

# Racial and Ethnic Disparities in Health

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*Despite significant improvements in the overall health of Americans over the past several decades, the health of racial and ethnic minorities continues to lag behind that of whites. For decades, there have been declarations identifying correction of health disparities as a national priority, but progress has been slow and disproportionate suffering, disability, and death continue (IOM 2006).*

Over the last century, advances in medicine and public health have led to substantial improvements in the nation's health, but minority health status continues to lag behind that of whites. In general, African Americans, Hispanics, Asians and

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Pacific Islanders, and American Indians and Alaska Natives have poorer health and shorter lives than whites. Minorities suffer disproportionately from many illnesses, even after controlling for socioeconomic status and insurance coverage. Consider that:

- The infant death rate among African-Americans is still more than double that of whites. Deaths from heart disease and cancer are more than 40 percent and 30 percent higher, respectively, for African Americans than for whites. African-American women are more likely to die from breast cancer despite having a mammography screening rate nearly the same as for white women. The death rate from HIV/AIDS for

African Americans is more than seven times that for whites, and the rate of homicide is six times that for whites.

- Hispanics are almost twice as likely to die from diabetes as are non-Hispanic whites. Hispanics account for 20 percent of the new cases of tuberculosis, and have higher rates of high blood pressure and obesity than non-Hispanic whites.
- American Indians and Alaska Natives have an infant death rate almost double that of whites. Diabetes rates for these populations are more than twice that of whites. American Indians and Alaska Natives also have disproportionately high death rates from unintentional injuries and suicide.
- While Asians and Pacific Islanders, on average, are one of the healthiest population groups in the United States, there is great diversity within this population group. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis also are higher in Asians and Pacific Islanders living in the United States than in whites (CDC 2006a).

## Multiple Factors at Work

Developing strategies for reducing racial and ethnic disparities in health is a complicated task. Addressing them will require work to address the many factors that affect health including: the condition of the social environment, including racism and poverty; access to care; health behaviors; structural aspects of the deliv-

## People of color experience systematic barriers in accessing care.

ery system that affect both quality and patient care experiences; and the condition of the environments in which minorities live and work, including air and water quality and exposure to other environmental hazards. Much of the work in recent decades has focused on improving understanding of how these complex factors contribute to disparities, and documenting the problem as a fundamental step in finding solutions.

Discrimination has had a direct impact on the health of minorities. Minority populations are more likely than whites to perceive discrimination in the delivery of health services, and are less likely to have access to care, to attain care, and then to be satisfied with the care they receive (Hogue 2000). Minority patients still face differences in the treatments they receive. For example, blacks, Hispanics, and Asian Americans all report, in numbers higher than the overall population, having a major problem getting specialty care. Perceptions about discrimination in the health care system can also be a powerful motive in preventing minorities from seeking care.

Race matters a great deal to the understanding of health disparities. Race is more than a qualifier or descriptor—it is an underlying condition that restricts participation in society. As historian David Barton Smith (1999) noted, “Its influence has been so permanent and pervasive that it becomes an almost

unrecognized part of the background of our culture.”

Racism in the health care delivery system has a long history dating back to the pre-Civil War era. More recent experiences include the Tuskegee syphilis experiment which began in 1932 and lasted for 40 years. Although the civil rights movement ended governmental acquiescence in practices that segregated patients by race, segregation persists in physician referral practices, treatment decisions, and residential location. David Barton Smith (2005) calls full integration and accountability in health care key parts of an unfinished civil rights agenda.

The effects of discrimination are also a leading cause in the development of conditions that can lead to illness. The history of discrimination in the health care delivery system merely illustrates the larger social problem of racism in the broader culture. In short, the history of slavery and segregation are at the very root of the substandard neighborhoods, housing, employment opportunities, education, and health care that many minorities face.

The experience of individual discrimination expands when one considers the larger picture of institutionalized racism, the clearest and most pervasive example of which is housing segregation. While the practice of legal segregation began to end more than 40 years ago, the ra-

cial composition of black and white neighborhoods remains largely unchanged. Concentrating poverty through segregation dictates the quality of education people receive and their opportunities for attending college or for employment after leaving school.

Socioeconomic status also plays a key role in determining the health of minorities and access to health care. Researchers have long debated the question of race, socioeconomic status, and their effect on health. In the end, the relative impact of one or the other of these causes of disparities in health may not be determinable, as each are critical components in explaining why minorities are less healthy, have poorer access to quality care, and die sooner than whites. It is indisputable, however, that minorities consistently fare less well on a variety of socioeconomic indicators. They have lower incomes, less wealth, are less educated, and have fewer employment opportunities than whites (Williams 2000).

Minorities are also more likely to live in environments that are hazardous to their health, whether it is the condition of the air, the quality of housing, or the experience of violence in their communities. While environmental hazards that represent potential sources of risk affect all races, a higher percentage of African Americans and Hispanics live in communities with higher levels of air pollutants associated with respiratory symptoms such as asthma and the exacerbation of other ailments (IOM 1999).

The health behaviors of minorities are also important to understanding

health disparities. Data on smoking among minorities are mixed. In the Commonwealth Fund's Minority Health Survey, for example, fewer minorities reported that they smoked compared to whites (Hogue 2000). Data from the National Center for Health Statistics, however, suggest that the prevalence of smoking for survey respondents in the month before being surveyed is highest among American Indian or Alaska Natives. African Americans are only 60 percent as likely as whites to eat a healthy diet at least four times a week, and African-American men are only 70 percent as likely as white men to report that they routinely and vigorously exercise (Hogue 2000). The age-adjusted obesity rate in 2005 was

higher among non-Hispanic blacks and Mexican Americans than among non-Hispanic whites. This is especially true among women (CDC 2006b).

People of color also experience systematic barriers in accessing care. The percentage of adults without health insurance is highest among Hispanics and African Americans. Substantially fewer blacks and Hispanics have reported having a regular doctor than whites. Blacks are more likely than whites to receive care in settings such as emergency rooms, outpatient clinics, and other hospital clinics (AHRQ 2006).

Finally, patients with limited English proficiency encounter many

#### RECENT MILESTONES IN FEDERAL POLICY ON DISPARITIES

**1985:** Publication of the report of the Health and Human Services (HHS) Secretary's Task Force on Black and Minority Health. This report revealed large and persistent gaps in health status among Americans of different racial and ethnic groups.

**1986:** Creation of the federal Office of Minority Health. This in turn led a number of states to establish an official minority health entity (such as an office, commission, council, or center) either through executive or legislative branch action.

**1998:** President Clinton announces a national goal to eliminate racial and ethnic disparities in six areas by 2010. Healthy People 2010 makes elimination of health disparities one of its two overall goals.

**1999:** Passage of the Healthcare Research and Quality Act and the Minority Health and Health Disparities Research and Education Act bolster research funding and create the National Center on Minority Health and Health Disparities at the National Institutes of Health.

**2000:** Publication of federal standards to promote culturally and linguistically appropriate services (CLAS). CLAS standards are primarily directed at health care organizations as recommended national standards.

**2003:** Institute of Medicine releases *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. First *National Healthcare Disparities Report* published by AHRQ.

obstacles including delays in making appointments and misunderstandings about diagnosis and treatment. Many have difficulty expressing their concerns, which may in turn lead to inappropriate tests, or even misdiagnosis (Diversity Rx 2000). The growing minority population also faces cultural barriers in the delivery of health care services. Culture plays a role in how patients perceive

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their illness, who should be involved in the treatment, the self-diagnosis of symptoms, basic notions about death and dying, and the appropriateness of invasive procedures.

**Eliminating Disparities: What's Next**

National attention to the issue of health disparities increased significantly after President Clinton announced a federal commitment to end health disparities in six key areas in 1998. A PubMed search of articles using health disparities as a key term found only 30 articles published between 1985 and 1999, for example, but 439 between 2000 and 2004 (IOM 2006). Even so, a 2005 poll funded by Robert Wood Johnson Foundation (RWJF) found that 68 percent of Americans are still unaware that health care disparities are a problem. Whites are least aware with 25 percent believing health care is worse for racial and ethnic minorities. In comparison, 44

percent of African Americans and 56 percent of Hispanic Americans said minorities received worse care than whites (RWJF 2005).

The Institute of Medicine's 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, has defined much of the work currently underway in both the public and private sector. This includes:

- improving reporting and collection of access and utilization data by patient's race and ethnicity,
- encouraging use of evidence-based guidelines and quality improvement,
- supporting use of language interpretation services in clinical settings,
- increasing awareness among health care providers and the general public about disparities in care,
- increasing the proportion of underrepresented minorities in the health workforce,
- integrating cross-cultural education into the training of all health professionals,
- expanding use of community health workers,
- improving patient education and empowerment, and
- conducting further research to identify sources of disparities and promising interventions (IOM 2003).

These recommendations were echoed in a project funded by The Commonwealth Fund in 2004 to create a state policy agenda to eliminate health disparities. In addition to many of the IOM recommendations, their agenda includes suggestions for state policymakers to:

- expand health screening and access through expanded insurance coverage;
- establish or enhance state offices of minority health;
- involve all health system stakeholders in minority health improvement efforts; and,
- create a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities (McDonough et al. 2004).

Since 2003, the federal Agency for Healthcare Quality and Research has been publishing an annual *National Healthcare Disparities Report* that examines racial and ethnic disparities in both access (13 core measures) and quality (46 core measures of quality, the same as those tracked in the companion *National Healthcare Quality Report*). It considers socioeconomic disparities as well. The most recent report (2007) concluded that, while some disparities are diminishing, disparities still exist. Opportunities for improvement remain, and information about disparities is improving.

#### DATA COLLECTION AND REPORTING

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A legal analysis funded by RWJF affirms that collecting race and ethnicity data about patients, when conducted as part of a program to improve health care quality, does not violate federal or state laws or increase the risk of race-based malpractice claims. The report also called for government guidelines to further encourage and shape the practice (Rosenbaum et al. 2006).

RWJF has also helped health plans follow up on the IOM's recommendation for health insurance companies to collect, report, and monitor patient care data as the foundation of efforts to address disparities in care. The RWJF-supported National Health Plan Collaborative is a groundbreaking project to identify how health care quality can be improved for racially and ethnically diverse patient populations, and has brought together nine major health insurance companies to work in partnership with organizations from the public and private sectors. Collaborative members have developed and tested new approaches for quickly estimating race and ethnicity to support disparities reduction in the short term, while they complete the longer process of collecting race and ethnicity information directly from their members. They also developed novel strategies and tools to help efficiently and effectively target interventions, began cultural competency training for health plan staff and provider networks, and tested strategies to educate and

reach out to underserved racial and ethnic populations.

Members of the collaborative shared their initial lessons learned in a report published in November 2006. They report three overarching lessons from their experience:

- Reorienting large organizations and developing institutionwide buy-in to disparities reduction takes time. Success depends on making disparities reduction a core business strategy.
- Companywide education efforts must also extend to the potentially sensitive task of collecting racial and ethnic data on health plan members, with efforts focused on explaining how the data will be used to help reduce disparities.
- Over time, the value of collective action became more apparent to the collaborative's members. Participation in the collaborative raised understanding of disparities within their companies (RWJF 2006).

#### LINKING CULTURAL COMPETENCE, LANGUAGE ACCESS, AND QUALITY

In order to be effective in the delivery of health services, health care providers must understand the impact that language and culture have on health and health care. Over the last decade, the foreign-born population in the U.S. increased 44 percent. Nearly 47 million people



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speaking a language other than English at home, and more than 21 million individuals are considered limited English proficient (U.S. Census Bureau 2003).

Providing language services is one element of a strategy to mitigate the myriad health and economic consequences of language and cultural barriers. It is also required by federal law. Under Title VI of the Civil Rights Act of 1964, recipients of federal funding are required to provide meaningful access to linguistic services, including interpreters. This includes all providers that accept Medicare and Medicaid patients and applies to their entire patient population. The U.S. Department of Health and Human Services reiterated this longstanding provision by issuing a policy guidance, drafted and enforced by its Office of Civil Rights, which explained the legal requirements of Title VI and outlined several broad strategies. The guidance was first issued in August 2000 and then republished in February 2002. In December 2000, the HHS Office of Minority Health also issued 14 national standards for ensuring culturally and linguistically appropriate services (CLAS) in health care. Currently, the Centers for Medicare and Medicaid Services provides the primary source of federal funding for language services to states under Medicaid and the State Children's Health Insur-

ance Program (SCHIP). Only nine states, however, are currently taking advantage of this funding option.

In the 1990s, cultural competence also came to be defined as intricately linked to the broader movement to improve health care quality. Although the evidence has yet to be fully developed, experts argue that "cultural competence is an essential part of a portfolio of activities to improve quality and eliminate racial and ethnic disparities in health care" (Betancourt 2006). The 2001 IOM report, *Crossing the Quality Chasm*, identified equity as one of the six principles that should guide the health system.

Both The Commonwealth Fund and RWJF have supported research to develop practical tools and evidence about the link between cultural competence and quality. For example, at the fifth National Conference on Quality Health Care for Culturally Diverse Populations in 2006, The Commonwealth Fund released a series of five reports summarizing the current evidence linking disparities and quality, and providing a road map to move from theory to action. The final report in the series recommends that organizations should:

- seek out leaders of community groups to solicit concerns and recommendations;

- make cultural competency a component of disease management, quality improvement, patient safety, customer service, and patient-provider interaction;
- consider how they will evaluate and quantify the positive impact of cultural competency efforts;
- explore the business case and social benefits of implementing cultural competency initiatives;
- recruit a diverse workforce and leadership that are committed to equality in health care; and
- provide time and resources for regular staff training (Wu and Martinez 2006).

Based in one of the most diverse states in the nation, The California Endowment has also made cultural competence one of its priorities since its founding in 1996. The foundation's work is guided by a multicultural approach to health, which is defined not only by race and ethnicity, but also includes financial status, cultural beliefs, gender, age, sexual orientation, geographic location, immigration status, and physical or mental abilities. Culturally competent health systems is one of its three program areas. The framework guiding its work is based largely on recommendations from IOM reports including ensuring patient safety, improving quality, reducing health disparities, and diversifying the health workforce.

The endowment is also using the Healthy People 2010 objectives to increase quality and years of life and eliminate health disparities.

To achieve these goals, the endowment supports activities ranging from policy change to education and training of health professionals, and quality improvements in health systems, plans, and providers. It also supports engagement with patients and consumers, promotion of a diverse health workforce to serve the underserved, efforts to assure equal access regardless of language, and health care services tailored to be effective for diverse populations. The Connecting Worlds Curriculum, for example, is a foundation-supported introduction to health care interpreting that combines a variety of teaching methods developed by a statewide collaboration of key stakeholders. The training curriculum provides bilingual participants an introduction to the skills required to master the consecutive mode of health care interpreting. Participants also have opportunities to apply their new skills through simulated interpreting sessions and case studies (The California Endowment 2006).

The Colorado Trust also began its work in cultural competency in the mid-1990s, when the Visiting Nurse Association (VNA) of Colorado voiced concerns about low rates of flu and pneumonia immunizations among minorities. The foundation responded by committing \$536,000 over three years to the Adult Immunization & Health Screening and Education Project. In addition to setting the goal of improving immunization rates in three counties, the initiative also sought to improve access to health prevention and education services for minority clients.

Between 2001 and 2004, the grant led to vaccinations for more than

7,500 people and increased the numbers of screenings, health education classes, and health information offered to adults in minority communities. An independent evaluation of the initiative found that the combination of three components: having classes in a familiar, easily accessible location; the use of culturally appropriate materials, content, and staff; and support provided by the program staff made this project successful. The evaluators also commented on the importance of the VNA's commitment to and flexibility in responding to community needs. This did not happen overnight; it took time, even for a well-established organization, to establish rapport and assist communities in accepting the program. One reason for initial feelings of distrust among participants was a lack of cultural competence on the part of health providers. Prior bad experiences made community members wary of programs with stated good intentions. Only the program coordinator's openness to learning more about cultural sensitivity

and differences eventually secured the necessary trust. The evaluation also found that the VNA's extensive relationship building, which laid the groundwork for tailored health education classes, was effective. All class participants made dietary and lifestyle changes needed to take control of their health.

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Building on these lessons, The Colorado Trust designed a seven-year (2005-2012), \$13.1 million Equality in Health Initiative. Under this initiative, nonprofit organizations and educational institutions across the state were funded to bring about improvements in one or more of the following areas: equality in medical treatment, equal access to care,

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equal environmental conditions, and healthy behaviors among racial and ethnic minorities. The initiative includes an independent evaluation to determine whether the cultural competency of grantees changes over time and how these changes influence their work. It also will identify the conditions necessary for an organization to bring about positive changes in cultural competency.

#### IMPROVING WORKFORCE DIVERSITY

The number of minority health professionals has a direct impact on the health of minorities. Having minority professionals can increase the comfort level of minority patients, and increases the likelihood that patients' cultural needs will be met. While racial and ethnic minorities make up one-quarter of the nation's population, with this share growing to nearly a third by 2010, minorities account for less than 10 percent of the health workforce (Sullivan Commission 2004).

Two reports issued in 2004 called for institutional and policy-level strategies to increase diversity among health professionals: *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, issued by the Institute of Medicine, and *Missing Persons: Minorities in the Health Professions* issued by a high-level commission chaired by former U.S. Secretary of Health and Human Services Louis W. Sullivan. Funded by the W.K. Kellogg Foundation, the Sullivan Commission emphasized the need for leadership, commitment, and accountability at the highest levels in educational institutions and professional organizations. It identified strategies to make training in the health professions more attainable and affordable for minority students, including shifting from student loans to scholarships; reducing dependency on standardized tests for admission; and enhancing the role of two-year colleges. In all, the commission made 37 separate recommendations, warning that failure to act quickly will only exacerbate the current disconnect between health care providers and the populations they serve.

In 2005, The California Wellness Foundation launched a \$1 million program to implement a public education campaign promoting the benefits of increasing ethnic diversity in California's health workforce. This program was developed based on the lessons learned from close to four years of previous grantmaking, including the following key findings:

- Overcoming the cumulative effects of inadequate preparation

in reading, math, and science; the absence of career and educational counseling; and the difficult lives lived by high-risk young people of color requires sustained commitment and significant funding.

- Middle school is not too early to start working with youth to prepare them for successful careers in health.
- Building this field requires seeding research and data analysis so that organizations have the evidence they need to make the case for support.
- Entry-level health workers have made tremendous gains when given consistent support and opportunities from their employers and local community colleges.
- Not nearly enough recognition is given to this pressing public health issue which needs more leadership from educational institutions, organizations, and individuals (The California Wellness Foundation 2005).

### Prioritizing Strategies and Targeting Interventions

Funders are working to find the niche where their resources can make a difference. They are funding efforts to improve cultural competence, promote workforce diversity, encourage community engagement in health, advocate for environmental justice, and improve health care quality. Many funders are convinced that there will not be a magic bullet solution to reduce disparities and instead are supporting interventions across this spectrum.

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The Blue Cross Blue Shield Foundation of Massachusetts, for example, has declared that reducing racial and ethnic health care disparities in Massachusetts will not be achieved by a single intervention or program model. Its grant program, Closing the Gap on Racial and Ethnic Health Care Disparities, supports initiatives that take a comprehensive and innovative approach to improving access and reducing barriers to health care and support services for racial and ethnic minorities. Grantees are asked to reduce inequities and gaps throughout the continuum of care by promoting access to culturally appropriate care and equal availability and utilization of services for specific racial and ethnic groups. The foundation is willing to consider a variety of interventions and expects that applicants will be guided by many of the recommendations made by the IOM and others. The goal is to establish a solid base for long-term, institutionalized solutions to reducing health care disparities for racial and ethnic minorities in Massachusetts. The funded programs are expected to serve as the groundwork for developing models that can be expanded and replicated.

Upon its founding in 1999, the Connecticut Health Foundation selected racial and ethnic health disparities as one of its three program priority areas. To date, the foundation has dedicated more than \$4.8 million in grants for work to reduce disparities throughout the state. It also seeks to change systemic and institutional policies that perpetuate health disparities. In December 2003, the foundation created the Policy Panel on Racial and Ethnic Health Disparities as an independent body charged with studying racial and ethnic health disparities in Connecticut, and developing pragmatic policy recommendations to address these inequities. The panel was made up of community, business, nonprofit, and government leaders. After a year of work including educational briefings and three public hearings, the panel released 14 recommendations for policymakers, nonprofit organizations, and private institutions related to social and environmental factors, data collection, language barriers, and workforce diversity. The foundation itself committed to incorporating the panel's recommendations into its strategic plan, and is channeling resources through grantmaking,

technical assistance, and public policy research.

Similarly, the MetroWest Community Health Care Foundation created a steering committee to better understand the nature of disparities in its region and to offer specific suggestions that the foundation could take. The committee conducted focus groups with African-American, Brazilian, and Hispanic residents in various communities, and consulted with provider and community stakeholders to identify community assets that could be deployed to eliminate disparities. Its final report concludes with a set of recommendations to assist providers to develop, implement, and evaluate cultural competency and interpreter services; establish information dissemination and programming activities to support community organizing for health and health care advocacy; assist in minority health professional recruitment and retention; establish and support a MetroWest area data collection system on race and ethnicity work group; and establish a communitywide disparities work group (Gibbs and Bitow 2006).

### Challenges for Funders

There is a fundamental tension between the urgency of addressing glaring disparities in access and quality of health care, and a desire to address the underlying social determinants of health such as poverty, racism, education, environment, housing, and neighborhood cohesion. Former U.S. Surgeon General Dr. David Satcher argues that the elements of a successful action plan include multiple components: “universal health insurance, a primary medical home for every

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citizen, proportionate representation of minority populations in health professions, bias-free interventions, nonviolent and exercise-friendly neighborhoods, nutritious food outlets; educational equality, career opportunities, parity in income and wealth, homeownership, and hope” (Satcher 2006).

Much of the work of the last decade, including that of philanthropy, has focused on disparities in care. Some believe that they will more likely see results if their funding is focused on a specific clinical condition or narrow set of quality indicators. Yet, the evidence base for this work is only now emerging. There is still a critical need for further research, model development, and testing “about community-based approaches to advance health promotion and disease prevention in communities wracked by poverty, racism, and other adverse environmental conditions” (Lavizzo-Mourey et al. 2005). Additionally, a Commonwealth Fund-supported study assessing the evidence base for cultural and linguistic competency in health care found that the field is in the early stages of development, with the preponderance of literature defining the concepts and identifying research questions (Goode et al. 2006).

Responding to this need, Robert Wood Johnson Foundation launched two new national programs in 2005. Finding Answers and Leading Change will test and disseminate potential solutions to the poorer quality of health care that patients from certain racial and ethnic backgrounds are more likely to receive. The two programs are working in coordination to identify and implement practical solutions to racial and ethnic disparities in health care, under the guidance of national experts in disparities and quality improvement.

Critics have also noted that “improving the health care system can reduce the effects of health disparities, but can do little to eliminate them” (Bell and Standish 2005). That is, health disparities cannot be addressed unless placed in a broader context of socioeconomic disparities, racism, and cultural empowerment. Those taking this broader view and focusing on community-based strategies are gaining a growing understanding and appreciation of the need for cross-sectoral partnerships to address the broad determinants of health.

The time frame necessary to see results in reducing disparities remains largely unknown, with changes in health behaviors and environmental factors possibly taking years to show results. Moreover, given the complexity of these issues, causal relationships between programs and outcomes cannot be easily determined. A 2005 analysis of rates of high-cost surgical procedures illustrates how difficult and slow change can be. Looking at rates of cardiac artery bypass graft, carotid endarterectomy, and total hip replacement in 158 hospital-referral regions, the authors sought to determine whether efforts in the 1990s to eliminate differences in the use of these procedures according to patients' race were successful. They found no evidence, either nationally or locally, that efforts to eliminate racial disparities in the use of these procedures were successful (Jha et al. 2005). An article published in the same volume of *The New England Journal of Medicine* showed, however, that quality of care for elderly Medicare beneficiaries in managed-care plans improved substantially from 1997 to 2003 for most, but not all, of the quality measures studied (Trivedi et al. 2005).

### Moving Forward

The current state of research on health disparities led one observer to recently write, "it is time to stop documenting disparities and turn our efforts to doing something about them" (Lurie 2006).

Health funders are doing something, but they will likely continue to struggle with how best to accelerate progress to reduce suffering and eliminate the unacceptable

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disparities that plague the nation's population. Moving forward will require dedicated efforts to learn what approaches work best in what circumstances. It will be important to continue to assess and track outcomes of interventions to guide future practice. Sharing results with others in the field of health philanthropy and beyond will help build the evidence base, spread knowledge, and lead to real change in the health of racial and ethnic minorities.

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# Fast Facts

## Increasing Diversity

The U.S. is becoming more racially and ethnically diverse, and future efforts to improve Americans' health will be shaped by important changes in demographics.

In recent decades, the percentage of the population that is Hispanic or Asian has more than doubled.

In 2005, nearly 30 percent of adults and almost 40 percent of children identified themselves as Hispanic, black, Asian, American Indian or Alaska Native, or Native Hawaiian or other Pacific Islander (CDC 2006).

The U.S. Census Bureau projects that by 2050, Hispanics will comprise nearly one quarter of the total U.S. population (U.S. Census Bureau 2004).



## Poverty

People of color are more likely to have family incomes less than 200 percent of the federal poverty level than are whites. Over half of Latinos, African Americans, and American Indian or Alaska Natives are poor or near poor, compared with 25 percent of whites and 32 percent of Asian or Pacific Islanders. The proportion of children who are poor or near poor is even higher (The Henry J. Kaiser Family Foundation 2003).

The overall poverty rate for blacks was 24.9 percent and 21.8 percent for Hispanics in 2005, compared to 8.3 percent for whites (U.S. Census Bureau 2006).



## Life Expectancy

Between 1990 and 2004, life expectancy at birth increased more for the black than for the white population, thereby narrowing the gap in life expectancy between these two racial groups.

In 1990, life expectancy at birth for the white population was 7.0 years longer than for the black population. By 2004, the difference had narrowed to 5.0 years (CDC 2006).



## Infant Mortality

Large disparities in infant mortality rates among racial and ethnic groups continue to exist.

In 2003, infant mortality rates were highest for infants of non-Hispanic black mothers (13.6 deaths per 1,000 live births), American Indian mothers (8.7 per 1,000), and Puerto Rican mothers (8.2 per 1,000); and lowest for infants of Cuban mothers (4.6 per 1,000 live births) and Asian or Pacific Islander mothers (4.8 per 1,000) (CDC 2006).



## Death Rates

Overall mortality was 29 percent higher for black Americans than for white Americans in 2004, compared with 37 percent higher in 1990.

In 2004, age-adjusted death rates for the black population exceeded those for the white population by 44 percent for stroke, 30 percent for heart disease, 23 percent for cancer, and 774 percent for HIV/AIDS (CDC 2006).



## Insurance Coverage

In 2004, persons of Hispanic origin and American Indians under 65 years of age were more likely to have no health insurance coverage at a point in time than were those in other racial and ethnic groups. Non-Hispanic white persons were the least likely to lack coverage (CDC 2006).

The uninsured rate in 2005 for non-Hispanic whites was 11.3 percent (22.1 million) and 19.6 percent (7.2 million) for blacks. The rate for Asians was 17.9 percent (2.3 million).

The uninsured rate for Hispanics, who may be of any race, was 32.7 percent (14.1 million) in 2005.

Based on a three-year average (2003-2005), 29.9 percent of American Indians and Alaska Natives were without coverage. The three-year average for Native Hawaiians and other Pacific Islanders was 21.8 percent (U.S. Census Bureau 2006).



## Usual Source of Health Care

In 2002, Hispanics (32.8 percent), Asians (27.1 percent), and blacks (20.9 percent) were all more likely than whites (15.2 percent) to lack a usual source of care.



Both Hispanic children and non-Hispanic Asian children were more than twice as likely as non-Hispanic white children to lack a usual source of care in 2002 (AHRQ 2006).



### Health Care Quality

The 2005 *National Healthcare Disparities Report* finds that significant disparities between whites and minorities continue, with some signs of improvements.

In measures related to the quality of care, more racial disparities were narrowing than widening.

Despite these trends, blacks received poorer quality of care than whites in 43 percent of the core measures, and American Indians and Alaska Natives received poorer quality of care than whites in 38 percent of measures.

In access to care, there were reductions in most racial disparities affecting blacks, Asians, and American Indians and Alaska Natives. However, this trend has been reversed for Hispanics, where disparities in quality and access to care are growing wider in a majority of areas. Only 41 percent of quality disparities were narrowing for Hispanics, while 59 percent were growing larger.

The report also indicated that disparities were growing for Hispanics in most measures related to access. For example, the quality of diabetes care declined among Hispanic adults as it improved among white adults. In addition, the quality of patient-provider communication (as reported by patients themselves) declined from among Hispanic adults as it improved among white adults. Access to a usual source of care increased more slowly among Hispanics than among whites.

Overall, the *National Healthcare Disparities Report* shows that low-income people, regardless of race or ethnicity, experienced many of the largest disparities health care quality and access. (AHRQ 2006).



### Injuries and Suicide

In 2003, young American Indian males 15–24 years of age continued to have substantially higher death rates for motor vehicle-related injuries and for suicide than young males in other race and ethnicity groups. Death rates for the American Indian population are known to be underestimated (CDC 2006).

### Obesity

Obesity, a major risk factor for many chronic diseases, is occurring in people across all socioeconomic and ethnic groups, although African Americans, Hispanics, and American Indians are disproportionately affected.

Fifty-one percent of black non-Hispanic women age 20 and over were obese in 2001–2004, compared with 39 percent of women of Mexican origin and 31 percent of non-Hispanic white women (CDC 2006).



### Health Workforce

Minorities account for 26 percent of the population, but African Americans and Hispanics compose only 12 percent of the health professional workforce (IOM 2004).



### Sources

Agency for Healthcare Research and Quality, *National Healthcare Quality Report, 2005*, <<http://www.ahrq.gov/qual/nhdr05/nhdr05.htm>> January 2006.

Agency for Healthcare Research and Quality, *Racial and Ethnic Differences in Health Insurance Coverage and Usual Source of Health Care, 2002*, <[http://www.meps.ahrq.gov/data\\_files/publications/cb14/cb14.shtml](http://www.meps.ahrq.gov/data_files/publications/cb14/cb14.shtml)>, March 2006.

Centers for Disease Control and Prevention, *Health, United States, 2006* (Hyattsville, MD: 2006).

The Henry J. Kaiser Family Foundation, *Key Facts: Race, Ethnicity & Medical Care* (Menlo Park, CA: 2003).

Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* (Washington, DC: The National Academies Press, 2004).

U.S. Census Bureau, "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin," <<http://www.census.gov/ipc/www/usinterimproj/>>, March 18, 2004.

U.S. Census Bureau, *Current Population Reports: Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington, DC: U.S. Government Printing Office, 2006).

## Recommended Reading

Agency for Healthcare Research and Quality, *National Healthcare Quality Report, 2006* (Rockville, MD: 2007). Available on-line at <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm>.

The *National Healthcare Disparities Report* examines national disparities in both the ability of Americans to access health care and in the quality of health care. It includes an analysis of disparities related to socioeconomic position as well as to race and ethnicity. The report provides baseline data to measure the effect of national initiatives to reduce disparities, and includes 46 core measures of quality, the same as those tracked in the companion *National Healthcare Quality Report*, along with 13 core measures of access to care.



Agency for Healthcare Research and Quality, *Racial and Ethnic Differences in Health Insurance Coverage and Usual Source of Health Care, 2002* (Rockville, MD: March 2006). Available on-line at [www.meps.ahrq.gov/data\\_files/publications/cb14/cb14.shtml](http://www.meps.ahrq.gov/data_files/publications/cb14/cb14.shtml).

This report presents current estimates of health insurance coverage and usual source of health care services for various racial and ethnic populations, based on data from the Medical Expenditure Panel Survey (MEPS).



The California Wellness Foundation, *Reflections on Increasing Diversity in the Health Professions* (Woodland Hills, CA: 2005). Available on-line at [www.tcwf.org/pub\\_reflections/dec\\_2005.htm](http://www.tcwf.org/pub_reflections/dec_2005.htm).

This report looks at the foundation's grantmaking; offers lessons learned from grants given to academic preparedness programs, research and advocacy efforts, and leadership development programs; and offers some thoughts on areas for future attention.



The Commonwealth Fund, *Cultural Competency: Moving the Agenda Forward* (New York City, NY: 2006). Available on-line at [www.cmwf.org/topics/topics\\_show.htm?doc\\_id=421983](http://www.cmwf.org/topics/topics_show.htm?doc_id=421983).

At the fifth National Conference on Quality Health Care for Culturally Diverse Populations in 2006, The Commonwealth Fund released a series of reports exploring the role of cultural competency in improving quality and outcomes for patients, reducing disparities, and helping patients become more active and engaged in their care.

The reports include:

- Beach, Mary Catherine, Somnath Saha, and Lisa A. Cooper, *The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality*,
- Betancourt, Joseph R., *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*,
- Goode, Tawara D., M. Clare Dunne, and Suzanne M. Bronheim, *The Evidence Base for Cultural and Linguistic Competency in Health Care*,
- Ngo-Metzger, Quyen, Joseph Telfair, Dara H. Sorkin, et al., *Cultural Competency and Quality of Care: Obtaining the Patient's Perspective*, and
- Wu, Ellen and Martin Martinez, *Taking Cultural Competency from Theory to Action*.



Fadiman, Anne, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and the Collision of Two Cultures* (New York, NY: Farrar, Straus and Giroux, 1998).

Award-winning reporter Anne Fadiman turned what began as a magazine assignment into an anthropological exploration of the Hmong population in Merced County, California. Following the case of Lia (a Hmong child with a progressive and unpredictable form of epilepsy), Fadiman maps out the controversies raised by the collision between Western medicine and holistic healing traditions of Hmong immigrants.

Grantmakers In Health, *For the Benefit of All: Ensuring Immigrant Health and Well-Being* (Washington, DC: 2005). Available on-line at [http://www.gih.org/usr\\_doc/GIH\\_Issue\\_Brief\\_24\\_FINAL.pdf](http://www.gih.org/usr_doc/GIH_Issue_Brief_24_FINAL.pdf).

This Issue Brief explores the unique health, social, and policy issues that affect immigrant populations. It looks at attitudes toward immigration and how these influence support for social programs and the provision of public benefits, and highlights philanthropic activities to improve health care access and coverage for immigrants and their families.



Grantmakers In Health, *Erasing the Color Line: Philanthropy's Role in Eliminating Health Disparities* (Washington, DC: 2003). Available on-line at [http://www.gih.org/usr\\_doc/Erasing\\_the\\_Color\\_Line\\_Report.pdf](http://www.gih.org/usr_doc/Erasing_the_Color_Line_Report.pdf).

This portfolio of information and resources on racial and ethnic health disparities contains two-page resources on the following topics: poverty, racism, environmental health, access, healthy behaviors, mental health, workforce diversity, cultural competency, men, women, children, and aging populations.



Grantmakers In Health, *In the Right Words: Addressing Language and Culture in Providing Health Care* (Washington, DC: 2003). Available on-line at [http://www.gih.org/usr\\_doc/In\\_the\\_Right\\_Words\\_Issue\\_Brief.pdf](http://www.gih.org/usr_doc/In_the_Right_Words_Issue_Brief.pdf).

This Issue Brief, based on an April 2003 Issue Dialogue, calls on grantmakers to take a leadership role in shaping the language access agenda to ensure that all individuals have equal access to quality health care.



Grantmakers In Health, *Strategies for Reducing Racial and Ethnic Disparities in Health* (Washington, DC: 2000). Available on-line at [http://www.gih.org/usr\\_doc/Issue\\_Brief\\_5.pdf](http://www.gih.org/usr_doc/Issue_Brief_5.pdf).

This Issue Brief, based on a May 2000 Issue Dialogue, begins by documenting disparities for six health conditions targeted by the federal government and explores some of the underlying causes of health disparities. The

report presents examples of philanthropic strategies, as well as federal and state initiatives, and offers reflection on the challenges foundations are likely to face in working to eliminate health disparities.



The Henry J. Kaiser Family Foundation, *Key Facts: Race, Ethnicity & Medical Care* (Menlo Park, CA: 2003). Available on-line at [www.kff.org/minorityhealth/upload/Key-Facts-Race-Ethnicity-Medical-Care-Chart-book.pdf](http://www.kff.org/minorityhealth/upload/Key-Facts-Race-Ethnicity-Medical-Care-Chart-book.pdf).

This report is intended to serve as a quick reference source on the health, health insurance coverage, health care access, and quality among racial and ethnic minorities in the United States. It highlights the best available data and research, providing a selective review of the literature. It includes sections on the demographic characteristics of the U.S. population, health status, measures, patterns of health insurance coverage, and findings on access to and use of primary and specialty medical care.



Institute of Medicine, *Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business* (Washington, DC: The National Academies Press, 2006).

The *NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities* is intended to provide an overarching structure and coordination for research being conducted by various NIH institutes and centers. This report assesses how well the plan provides needed guidance and recommends ways to improve oversight and coordination of these research efforts.



Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* (Washington, DC: The National Academies Press, 2004).

The report examines institutional and policy-level strategies to increase diversity among health professionals. The report includes an assessment and description of the potential benefits of greater diversity among health professionals and an assessment of strategies that may increase diversity in five areas: admissions policies and practices of health professions education institutions; public sources of financial support for health professions

training; standards of health professions accreditation organizations pertaining to diversity; the institutional climate for diversity at health professions education institutions; and the relationship between community benefit principles and diversity.



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

In this landmark report, a panel of experts presents a consistent body of research that shows significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. The book explores how persons of color experience the health care environment, and how disparities in treatment contribute to health disparities. The report offers recommendations for improvements in medical care financing, allocation of care, availability of language translation, community-based care, and other arenas. The committee highlights the potential of cross cultural education to improve provider patient communication and offers a detailed look at how to integrate cross-cultural learning within the health professions. The book concludes with recommendations for data collection and research initiatives.



LaVeist, Thomas, *Race, Ethnicity, and Health: A Public Health Reader* (Hoboken, NJ: Jossey Boss, 2001).

This compendium brings together articles from the best peer-reviewed research literature. The book provides a historical and political context for the study of health, race, and ethnicity, with key findings on disparities in access, use, and quality.



Lowe, Jane Isaacs and Constance Pechura, "The Robert Wood Johnson Foundation's Commitment to Increasing Minorities in the Health Professions," in Stephen L. Isaacs and James R. Knickman, eds., *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Volume VII* (San Francisco, CA: Jossey-Bass, 2004).

This chapter reviews the strategies Robert Wood Johnson Foundation has pursued to increase the number of minority physicians, nurses, and other health care providers. It discusses the motivation behind this interest, which is to improve access to and the quality of care for minority patients, and includes analysis of the 2003 Supreme Court decisions on affirmative action and their potential effect on programs to increase minorities in the health care workforce.



McDonough, John, Brian Gibbs, Janet Scott-Harris, Karl Kronebusch, et al., *State Policy Agenda to Eliminate Racial and Ethnic Health Disparities* (The Commonwealth Fund: New York, NY, June 2004). Available on-line at [http://www.cmwf.org/programs/minority/mcdonough\\_statepolicyagenda\\_746.pdf](http://www.cmwf.org/programs/minority/mcdonough_statepolicyagenda_746.pdf).

This report provides state policymakers with a menu of policy interventions that have been implemented to address disparities in minority health and health care. The authors divide these state and local programs into those targeting infrastructure, management, and capacity, and those targeting specific health conditions.



Robert Wood Johnson Foundation, *Americans' Views of Disparities in Health Care* (Princeton, NJ: December 9, 2005). Available on-line at [www.rwjf.org/files/research/Disparities\\_Survey\\_Report.pdf](http://www.rwjf.org/files/research/Disparities_Survey_Report.pdf)

In September 2005, the Harvard School of Public Health and the Robert Wood Johnson Foundation conducted a survey to examine the extent to which the American public is aware of racial and ethnic disparities in health. This report provides in-depth information on how Americans view the problem of health disparities, and shows that most of the population does not think that the problem of getting quality health care is any worse for racial and ethnic minorities than it is for white Americans.

Smith, David Barton, *Health Care Divided: Race and Healing a Nation* (Ann Arbor, MI: University of Michigan Press, 1999).

David Barton Smith offers a complete chronicle of racial segregation and discrimination in health care in the United States using vivid first-hand accounts as well as current evidence of inequity in patterns of use and outcomes. Smith details judicial and federal efforts to address these disparities, discusses their persistence in more subtle forms, and offers possible strategies for ending them.



The Sullivan Commission, *Missing Persons: Minorities in the Health Professions* (Chapel Hill, NC: Duke University School of Medicine, 2004). Available on-line at [http://www.amsa.org/advocacy/Sullivan\\_Commission.pdf](http://www.amsa.org/advocacy/Sullivan_Commission.pdf).

The Sullivan Commission on Diversity in the Health-care Workforce released its findings in this report funded by the W.K. Kellogg Foundation. The Sullivan Commission aims to increase diversity in America's health professions education training programs at all levels of preparation, across the country. The report recommends strategies to increase the numbers of students from underrepresented and underserved communities available for service in the nation's health care system.