

THE JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES

Addressing Racial and Ethnic Health Inequities: Tri-Committee Discussion Draft for Health Care Reform

Testimony Before the House Energy and
Commerce Committee, Health Subcommittee

Brian D. Smedley, Ph.D.
Health Policy Institute
Joint Center for Political and Economic Studies

June 23, 2009



SUMMARY

Many racial and ethnic minorities – particularly African Americans, American Indians and Alaska Natives, Native Hawaiians and Pacific Islanders – experience poorer health relative to national averages from birth to death, in the form of higher infant mortality, higher rates of disease and disability, and shortened life expectancy. Health inequities carry a significant human and economic toll and therefore have important consequences for all Americans. Health inequities impair the ability of minority Americans to participate fully in the workforce, thereby hampering the nation’s efforts to recover from the current economic downturn and compete internationally. Because many people of color are disproportionately burdened with unmet health care needs, these inequities also limit our ability to contain health care costs and improve overall health care quality. And by the year 2042, about half of all Americans will be people of color, which means that their health status increasingly defines the nation’s health. It is therefore important that Congress view the goal of achieving equity in health and health care not as a “special interest,” but rather as an important central objective of any health reform legislation.

To that end, the draft Tri-Committee legislation contains a number of important provisions that will strengthen the federal effort to eliminate health and health care inequities. They:

- **Emphasize and support disease prevention and health promotion;**
- **Improve access to primary care and medical homes;**
- **Improve the diversity and distribution of the health professional workforce;**
- **Strengthen Medicaid by expanding eligibility and increasing reimbursement rates;**
- **Improve access to language services;**
- **Improve the accessibility of Health Information Technology (HIT) in underserved communities;**

While the Tri-Committee draft bill addresses a number of important needs to achieve health and health care equity, there are several areas where the legislation could be strengthened with evidence-based strategies that will improve the federal investment in health equity.

These include strategies such as:

- **Expanding successful community-based health programs;**
- **Assessing the health impact of non-health policies through the use of Health Impact Assessment;**
- **Strengthening the federal health research effort by elevating the NIH National Center on Minority Health and Health Disparities to an NIH Institute;**
- **Strengthening federal data collection;**

Addressing health inequities requires comprehensive strategies that span community-based primary prevention to clinical services, a long-term commitment and investment of resources, and a focus on addressing equity in all federal programs and in all elements of health reform legislation. To fail to do so ignores the reality of important demographic changes that are happening in the United States, and fails to appreciate the necessity of attending to equity as a necessary step to help achieve the goals of expanding insurance coverage, improving the quality of health care, and containing costs. Encouragingly, the Tri-Committee draft bill recognizes the importance of achieving equity in health and health care and proposes a number of policy strategies to reach this goal.

Addressing Racial and Ethnic Health Inequities: The Tri-Committee Discussion Draft

Brian D. Smedley, Ph.D.

Director, Joint Center for Political and Economic Studies Health Policy Institute

Thank you, Mr. Chairman, for the opportunity to provide testimony on the potential to address racial and ethnic inequities in health and health care in the context of the Tri-Committee Health Reform legislation. For nearly forty years, the Joint Center for Political and Economic Studies 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 to comment on this important legislation.

Many racial and ethnic minorities – particularly African Americans, American Indians and Alaska Natives, Native Hawaiians and Pacific Islanders – experience poorer health relative to national averages from birth to death, in the form of higher infant mortality, higher rates of disease and disability, and shortened life expectancy. Health inequities carry a significant human and economic toll and therefore have important consequences for all Americans. Health inequities impair the ability of minority Americans to participate fully in the workforce, thereby hampering the nation's efforts to recover from the current economic downturn and compete internationally. Because many people of color are disproportionately burdened with unmet health care needs, these inequities also limit our ability to contain health care costs and improve overall health care quality. And by the year 2042, about half of all Americans will be people of color, which means that their health status increasingly defines the nation's health. It is therefore important that Congress view the goal of achieving equity in health and health care not as a “special interest,” but rather as an important central objective of any health reform legislation.

This testimony will briefly review the extent and causes of health and health care inequities, comment on the provisions of the Tri-Committee draft legislation to address inequities, and offer recommendations to strengthen the impressive and comprehensive strategies outlined in the bill.

The Extent of Health and Health Care Inequities

While the nation has made progress in lengthening and improving the quality of life, racial and ethnic health inequities are stubbornly persistent, and in some cases are increasing. These inequities begin early in the life span and exact a toll throughout the life-course. For example:

- While the life expectancy gap between the African Americans and whites has narrowed slightly in the last two decades,¹ African Americans still can expect to live 6-10 fewer years than whites, and face higher rates of illness and mortality.²
- The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States;³

- Among African Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for white Americans;⁴
- Although infant mortality decreased among all races during the 1980-2000 time period, the black-white gap in infant mortality widened;⁵ and

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 during this time period, over 880,000 deaths would have been averted.⁶

Communities of color also experience significant disparities relative to whites in both access to care and in the quality and outcomes 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 percent of the measures, while the remaining access measures were overwhelmingly poorer for Latinos (83 percent).⁷ 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 percent and 77 percent of measures, respectively, and Asian Americans and American Indians received poorer care on 32 percent and 41 percent 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 percent to 59 percent) but decreased for Asians (from 41 percent to 35 percent), and from 2000 to 2003 colorectal cancer screening rates increased for whites while falling off sharply for American Indians and Alaska Natives.⁸ 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 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.⁹ 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 surgery¹⁰ or kidney transplantation.¹¹
- Black cancer patients fail to get the same combinations of surgical and chemotherapy treatments that white patients with the same disease presentation receive.¹²
- 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.¹³
- 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.¹⁴
 - Minorities are more likely to receive undesirable treatment than whites, such as limb amputation for diabetes.¹⁵

Of these health care disparities, inequities in long-term care services are 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.¹⁶ 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.¹⁷ 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 are more likely to admit residents with cognitive and/or physical impairment, and have lower ratings of cleanliness/maintenance and lighting.¹⁸ 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.¹⁹ 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 admitted to nursing homes with 32 percent higher rates of deficiency (defined as evaluations of poor quality made by state surveyors under the federal nursing home certification regulation).²⁰

Oral health disparities are also alarming. Many racial and ethnic minority groups experience poorer oral health than national averages, and these disparities contribute significantly to health inequity. The landmark 2000 Surgeon General's Report, *Oral Health in America*, found that African Americans, Hispanics, and American Indians and Alaska Natives generally have poorer oral health than other racial and ethnic groups in the United States.²¹ These problems begin early in the lifecycle, and persist or widen with age. Hispanic and African-American preschoolers experience tooth decay at rates 2.5 and 1.5 times higher, respectively, than white children. This inequity is even more profound among American Indian and Alaska Native children, who are nearly six times more likely to experience tooth decay than white children. Destructive periodontal disease occurs in nearly 60 percent of American Indians and Alaska Natives, 33 percent

of African Americans, 25 percent of Mexican Americans, and 20 percent of whites. And a disproportionate percentage of minority retirees have lost teeth due to gum disease.²²

Access to dental services and dental insurance explains some of these disparities, but community-level factors—such as the availability of dental services, high-sugar products in schools and stores, and fluoridation in drinking water—also contribute to racial and ethnic disparities in oral health.²³ Many racial and ethnic minority groups are less likely than whites to receive dental services. While nearly half of whites report receiving dental services in the past year, just 27 percent of African Americans and Hispanics, 36 percent of Asian and Pacific Islander Americans, and 41 percent of Native Americans and Alaska Natives reported receiving services in the same time period. Among children, white preschoolers are 1.5 times more likely to have a dental visit than minority children and are 2.4 times more likely to receive preventive services. Differences in preventive care persist after adjusting for income; among poor children, only 13 percent of Blacks and 16 percent of Hispanics received a preventive dental visit in the past year, relative to 25 percent of white children. Disparities in dental insurance coverage also explain many of these gaps; a disproportionate number of the 108 million American who lack dental coverage are minorities. White children, for example, are 70 percent more likely than non-white children to have private dental insurance. Workers without dental coverage are only about half as likely as those with coverage to have a dental visit in a year.²⁴

What Are the Factors that Contribute to Health and Health Care Inequities?

Many factors contribute to health inequities, but some of the most important underlying causes are socioeconomic inequality and differences in living conditions. A large and growing body of public health research demonstrates that to address health inequities, we must improve the social and economic contexts that shape health. As the World Health Organization's report on social determinants of health states, "[I]nequities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces."²⁵ It is therefore important to address factors outside of health care by improving socioeconomic opportunity and community conditions for health, as will be discussed below.

Many of the same problems associated with racial and ethnic inequality in education, employment, housing and criminal justice are implicated in health care inequities. One of the most pressing fundamental causes of these inequities 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.²⁶ 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.

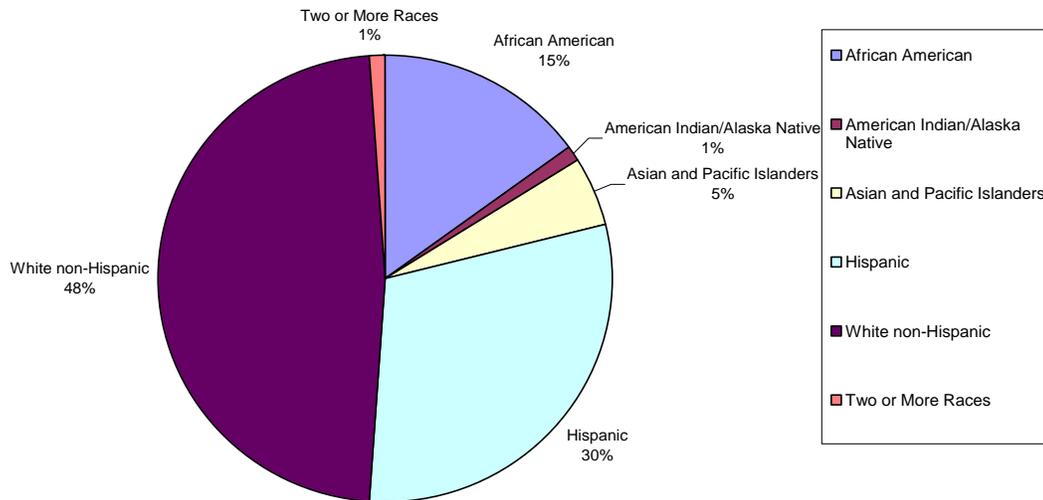
Racial and ethnic segregation and inequality therefore “sets the stage” for inequitable health care in the United States.²⁷ But many other causal factors – such as policies and practices of health care systems, the legal and regulatory context in which they operate and the behavior of people who work in them – are also involved.²⁸ 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.²⁹ Racial and ethnic minority and immigrant communities are disproportionately uninsured (see Figure 1), making them especially vulnerable to health crises.³⁰ 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 dependent upon public sources of health insurance.³¹
- While Hispanic children constitute less than one-fifth of children in the United States, they represent over one-third of uninsured children.³² And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic.³³
- More than 11 million immigrants were uninsured in 2003, contributing to one-quarter of the U.S. uninsured.³⁴ Between 1998 and 2003, immigrants accounted for 86 percent of the growth in the uninsured population.³⁵
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993.³⁶

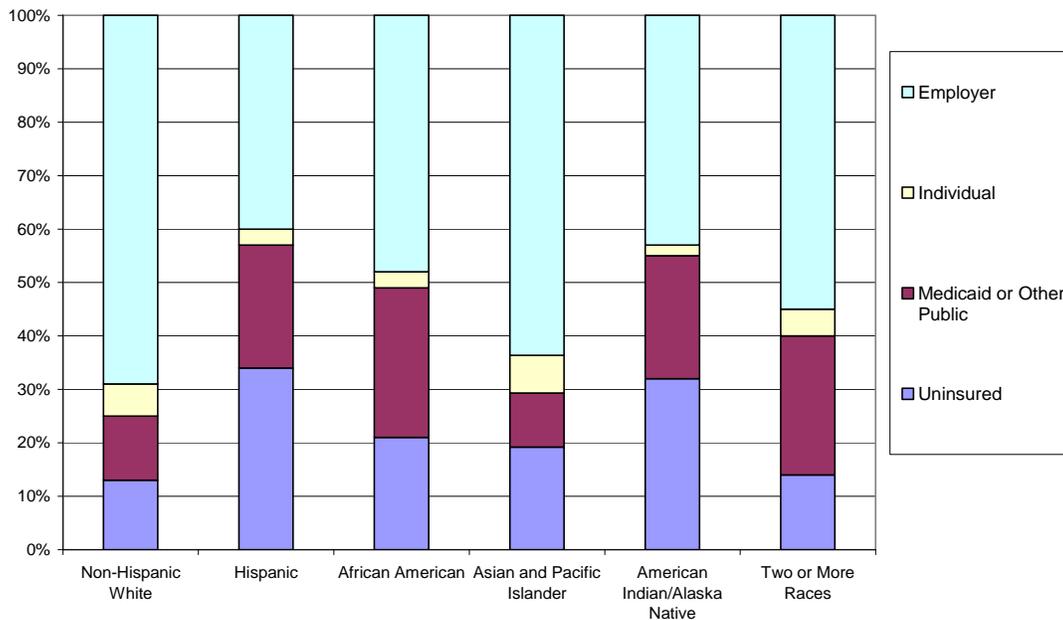
Figure 1: Nonelderly Uninsured by Race/Ethnicity, 2005
Source: Kaiser Family Foundation, 2007



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.³⁷ 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.³⁸ A recent study of African-American and white Medicare patients found the risk of admission to high-mortality hospitals was 35 percent higher for blacks than for whites in communities with high levels of residential segregation.³⁹ Another recent study of over 300,000 patients treated at 123 hospitals across the country found that minorities disproportionately receive care in lower-quality hospitals, a problem that explained the largest share of disparities.⁴⁰ 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 percent of pharmacies in predominantly white neighborhoods.⁴¹ Nearly one in five Latinas (18 percent) and one in ten African-American women reported not seeking needed health care in the last year due to transportation problems, compared to five percent of white women.⁴² 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.⁴³

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.⁴⁴ 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.⁴⁵ 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 1996.⁴⁶
- 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 2002.⁴⁷
- 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.⁴⁸
- 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).⁴⁹

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.”⁵⁰ 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.⁵¹ 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.⁵²
- Over one in five non-English speaking patients avoid seeking medical help altogether because of language barriers.⁵³

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.⁵⁴

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-bursting 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.⁵⁵

Eliminating Health and Health Care Inequality

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

Several evidence-based strategies can improve access 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 the Diversity and Distribution 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 should be empowered to participate in treatment decisions, and in the same vein, communities should be empowered to inform policies regarding the distribution of health care resources at the community level.
5. **Address Social and Community-Level Influences on Health.** As noted above, health inequities are largely the by-product of socioeconomic inequality and community-level conditions that shape health. Several policy approaches can improve these social determinants of health in ways that provide broad returns to society.

Each of these is discussed below.

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.⁵⁶

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 health care 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. 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 expand insurance options and take significant steps toward improving health care efficiency and lowering costs.

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.⁵⁷ 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 relatively small provider networks. These limits can harm access to quality care.⁵⁸ Given that several states are examining strategies to expand health insurance coverage, it is important that these coverage expansion proposals 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 evaluating 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.⁵⁹ 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.⁶⁰ 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.⁶¹

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 and to 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.⁶²

Promote Equal High Health Care Access and Quality

As the studies cited 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 inconsistent. 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 have access to satisfactory health care. 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 that 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.⁶³

Social and Community-Level Influences on Health Disparities

The policy strategies outlined above aim to improve the ability of our health care systems to respond to the needs of communities of color. As discussed above, 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. At the federal level, these strategies should include a mandate to execute, administer, and enforce provisions to address environmental justice in minority and low-income populations. The federal government should also establish health empowerment zones—which create incentives for health investments—in communities that disproportionately experience disparities in health status and health care.

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.¹ 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.¹ 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 injustice (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.

Promising Strategies to Address Health and Health Care Inequities in the Tri-Committee Draft Legislation

The draft Tri-Committee legislation contains a number of important provisions that will strengthen the federal effort to eliminate health and health care inequities. Importantly, the legislation offers the kind of comprehensive strategy of targeted investments that are likely to help prevent illness in the first place, manage costs when illness strikes, and improve health. Over the long haul, these provisions will result in a healthier nation with fewer health inequities, greater workforce participation and productivity, and long-term cost-savings. These provisions:

Emphasize and support disease prevention and health promotion. Community-based primary prevention would be strengthened through this legislation. The draft legislation targets at least half of new grant funds for the delivery of preventive health services at the community level, establishes a Public Health Investment Fund, and would prioritize funds to community health centers and others to create community-based interventions and expand data collection to understand what works to promote health and reduce health inequities. The legislation would also require the CDC Clinical Preventative Task Force to prioritize the elimination of disparities as they draft clinical guidelines, and similarly would authorize the Community Preventative Task Force to prioritize the elimination of health inequities. The bill also would require that 50% of Community Intervention funds must be allotted toward addressing health inequities. In addition, the legislation would authorize Health Empowerment Zones, locally-focused initiatives that stimulate and seed coordinated, comprehensive health promotion and community capacity-building.

Improve the diversity and distribution of the health professional workforce. The draft bill contains several important provisions that will improve the diversity and distribution of the health professional workforce. The bill would increase funding for the National Health Service Corps, expand scholarships and loans for individuals in needed professions and shortage areas, encourage the training of primary care physicians by increasing training opportunities outside of hospitals, and reauthorize the Centers of Excellence program for underrepresented minorities. The proposal also reauthorizes the scholarship program for individuals from disadvantaged backgrounds and reauthorizes the faculty loan program for individuals from disadvantaged backgrounds. The draft bill also increases the maximum annual amount of awards and reauthorizes the Health Careers Opportunity Program (HCOP) for disadvantaged backgrounds. With regard to Title VIII programs, the bill would reauthorize the workforce diversity grants to increase nursing education opportunities for individuals from disadvantaged backgrounds and authorizes \$90 million dollars in mandatory funding above baseline appropriations for these activities. The legislation also authorizes training grants for the purpose of addressing health disparities by promoting cultural and linguistic competency. The bill would also require the Secretary of HHS to coordinate diversity activities and cultural and linguistic competency programs to foster collaboration.

Create incentives to reduce health care inequities. In the context of the proposed public plan option, the draft legislation creates innovative payment mechanisms to determine payments for services, including patient-centered medical home and other care management payments that reduce health disparities and address geographic variation in the provisions of health services. In addition, the bill would include the reduction of health inequities among the National Priorities for Quality Improvement.

Strengthen Medicaid. The draft bill includes provisions to expand Medicaid with federally-financed dollars and will improve provider participation in the program by increasing reimbursement rates for primary care providers to ultimately match those of the Medicare program.

Improve access to language services. The legislation would require a Medicare study and demonstration on language services, similar to be provisions included in CHIPRA for CHIP enrollees and Medicaid-eligible children. The legislation would also expand this demonstration program as a state option for adults in Medicaid.

Improve the accessibility of Health Information Technology (HIT) in underserved communities. The draft legislation would expand grants and training programs to ensure that health care providers working in underserved communities have access to HIT tools and appropriate training to effectively incorporate HIT in clinical practice.

Improve the application of Comparative Effectiveness Research to address health inequities. The legislation would require that research take into account various subpopulations (including racial and ethnic minorities, women, and people of different age groups) and seek to include these populations in the research where appropriate. In addition, the bill would require the dissemination of appropriate findings among health care providers, patients, vendors of HIT focused on clinical decision support, professional associations, and federal and private health plans.

Suggestions for Additional Provisions to Address Health Inequities

While the Tri-Committee draft bill addresses a number of important needs to achieve health and health care equity, there are several areas where the legislation could be strengthened with evidence-based strategies that will improve the federal investment in health equity. These include:

Codifying the federal Cultural and Linguistic Appropriate Services (CLAS) standards. The federal government currently requires providers receiving federal funds to meet only four of the 14 CLAS standards.⁶⁴ Expanding the requirement to all 14 standards and to all providers would help improve access and quality of care for diverse populations. The standards call for health care organizations to take a number of steps including providing culturally competent care, offering language assistance and ensuring a diverse workforce that undergoes ongoing CLAS training. In addition, the federal government should provide explicit funding for language assistance services in all public programs.

Expanding successful community-based health programs. Several community-based health disparities elimination programs, such as the Centers for Disease Control and Prevention’s Racial and Ethnic Approaches to Community Health (REACH) program, are demonstrating positive results. The CDC REACH program provides grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs that will reduce or eliminate inequities in health and healthcare experienced by racial and ethnic minority individuals. Supporting such programs will ensure that an array of public and private community-based organizations, public health departments, university and research organizations, American Indian tribal organizations, and others can continue to receive grants to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based and community-driven sustainable strategies to eliminate racial and ethnic health and healthcare disparities.

Addressing health in all policies. As noted above, health inequities are driven largely by social and economic inequality and unhealthy living conditions. Developing strategies to address these conditions requires an understanding of how policies, practices, and programs regarding transportation, housing, education, employment, the environment and other sectors shape health and health inequities. The committee might consider requiring the use of Health Impact Assessments (HIA) to understand how federal policies and projects in a range of sectors influence health, and to consider options to enhance health and/or mitigate potential negative health influences. HIA is being used in a number of jurisdictions around the country, and brings public health issues to the attention of policymakers in areas that fall outside of traditional public health arenas, such as transportation or land use.

Strengthening the federal health research effort. Federal research on health inequities has expanded significantly in the last decade, but some of the problems found in the Institute of Medicine’s 1999 report, *The Unequal Burden of Cancer*, remain. These problems include insufficient attention to the problem of health inequities and a lack of focused and coordinated effort to expand minority participation in research and minority investigators.⁶⁵ The committee might consider elevating the National Center on Minority Health and Health Disparities, which has led an impressive effort to improve research on health inequities at NIH, to Institute status. This action should be accompanied by an appropriate increase in research and administrative resources to ensure that health equity research receives the appropriate level of attention at NIH.

Strengthening federal data collection. The draft legislation takes an important step in that it would create an Assistant Secretary for Health Information, part of whose responsibility would be to ensure that data on race and ethnicity is consistent with 1997 OMB standards in consultation with the U.S. DHHS Office of Minority Health and Office of Civil Rights. But because these broad racial and ethnic categories often obscure subpopulation differences, it is important to go beyond these categories where possible. For example, Asian Americans appear to be among the healthiest populations in the nation when data are collected by OMB “race” categories. But several subpopulations face high risk for certain diseases, such as Vietnamese-American women,

who face the highest rates of cervical cancer in the nation.⁶⁶ Data for these subpopulations can be collected and “rolled in” to the OMB categories. In addition, because data are essential to track the use and quality of care, document disparities, and tailor interventions, the legislation could require and fund the standardized collection of race, ethnicity, and primary language data across all public and private health insurance plans and care settings, and fund the use of data to set benchmarks for improvement.

Ensuring that immigrants lawfully present in the United States face the same eligibility rules as citizens for public programs, including Medicaid, Medicare and CHIP, and that they have the same access as citizens to subsidies. Many lawfully present immigrants work in sectors of the economy that are less likely to provide employer-sponsored health insurance, and many are categorically barred from public insurance programs. As a result, 24 percent of lawfully present immigrant adults are uninsured, compared to 14 percent of US-born citizens.⁶⁷ As noted above, to the extent that many remain uninsured, we will continue to see inefficiencies in the delivery of care, higher costs, and unnecessary human suffering.

Conclusion

Health and health care access and quality are more often compromised for racial and ethnic minorities than for whites. 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.⁶⁸ Because people of color are disproportionately among the uninsured, these numbers carry a greater burden in minority communities.

Addressing these inequities requires comprehensive strategies that span community-based primary prevention to clinical services, a long-term commitment and investment of resources, and a focus on addressing equity in all federal programs and in all elements of health reform legislation. To fail to do so ignores the reality of important demographic changes that are happening in the United States, and fails to appreciate the necessity of attending to equity as a necessary step to help achieve the goals of expanding insurance coverage, improving the quality of health care, and containing costs. Encouragingly, the Tri-Committee draft bill recognizes the importance of achieving equity in health and health care and proposes a number of policy strategies to reach this goal. The authors of this legislation recognize that no single policy – such as expanding access to health insurance – will fully address health care inequality. Health care inequities 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.

¹ Harper S, Lynch J, Burris S, and Smith GD. Trends in the Black-White life expectancy gap in the United States, 1983-2003. *Journal of the American Medical Association*, 297(11):1224-1232.

² U.S. Department of Health and Human Services, 2007.

³ U.S. Department of Health and Human Services, National Center for Health Statistics. 2007. *Health, United States, 2006*. Washington, DC: U.S. Department of Health and Human Services.

⁴ *Ibid.*

⁵ *Ibid.*

⁶ Woolf SH, Johnson RE, Fryer GE, Rust G, and Satcher D. 2004. The health impact of resolving racial disparities: An analysis of US mortality data. *American Journal of Public Health*, 94(12): 2078-2081.

⁷ *National Healthcare Disparities Report, 2006*. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm>, accessed June 28, 2007.

⁸ *National Healthcare Disparities Report, 2006*. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm>, accessed June 28, 2007.

⁹ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academy Press, 2003.

¹⁰ Henry J. Kaiser Family Foundation and the American College of Cardiology, "Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence," October 2002.

¹¹ A.C. Klassen, et al., "Relationship Between Patients' Perceptions of Disadvantage and Discrimination and Listing for Kidney Transplantation," *American Journal of Public Health* 92.5 (May 2002).

¹² IOM, *Unequal Treatment*, 2003.

¹³ Henry J. Kaiser Family Foundation and the American College of Cardiology, "Racial/Ethnic Differences in Cardiac Care"

¹⁴ IOM, *Unequal Treatment*, 2003.

¹⁵ *Ibid.*

¹⁶ Akhter MN, Levinson AR, Eliminating health disparities associated with long-term care to promote graceful aging in place. *Care Management Journal*, 2003 Summer;4(2):88-93.

¹⁷ Akamigbo AB, Wolinsky FD, New evidence of racial differences in access and their effects on the use of nursing homes among older adults. *Medical Care*, 2007 45(7):672-9.

¹⁸ Howard DL, Sloane PD, Zimmerman S, Eckert JK, Walsh JF, Buie VC, Taylor PJ, Koch GG, Distribution of African Americans in residential care/assisted living and nursing homes: more evidence of racial disparity? *American Journal of Public Health*. 2002 Aug;92(8):1272-7.

¹⁹ Mor V, Zinn J, Angelelli J, Teno JM, Miller SC. Driven to tiers: socioeconomic and racial disparities in the quality of nursing home care, *Milbank Quarterly*, 2004, 82(2):227-56.

²⁰ Grabowski DC, The admission of blacks to high-deficiency nursing homes. *Medical Care*, 2004, 42(5):456-64.

²¹ US Department of Health and Human Services. (2000). *Oral Health in America: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

²² Children's Dental Health Project. (n.d.) "Racial and ethnic disparities in oral health," available at <http://www.cdhp.org/downloads/Disparityfactsheet.pdf>, accessed March 22, 2009.

²³ Patrick DL et al. (2006). Reducing oral health disparities: a focus on social and cultural determinants, *BMC Oral Health*, 6(Suppl 1):S4, available at <http://www.biomedcentral.com/1472-6831/6/S1/S4>, accessed March 22, 2009.

²⁴ *Ibid.*

²⁵ World Health Organization Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*, Final Report of the Commission on Social Determinants of Health, available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf, accessed March 22, 2009.

²⁶ Chiquita A. Collins and David R. Williams, 1998. "Segregation and Mortality: The Deadly Effects of Racism?" *Sociological Forum* 14(3): 495-523.

²⁷ Institute of Medicine, *Unequal Treatment*, 2003.

²⁸ *Ibid.*

²⁹ Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: National Academy Press, 2003.

³⁰ People of color comprise only about 30% of the U.S. population, but over half of the nation's uninsured are racial and ethnic minorities. See U.S. Department of Health and Human Services, 2007.

³¹ U.S. Department of Health and Human Services, *The National Healthcare Disparities Report*, January 2006, <http://www.ahrq.gov/qual/nhdr05/nhdr05.htm> (18 January 2006).

³² Robert Wood Johnson Foundation, *Going Without: America's Uninsured Children*, www.rwjf.org (August 2005).

³³ The Urban Institute, "Fast Facts on Welfare Policy," www.urban.org 19 July 2005.

³⁴ The uninsurance rate among immigrants increased dramatically in the late 1990s, following passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which imposed a five-year limit on most new immigrants' ability to participate in public health insurance programs. Prior to and shortly following passage of the Act (between 1994 and 1998), immigrants accounted for about one-third of the increase in the number of uninsured individuals.

³⁵ Employee Benefit Research Institute, "The Impact of Immigration on Health Insurance Coverage in the United States," *Employee Benefit Research Institute Notes*, 26, no. 6 (2005).

³⁶ U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2004* (Washington, D.C.: U.S. Government Printing Office, 2005).

³⁷ Bronx Health Reach, *Separate and Unequal: Medical Apartheid in New York City*, available at http://www.institute2000.org/policy/medical_apartheid.pdf, accessed July 30, 2006.

³⁸ Bach PB, Pham HH, Schrag D, Tate RC, Hargraves JL. (2004). Primary care physicians who treat blacks and whites. *The New England Journal of Medicine*, 351(6):575-84.

³⁹ Sarrazin MV, Campbell M, and Rosenthal GE. (2009). Racial differences in hospital use after acute myocardial infarction: Does residential segregation play a role? *Health Affairs*, 28(2): w368-w378.

⁴⁰ Hasnain-Wynia R, Baker DW, Nerenz D, Feinglass J, Beal AC, Landrum MB, Behal R, and Weissman JS. (2007). Disparities in health care are driven by where minority patients seek care, *Archives of Internal Medicine*, 167:1233-1239.

⁴¹ Morrison, R.S., Wallenstein, S., Natale, D.K, Senzel, R.S., and Huang, L. (2000). "We Don't Carry That"— Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics. *The New England Journal of Medicine* 342(14):1023-1026.

⁴² The Henry J. Kaiser Family Foundation, "Racial and Ethnic Disparities in Women's Health Coverage and Access to Care: Findings from the 2001 Kaiser Women's Health Survey, available at www.kff.org, accessed September 25, 2004.

⁴³ Smith, DB. (2005). *Eliminating Disparities in Treatment and the Struggle to End Segregation* (New York: The Commonwealth Fund).

⁴⁴ Henry J. Kaiser Family Foundation, *Key Facts: Race, Ethnicity, and Health Care* (Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2003).

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ Lillie-Blanton, M, Martinez, R. M., & Salganicoff, A. (2001). Site of medical care: Do racial and ethnic differences persist? *Yale Journal of Health Policy, Law, and Ethics*. 1(1), 1-17.

⁵⁰ U.S. Census Bureau, "Ability to Speak English by Language Spoken at Home." Available at <http://www.census.gov/population/cen2000/phc-t37/tab01a.pdf> (Accessed 19 March 2007).

⁵¹ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academies Press, 2003).

⁵² Pew Hispanic Center and the Henry J. Kaiser Family Foundation, "Survey Brief About the 2002 National Survey of Latinos," March 2004, www.kff.org (23 January 2006).

⁵³ *Ibid.*

⁵⁴ IOM, *Unequal Treatment*, 2003.

⁵⁵ Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, Banaji MR. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine*, 2007, 22(9):1231-8.

⁵⁶ H. Boushey and M.M. Diaz, "Improving Access to Health Insurance," Health Insurance Data Briefs no.1 (Washington, D.C.: Center on Budget and Policy Priorities, April 13, 2004).

⁵⁷ For example, see: Doty MM and Holmgren AL, *Health care disconnect: gaps in coverage and care for minority adults. Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2005*, Issue Brief. New York: The Commonwealth Fund, 2006; Hargraves JL, and Hadley, J, The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care, *Health Services Research*, 2003, 38(3):809-29; Lillie-Blanton M, and Hoffman C, The role of health insurance coverage in reducing racial/ethnic disparities in health care, *Health Affairs*, 2005, 24(2):398-408; [Weinick RM, Byron SC, Bierman AS](#), Who can't pay for health care? *The Journal of General Internal Medicine*, 2005, 20(6):504-9.

⁵⁸ Institute of Medicine, *Unequal Treatment*, 2003.

⁵⁹ Institute of Medicine. (2004). *In the Nation's Compelling Interest: Enhancing Diversity in the Health Professions*, B.D. Smedley and L.R. Bristow, eds., Washington, D.C.: National Academies Press.

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

⁶² Smith DB, 1999.

⁶³ The Public Health Institute, *Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability*, November 2004, available at <http://www.phi.org/pdf-library/ASACB.pdf> (accessed August 30, 2007).

⁶⁴ U.S. Department of Health and Human Services Office of Minority Health. National Standards on Culturally and Linguistically Appropriate Services. <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

⁶⁵ Institute of Medicine, *The Unequal Burden of Cancer: An Assessment of NIH Research on Minorities and the Medically Underserved*. Alfred E. Haynes and Brian D. Smedley (Eds.), Washington, DC: National Academy Press, 1999.

⁶⁶ *Ibid.*

⁶⁷ Jeffrey S. Passel and D'Vera Cohn. A Portrait of Unauthorized Immigrants in the United States. Pew Hispanic Center. April 2009.

⁶⁸ Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: National Academy Press, 2003.