Health Equity Governance

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Date : June 30, 2021

Wendy Netter Epstein, *A Legal Paradigm for the Health Inequity Crisis* (Feb. 17, 2021), available on SSRN.

"It Shouldn't Take a Pandemic," read the title of an essay published several months into the COVID-19 pandemic. The bioethicist authors argued that, by focusing on moral issues relating to patient care, bioethics had "gone too small" and should be paying more attention to broader moral issues of injustice. Of course, anyone paying the slightest attention to the news over the past fifteen months has witnessed to how the pandemic has laid bare the greater suffering and death endured by people who are Black, Brown, Indigenous, poor, or disabled. The essayists point out that the inequity of poorer health and unevenly borne suffering is not new. Avoidable, and thus unjust, disparities in health, health care, and social determinants of health have been part of the health landscape in the U.S. seemingly forever, and efforts over the past decades have largely failed to dent them. Wendy Netter Epstein's new article, *A Legal Paradigm for the Health Inequity Crisis*, argues that governance challenges offer one explanation for the lack of meaningful progress and suggests an approach to addressing those challenges. And she turns to an improbable chapter in health law's history for her model: HIPAA Administrative Simplification.

By squarely focusing on how challenges in addressing health inequity are partly a governance problem, Epstein's article makes a valuable contribution. It helps explain why health inequity has proven so intractable—it is embedded in a fragmented system where no single actor has "both adequate incentive and adequate wherewithal to create progress." Problems of churn among various payers, the compartmentalization of government actors, and siloed funding for health and other issues are all part of this fragmentation. Currently, nothing supports, much less compels, these fragmented entities to undertake collective planning and action in pursuit of health equity.

After making the case that a lack of effective governance hampers progress towards health equity, the article makes its second key contribution. Epstein draws a parallel to how the health care industry met "a different, seemingly impossible problem" several decades ago in developing the Administrative Simplification provisions of HIPAA. Those provisions of the 1996 legislation addressed a technical challenge—the need to standardize communications between health care providers and payers in health data sharing and payment technologies. When HIPAA was enacted, severe fragmentation typified data technology in the health care industry. And, despite much industry wailing and gnashing of teeth on HIPAA's enactment, Epstein asserts that "the desired standardization was ultimately achieved." I'm guessing that these provisions have fallen off many health law teachers' and scholars' radar screens, but Epstein describes how challenges posed by administrative simplification resembled those health equity advocates face today.

To start, industry fragmentation creates a collective action problem for private actors who might be motivated to pursue greater equity. Federalism and fragmentation of government agencies silo health agencies and budgets from agencies responsible for social spending. It's unclear exactly what steps will best move the needle toward health equity. And, even if achieving the goal will produce enormous savings in the long run, it requires substantial front-end investments. This part of Epstein's paper persuaded me that, even though the moral stakes in addressing health inequity are distinctively high,

many of the characteristics making it so difficult to address are not unique.

Epstein proceeds to make the case for using HIPAA's approach as a template for addressing health equity's governance challenges. That template would entail several elements. At the federal level, hard-law mandates of milestones towards achieving health equity goals would carry deadlines and penalties for noncompliance, creating a sense of urgency and forcing involvement of industry actors who might otherwise be recalcitrant. Those mandates could also force the collection of data critical to understanding and addressing disparities and prompt the development of non-binding soft-law solutions and mechanisms. Epstein forecasts that collaboratives of public and private entities at local, regional, and state levels will test out strategies and share knowledge about what works (and doesn't).

The article acknowledges several challenges to the proposed approach. To start, it's not clear what the substance of a health equity mandates should be: what is the measurable outcome that the federal government should order, and who should be subject to that order? Moreover, given the important roles of environmental and social factors in producing health inequity, health systems actors cannot achieve health equity goals alone. Any mandate will need to spur action and cooperation by state and local governments and a broad range of private entities. True health equity will require tackling housing policies, discriminatory policing and mass incarceration, environmental racism, and unjust school funding, to name just several incredibly thorny problems. And effective interventions to address the upstream and proximate causes of health injustice won't be cheap. Epstein argues that the federal government must make a serious financial investment if the proposed hard law-plus-soft law approach is to produce results.

Despite these challenges, I think that Epstein is onto something in focusing on governance, an under-examined aspect of the health equity puzzle. Her article is in the tradition of legal scholarship that considers how the law might most effectively play a role in solving a difficult societal problem. Like the best of that scholarship, Epstein's article is creative: She identifies a model for making health equity progress in an unlikely place – a decidedly unsexy law regarding technology administrative simplification from a quarter-century ago. And, to her credit, Epstein doesn't overclaim. She acknowledges that addressing structural racism in the U.S. is a necessary component of true health equity. But the article implicitly heeds the warning (often attributed to Voltaire) about not letting the perfect be the enemy of the good. A governance model will never be "the" answer to health injustice in the U.S. But a model that addresses collective action, knowledge-sharing, and funding problems could help us make sorely needed headway toward health equity.

Cite as: Mary Crossley, *Health Equity Governance*, JOTWELL (June 30, 2021) (reviewing Wendy Netter Epstein, *A Legal Paradigm for the Health Inequity Crisis* (Feb. 17, 2021), available on SSRN), https://health.jotwell.com/health-equity-governance/.