

## State Strategies for Overcoming Barriers to Advance Health Equity

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### Introduction

The COVID-19 pandemic has highlighted longstanding health inequities which have resulted in an increased risk of sickness and death for people of color. The crisis has also propelled a nationwide focus on understanding and addressing health inequities. As compared to White, Non-Hispanic individuals, American Indians or Alaska Natives are over five times as likely to be hospitalized, and Black or African-American individuals are over twice as likely to die from [COVID-19](#). While COVID-19 and the reckoning on racial justice have mobilized some state officials working in Medicaid, public health, insurance departments, and Marketplaces, alike, states are at different places on their journeys to confront systemic racism and inequities in health care, and each faces unique and challenging barriers. As early as August of this year, [over one third](#) of states had launched task forces to take a closer look at health [disparities](#) (or differences in health based on population group) in response to the pandemic. These new task force efforts stand in contrast to decades of siloed and often poorly funded work to advance health equity by state offices of minority health or health equity. The new wave of state health equity activities aims to mitigate structural, institutional, political, financial, and analytical barriers to ensure everyone has a fair opportunity to be as healthy as possible. This issue brief explores impediments and accelerants to advancing health equity as states are increasingly being called upon to drive change.

“**Health equity** means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

– [The Robert Wood Johnson Foundation](#)

## Barriers to Health Equity

Health inequities are deeply rooted in structural or systemic racism. Understanding that racial bias and racism (such as [redlining](#)) underlie health inequities, states are working to understand structural, institutional, political, financial, and analytical barriers to health equity in order to identify and implement strategies to overcome them.

[The Aspen Institute](#) defines **structural racism** as “A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead, it has been a feature of the social, economic and political systems in which we all exist.”

Barrier Type	Challenges to Achieving Health Equity <sup>1</sup>
<p><b>STRUCTURAL</b> <i>Systemic obstacles and societal norms that reinforce inequities.</i></p>	<ul style="list-style-type: none"> <li>&gt; Lack of diversity in decision-making structures.</li> <li>&gt; Inconsistent internal practices; and lack of consensus around what is meant by health equity, inequities, and structural racism.</li> <li>&gt; Lack of intra-and-cross agency coordination (including with the private insurance market) and engagement with state leadership (e.g., governor’s office, state legislature) on health equity issues; and insufficient authority of health equity officers within agency structure.</li> <li>&gt; Limited or insufficient engagement with constituents/enrollees impacted by health inequities.</li> </ul>
<p><b>INSTITUTIONAL</b> <i>Policies and practices that are designed and/or implemented – intentionally or not – in a manner that disproportionately disadvantages certain groups and perpetuates disparities.</i></p>	<ul style="list-style-type: none"> <li>&gt; Federal constraints that hinder state efforts to advance health equity or federal actions that permit or encourage states’ policies that impede health equity.</li> <li>&gt; Failure of federal or state governments to enforce equity-promoting policies.</li> <li>&gt; Historical legacy of racism reinforced by state laws and policies and bureaucracy that create “friction” for people of color related to obtaining coverage or services through health and social service programs.</li> <li>&gt; Discriminatory design and implementation of policies that unfairly impose obstacles to health equity for certain groups (e.g., Medicaid work requirements applied and enforced in racially discriminatory ways).</li> </ul>

<sup>1</sup> Barriers to advancing health equity were informed by a review of the available literature and discussions with states.

Barrier Type	Challenges to Achieving Health Equity <sup>2</sup>
<p><b>POLITICAL</b> <i>Decisions made by executive and legislative branches that ignore or discredit the existence of health inequities.</i></p>	<ul style="list-style-type: none"> <li>&gt; Lack of “political will” or commitment to racial equity/justice and accountability from key political leaders in the state (e.g., governor, key cabinet level officials, legislature).</li> <li>&gt; Lack of authority and political power among individuals/groups making recommendations to implement health equity policies.</li> <li>&gt; Discomfort engaging in conversations on racial justice or equity, and fear of being associated with politically charged language surrounding racial justice or equity.</li> </ul>
<p><b>FINANCIAL</b> <i>Inadequate financial resources allocated to implement initiatives that advance health equity.</i></p>	<ul style="list-style-type: none"> <li>&gt; Insufficient funding to support department-led health equity programs (e.g., funding for staffing).</li> <li>&gt; Insufficient payments across all payors to providers serving communities facing racial health disparities because they lack market power.</li> <li>&gt; Gaps in income and wealth at the individual and community levels that contribute to health inequities.</li> </ul>
<p><b>ANALYTICAL</b> <i>Challenges in collecting and analyzing quantitative and qualitative data stratified by demographic factors, such as race, ethnicity, and language, to effectively design and evaluate strategies to achieve health equity.</i></p>	<ul style="list-style-type: none"> <li>&gt; Inconsistent collection and varying degrees of accuracy of race, ethnicity, language, disability (RELD) data.</li> <li>&gt; Inconsistent collection and application of qualitative data (e.g., from constituents/enrollees).</li> <li>&gt; Difficulty evaluating the effectiveness of initiatives and what solutions might work better.</li> </ul>

## Strategies to Address Structural, Institutional, and Political Barriers to Advancing Health Equity

States are implementing a range of initiatives to overcome barriers to advancing health equity. States that are newly engaging in this work may consider implementing the following strategies to begin tackling structural, institutional, and political barriers that undergird financial and analytical challenges.

**Establish diverse and accountable leadership to drive health equity efforts.** Leadership direction and support are essential for setting and following through on initiatives to advance health equity. Governing and decision-making bodies (e.g., governors’ offices, secretariats, Medicaid agencies) should prioritize internal transformation to create racial and lived experience diversity across their leadership, staff, and advisory bodies to consider various perspectives in decision-making processes. As part of these efforts, states are shifting the longstanding culture and practice of treating the work of equity and diversity offices as subordinate to program, policy, and budgetary decision-making. Diversity at the top, as well as throughout the organizational structure, can help address resistance to change or “the way we

<sup>2</sup> Barriers to advancing health equity were informed by a review of the available literature and discussions with states.

have always done it” mentality as well as implicit bias in developing, implementing, evaluating, and communicating health equity initiatives. Leaders can also advance their equity agendas through language, such as naming structural racism as the cause of inequities.

**Develop common terminology and internal understanding.** Several states have developed their own health equity definitions – including through the lens of structural racism, while others have adopted the Robert Wood Johnson Foundation or [Healthy People 2020](#) definitions. [Virginia](#), for example, adapted the Healthy People 2020 definition to define health equity as, “achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.” To establish common understanding of health equity-related terminology and consistent messaging to address head-on apprehension about language surrounding racial justice or equity, states can develop internal language guides and trainings. [Connecticut](#) developed a Health Equity Glossary, which includes a definition of health equity (adapted from the [World Health Organization’s](#) definition), among other definitions of key terminology.

**Create an integrated state health equity plan and collaborate across agencies to implement.** States can accelerate their work in health equity by breaking down [current silos](#) across public health, Medicaid, and the Marketplace to devise and implement a health equity plan. Cross-agency communication and data sharing are essential to meaningfully developing a plan to address disparities for populations being served. Rather than relying solely on a state’s office of minority health or health equity to solve issues with limited resources, health equity can be infused throughout cross-agency state teams, and priorities can be aligned and funded across agencies. As a best practice, states can catalog their health equity-related initiatives, establish a shared vision or charter, and develop strategic goals and action plans for their collaborative health equity work. [Louisiana’s Office of Community Partnerships and Health Equity](#) collaborates across the Louisiana Department of Health (LDH) to develop and implement agency-wide plans, protocols, and tools that advance health equity. Each LDH office has a Health Equity Action Team that works with Department leadership on topics including data analysis and community engagement to design effective solutions for Louisiana’s [Health Equity Action Plan](#).

**Ensure health equity initiatives are community-driven.** While some states have centered community voices in setting priorities and developing policies to promote health equity (i.e., a “government follows the community” approach), other states have experienced challenges in engaging the community (more specifically, enrollees and their families – not just advocates, associations, or community-based providers). This challenge is, in part, due to the fact that administrative timelines are not designed to accommodate community engagement. Because of longstanding institutional practices that have resulted in mistrust of governmental entities, states may consider taking new and intentional measures to foster collaboration with community members and avoid re-traumatizing people of color who have actively worked for decades to elevate inequities and disparities in health care. [North Carolina Department of Health and Human Services](#) has deployed over 250 community health workers from the communities they serve to connect individuals with needed services and supports, such as COVID-19 testing, primary care, and behavioral health services. The state also partnered with community-based organizations and local leaders to design strategies for outreach to

historically marginalized populations in response to COVID-19, using [trusted communication](#) channels, such as radio stations, to communicate key messages. Ongoing engagement and elevation of community voices – if done well – strengthens the message to state leaders and creates programs that are reflective of the community’s needs.

**Develop creative strategies given institutional constraints.** The federal [executive order](#) released on September 22, 2020 prohibits the use of workplace trainings on “divisive concepts” and “race or sex scapegoating” for federal employees and contractors. This may hinder states’ anti-racism and equity promotion efforts, just as it has at the federal level with the United States Department of Justice’s recent [suspension](#) of diversity and inclusion trainings. Similarly, federal regulations and policies that disproportionately impact people of color, such as public charge and [work requirements](#) perpetuate historic structural inequities and widen the health equity gap. When states pursue, apply, and enforce these discriminatory policies, they inhibit the ability of certain groups to achieve their full health potential and reinforce the racist notion that people of color and immigrant families are undeserving of health care coverage and access. Amid institutional constraints, states can still move forward with creative solutions to advance health equity, such as incorporating health equity-related requirements into their [Medicaid managed care contracts](#) and quality improvement strategies. States might also gain some relief, as the incoming administration is expected to rescind the executive order and move away from requirements that make it more difficult for individuals to access health care. Together, states and the federal government can [seize the opportunity](#) to break away from structural and institutional laws, policies, and practices that disproportionately harm people of color, and work together to advance health equity as COVID-19 cases continue to surge and states face severe budget crises.

## Conclusion

While states are taking unprecedented steps in the right direction, they are still grappling with the challenges of advancing health equity, which can at times feel insurmountable. Engaging in honest conversation, both internally with state leaders and staff as well as with communities impacted by inequities, is critical to identifying barriers to equity and taking concrete action steps to remove them. States can also take on the arduous and important work of culture change to put health equity at the forefront of decision-making as they create new programs and make changes to existing initiatives across public health, Medicaid, and the Marketplace. These steps are critical to beginning what, for many state health policymakers, will be a lifetime of work necessary to repair health inequities and eliminate disparities in our health care system.

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