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# Addressing Racial and Ethnic Health Care Disparities

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Testimony to the House Energy and  
Commerce Committee, Health Subcommittee

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## **Addressing Racial and Ethnic Health Care Disparities: A Multi-Level Approach**

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Thank you, Mr. Chairman, for the opportunity to provide testimony on racial and ethnic disparities in healthcare access and quality. For nearly forty years, the Joint Center has served as one of the nation's premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color. We therefore welcome the opportunity comment on prospects for addressing health care disparities in the context of health reform legislation to be considered by Congress.

Health care disparities are differences in access to and the quality of health care experienced by racial and ethnic minorities, immigrants, those who aren't proficient in English, and others, relative to more advantaged groups. Left unaddressed, these disparities have the potential to unravel even the best efforts to contain health care costs and improve the overall quality of care. In addition, their persistence leaves U.S. health care systems poorly prepared to address the needs of some of the fastest-growing segments of the population. This testimony will examine the causes and consequences of health care disparities, and offer a policy framework for their elimination.

### **Health Care Disparities: The U.S. Context**

Health care disparities are not new—they are a persistent relic of segregation and inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention (and in some cases, explicit blessing of inequality) for over 100 years after the end of the Civil War. Even less than 40 years ago, minorities routinely received inequitable care in segregated settings, if care was received at all.<sup>1</sup> The nation's nascent civil rights laws had yet to make a significant dent in practices such as medical redlining and de facto segregation of health care facilities. Today, these problems are largely ameliorated, but the contemporary health care context remains shaped by this history. This section reviews evidence that disparities in health care persist. The next section attempts to disentangle the effects of race, place, and insurance status in contributing to health care disparities.

Access to high-quality health care is particularly important for communities of color because deep health status gaps persist among U.S. racial and ethnic groups. While the nation has made progress in lengthening and improving the quality of life, racial and ethnic health disparities begin early in the life span and exact a significant human and economic toll. For example:

- The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States;<sup>2</sup>
- Among African Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for White Americans;<sup>3</sup>

- Although infant mortality decreased among all races during the 1980-2000 time period, the Black-White gap in infant mortality widened;<sup>4</sup>
- While the life expectancy gap between the African Americans and whites has narrowed slightly,<sup>5</sup> African Americans still can expect to live 6-10 fewer years than whites, and face higher rates of illness and mortality.<sup>6</sup>

In terms of lives, this gap is staggering: A recent analysis of 1991 to 2000 mortality data concluded that had mortality rates of African Americans been equivalent to that of whites in this time period, over 880,000 deaths would have been averted.<sup>7</sup>

Despite these health gaps, communities of color experience significant disparities relative to whites in both access to care and in the quality of care received. The National Healthcare Disparities Report (NHDR), prepared and released annually by the U.S. Agency for Healthcare Research and Quality, is an authoritative source for the documentation of access and quality gaps. Summarizing a range of measures of health care access, the report found that access for some groups, such as African Americans and American Indians, was worse than for whites in the preponderance of the study's measures. Latinos experienced the greatest access problems of all ethnic groups; they received equivalent care as whites in only 17% of the measures, while the remaining access measures were overwhelmingly poorer for Latinos (83%).<sup>8</sup> With regard to health care quality, minority groups again fared poorly relative to whites: African Americans and Latinos receive poorer quality care than whites on 73% and 77% of measures, respectively, and Asian Americans and American Indians received poorer care on 32% and 41% of measures, respectively. These growing access and quality gaps are not trivial. For example, from 1999 to 2004 the proportion of adults age 65 and over who received a pneumonia vaccine increased for Whites (from 52% to 59%) but decreased for Asians (from 41% to 35%), and from 2000 to 2003 colorectal cancer screening rates increased for whites while falling off sharply for American Indians and Alaska Natives.<sup>9</sup> These growing gaps are not unexpected given that the increase in the numbers of the uninsured has been more dramatic in communities of color than in non-minority communities.

The NHDR provides a window in to the health care experiences of a diverse patient population, but it does not disentangle the influences of race, income, and insurance on health care. A substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients, even when they are insured at the same levels, have similar incomes, and present with the same types of health problems.<sup>10</sup> Below are a few examples from the research literature:

- Insured African-American patients are less likely than insured whites to receive many potentially life-saving or life-extending procedures, particularly high-tech care, such as cardiac catheterization, bypass graft surgery,<sup>11</sup> or kidney transplantation.<sup>12</sup>
- Black cancer patients fail to get the same combinations of surgical and chemotherapy treatments that white patients with the same disease presentation receive.<sup>13</sup>
- African-American heart patients are less likely than white patients to receive diagnostic procedures, revascularization procedures, and thrombolytic therapy,

- even when they have similar incomes, insurance, and other patient characteristics.<sup>14</sup>
- Even routine care suffers. Black and Latino patients are less likely than whites to receive aspirin upon discharge following a heart attack, to receive appropriate care for pneumonia, and to have pain – such as the kind resulting from broken bones – appropriately treated.<sup>15</sup>
  - Minorities are more likely to receive undesirable treatment than whites, such as limb amputation for diabetes.<sup>16</sup>

Of these health care disparities, inequality in long-term care services is among the most troubling. Population trends show that people of color are the fastest-growing segments of the U.S. population. Racial and ethnic minorities are also burdened with a higher prevalence of chronic diseases. These realities require long-term care policies and funding streams that address the needs of minority patients, their families, and their communities.<sup>17</sup> Yet people of color requiring long-term care are less likely to be treated in such a system. Despite the increasing supply of nursing home beds and the emergence of assisted living facilities, African Americans are less likely than similarly-situated whites to be placed in a nursing home.<sup>18</sup> Studies also show that nursing home care remains largely separate and unequal. Most African American nursing home residents tended to be concentrated in a few predominantly African American facilities, whereas the vast majority of White nursing home residents live in predominantly White facilities. Facilities housing African Americans tend to admit individuals with mental retardation and difficulty in ambulating, and to have lower ratings of cleanliness/maintenance and lighting.<sup>19</sup> The nearly 15 percent of U.S. nursing homes that serve predominantly African American residents have fewer nurses, lower occupancy rates, and more health-related deficiencies. They are more likely to be terminated from the Medicaid/Medicare program, are disproportionately located in the poorest counties, and are more likely to serve Medicaid patients than are other facilities.<sup>20</sup> Other studies document a strong relationship between nursing home or long-term care facility racial concentration and quality. For example, controlling for individual, facility, and market characteristics, blacks were found to be admitted to nursing homes with 32% higher rates of deficiency (defined as evaluations of poor quality made by state surveyors under the federal nursing home certification regulation).<sup>21</sup>

### **What Are the Factors that Contribute to Health Care Disparities?**

Many of the same problems associated with racial and ethnic inequality in education, employment, housing, and criminal justice are implicated in health care disparities. One of the most pressing fundamental causes of these disparities is residential segregation. Racial and ethnic minorities are more likely to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment. The result too often is that the geographic distribution of health care resources within and across communities results in racially disparate health care: institutions that serve communities of color are more likely to experience quality problems and have fewer resources for patient care than institutions serving non-minority communities.

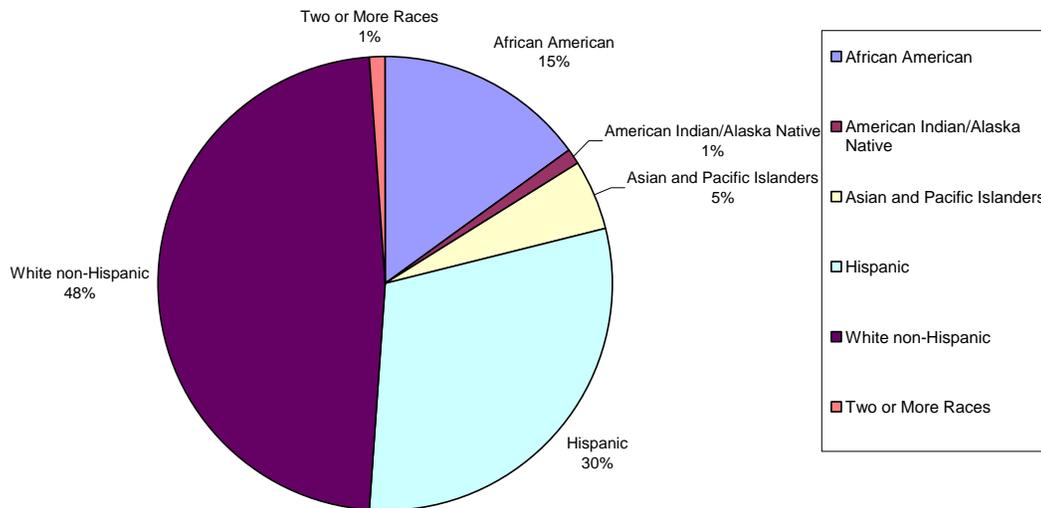
Racial and ethnic segregation and inequality therefore “sets the stage” for inequitable health care in the United States. But many other causal factors – such as policies and practices of health care systems, the legal and regulatory context in which they operate, and the behavior of people who work in them – are also involved.<sup>22</sup> Some of these causal factors include 1) differences in insurance coverage and sources of coverage, 2) the inequitable distribution of health care resources, and 3) aspects of the clinical encounter, including cultural and linguistic barriers in health care systems and the interaction of patients and providers. These examples are explored in greater detail below.

### **Sources of Insurance Coverage**

In its landmark series on the causes and consequences of uninsurance, the Institute of Medicine concluded that the availability and quality of health care in the United States suffers when large segments of the population lack health insurance.<sup>23</sup> Racial and ethnic minority and immigrant communities are disproportionately uninsured (see Figure 1), making them especially vulnerable to health crises.<sup>24</sup> For example:

- While about 21 percent of white Americans were uninsured at any point in 2002, communities of color were more likely to be uninsured at any point (including 28 percent of African Americans, 44 percent of Hispanic Americans, 24 percent of Asian Americans and Pacific Islanders, and 33 percent of American Indians and Alaska Natives), and are more likely to be dependant upon public sources of health insurance.<sup>25</sup>
- While Hispanic children constitute less than one-fifth of children in the United States, they represent over one-third of uninsured children.<sup>26</sup> And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic.<sup>27</sup>
- More than 11 million immigrants were uninsured in 2003, contributing to one-quarter of the U.S. uninsured.<sup>28</sup> Between 1998 and 2003 immigrants accounted for 86 percent of the growth in the uninsured population.<sup>29</sup>
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993.<sup>30</sup>

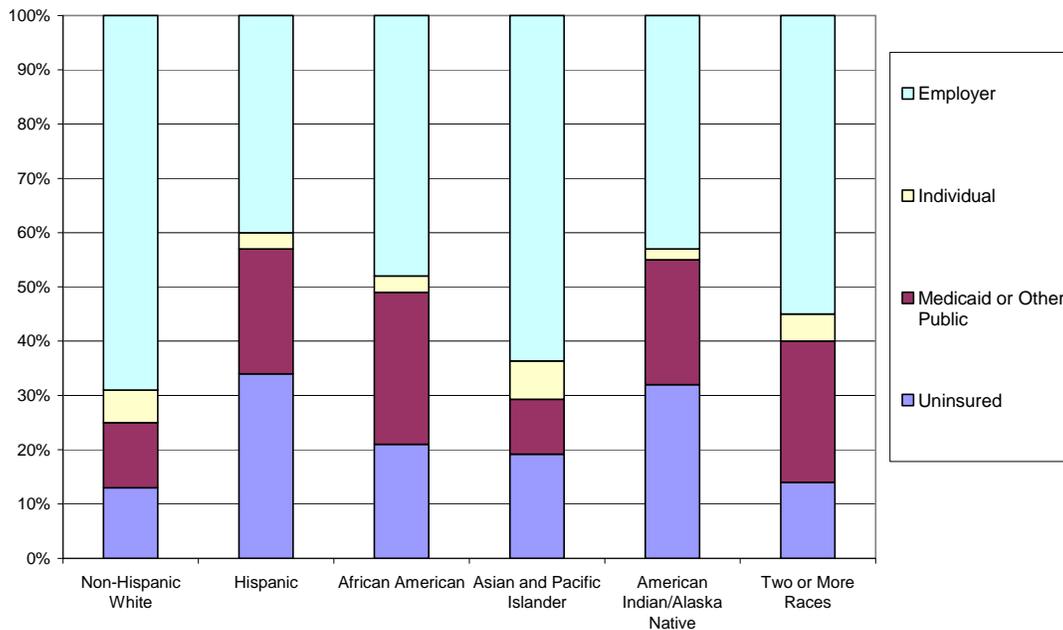
**Figure 1: Nonelderly Uninsured by Race/Ethnicity, 2005**  
Source: Kaiser Family Foundation, 2007



The crisis of health insurance disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Higher-paying jobs tend to offer more comprehensive health benefit packages, while lower-paying jobs – jobs disproportionately occupied by people of color – tend to offer only limited health benefits, if offered at all, that are often accompanied by high cost-sharing arrangements with employees. Moreover, as noted above, racial and ethnic minorities are disproportionately dependent on public insurance sources, such as Medicaid (see Figure 2). While Medicaid has been vital for expanding access to health insurance, its limited benefit package and low reimbursement rates have a dampening effect on health care access and quality among its beneficiaries.

**Figure 2: Health Insurance Coverage of the Nonelderly by Race/Ethnicity, 2005**

Source: Kaiser Family Foundation, 2007



### The Distribution of Health Care Resources

These economic pressures can sustain a form of “medical apartheid”—that is, separate and unequal care for low-income and minority patients.<sup>31</sup> For example, physicians who serve predominantly racial and ethnic minority patients are less likely to possess board certification, and have greater difficulties accessing high-quality specialists, diagnostic imaging, and non-emergency admission of their patients to the hospital than physicians who serve predominantly non-minority patients.<sup>32</sup> A recent study over 300,000 patients treated at 123 hospitals across the country found that minorities were disproportionately likely to receive care in lower-quality hospitals, a problem that explained the largest share of disparities.<sup>33</sup> The geographic mal-distribution of services likely contributes to the problem. For example, a study of the availability of pain medication revealed that only one in four pharmacies located in predominantly non-white neighborhoods carried adequate supplies, compared to 72% of pharmacies in predominantly white neighborhoods.<sup>34</sup> Nearly one in five Latinas (18%) and one in ten African-American women reported not seeking needed health care in the last year due to transportation problems, compared to 5% of white women.<sup>35</sup> These problems are the by-product of residential segregation and economic pressures that reward the concentration of services in outer suburbs and wealthier communities, and create disincentives for practice in urban centers.<sup>36</sup>

### Regular Source of Health Care

Having a regular source of health care – a local physician, clinic, or health center that patients can consider their “medical home” – is important, particularly for individuals who face or are at risk for chronic illness. When patients are able see a health care

provider consistently, they are better able to build trusting relationships, ask questions, and give and receive information. Patients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care.<sup>37</sup> The uninsured and underinsured, many racial and ethnic minorities, people who are not proficient in English, those who live in rural communities, and those who have low incomes are more likely to report not having a regular source of health care.<sup>38</sup> Yet the regular-source-of-health-care gap among racial/ethnic and income groups is growing:

- African Americans, Hispanics, and the poor and near poor (of all racial and ethnic groups) are more likely than white non-poor groups to face barriers to having a regular source of health care. These gaps have increased since 2000. Over 42 percent of Hispanic poor and 37 percent of Hispanic non-poor people lacked a regular source of health care in 2001 and 2002, an increase of more than 30 percent and 18 percent, respectively, since 1995 and 1996.<sup>39</sup>
- During this same period, the percentage of poor and near-poor African Americans and whites without a regular source of health care went largely unchanged. But these groups were up to 75 percent more likely than non-poor African Americans and whites to lack a regular source of health care in 2001 and 2002.<sup>40</sup>
- The percentage of Hispanics from all income groups who lacked a regular source of health care increased between 1993 and 2002, despite a 15 percent decline over the same period in the ranks of white poor individuals who lacked a regular source of health care.<sup>41</sup>
- African American and Hispanic patients are nearly twice as likely as whites to report having a “non-mainstream” usual source of care (e.g., a hospital-based provider, rather than a private physician).<sup>42</sup>

### **Language Barriers**

More than 46 million people in the United States speak a language other than English. Of those, more than 35 million speak English “well” or “very well,” but over 10 million speak the language “not well” or “not at all.”<sup>43</sup> Individuals with limited English proficiency are less likely than those with strong English language skills to have a regular source of primary care or to receive preventive care. Moreover, they tend to be less satisfied with the care they receive, are more likely to report overall problems with care, and may be at increased risk of experiencing medical errors.<sup>44</sup> The quality of their health care therefore depends on the ability of medical professionals to effectively communicate. But many health care organizations do not provide adequate interpretation services:

- Nearly half of Latinos who are primary speakers of Spanish report having difficulty communicating with doctors or other health care providers because of language barriers.<sup>45</sup>
- Over one in five non-English speaking patients avoid seeking medical help altogether because of language barriers.<sup>46</sup>

### **The Clinical Encounter**

Aspects of the clinical encounter – the interaction between patients, their providers, and the health systems in which care is delivered – can play a powerful role in contributing to

health care inequality. Patients and providers bring a range of expectations, preferences, and biases to the clinical encounter that can be expressed both directly and indirectly. For example, at least part of the disparity results from biases and stereotypes that health care providers may carry about racial and ethnic minorities. Experimental studies confirm that physicians can hold a host of negative beliefs about minority patients. They are presumed to be more likely to abuse drugs or alcohol and to be less educated. They aren't expected to comply with physicians' instructions, to want an active lifestyle or to participate in rehabilitation if prescribed. Doctors are likely to consider white patients more "pleasant" and "rational" than Black patients, and to prefer white patients as "the kind of person I could see myself being friends with." These kinds of stereotypes and biases are often unconscious, the IOM reported, but nonetheless can influence physicians' decisions regarding when and what treatments to offer.<sup>47</sup>

More recent research confirms that implicit biases (that is, unconscious biases that may reflect racial socialization) influence medical professionals' decision-making. For example, Green and colleagues assessed the relationship between implicit biases (as measured by a widely-accepted computer-based test of the speed with which individuals make associations between people and concepts) and physicians' decisions regarding the use of thrombolysis (i.e., clot-busting medications) among hypothetical patients in the midst of a heart attack. While physicians reported no explicit preference for white versus black patients or differences in perceived cooperativeness, scores on implicit association tests revealed a preference favoring white Americans and implicit stereotypes of black Americans as less cooperative with medical procedures, and less cooperative generally. More importantly, physicians' level of pro-white implicit bias significantly predicted their likelihood of treating white patients and not treating black patients with thrombolysis. That is, physicians who harbored the highest level of implicit racial bias were less likely to treat black heart attack patients with a potentially life-saving treatment.<sup>48</sup>

Many of the problems identified above can be addressed by improving the racial and ethnic diversity of the health professional workforce.

### **Eliminating Health Care Inequality**

Health care disparities are a complex problem rooted in systemic racial and ethnic inequality and are embedded in multiple institutions. Their elimination will require a long-term commitment and investment to address multiple problems, involving many public and private stakeholders.

Table 1 presents a framework for policy steps that can be adopted by federal, state, and local governments to improve access to and equalize the quality of health care for all, with particular attention to the needs of communities of color. These include strategies to:

1. **Expand Access to Health Insurance.** The most important step toward eliminating racial and ethnic health care disparities is to achieve universal health

- insurance coverage. Benefits should be comprehensive, and should include services that many communities of color need to access appropriate care, such as interpretation services.
2. **Improve Access to and the Diversity of Health Care Providers.** Even if the United States achieved universal health insurance coverage, because of residential segregation and the dearth of health care providers and resources in communities of color, special efforts must be made to ensure that health care resources are better aligned with these communities’ needs.
  3. **Promote Equal High Health Care Access and Quality.** As the studies noted above demonstrate, health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high quality health care. Several policies offer mechanisms to elevate and promote equitable care for all.
  4. **Empower Patients and Communities.** To ensure that health care meets their needs, patients and communities should be empowered to participate in treatment decisions and to inform policies regarding the distribution of health care resources at the community level.

Table 1. Achieving Health Care Equity: A Policy Framework

Expand Access to Health Insurance	Improve Access to Providers and Services	Promote Equal High Health Care Access and Quality	Empower Patients and Communities
Strive for Universal Insurance Coverage	Increase Provider Diversity	Collect and Monitor Data on Disparities	Promote Patient Education and Health Literacy
Promote Fair Sharing of Costs	Support Safety Net Institutions	Publicly Report Data	Promote the Use of Lay Health Navigators
Promote Comprehensive Benefits	Provide Incentives to Providers for the Underserved	Adopt Cultural and Linguistic Standards	Promote Community-Based Health Care Planning
Target and Evaluate Outreach Efforts to Underserved	Address Geographic Imbalance of Health Care Resources	Encourage Attention to Disparities in Quality Improvement	Strengthen Community Benefits Obligations

**Expand Access to Health Insurance**

High rates of uninsurance and underinsurance among for people of color are the foremost problems to solve to eliminate health care inequality. The United States is the last modern, industrialized nation to adopt a universal health care program. Health insurance coverage is primarily provided by employers, but as benefit costs rise employers are declining to offer coverage or are purchasing plans that require greater employer cost sharing. These economic pressures contribute to growing inequality in insurance coverage. Health insurance coverage is increasingly unequal, disproportionately hurting those who need health care the most—particularly racial and ethnic minorities, children,

and lower-income women and their families. For example, less than half of low-wage workers have employer-provided health insurance from their own employer or a family member's employer, and female low-wage workers are half as likely as male low-wage workers to receive health insurance from their employer.<sup>49</sup>

*Strive for Universal Insurance Coverage.* Health care access inequality must be tackled by state and federal efforts to develop a universally accessible, comprehensive, and equitable healthcare system. The most cost-effective way to achieve this goal is by pooling risk as broadly as possible in a common, comprehensive health insurance system—a national, single-payer health insurance plan. Such an approach allows patients to choose their health care provider, and insures that the delivery of care remains in public and private systems while allocating health care resources more fairly. For example, by allowing employers and individuals to buy into a public health insurance plan, policymakers can take significant steps toward improving health care efficiency and lowering costs. Medicare is more efficient than private plans because of its low administrative costs (about 2%, a figure seven times lower than most estimates of administrative costs in private health plans). And because Medicare is a federal program, subject to the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, ethnicity, language status, and other factors, it contains mechanisms of accountability that can be expanded and enhanced to ensure that any instances of discriminatory health care are thoroughly investigated and prosecuted.

*Promote Fair Sharing of Costs.* Many health care expansion proposals weigh new cost-sharing arrangements that are intended to make costs more transparent and promote cost-conscious consumer behavior. But several studies demonstrate that low-income communities are less likely to access health care as out-of-pocket costs rise.<sup>50</sup> Equitable cost-sharing takes into account and attempts to minimize the disproportionate impact that cost-sharing arrangements can have on health care access and utilization among currently underserved groups. These include public subsidies for those with low incomes to purchase health insurance, sliding fee scales for premiums, co-payments, and out-of-pocket costs, and efforts to study and respond to potential unintended effects of cost-sharing on utilization.

*Promote Comprehensive Benefits.* As noted above, many in communities of color require services such professional interpretation and translation. In addition, because these communities are less likely to access other needed services, such as dental and mental health services, comprehensive benefit packages should cover these services. Equalizing access to the same kinds of health care products and services regardless of insurance source will also help to reduce “fragmentation” of the health insurance market. A potentially significant source of racial and ethnic health care disparities among insured populations lies in the fact that minorities are likely to be disproportionately enrolled in “lower-tier” health insurance plans. Such plans tend to limit services, offer fewer covered benefits, and have relative small provider networks. These limits can harm access to quality care.<sup>51</sup> Given that several states are examining strategies to expand health insurance coverage, it is important that these coverage expansion proposals to

improve access to the same health care products and services, regardless of coverage source.

*Target and Evaluate Outreach Efforts to the Underserved.* Racial and ethnic minorities and immigrants are underrepresented, relative to eligibility rates, in public health insurance programs. States that have achieved greater success in increasing minority participation in public programs have developed and sustained aggressive outreach programs and have taken steps to improve and streamline enrollment, with particular attention to the needs of cultural and language-minority groups. Moreover, because state health insurance expansions may not reach communities of color equally, states should consistently evaluate outreach to and enrollment of underserved groups in public health insurance programs. Measurement of public insurance take-up rates in low-income communities and communities of color is an important step to ensure that health care expansion efforts reach underserved groups. States that regularly conduct such evaluations can be expected to see improved coverage rates among eligible populations.

### **Improve Access to Health Care Providers and Services**

Universal health insurance coverage is an important step toward improving the geographic distribution of health care providers and resources, but federal, state and local governments must take steps to improve underserved patients' access to providers. Several jurisdictions have adopted strategies that improve community-level access to providers and services with particular attention to the needs of communities of color.

*Improve Provider Diversity.* State and federal governments must also take steps to strengthen the health professions' ability to serve the nation's increasingly diverse population. By the middle of this century, nearly half of all who live in the United States will be members of racial or ethnic minority groups, and four states – California, Hawaii, New Mexico, and Texas – are already “majority minority.” Racial and ethnic minority patients are more likely than majority-group patients to experience cultural and linguistic barriers when attempting to get the health care they need, and often express greater satisfaction when they receive care from a provider of the same background.<sup>52</sup> In addition, several studies demonstrate that racial and ethnic minority health care providers are more likely to express interest in and work in medically underserved communities.<sup>53</sup> To help health care systems to address the needs of an increasingly diverse patient population, state and federal governments should take steps to increase the racial and ethnic diversity of health care providers by reducing or eliminating financial barriers to health professions education for low-income students, strengthening magnet science programs in urban high schools, and, consistent with the U.S. Supreme Court's ruling in the 2004 *Gutter v. Bollinger* decision, supporting the consideration of applicants' race or ethnicity as one of many relevant factors in higher education admissions decisions.

*Support Safety Net Institutions.* People of color and low-income individuals are more likely to access health care in safety net institutions, such as public hospitals and community health centers. In many cases, these institutions face financial vulnerability because of low Medicaid reimbursement rates and/or the costs of providing uncompensated care to uninsured individuals. These institutions may fare better in states

where near-universal health insurance coverage proposals are enacted and where health insurance expansions are realized, but they will likely to continue to face financial vulnerability until truly universal coverage is achieved. States vary widely, however, in their support for safety net institutions. California, for example, has assumed much of the cost of hospital indigent care, Maryland and Massachusetts have established statewide uncompensated care funds, but many other states fail to assist institutions that serve low-income and uninsured populations.

*Provide Incentives to Providers for the Underserved.* Creating and/or enhancing incentives – such as education loan repayment or debt forgiveness – to encourage health care professionals to establish practices in underserved communities can be an important strategy to balance the distribution of health care providers, particularly primary care providers. Low-income and minority communities often have the most pressing need for health care services, but they are served by a dwindling number of providers and institutions that lack resources to expand and improve services. State and federal governments have attempted to address this imbalance by providing incentives, such as funds for graduate medical education programs that focus on underserved populations, tuition reimbursement and loan forgiveness programs that require service in health professional shortage areas.<sup>54</sup>

*Address Geographic Imbalance of Health Care Resources.* State and local governments are increasingly returning to Certificate of Need (CoN) assessments as a tool to reduce geographic disparities and reduce the “fragmentation” of the health insurance market. Historically, the purpose of the CoN process has been to control health care costs and ensure that capital and technology investments in the health care industry reflect community needs. In most states that employ CoN, the process has required hospitals or other health care institutions that seek to establish or expand services to submit proposals so that state boards can evaluate projects to eliminate unnecessary duplication of services and ensure that investments strategically address health care needs. But the process has met significant resistance and criticism for its failure as a cost-containment measure. The CoN process, however, has great potential to encourage a better distribution of health care resources, reflect community and statewide need. States should re-evaluate, and in some cases reinvigorate CoN through new policies that ensure accountability for the use of public funds.<sup>55</sup>

### **Promote Equal High Health Care Access and Quality**

As the studies noted above demonstrate, universal health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high quality health care. Federal, state and local governments are increasingly examining mechanisms to promote “equality of health care quality.” These strategies have the potential to improve the accountability of health care systems to patients and employers, and reduce health care costs and improve quality for all patients by encouraging greater use of evidence-based guidelines and by rewarding the provision of cost-effective primary care.

*Collect and Monitor Data on Disparities.* State and federal contracts and policies are increasingly requiring all public and private health systems to collect data on patients' race, ethnicity, gender, primary language, and educational level, and to monitor for inequality in access to needed services and in the quality of care received. Currently, federal and state data collection efforts with regard to health care disparities are uneven. Some states require recipients of state funding (e.g., Medicaid managed care organizations) to collect and report health care access and quality data by patient demographic factors, but many others fail to utilize their leverage as regulators, payers, and plan purchasers to encourage all health systems to collect and report data using consistent standards. And given that federal and some states non-discrimination laws apply to health care settings and require diligence to enforce, federal and state requirements to collect and report standardized data are an important benchmark for efforts to reduce health care inequality.

*Publicly Report Data.* Publicly reporting health care access and quality disparities at the institutional (e.g., hospital or health clinic) level is important to ensure that the public and policymakers are aware of when and where health care inequality occurs. Once state and federal governments have obtained health care access and quality data by patient demographic data, this information should be publicly reported at the smallest possible level (e.g., hospitals and health centers), to promote greater public accountability, to allow consumers to make more informed decisions about where to seek care, and to assist efforts to monitor disparities and take appropriate action to investigate potential violations of law.

*Adopt Cultural and Linguistic Standards.* To ensure truly accessible health care, health care systems must also be responsive to patients' cultural and linguistic needs. State and federal policies can expand access for disparity populations by promoting cultural and linguistic competence in health care settings, and diversity among health care professionals. The federal Cultural and Linguistic Access Standards (CLAS) identify over a dozen benchmarks that have been widely accepted and increasingly adopted by health systems and providers. And despite the fact that federally-funded health care organizations are mandated to meet four of the standards, few states have taken steps to encourage more widespread adoption of the guidelines and recommended standards. Such programs improve the cultural competence of health systems and increase the likelihood that patients of color will access and be satisfied with the health care they receive. In addition, some jurisdictions are requiring cultural competency training for all health care professionals as a condition of licensure. As of 2005, for example, New Jersey required that all physicians practicing in the state must attain minimal cultural competency training as a condition of licensure.

*Encourage Attention to Disparities in Quality Improvement.* State and local jurisdictions are also increasingly extending financial incentives to health systems that adhere to evidence-based clinical guidelines as a means of promoting the highest standards of health care for all patients. Health care quality improvement efforts, such as pay-for-performance or performance measurement, are gaining increasing attention. But they can unintentionally deepen health care access and quality gaps. Because underserved

communities are typically sicker and face greater barriers to treatment compliance, performance measurement can inadvertently dampen provider enthusiasm for treating low-income communities or communities of color. Quality improvement efforts should take into account the challenges and needs of underserved communities and reward efforts that reduce disparities and improve patient outcomes relative to baseline measures. Some quality improvement measures adjust for patient case mix or emphasize disparities reduction efforts, to avoid unfairly penalizing providers while holding them and health systems accountable for improvements in health outcomes.

### **Empower Patients and Communities**

Too often in American health care, patients are expected to make sound health care decisions and advocate for their needs absent the knowledge and power necessary to do so. Such an approach can be particularly problematic for communities of color, who face lower levels of health literacy and who often – because of historical and cultural reasons – feel less empowered to aggressively advocate for their health care needs than more socially and educationally advantaged groups. Moreover, governments have the power to lessen the impact of a market-driven health care industry has tended to overlook the needs of low-income communities and communities of color in favor of wealthier communities that promise lower financial risks and greater financial reward. State and federal governments should give all communities the power to make recommendations and weigh in on decisions regarding health care policies that affect them.

*Promote Patient Education and Health Literacy.* Several jurisdictions are developing and assessing the efficacy of patient education programs, such as health literacy and navigation programs, and are replicating effective strategies. Patient education programs commonly seek to help patients understand how to best access health care services and participate fully in treatment plans. Successful programs are well-researched and are tailored to the need of underserved communities. Such efforts to empower patients can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. Patient education programs are most effective when designed in partnership with target populations and when language, culture, and other concerns faced by communities of color are fully addressed.

*Promote the Use of Lay Health Navigators.* Health departments can support the training of and reimbursement for community health workers, sometimes also known as “lay health navigators” or *promotores*, who can serve as a liaison between health care institutions and their patients. Community health workers are trained members of medically underserved communities who work to improve community health outcomes. Several community health workers models train individuals to teach disease prevention, conduct simple assessments of health problems, and help their neighbors access appropriate health and human resources. In health care contexts, they serve as a liaison between patients and health systems. Community health worker models are rapidly spreading, as research and practice indicates that such services can improve patients’ ability to access care and understand how to manage illness. State and federal

governments can stimulate these programs by providing grants, seed funding, or other resources to help stimulate their promulgation.

*Promote Community-Based Health Care Planning.* States can promote and/or (in most cases) reinvigorate community health planning, in which members of the community identify their needs and assist policymakers in planning, implementing, and evaluating the effectiveness of public health care systems. Community health planning has a long history, but its promise as a tool to reduce health care disparities has yet to be fully realized. Community health planning seeks to strengthen communities to play a greater role in their own health, actively involving residents in the planning, evaluation, and implementation of health activities in their communities. The 1974 National Health Planning Law sought to create and support a network of community Health Services Agencies (HSAs), but a lack of funding and effective mechanisms for community input to shape health policy has led to a decline of HSA power and influence. Some states, such as New York, are examining strategies to reinvigorate HSAs and to include disparities reduction efforts as part of the mission of these planning agencies.

*Strengthen Community Benefits Obligations.* Non-profit and tax-exempt health care institutions attain their special status as a result of contributions they make to the broader public good. By far, most tax-exempt institutions allocate their charitable resources to the costs of care (particularly emergency room services) for the uninsured. But policymakers are increasingly seeking a more in-depth understanding of the potential charitable contributions of non-profit hospitals and health systems. These can include comprehensive approaches such as strategies to encourage healthy behaviors and improve social and physical conditions in communities. If successful, these efforts meet both the community's and the hospital's goals of improving health status and reducing the demand for high cost emergency room and inpatient care. Such strategies centralize the importance of improving community health, empower community members to voice concerns, and increase non-profits' public accountability for their tax-exempt status.<sup>56</sup>

### **Social and Community-Level Influences on Health Disparities**

The policy strategies outlined above are directed at improving the ability of health care systems to respond to the needs of communities of color. As discussed, however, improving the health status of many racial and ethnic minority groups will require policy strategies focused outside of the health care arena. These include efforts to improve housing and community living conditions, improve food resources and nutrition options, improve conditions for exercise and recreation, and ultimately, to reduce economic and educational gaps. These social and community-level strategies – along with examples of state and local efforts to implement them – are discussed in Text Box 2.

## Text Box 2 - Addressing Social and Community-Level Determinants of Health

Social and economic inequality among racial and ethnic groups and other marginalized populations is the most significant underlying factor behind most health status inequality. Racial and ethnic discrimination and segregation perpetuate and deepen these gaps. Health care, therefore, cannot eliminate health status gaps between population groups. Federal efforts should look to a broad range of social and economic policy when crafting strategies to improve and equalize health status for all, and state health agencies should play a leadership role in coordinating these efforts. And states can play a large role in providing incentives for effort to improve health conditions in a community and more effectively punish acts that weaken community health conditions. These include efforts to:

- Improve the coordination of relevant state and federal agencies that should address determinants of health inequality (e.g., in education, housing, employment, criminal justice). Governments that seek to reduce racial and ethnic social and economic gaps are inherently engaging in health equity work. Almost all aspects of federal, state, and local policy in education, transportation, housing, commerce, and criminal justice influence the health of residents, and can have a disproportionate impact on marginalized communities. Governments that have taken steps to coordinate the work of agencies that impact health disparities are likely to reduce duplication of effort, increase efficiency, and more effectively address health outcome disparities.
- Create incentives for better food resources and options in underserved communities (e.g., grocery chains, “farmers’ markets”). Several local jurisdictions have established public-private partnerships to bring supermarkets to underserved areas. For example, the city of Rochester, New York, which experienced an 80 percent decline in grocery stores in the 1970s and 1980s, used public resources (the Federal Enterprise Community Zone program, the Community Development Block Grant program, and other sources) to attract a major supermarket chain to open stores in the city.<sup>1</sup> More recently, Pennsylvania awarded a \$500,000 grant to help establish a supermarket in the Yorktown section of Philadelphia, part of a broader initiative to support the development of supermarkets and other food retailers in urban and rural communities that lack adequate access to supermarkets.<sup>1</sup> State and federal governments can make similar investments.
- Develop community-level interventions for health behavior promotion (e.g., smoking cessation, exercise). Federal and state programs to promote healthy behaviors are increasingly recognizing the need to target community-level risk factors and strengths that affect individual health behavior. Such programs are often vital for low-income communities and communities of color, which have fewer community resources for exercise (e.g., safe public parks and recreation centers), effective nutrition, and reduction of individual health risks (e.g., low-income urban communities have more public advertisement of tobacco products and greater availability of alcohol). State and federal agencies can exert legal and regulatory authority to reduce community-level health risk and promote healthy behavior.
- Address environmental racism (e.g., by aggressive monitoring and enforcement of environmental degradation laws). Racial and ethnic minority communities are disproportionately hurt by the presence of toxic waste dumps, and industrial and occupational hazards. Through legal and regulatory strategies, state and federal agencies can reduce environmental health risks and monitor whether and how communities are affected by governmental or commercial activity.

## Conclusion

Health care access and quality is more often compromised for racial and ethnic minorities than for whites, for those who don't speak English well relative to those who are English-proficient, and for immigrants relative to U.S. natives. These disparities have a long history in the United States and are both a symptom of broader structural inequality and a mechanism by which disadvantage persists. Moreover, they carry a significant human and economic toll; the Institute of Medicine estimates that 18,000 people die prematurely each year because they lack health insurance, and that the annual cost to the nation of the poorer health and shortened life spans attributable to uninsurance is between \$65 and \$130 billion.<sup>57</sup> Because people of color are disproportionately among the uninsured, these numbers carry a greater burden in minority communities.

Encouragingly, policymakers are increasingly focused on eliminating these disparities. A range of policy strategies are available to federal, state, and local governments, but it is important to recognize that no single policy – such as expanding access to health insurance – will fully address health care inequality. Health care disparities are complex and are rooted in many causal factors that span across a range of levels – including institutional, governmental, and individual levels. It is therefore important to identify, implement, and evaluate multi-level strategies addressing health care financing, systems, and workforce development. Such strategies should operate together to improve health care access and quality for vulnerable populations. The strategies identified here are only a first step toward creating a more equitable health care system for all.

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