	14

Note. OMH = Office of Minority Health. Because each bill could fall under more than 1 category, percentages presented here do not total 100%.
[a]44.9% of infrastructure bills.
[b]41.0% of infrastructure bills.
[c]14.1% of infrastructure bills.

TABLE 2—Proportion of Yearly Trends of Bills Analyzed by Topic: State Legislative Approaches to Eliminating Racial and Ethnic Health Disparities, United States, 2002–2011

Category	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Overall Mean
Infrastructure, %	29.4	50.0	49.2	36.6	45.1	51.9	38.9	38.8	47.1	37.7	43.2
OMH, %	17.6	19.0	27.0	19.7	32.4	32.5	18.5	22.4	23.5	21.3	24.0
Task force/committee, %	8.8	32.8	23.8	18.3	14.1	22.1	27.8	20.9	25.5	23.0	21.9
Representation, %	2.9	13.8	4.8	5.6	9.9	9.1	9.3	6.0	3.9	8.2	7.6
Appropriations, %	55.9	43.1	28.6	39.4	38.0	49.4	38.9	50.7	35.3	36.1	41.2
Disease, % specific	20.6	20.7	17.5	31.0	16.9	26.0	25.9	26.9	27.5	36.1	25.0
Data collection/reporting/planning, %	8.8	12.1	19.0	12.7	15.5	18.2	14.8	19.4	13.7	26.2	16.5
Cultural competency, %	11.8	10.3	14.3	14.1	23.9	11.7	11.1	14.9	11.8	14.8	14.2
Workforce, %	11.8	6.9	9.5	9.9	14.1	11.7	9.3	17.9	7.8	11.5	11.2
Recognition/awareness, %	11.8	12.1	7.9	12.7	9.9	2.6	16.7	4.5	13.7	8.2	9.6
Race-specific, %	11.8	10.3	9.5	12.7	4.2	7.8	14.8	11.9	3.9	3.3	8.9
Research study, %	2.9	6.9	7.9	5.6	2.8	7.8	3.7	6.0	0.0	1.6	4.8

Note. OMH = Office of Minority Health.

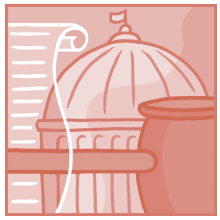


TABLE 3—Proportion of State-Level Bills Passed Into Law by Topic: State Legislative Approaches to Eliminating Racial and Ethnic Health Disparities, United States, 2002–2011

Topics	Pass, %
Recognition/awareness	72.4
Appropriations	67.6
Representation	56.5
Research study	55.2
Infrastructure	54.6
Task force/committee	54.1
Disease-specific	52.0
OMH	51.4
Race specific	49.1
Workforce	41.2
Cultural competency	40.7
Data collection/planning/reporting	36.0

Note. OMH = Office of Minority Health.

collection, reporting, and planning activities, and 27 states targeted a particular disease through health disparities legislation.

By geographic region, most bills were introduced in the South and the fewest in the West. States in the Midwest census region were most likely to introduce bills for appropriations, research studies, and disease-specific topics. In the South, bills tended to be categorized as OMH, task force or committee, recognition or awareness, and research study. In the Northeast census region, bills were most likely to be categorized as disease-specific, workforce, and OMH. States in the West census region tended to introduce bills categorized as race-specific, cultural competency, and workforce. There was also geographic variation in the number of categories or topics each state used.

There was geographic variation in the number of bills introduced between 2002 and 2011. The average number of bills introduced per state was 13, with 4 states introducing 30 or more bills (AR, CA, FL, and NY) and 14 states introducing 5 or fewer bills (AL, AK, AZ, HI, KS, KY, LA, ME, OK, SC, VA, VT, WI, and WV). States also varied on the categories or topics addressed in their bills. Eight states covered 3 or fewer topics (AK, KS, MI, NV, SC, VT, WI, and WV) and 6 states targeted 10 or 11 topics (AR, FL, IL, MD, NJ, and NM). States that introduced more than the average number of bills (15 states) tended to also address more health disparities topics in those bills compared with states that introduced less than 13.0 bills between 2002 and 2011 (8.3 topics and 5.0 topics, respectively).

Bill Passage by Topic

Table 3 shows the proportion of introduced bills that passed or failed by topic. Bills falling under recognition or awareness had the highest passage rate (72.4%). Data collection, reporting, or planning bills were the least successful, with only 36.0% of introduced bills passed into law.

DISCUSSION

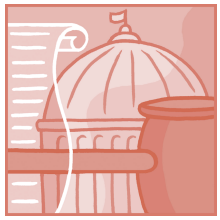
To our knowledge, we presented the newest data on state legislative action to eliminate racial/ethnic disparities. Several important findings emerged from our analysis. First, states continued to use their legislative powers to address racial/ethnic health disparities. Second, states were likely to approach eliminating racial/ethnic health disparities by developing governmental infrastructure (e.g., minority health or health disparities agencies and statewide and local task forces), providing appropriations, and focusing on specific diseases and data collection. These approaches, although common, had different passage rates. Third, contrary to previous findings, state legislatures used bills to address health disparities among the Hispanic population. Finally, gaps remained in state bills related to facilitating cross-sector approaches to eliminating racial/ethnic health disparities and the collection of integrated health data, such as data on the social determinants of health.

State Legislative Approaches to Health Disparities

Creating or supporting health disparities-related governmental infrastructure provides dedicated resources toward eliminating racial/ethnic health disparities. Most states have an office or related entity focused on minority health, health disparities, or health equity. States have also created commissions and task forces related to racial/ethnic health disparities, mainly for reporting and research purposes. Such governmental infrastructure could augment or institutionalize state and local capacity to tackle racial/ethnic health disparities. Despite this being a common state-level approach to address racial/ethnic health disparities, except for 1 study that illustrated some dedicated financial and human resources at state OMHs,[24] little is known about these entities, such as OMH implementation or impacts. Future research should focus on this knowledge gap.

Appropriations could signal a commitment to implementation by dedicating specific funds toward health disparities elimination and possibly preventing the reallocation of funds, or at least making it somewhat challenging to reallocate funds to other competing priorities.[25] Appropriating funds toward health disparities elimination could also signal at least some commitment to the issue, and could also influence policy implementation, because a lack of financial and other resources could be a determinant of challenges to policy implementation. However, not every mandate as directed in state legislation requires funding, such as legislation that provides enabling powers to local health agencies to create coalitions to study community racial/ethnic health disparities.[26] Although we did not consider actual appropriation levels for racial/ethnic health disparities programs or initiatives, these levels should be analyzed in future research.

Overall, disease-specific bills were the third most common topic targeted in state bills that focused on racial/ethnic health disparities. The most common disease targeted by these bills was HIV/AIDS. This finding was similar to the results of previous research.[17] The commonality of disease-specific bills could reflect a perspective about the



causes of racial/ethnic health disparities and the appropriate responses to tackling the issue. Focusing on a specific disease could signal that targeting the diseases with the highest disparities or affecting a certain racial/ethnic group is preferred over taking a more comprehensive approach to state legislation that could affect more than 1 disease.

States shared commonalities in the bill topics related to health disparities, but they varied in the rates of successful bill passage (36%–72.4%). This observed variation could be the result of several factors. For example, the most successful bills were those that served to recognize or increased awareness of racial/ethnic health disparities in the state. These bills tended to not require substantive action or devoted state resources, which could be why they were more successful. This finding was similar to a study that examined obesity legislation, in which researchers found that legislation that required fewer state resources was more likely to pass.[27] Factors related to a successful bill and the implementation of the bill after its passage should be analyzed further.

Addressing Hispanic Health Disparities

Ladenheim and Groman included statutes and bills from 1 legislative year (2001–2002) that targeted some racial/ethnic groups, but they also found a lack of legislation that specifically addressed Hispanic populations.[17] Our findings identified a new trend, which was likely caused by the significant growth of the US Hispanic population since the early 2000s. We showed that states used the legislative process to target Hispanic health by introducing Hispanic-specific health disparities bills. Race-/ethnicity-specific bills focused on the Hispanic population were third in frequency, following those focused on American Indian/Alaskan Natives and African Americans. Although bills specifically focused on the Hispanic population only passed in 2 states during the study period, this was still a significant finding, because previous research found a lack of Hispanic-specific health disparities bills. Future research should continue to monitor the number and types of Hispanic-specific health disparities bills, especially as US demographic characteristics evolve.

The United States is poised to become a majority-minority nation by 2050. However, the composition of the public health and health care workforces does not reflect these demographic trends.[28,29] Thus, the nation faces emerging questions related to the public health and health care workforces that affect the advancement of the science and practice of eliminating racial/ethnic health disparities. How can we develop a public health workforce that is representative of the nation? What core competencies are needed from the public health and health care workforces to eliminate health disparities in the United States? How can we recruit and retain public health and health care professionals to practice in underserved areas? Study results could help shape future advocacy and policymaking efforts to eliminate racial/ethnic health disparities.

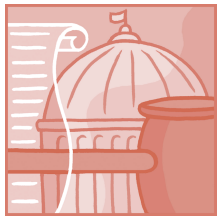
State legislators have introduced bills designed to address workforce diversity and to provide opportunities to improve cultural competency among public health and health care practitioners. For example, 1 successful bill in Illinois created the State Healthcare Workforce Council, whose work focuses on cultural competency and minority participation in health professions education to improve the diversity of the health care workforce.[30] Cultural competency will likely continue to be a focus in state racial/ethnic health disparities legislation, not only because of demographic changes and subsequent health care and public health needs, but also because of a continued federal focus on cultural competency training and standards.

Gaps in State Legislation

One limitation facing practitioners and advocates when working toward eliminating racial/ethnic health disparities is a lack of quality data. This is true of public health data in general.[31] The lack of reliable and quality health disparities data limits the ability of health departments to monitor and identify racial/ethnic health disparities. However, most states proposed and enacted bills related to health disparities data collection. This action might be to promote the goal of improving racial/ethnic health disparities data monitoring and strategic planning, as suggested by some legislation that requires annual reporting of health disparities data, evaluation outcomes, and research findings to the state legislature (e.g., disparities over time or number of minority populations reached).

Health disparities are the result of multiple and interrelated determinants. As such, legislation targeting racial/ethnic health disparities should encourage and support a multidisciplinary, cross-sector approach; health departments and the health care system cannot eliminate racial/ethnic health disparities alone. A lack of state policies directing the collection of socioeconomic racial/ethnic data in the context of health disparities still remains.[32] Because health disparities are the result of social factors (e.g., education, income, and transportation), the collection of socioeconomic data could greatly affect the design and delivery of policies and programs to eliminate racial/ethnic health disparities.

One promising strategy is a Health in All Policies approach to decision-making.[33] This systems-wide approach encourages non-health agencies to consider health consequences when designing programs and policies. Some successful examples of facilitating the Health in All Policies approach through state legislation related to health disparities were developed in the California state legislature; this approach required the state transportation commission to acknowledge policies, practices, or projects that were used by metropolitan planning organizations to promote health and health equity,[34] and also encouraged interdepartmental collaboration to emphasize the environmental factors that contributed to poor health and inequities



when developing policies.[35] Such legislation is uncommon across the United States; however, this legislative approach helps to eliminate racial/ethnic health disparities by targeting the social determinants of health that have been shown to drive racial/ethnic health disparities, such as social class, income, transportation, education, and housing.

Finally, 14 states introduced bills to support research related to racial/ethnic health disparities; however, only 8 states passed such bills. This category of state legislation is important in supporting research to not only understand the drivers of racial/ethnic health disparities, but also to support evaluation of these policies, including implementation. Demonstrating the effectiveness and understanding the implementation of state legislation could support future legislation and also the application of lessons learned from previous policies.

Limitations

We noted some study limitations. Each state legislature operated in a unique demographic and social environment, which might influence how health disparities are framed and addressed. For example, states that introduced no health disparities bills might have targeted racial/ethnic health disparities without using specific language that the keywords could have identified. In addition, state policy approaches could fall outside of legislative action. An administrative agency in the executive branch could promulgate regulations affecting racial/ethnic health disparities using powers granted to the agency through legislation that did not explicitly address racial/ethnic health disparities. Governors could exercise their executive order power to address racial/ethnic health disparities; however, this fell outside of our study's scope because of its focus on legislative activity. In addition, governor-issued executive orders might only remain in effect for the duration of their term and might not have as much of a long-term impact as legislation.

Our data analysis only focused on the most recent version of proposed legislation, even if there were multiple previous versions of a bill. This method of analysis might bias the passage rates presented here. We also only focused on the 50 US states and did not include US territories or the District of Columbia, which might have undercounted health disparities bills. Our analysis of these bills did not include a rating of the strength of the proposed legislation, which could potentially be derived from the bill text. Finally, not all state legislatures meet every year; as such, legislators in some states had fewer opportunities to introduce health disparities bills, which could bias the appearance of commitment to eliminating racial/ethnic health disparities through state legislation.

Conclusions

We identified areas in which state policymakers focused on legislative efforts to address the elimination of racial/ethnic health disparities. We also identified gaps in state legislative efforts. These were important areas for public health in which there might be future opportunities to expand legislative approaches to eliminate racial/ethnic health disparities. Continuing to develop and support state-level legislation across the United States to eliminate racial/ethnic health disparities, achieve health equity, and improve population health, should be a priority for public health advocates, researchers, and policymakers. ■

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Contributors

J. L. Young conceptualized and designed the study, collected and analyzed data, interpreted results, and wrote the first draft of the article. K. Pollack and L. Rutkow provided support on the analysis plan, results interpretation, and provided critical review of the article. All authors contributed to editing and revising the article.

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Human Participant Protection

This research article does not involve human participants. Our research adheres to the Principles of Ethical Practice of Public Health of the American Public Health Association.

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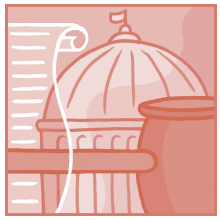

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