EQUITY & ACCESS

*" **Equity:** The ideal or quality of being just, impartial or fair (in law). Justice applied in circumstances not covered by law. [From the Latin aequus, meaning equal]."*

– The American Heritage Dictionary. 1979. Equity. Houghton Mifflin Co: Boston. p. 443

*"**Access** is the timely use of personal health services to achieve the best possible health outcomes."*

– Institute of Medicine. 1993. Access to Health Care in America. National Academy Press: Washington D.C. p. 4

EQUITY & ACCESS

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How is this parish doing?

Insurance coverage	☹
Medicaid enrollment	😐
Medicare enrollment	☺
LaCHIP enrollment	☺
Access to daycare	😐
Strategies to improve access	😐

DID YOU KNOW?
According to the 1994 National Access to Care Survey, the highest unmet need in the United States was the need for dental care.
- (3) U.S. Department of Health and Human Services, 1998.

According to estimates from a recent survey by the U.S. Census, in 1998 16.3 percent of the U.S. population was uninsured through the year. **Estimates from that survey indicate that 19 percent of Louisianians were uninsured in 1998.** Texas had the highest estimate of uninsured, at 24.4 percent of the population, while Hawaii had the lowest at ten percent. **Louisiana ranked 8th highest for numbers of uninsured people in 1998** (U.S. Census, 1999).

In the United States, 41,716,000 people (15.6 percent) of the total population were uninsured in 1996. Many more could not find or get preventive care in a timely fashion. Even people with insurance or public assistance can suffer from not being able to get timely care. **In Louisiana, 890,000 (20.8 percent) of people were uninsured in 1996 and the trend is towards increasing numbers of uninsured** ([1] National Center for Health Statistics, 1998). See Figure 1 for trends from the National Center for Health Statistics.

According to the Federal Bureau of Primary Health Care, one in three Louisiana residents does not have access to a nearby primary health care provider. The Federal Bureau of Primary Health Care also estimates that there is one primary care provider for every 6,368 people in Louisiana (Bureau of Primary Health Care, 1998).

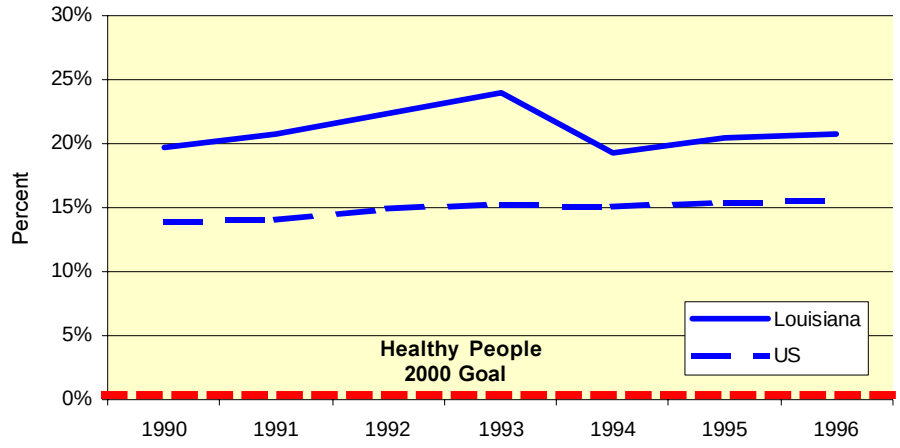
"In Louisiana, one in five people has no health insurance. . . and one in three residents does not have access to a nearby primary care provider."

A primary care provider is a physician who deals with overall health needs. The provider can be any one member of a team dedicated to an individual's health ([1] U.S. Department of Health and Human Services, 1998). Primary care providers include general practice, family medicine, pediatric, gynecological, internal medicine or geriatric medicine doctors.

Access-to-care was defined by the Institute of Medicine in 1993 as "the timely use of personal health services to achieve the best possible health outcomes". This means getting preventive care, getting care for ongoing problems, or care for emergencies. As shown in the chart in "Using the Parish Health Profiles," medical care may contribute no more than ten percent to overall health.

Access-to-care is a very difficult concept to measure. National and state estimates of coverage and barriers may not accurately reflect an individual community's access-to-care status. Defining the local barriers to care and local capacity to provide care is a key step communities can take to improving quality of life. Much of the time, people do not even consider access until they need care. Crises force people to find care which meets immediate needs, within the limitations of their lives. This chapter closes with suggestions for community action around access-to-care issues.

Figure 1:
Percent of Population with No Health Care Coverage, United States and Louisiana, 1990 - 1996



Source: (1) National Center for Health Statistics, 1998

DID YOU KNOW?
An estimated three million of the nation's ten million uninsured children are already eligible for Medicaid, but are not receiving it because their parents have not signed them up.
- Froomkin, 1998.

Barriers to Care

When people are asked what prevents them from getting needed care, they are most likely to say a lack of health care coverage. People also mention that not having a source of regular care is a barrier ([3] U.S. Department of Health and Human Services, 1998). There are many other barriers to access. This section addresses several kinds of barriers identified by the U.S. Department of Health and Human Services in its draft objectives for Healthy People 2010. The most salient barrier is cost. Another set of barriers is evidenced by the disparities in care and health outcomes throughout this book. Disparities in care are discussed towards the end of the section. There are other barriers as well, which will be briefly described at the end of this section, as will some potential solutions for access-to-care concerns.

Cost can be a very real barrier when people have no health coverage and their income approaches poverty levels. Cost can also be a barrier when people have to handle premiums, copays and deductibles, even if their coverage is provided by an employer. Vague information about what is or is not covered in a health plan, including lab work, pharmaceuticals and equipment and supplies, can make this even more confusing. Cost can also be thought of in terms of the time people have to take off from work to go to a doctor, or the

Types of Coverage, Louisiana Citizens

Health Insurance Status	**Percent**
Uninsured in Louisiana, 1996	20.8%
Source: (1) National Center for Health Statistics, 1998	
Medicaid recipients, 1997	17.3%
Source: Medicaid Program Financial Report, 1999	
Medicare recipients, 1997	13.6%
Source: Louisiana Department of Insurance, 1998	
Enrolled in a Health Plan	**Percent**
Enrolled in an HMO, 1997	14.7%
Source: (1) National Center for Health Statistics, 1998	
Enrolled in a PPO, 1994	44.2%
Source: Louisiana Department of Insurance, 1998	

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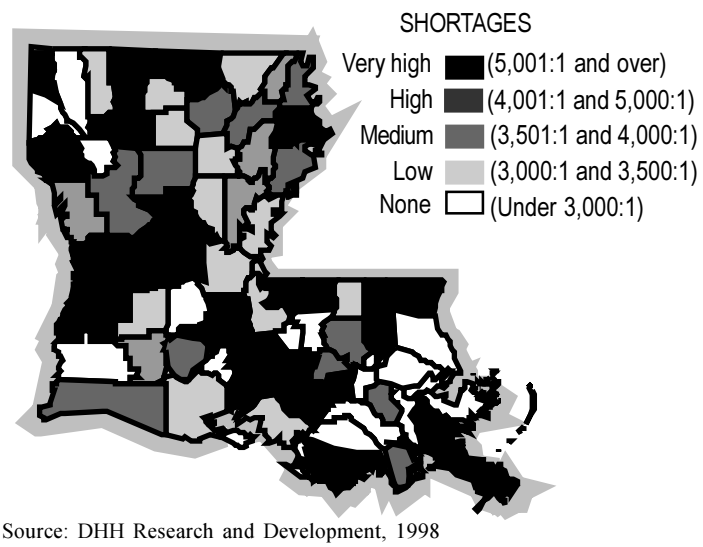
Figure 2:
Primary Health Professional Shortage Areas
Population to One Provider, Louisiana, 1997



Source: DHH Research and Development, 1998

DID YOU KNOW?
A recent study showed that children without health insurance were six times more likely than insured children (24% versus four percent) not to have a usual source of care. Uninsured children were four times as likely to have been unable to get dental care as insured children (17% versus four percent).
- (3) U.S. Department of Health and Human Services, 1998.

expense of transportation and going a long distance.

Sixty-three parishes in Louisiana are "medically underserved" (Health Resources and Services Administration, 1998). Figure 2 shows the ratio of providers to population in each parish. In many areas, there are not enough primary health care providers to serve the population. Even within parishes, some areas are more under-served than others. Sometimes people don't know how to find a clinic or provider who meets their needs or accepts their health care coverage. Vulnerable populations, such as children, the elderly or persons with disabilities, often have to rely on someone else to get them to care. Dependence on others means that the burdens of access can be compounded by another person's schedule and capability.

Real or perceived limitations of health care access are widely recognized as barriers to the health of individuals. Many people wait to seek help until problems are severe and then go to emergency rooms. **Louisiana has one of the highest rates of emergency outpatient visits in the nation** (Louisiana State Center for Health Statistics, 1999). Emergency room care is more costly and less comprehensive than routine primary care.

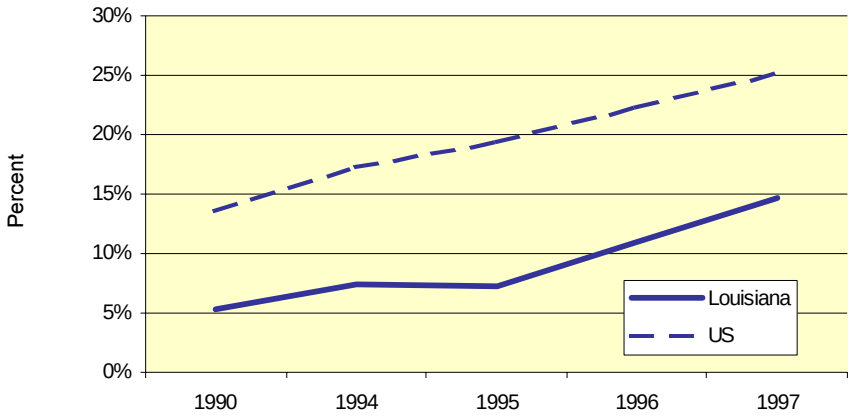
FINANCIAL ISSUES

The term "coverage" is used to describe when people have a health plan that pays for part or all of their medical care. There are many different types of health plans that provide varying levels of coverage. Each one provides people with a different range of options for care. **In 1997 47.9 percent of Louisianians had private insurance** ([1] Louisiana Medicaid Program, 1998). Private insurance is an option, if people can afford it.

Private insurance

Many times employers will arrange group benefits that employees that pay part of their employees' health costs. For people who are self-employed, work part-time or have very

Figure 3:
Percent of Population Enrolled in HMOs
United States and Louisiana, 1990 -1997



Source: (2) National Center for Health Statistics, 1998.

little income, insurance can be a financial burden. Those who make the lowest wages or who work part-time are the ones most likely to find themselves without coverage (see Figure 5). According to the U.S. Census, 47.5 percent of low-income, full-time workers did not have coverage of any kind throughout 1998 (U.S. Census, 1999).

Managed care

There are a variety of managed care plans available to consumers. HMO's and PPO's offer different options for seeking care. **In 1997, 14.7 percent of the Louisiana population was enrolled in an HMO, up from 11 percent in 1996** (see Figure 3). Nationally, 25.2 percent of people are covered by an HMO ([2] National Center for Health Statistics, 1998).

On a national level, the status and regulation of HMOs is in constant debate, with an emphasis on improving outcomes and satisfaction of patients. As of fall, 1999, the Patients' Bill of Rights was still in debate in national government. The Patients' Bill is intended to protect patients' abilities to self-advocate within the system. HMOs and providers are still trying to negotiate how best to work together to serve their clients.

Government sponsored insurance programs

Government sponsored insurance programs cover those in certain categories of need. Medicaid covers some members of families with the lowest incomes. **In 1997, 73.8 percent of people below the Federal Poverty Level in Louisiana were eligible for Medicaid** ([1] Louisiana Medicaid Program, 1998). Medicare provides coverage for people over 65 years old, who are disabled or who have permanent kidney failure. Medicare is entirely federally funded and administered. Medicaid, on the other hand, is funded by both the state and the federal government ([2] and [3] Health Care Financing Administration, 1998).

DID YOU KNOW?
A family of three receiving maximum Financial Independence Temporary Assistance Program (FITAP) and food stamp benefits still has only met 46% of the 1997 U.S. Poverty guidelines.
- *Office of Family Support. 1998.*

A family of three receives $190 per month under FITAP, and $321 per month in food stamps.
- *Office of Family Support. 1998.*

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For other government sponsored insurance, children are of special concern because of their vulnerability and dependency upon parents or other care givers. Therefore, extra measures are taken to assure their opportunities to be healthy. Many children in low-income families are eligible for Medicaid services. This means that depending on their age, the number of people in their family and the family income, they may get help with the cost of health care.

Not all children are insured. Some low-income families make only slightly more than the amount that qualifies them for government sponsored health care coverage. They may also have difficulty obtaining private insurance. In recognition of the gap in coverage that exists between being Medicaid-eligible and being able to afford private insurance, the federal government has established and Louisiana has initiated a Child Health Insurance Program (LaCHIP). This program expands upon existing Medicaid eligibility and covers children through a range of incomes and family sizes (White House, 1999).

Overall, 19 to 24 year-olds are the least likely to have health care coverage ([1] Cunningham, 1998). In low income groups, the number of people in this age group who have no coverage approaches 50 percent (U. S. Census, 1999).

Medicaid

Medicaid populations include, but are not limited to, blind or disabled people, children in families at or below certain income levels and the elderly in nursing home care ([2] Health Care Financing Administration, 1998).

Medicaid in Vermilion, 1997

Number of eligible persons	**8,744**
Number of recipients	8,423
Portion of parish on Medicaid	17.0%
Total expenditure	$27,835,437
Per capita expenditure	$542
Expenditure per eligible	$3,183
Expenditure per recipient	$3,305

Source: (2) Louisiana Medicaid Program, 1999.

Select Medicaid Services Expenses, Louisiana, 1997

Inpatient hospital services	$415,079,718
Outpatient hospital services	118,854,893
Other laboratory and X-ray services	37,854,097
Physician services (including dentist)	179,171,757
Home health care services	22,316,286
EPSDT	48,666,190
Family planning services	4,814,304
Rural health clinic services	7,440,772
Federally qualified health centers	6,046,970

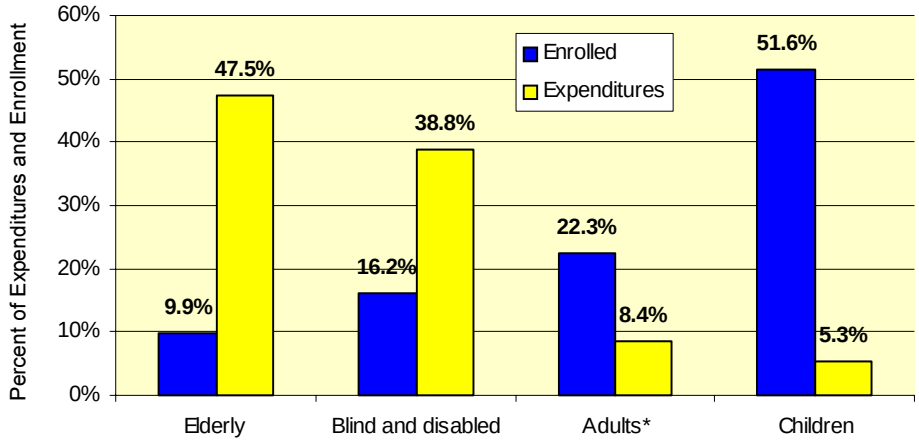
Souorce: (2) Louisiana Medicaid Program, 1999.

Medicaid for children less than 21 years old is nationally known as the Early Periodic Screening, Diagnostic and Treatment (EPSDT) program. EPSDT is called KidMed in Louisiana. It is the medical plan for children that covers a broad range of preventive care and all services medically necessary to diagnose and treat conditions for enrolled children.

Pregnant women of a low income status, as well as persons older than 20 with a disabling condition, may be eligible for Medicaid. In addition, elderly persons living in nursing homes can have part of their health care expenses covered by Medicaid. See Figure 4 for expenditures by these categories of enrollment.

In 1997, 752,747 people, young and old, in Louisiana were eligible for Medicaid.

Figure 4:
Percent of Medicaid Expenditures and Enrollment by Eligibility Category, United States, 1995



** Adults include pregnant women*

Source: Kaiser Family Foundation, 1998

Of that number, 8,744 reside in Vermilion Parish. Just over 17 percent of the state population was enrolled in Medicaid compared to 17 percent of Vermilion Parish residents ([2] Louisiana Medicaid Program, 1998).

Many services go unused because eligible children are not enrolled in Medicaid or do not have the ability to find or get to the health care provider. As a result, problems that might have required low cost preventive care can become expensive and serious before Medicaid is accessed.

Louisiana Children's Health Insurance Program (LaCHIP)

The national CHIP program was created by the 1997 Federal Balanced Budget Act. This program provided $24 billion in federal matching funds over five years to help states expand Medicaid, create their own federally supported non-Medicaid health care programs or develop a combination of both.

In 1998, the Louisiana legislature created LaCHIP, Louisiana's version of the national CHIP program. The current plan is to do a three-phase roll-out of LaCHIP over the next few years, expanding eligibility for coverage each year. The first roll-out expanded eligibility to 133 percent of the Federal Poverty Level (FPL) and in October, 1999, eligibility expanded to 150 percent of the FPL.

Can Your Child(ren) Get LaCHIP?*

Number of Family Members**	Approx. Annual Income
1	$12,360
2	$16,590
3	$20,820
4	$25,050
5	$29,280
6	$33,510
7	$37,740

* *As of October 1999, the criteria for enrollment is based on 150% of the federal poverty levels, which is presented here.*

** *A family is the parent(s) and child(ren). It is possible for an emancipated youth between 17 and 19 to apply as a family of one.*

Source: Louisiana Medicaid Program, 1999.

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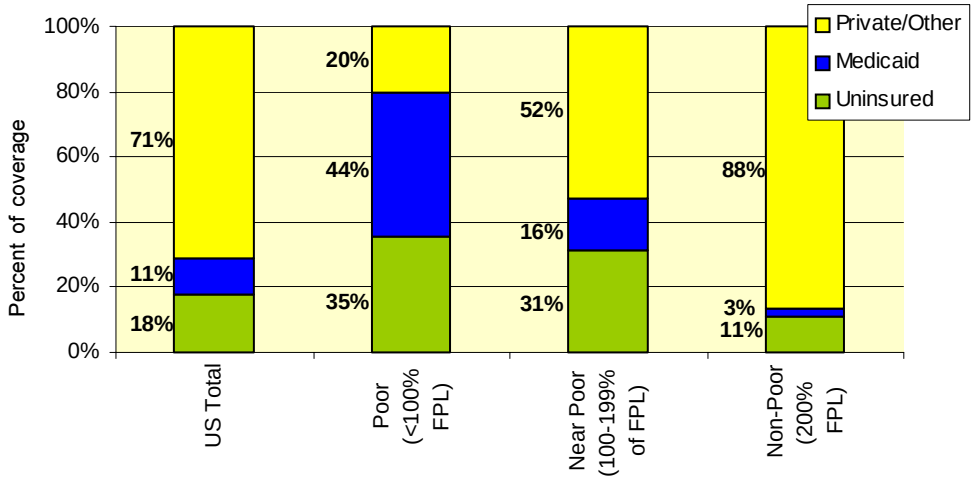
DID YOU KNOW?
Sixty-four percent of uninsured families in the United States in 1997 had at least one full-time worker. In 1996, 55% of low-income families had access to health insurance through their employer, while 96% of higher income families had access to employer-sponsored health insurance.
- Kaiser Family Foundation, 1999.

Figure 5:
Sources of Health Care Coverage by Income Level, United States, 1997



Source: Kaiser Family Foundation, 1998.

According to the Children's Defense Fund, there were nearly 300,000 uninsured children in Louisiana when the first roll-out phase of LaCHIP went into effect. This number included children who became newly eligible under the medicaid expansion and children who were previously eligible for Medicaid but were not enrolled (Maternal and Child Health Program, 1999). In its first year, LaCHIP aimed to enroll 58,000 children (LaCHIP, 1999). The new toll-free hotline will help families find CHIP programs in any state in the country. The number is 877-KIDS-NOW ([1] Health Care Financing Administration, 1998).

Medicare

Medicare is a government sponsored health insurance program administered by Health Care Financing Administration (HCFA). It is available for all people 65 years and older and some younger people in special circumstances. The original Medicare is a traditional fee-for-service system that covers health care needs. Eligible people could receive either Medicare Part A, hospital insurance, or Medicare Part B, supplementary medical insurance or both. Medicare pays the balance of health care costs after clients pay premiums and deductibles ([3] Health Care Financing Administration, 1998). In recent years, Medicare has offered managed care options.

Traditionally, Medicare has not covered the costs of prescription drugs other than cancer drugs. Some Medicare eligible persons can choose a plan with

Federal Poverty Level (FPL) Guidelines
Effective April 1, 1999

Family Size	100% FPL Annual Income	200% FPL Income
1	$8,420	$16,840
2	$11,060	$22,120
3	$13,880	$27,760
4	$16,700	$33,400
5	$19,520	$39,040
6	$22,340	$44,680
7	$25,160	$50,320
8	$27,980	$55,960

Source: Maternal and Child Health Program, 1999.

greater prescription drug availability. Prescription drug coverage policies will continue to be debated as the population of elderly grow and more people struggle to pay for the medicine they need.

OTHER ACCESS-TO-CARE CONCERNS

Other barriers to care are those things that put a strain on resources and time. Speaking a language other than English, not having a phone or moving frequently can become barriers. Similarly, having many children in a family, more than two jobs or competing medical needs, e.g. pregnancy or disability, can all put constraints on people's ability to seek preventive care in a timely fashion. Communities can look at barriers that may be unique to their location or population.

Childcare

Access to quality and affordable childcare is a high priority for many families. The expense of childcare can be a cost that affects a family's ability to seek and afford health care. At the same time, low quality childcare can have an impact on the health and well-being of both parents and children. Getting quality childcare is an access-to-care issue in its own right. Quality care is defined by the Children's Defense Fund as a safe and healthy environment with nurturing and knowledgeable care givers and a small number of children per care giver (Children's Defense Fund, 1999).

The Annie E. Casey Foundation reported in 1998 that childcare costs an average of $4000 per child per year across the nation (Annie E. Casey Foundation, 1998). In urban areas, costs can be a lot higher. Concerns about childcare can interfere with parents' efforts to get steady jobs at decent wages. Many children have inconsistent childcare from neighbors and family members. **As of fall, 1999, there were approximately 2,100 Class A and Class B licensed childcare centers in Louisiana** (Bureau of Licensing, 1999)**.** Class A child care centers are those that receive federal or state funds. In addition to meeting all the license requirements, both Class A and Class B must meet fire and health codes in order to remain open. Home care providers are registered only if they receive state or federal funding. The centers, too, must meet fire safety standards. There are many unlicensed home care providers who operate without any obligation to meet health and safety standards. Louisiana is the only state with separate and different Class A and Class B requirements.

Childcare providers are not required to be trained in child development and safety (Children's Defense Fund, 1999). However, there is a national movement headed by the Annie E.Casey Foundation to require training. Very small amounts of training for childcare workers has been shown to improve the quality of care children receive. Even in areas where home care is the only option, home care providers should be networking with one another to share resources and solutions. A recent study done by the Office Maternal and Child Health and the Office of Infectious Disease Epidemiology showed that the more years of education the childcare center director has, the less likely children are to get sick or injured in their care (Frontini and Kelso, 1996).

DID YOU KNOW?

The higher the day care center (DCC) director's education level, the less likely children are to suffer illness or injury. In Louisiana in 1996, 11.2% of children in the care of a DCC director with 12 or fewer years of education experienced injuries and 29% were ill with disease. In comparison, only 0.9% of children in the care of a DCC director with 13 - 19 years of education were injured and 26% were ill with disease.

– *Frontini, M. and Kelso, K., 1996.*

Nationally, childcare workers are only required to get 12 hours of training per year; while in-home providers are not required to get any training at all.

- *The Annie E Casey Foundation, 1998.*

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The Child Care Assistance Program (CCAP) helps parents pay for childcare while they work or go to school. Parents may choose a Class A childcare center or a school-based before or after-school program. They may also choose a registered child care home or an in-home provider. **In 1994, the CCAP in Louisiana served approximately 7,000 children each month. The average subsidy paid to the provider per child was $138.** In 1997, the program served 15,000 children and provided nearly $2.5 million in assistance each month (Office of Family Support, 1998).

DID YOU KNOW?
"In some American cities, more than one-third of African American girls and three-quarters of boys who reach their 15th birthdays do not live to see their 65th – largely as a result of chronic diseases . . .(the) cumulative experience with social inequality contributes to this rapid health decline."
- *Geronimus, et al. 1996.*

DISPARITIES IN CARE AND HEALTH OUTCOMES

Disparities in care and health outcomes suggest another kind of barrier to accessing health care and being healthy. For most indicators presented in this book, minorities have poorer reported health outcomes than non-Hispanic whites. Social characteristics are correlated with disparities in care ([1] American Medical Association Council on Ethical and Judicial Affairs, 1990). If barriers based on social characteristics (e.g. race, income-level, native language or education level) exist, or are even perceived to exist, they may prevent people from seeking care. These barriers could also interfere with providers' abilities to give consistent and quality care.

The Office of Public Health works to assure fair access to care for all individuals and families. Knowing who is vulnerable and offering them dignified care are priorities for the Louisiana Department of Health and Hospitals and the Office of Public Health.

Race

The U.S. Department of Health and Human Services, in partnership with experts around the country, has identified racial disparities as a priority for change in the next decade ([2] U.S. Department of Health and Human Services, 1998). Some of the most telling health disparities occur among races.

According to the DHHS, race and ethnicity correlate with continued disparity in health status and outcomes. These disparities exist despite an overall improvement in the nation's potential for residents to be healthy and live longer. Lack of education, low income, poor nutrition, stress and distrust of medical institutions all contribute to poor health in every race (David and Collins, 1991).

Furthermore, both providers and patients bring expectations with them to the clinic situation. These expectations influence the way they treat one another and even the decisions and recommendations they make about giving and accepting care (Wenneker and Epstein, 1989).

Health Care Providers, Vermilion, 1998

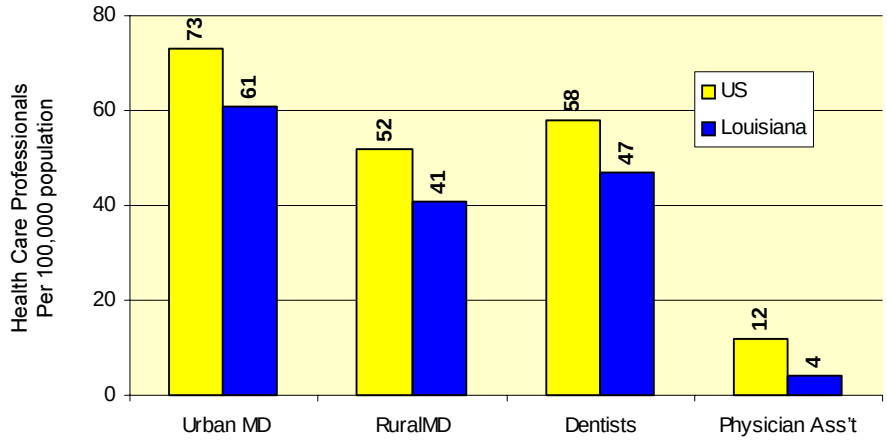
Kind of provider	Number
Family practice	2
General practice	3
Infectious disease	0
Internal medicine	11
OB/Gyn	0
Pediatrics	1

Source: Louisiana State Center for Health Statistics, 1999.

Kind of facility	Number	Number of beds
Hospitals	2	201 beds
Nursing homes	6	555 beds

Source: LEAP, Center for Business & Economic Research, 1999.

Figure 6:
Health Care Professionals per 100,000 Population,
United States and Louisiana, 1997



Source: Health Resources and Services Administration, 1998.

OVERCOMING THE BARRIERS

It is important to bear in mind that there is a link between access and utilization. Reducing provider shortages and making preventive services more available are beginning steps to increasing access-to-care. Many programs support these changes. National groups, such as the Health Resources and Services Administration (HRSA), provide a process to get money and staff for communities with a need for care, see Figures 6 and 7. Other programs can be taken on by the state government. There are many efforts trying to improve access across the state. Some are statewide efforts and some are local. A few efforts are discussed here, but there are many others in communities everywhere.

Education Loan Reimbursements

Louisiana's State Loan Repayment program is helping to increase access-to-care. The state repays loans for dentists and physicians who commit to work in underserved areas. Providers' loans will be repaid up to $13,333 a year for a two-year commitment or $20,000 yearly for a three-year commitment. Mid-level medical professionals receive somewhat less for their commitments. Several other programs, including the National Health Service Corps (NHSC) Scholarship and Loan Repayment programs and the J-1 Visa Waiver program also place physicians in under-served areas in exchange for loan repayment or residency ([1] Health Policy Tracking Service, 1998).

Louisiana Rural Health Access Program

The Louisiana State University Medical School has partnered with the Louisiana Department of Health and Hospitals to lead the Louisiana Rural Health Access

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Program. The initiative, sponsored by the Robert Wood Johnson Foundation, focuses on the development of a rural health network, community-based "chambers of health," loans for health-related businesses and recruitment of health professionals (Southeast Louisiana AHEC, 1999).

Louisiana Turning Point Partnership's Access to Care Workgroup

The Louisiana Turning Point Partnership is a statewide coalition made up of representatives from major statewide and local organizations to work together to improve the state's ability to perform activities that impact population based health. The areas addressed by the Partnership include policy development, health assessment, health promotion and assuring access to health services.

The statewide workgroup on Access to Care is made up of representatives from public and private provider organizations, consumer advocacy groups, social services agencies, universities, state governmental health care agencies and other major statewide and regional organizations. They have all come together to develop strategies and recommendations for how to improve access to care in Louisiana for the indigent uninsured and underinsured. The mission of the group is to develop legislative and organizational policy recommendations that enhance access-to-care throughout the state. Work is also being done to enable local communities to bring public and private providers and community members together to create innovative solutions to access-to-care barriers. The workgroup facilitates communication among various access-to-care initiatives and activities throughout the state. It is documenting best practices, developing on-going assessment activities to assess and understand access barriers, recommending appropriate policy changes and pilot testing innovative solutions at the local level (Louisiana Turning Point Partnership, 1999).

Mobile health units

Some rural areas can benefit from clinics with vans that take their services or screenings on the road. Urban neighborhoods without clinics also find that mobile vans help them maintain screening and testing. Private and public groups have supported these mobile health units.

Telemedicine

The program was established in 1992 and was reorganized in 1995. The Louisiana State University Medical Center plays a leadership role in providing this interactive care opportunity for rural communities. In 1997, the legislature approved Medicaid reimbursement for telemedical services. Telemedicine allows people to get preventive care and some examinations interactively by real-time video ([1] Health Policy Tracking Service, 1998).

Training and recruitment

Having a diverse population of providers is a good way to meet the needs and expectations of the many different people across our communities. The Louisiana Rural Access Program (1998) has put a high priority on recruiting and training medical and pre-medical students in college and at earlier levels. They make an effort to recruit people of different cultural backgrounds, as well as people from rural and

underserved areas, who would be likely to return there to practice([2] Health Policy Tracking Service, 1998).

ADDRESSING RACIAL DISPARITIES

Study after study shows that minorities are less likely to receive intensive or aggressive treatments, such as kidney transplants, angioplasties and critical care than whites ([1] American Medical Association, 1990). Throughout the Profiles, health outcomes are shown to differ between racial and ethnic groups. Current research indicates that these disparities are associated with a wide variety of factors, including access to quality care, economic status, education level and cultural practises. Understanding and eliminating racial disparities remains a high priority for both health research and health planning.

What can be done about racial disparities

There are many recommendations for resolving racial disparities in health care. The American Medical Association Council on Ethical and Judicial Affairs recommended four steps in 1990 ([3] American Medical Association, 1990):

- Greater access to ensure that African American people of all ages have the means for access to necessary care. Adequate access can be accomplished by expanding the number of employers who provide health benefits to full-time employees. It can also be accomplished by adjusting Medicaid to cover the working poor who do not have full-time employment;
- Increase awareness of disparities; the goal being an attempt to bring attention to the ways in which subconscious perceptions affect care;
- Increase minority representation in medicine through recruitment efforts, government aid and more supportive academic programs; and
- Develop practice parameters to preclude racial disparities.

THE COMMUNITY CAN . . .

❶ **Gather information about local providers and services.**

- Your community can benefit from knowing what services are available and what hours of operation they have, as well as what types of coverage they will accept.

❷ **Form a phone-tree for people to use when they need care and need assistance getting there.**

- Many people do not have access to transportation. If this is a problem in your parish, consider raising money to buy or rent a

van or bus for medical purposes. Your community group can coordinate to care for vulnerable groups, such as children, the elderly and the disabled.

❸ **Help community members to find appropriate coverage.**

- Medicaid and LaCHIP both need to be *APPLIED FOR*. Recruit someone to volunteer their services advising people about their health care options and helping them apply for coverage.

❹ **Create a list of daycare options and design transportation options for children in daycare.**

- Encourage providers to visit schools and day-cares to be available for children and their families for education, screenings and care.

❺ **Hold health fairs with screenings and build in a follow-up method.**

- Preventive services, such as screenings, are only useful if action is taken. When your group plans a health fair, engage local providers who will do a more thorough examination on the spot and follow-up.

❻ **Encourage employers with small businesses to work together to provide health insurance for workers.**

- Small businesses, through their Chambers of Commerce and other networking organizations, may be able to pool resources to provide more affordable options for their employees and employees' families.

References

(1) American Medical Association. 1990. Black-White Disparities in Health Care. Council on Ethical and Judicial Affairs. Connecticut Medicine, November 1990. 54:11. p.625-626.

(2) ibid., p. 627.

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