A CLOSER LOOK

at Racial and Ethnic Health Disparities

Over the last century, advances in medical science have led to substantial improvements in the nation's health. These advances, however, mask the fact that racial and ethnic minorities often fare worse than whites on a variety of health indicators, including mortality, morbidity, and many of the underlying causes of disease. The impact of these disparities will become even more pronounced as the nation becomes more diverse. By 2030, minorities will make up nearly 40 percent of the population.

Developing strategies to reduce health disparities is a complicated task. It requires work to reduce unhealthy behaviors, as well as thoughtful attention to the other factors that affect health, such as:

- the condition of the environments in which racial and ethnic minorities live and work, including the quality of the air and exposure to other environmental hazards;
- the condition of the social environment, including racism and poverty;
- the level of access to care; and
- the structural aspects of the health care delivery system that affect both quality and patient care experiences.

Eliminating or reducing racial and ethnic disparities in health will require the combined efforts of the public and private sectors, including government, business, health care providers, community advocates, and individuals, as well as philanthropy. Success also depends upon attention to nuances: understanding the relationships among race, socioeconomic status, and health; appreciating the complexities of working with different racial and ethnic groups and with intergroup dynamics; and grappling with sensitive subjects, such as racism, power, and privilege. These are daunting tasks, especially as grantmakers are faced with fewer resources and many valid needs. But with so many avenues to explore in both traditional programming and nontraditional measures, any health philanthropy can make a difference.

CLOSING THE DISPARITIES GAP

In 1998, then-President Bill Clinton set an ambitious goal for the nation: eliminate the long-standing disparities in six areas of health status by the year 2010, while continuing the progress made in improving the overall health of the American people. The U.S. Department of Health and Human Services (HHS) assumed leadership in this effort, with the elimination of racial and ethnic health disparities as an overarching goal of *Healthy People 2010*. The Administration's charge inspired efforts across the federal government's portfolio of programs in research, policy, and practice, as well as within other sectors.

EXAMINING RACIAL AND ETHNIC HEALTH DISPARITIES

The following findings from the Centers for Disease Control and Prevention highlight disparities for selected health indicators known to affect multiple racial and ethnic minority groups at all life stages:

- **Cardiovascular Disease:** In 1998, rates of death from cardiovascular disease were about 30 percent higher among African-American adults than among white adults.
- **Diabetes:** The prevalence of diabetes is 70 percent higher among African Americans and nearly 100 percent higher among Hispanics than among whites. The prevalence of diabetes among American Indians and Alaska Natives is more than twice that of the total population.
- **HIV/AIDS:** Although African Americans and Hispanics represented only 25 percent of the U.S. population in 1999, they accounted for roughly 55 percent of adult AIDS cases and 82 percent of pediatric AIDS cases.
- **Immunizations:** In 1999, Hispanics and African Americans aged 65 years and older were less likely than whites to report having received influenza and pneumococcal vaccines.
- **Infant Mortality:** African-American, American Indian, and Puerto Rican infants have higher death rates than white infants. In 1998, the death rate among African-American infants was 2.3 times greater than that among white infants.

Source: Centers for Disease Control and Prevention, "Fact Sheet: Racial and Ethnic Disparities in Health Status," <http://www.cdc.gov/ od/oc/media/pressrel/fs020514b.htm>, accessed September 11, 2003.

Racial and ethnic disparities in health have gained additional attention as a result of the work of the Institute of Medicine, which exposed widespread disparities in the treatment of minorities accessing the health care system in its landmark 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley et al. 2002). Efforts by HHS to close the disparities gap continue. In 2002, the department provided $85 million in grants to augment its *Initiative to Eliminate Racial and Ethnic Disparities in Health* and further the efforts of medical research and community-based programs. In 2003, the department committed $60.5 million to establish eight Centers for Population Health and Health Disparities, designed to support research to understand and reduce differences in health outcomes, access, and care (NIH 2003).

GIH's work to support foundations in their efforts to eliminate racial and ethnic health disparities dates back to 1998, when the organization cosponsored a national leadership conference with HHS that served as a call to action for all sectors to begin reducing disparities. Since then, GIH has continued to focus on disparities as a specific area of work; in addition, this theme is interwoven throughout GIH meetings and publications, even when it is not the primary focus. The 2003 Fall Forum is intended to keep this issue at the forefront of philanthropic discussions about improving the health of the nation. The following timeline highlights some of GIH's efforts:

- **February 1999:** GIH's Annual Meeting on Health Philanthropy focused on social inequalities in health. This gathering explored the roots of these disparities and focused on strategies grantmakers could adopt to address social inequalities in health. Sessions of note focused on grantmaker strategies in the areas of multicultural health, environment and health, community development, and access to care.
- **May 2000:** GIH brought grantmakers, HHS officials, and experts in research and practice together for an Issue Dialogue intended to identify collaborative strategies for reducing racial and ethnic health disparities. The subsequent Issue Brief, *Strategies for Reducing Racial and Ethnic Disparities in Health*, outlines federal, state, and foundation activities that, if implemented, could begin to remove the obstacles that impede minorities seeking even the most basic health care services.
- **February 2001, 2002, and 2003:** GIH's annual meetings for each of these years included sessions addressing health disparities. In 2001, there were sessions focusing on asthma, border health, diversity in philanthropy, and community-based collaborations. The 2002 convening addressed environmental justice, race and aging, underserved men, and interpretation/translation. The 2003 meeting included sessions highlighting HHS' *Healthy People 2010* initiative, immigrant access, HIV/AIDS and border health, palliative care in underserved communities, environmental justice, and the mental health needs of children traumatized by war and violence.
- **April 2003:** GIH convened a group of experts from philanthropy, research, health care practice, and policy to discuss the roles of language and culture in providing effective health care. The subsequent Issue Brief, *In the Right Words: Addressing Language and Culture in Providing Health Care*, describes the consequences of language barriers on health outcomes, provides an overview of relevant laws and policies, and highlights strategies for improving language access for the growing number of individuals who have limited English proficiency.

Over this time period, we have seen growth in the number of foundations heeding the call for action and devoting significant resources to addressing the health needs of minority populations. These efforts to reduce or eliminate racial and ethnic health disparities focus on cultural competency training and education, chronic disease management, and minority underrepresentation in the health professions, among other issues.

ABOUT THIS FOLDER

The enclosed materials provide grantmakers with information on the social determinants and health systems barriers that affect health disparities, as well as population-specific information on health status. The materials are intended to bolster philanthropic efforts in addressing racial and ethnic health disparities by highlighting how foundations are already taking action and providing information on opportunities for grantmakers to get involved. Additional resources on racial and ethnic health disparities provide information on organizations and publications that may be of interest to individuals desiring more information on specific issues or strategies.

Although the enclosed articles were produced for GIH's 2003 Fall Forum, we are hopeful that they will serve as a lasting resource for grantmakers working to improve the nation's health. Other materials relevant to eliminating racial and ethnic health disparities, including GIH's *Issue Brief*, *Issue Focus*, and *Findings* series, are available on-line at www.gih.org.

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ADDRESSING

Poverty

Researchers have long debated the relationship between poverty and health. While poverty is commonly identified as a risk factor for poor health, it is also true that deficits in health both aggravate and perpetuate poverty (Lozano 1997). When considering racial and ethnic disparities in health, the relationships become even more complex as to whether poverty or race exerts more influence. Williams (2000) argues that "Just focusing on race misses the larger picture. The socioeconomic differences between the races account for much of the racial difference that we see in the first place." For example, the gap in health status between high-income African Americans and low-income African Americans is larger than the overall gap between African Americans and whites. Moreover, low-income whites have rates of heart disease that are twice that of high-income African Americans (Williams 2000).

Numerous studies have found a strong linear relationship between socioeconomic status and health. Because health status for groups at the higher rungs of the socioeconomic ladder is consistently higher than for those on the lower rungs, there is an assumption of causality between resources (measured by education, income, occupation, and wealth) and better health (PolicyLink 2000).

People of color are more likely to be on the lower rungs of the socioeconomic ladder and to live in communities where poverty is the norm. For example:

- People of color are more likely than whites to have family incomes less than 200 percent of the federal poverty level. In 2001, this translated into less than $28,256 annually for a family of three (Kaiser 2003).
- Over half of Hispanics, African Americans, and American Indian/Alaska Natives are poor or near poor, compared with 25 percent of whites and 32 percent of Asians and Pacific Islanders (Kaiser 2003).
- White households are generally 10 times wealthier than African-American households – taking into account real estate property, stock portfolios, and inherited wealth. This is true at all equivalent levels of income (Williams 2000).

In the report *Reducing Disparities Through a Focus on Communities* (2002), funded by The California Endowment, a team of analysts from PolicyLink offers a conceptual framework for understanding the effects of the social and economic environment on health, noting that "Neighborhoods that are poor, segregated, less organized socially and politically, and negatively perceived by outsiders tend to be less healthy than those that are higher income and well organized." In response to these factors, the report calls for the creation of community-driven initiatives to strengthen community assets, provision of health services, and linkages between efforts to improve health and those focused on community or regional economic development.

OPPORTUNITIES FOR GRANTMAKERS

Foundations and corporate giving programs have long been funding efforts to reduce poverty and assist low-income populations. While it can be difficult at times for health funders to devise a strategy for taking on large and complex societal issues, such as poverty, investments in reducing poverty have the potential to have profound effects on racial and ethnic health disparities. Funders are supporting activities to promote community development, empower workers, and strengthen community involvement.

➤ **Supporting efforts to promote community development** – As part of its mission to improve the health of the people in Pennsylvania's Lehigh Valley, The Dorothy Rider Pool Health Care Trust has made several grants focused on building social capital and community development. In particular, the foundation funded the Alliance for Building Communities in support of its *Doorway to Home Ownership Program*, which provides affordable housing options to low- and moderate-income families by incorporating a number of local housing initiatives and approaches that provide flexibility in addressing a variety of obstacles to home ownership. The Rapides Foundation, serving a nine-parish area of central Louisiana, recently refined its funding priorities and will be pursuing efforts to build the skills of the local workforce, strengthen community development organizations, and develop the business environment of the region. These funding strategies are built on the notion that improving the overall health of individuals requires investment in both new and existing organizational structures within a community.

- **Supporting activities that empower workers** – The Public Welfare Foundation in Washington, DC, which focuses its grantmaking on a strategy of service, advocacy, and empowerment for meeting basic human needs, has funded many projects that empower low-income workers to fight for basic health and safety protections, as well as better wages and job security. For example, it has funded Asian Immigrant Women Advocates in Oakland, California, for efforts to improve working conditions for high-tech assembly workers (many of whom are immigrants) through community organizing, litigation, and policy advocacy. Its grantee, Center for Popular Education and Community Organizing in El Paso, Texas, is working to educate and organize low-wage and displaced workers to provide input into state and local economic policymaking. It also funded the Labor/Community Strategy Center to facilitate the participation of low-income people in shaping city transit policies to ensure better access to public transportation and jobs in the Los Angeles area.

- **Supporting multipronged efforts to expand economic opportunities and advance health** – The Boston Foundation developed the Boston Community Building Network as an outgrowth of the foundation's previous *Boston Persistent Poverty Project*, which ran from 1989 through 1997 and was originally funded by the Rockefeller Foundation as part of a national initiative. The network works to create opportunities for community residents to strengthen the skills and networks necessary to be full partners in community planning; convene key community stakeholders, including residents, public agencies, nonprofit organizations, and private institutions, to discuss and respond to issues that are important to communities in distress; provide reliable data concerning community change to individuals and organizations at all levels of decisionmaking; and mobilize collaborations to generate and advance goals for local neighborhoods, the city of Boston, and its surrounding area.

  The California Wellness Foundation began its five-year, $20 million grantmaking program, *Work and Health*, in 1995 and continues to support activities based on the premise that work is an important social determinant of health. Under this initiative, the foundation focused its efforts in four areas: creating opportunities for low-income youth to develop computer skills that will help them get jobs that pay well and offer opportunities for advancement; enabling the recently unemployed to regain jobs, while minimizing the deterioration of their health; providing information to key California decisionmakers about the status of health insurance coverage and its strong relationship with employment; and convening groups attempting innovative approaches to expand the availability of health insurance in California. Specifically, 11 community-based technology centers across the state were funded and are now providing technological training to youth from low-income neighborhoods to help prepare them for higher-paying jobs. Also, several thousand unemployed individuals received skills training to help them find new jobs and prevent negative physical and mental health consequences while out of work (Brousseau and Peña 2002).

  The California Endowment and The Rockefeller Foundation jointly fund and operate *California Works for Better Health*, a $16 million program, to support community-based efforts aimed at improving the health of people residing in poor California communities. The initiative works to expand economic opportunities in targeted geographic regions throughout the state. The mission of the program is to increase economic opportunities and improve health by building and strengthening community involvement in local and regional economies. Its central strategy is to connect low-income communities with regional labor markets. Program activities include building region-wide networks for training, job opportunities, and career advancement; supporting entrepreneurship and micro-enterprise; and partnering with private firms, government agencies, and unions to improve employment outcomes for low-income residents. Program efforts will focus on communities in several regions of the state with particularly poor health outcomes, high unemployment, and limited economic opportunity. A segment of the project will include partnering with community organizations throughout the state to create locally tailored health and employment/economic data collection systems, develop data and policy analysis capacity, build networking and organizing skills, and participate in leadership training programs.

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TACKLING Racism

Understanding the nature of race and racism is important to appreciating the roots of health disparities. More than a qualifier or descriptor, it is an underlying condition that restricts participation in society. As 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. Its impact is felt today in both the experiences individuals have in entering the system and the quality of care they receive. Its effects can be seen in the lack of recognition of the importance of culturally sensitive approaches to care in both training and practice and in the evidence of prejudicial treatment decisions that have a negative impact on the health of minorities.

Discrimination in health care mirrors discrimination elsewhere in society. Before the Civil War, slaves on larger plantations received care in slave-administered hospitals; those on smaller plantations may not have received any formal health care. After the war, blacks and other minorities still had problems obtaining health care. Discrimination also affected minorities wishing to practice medicine. Few medical schools accepted black students. Black doctors could only serve black patients, constraining both the opportunities of providers to practice and the supply of health care in black communities. Racism also found its way into research and experimentation, most notoriously in the Tuskegee syphilis experiment, which began in 1932 and lasted 40 years.

Today, minority patients continue to face differences in treatment. After suffering a heart attack, African Americans are less likely than whites to receive diagnostic, invasive, and therapeutic coronary procedures (LaVeist et al. 2000). African Americans, Hispanics, and Asian Americans all report, in numbers higher than the overall population, having a major problem getting specialty care. This is especially true for Asian Americans, among whom more than one-quarter have reported problems getting specialty care. African Americans have been shown to be three times as likely as whites to have a lower limb amputation (most likely due to lack of preventive care for diabetes) and also experience disparities in use of other specialized procedures for breast cancer and hip fractures (Gornick 1999).

The effects of discrimination have left their mark on the industry of health care, but 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 substandard neighborhoods, housing, employment opportunities, education, and health care that many minorities, not just African Americans, face.

The experience of individual discrimination expands when one considers the larger picture of institutionalized racism. The clearest, most pervasive, and most influential example of institutional racism is housing segregation. While the practice of legal segregation began to end more than 40 years ago, many communities remain racially segregated. Concentrating poverty through segregation restricts social networks, dictates the quality of secondary education, and mitigates opportunities for attending college or for employment after leaving school.

DEFINING RACISM

Camara Phyllis Jones (2000) of the Centers for Disease Control and Prevention has developed the following framework for understanding racism on three levels:

- *Institutional racism* refers to differential access to the goods, services, and opportunities of society by race. This term describes how certain policies and structures (for example, those affecting housing, credit, and the environment) systematically confer privilege to whites, while marginalizing people of color.
- *Personally mediated racism* is defined as negative assumptions about the abilities, motives, and intentions of others according to their race and differential actions toward those individuals. This is what most people think of when they hear the word racism. Examples include: a shopkeeper's vigilance, surprise at the competence of a person of color, refusing to provide service, and public avoidance.
- *Internalized racism* is defined as acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth. It is characterized by not believing in themselves and others who look like them, and accepting limitations to their own full potential and self-expression.

The experience of racism may also have a direct effect on health status. For example, Krieger and Sidney (1996) found that systolic blood pressure among working-class black adults was higher among those reporting that they typically accept unfair treatment and had experienced racial discrimination. Those who challenged the unfair treatment had lower blood pressure rates than those who accepted the occurrences as a way of life. It has also been documented that a 1 percent increase in incidence of racial disrespect (measured by a nationwide survey that assessed collective discrimination) is correlated with an increase in 350 deaths per 100,000 African Americans (McKenzie 2003).

OPPORTUNITIES FOR GRANTMAKERS

For foundations with a specific mission to improve the health status of individuals or communities, taking on a broad social issue, such as racism, is not easy. Some grantmakers, however, are confronting racism head on in ways that are consistent with a mission of improving community health and well-being.

- **Supporting research to explain the relationship between racism and health** – The Moses Cone-Wesley Long Community Health Foundation is working with the Partnership Project, an organization in Greensboro, North Carolina working to combat racism. The foundation is funding the first of a three-phase project to research what causes racial and ethnic health disparities in its community. The research framework will include a specific focus on racism and how its effects, both within and outside of the health care system, lead to health disparities. This first phase of the project will focus on developing the research framework and study questions; subsequent phases will include conducting the actual research and disseminating the resulting findings.

- **Supporting activities to eliminate bias and prejudice among young children** – Through the *Miller Early Childhood* initiative, the Quantum Foundation, Inc. in Palm Beach County, Florida has provided over half a million dollars to the Anti-Defamation League to extend its *A World of Difference*® program, currently in 40 Palm Beach schools, to preschool children. The initiative's goals are to help children understand prejudice and bias, recognize bias in themselves, and teach personal responsibility for combatting bias. It also teaches practical and age-appropriate skills for living and working together peacefully in a diverse society. Components include: parent and teacher workbooks, posters and videos, and a media campaign utilizing Sesame Street characters to promote understanding and respect.

- **Supporting convenings to educate stakeholders on the effects of racism** – The *Education Research Advocacy and Support to Eliminate Racism* (*ERASE Racism)* initiative of the New York-based Long Island Community Foundation began in 2001 as an aggressive campaign to identify and address how institutional racism perpetuates social, economic, and political isolation of people of color, with a focus on economic opportunity, housing, health, and public education. *ERASE Racism* includes stakeholder convenings, briefing sessions for local leaders; public education campaigns; identification of public and private policies and practices that perpetuate institutional racism; and suggestions for possible remedies. Similarly, The California Endowment provided funding for a meeting in July 2003 to discuss the relationship between racism and health. This three-day meeting brought together foundation representatives, health experts, community groups, and researchers to begin mapping a national strategy for eliminating racism and its effects on racial and ethnic health disparities.

- **Supporting activities to educate physicians about disparities in health care** – The Henry J. Kaiser Family Foundation and The Robert Wood Johnson Foundation are cofunding a national initiative to raise physician awareness about racial and ethnic disparities in medical care, with a specific focus on cardiac care. The initiative, *Why the Difference*, has three main components: a review of the evidence on racial and ethnic disparities in cardiac care; an advertising campaign in major medical publications; and an outreach effort to engage physicians in dialogue. The goal is to raise physician awareness about the pervasiveness of disparities in treatment and health outcomes and learn from physicians how they think disparities can be eliminated.

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BUILDING a Healthier Environment

Environmental factors, such as air and water quality, exposure to pesticides and toxic waste, and housing conditions, play a major role in human development, health, and disease. Poor air and water quality have been directly associated with diseases such as cancer, asthma, certain birth defects, and some neurological disorders. Many cancers are linked to toxins in the environment, such as dioxin, polychlorinated biphenyls, and mercury. Air-borne particulate matter, tobacco smoke, and ground-level ozone, have been shown to trigger asthma attacks in children. Exposure to lead, found in peeling paint or in the soil and air in many low-income communities, can impair cognitive and behavioral development, lead to low birthweight among infants born to exposed mothers, and cause kidney damage. While these factors affect all racial and ethnic groups, low-income and minority individuals are more likely to be exposed to environmental hazards at home and on the job and, therefore, face much higher health risks.

ENVIRONMENTAL HAZARDS AND MINORITIES

The impact of environmental hazards on communities of color is staggering. For example:

- Over 90 percent of all lead poisoning cases in New York City involve children of color living in 10 key neighborhoods with substandard housing.
- Compared to the general population, a disproportionate number of Latinos, Asian Americans, and Pacific Islanders live in areas that fail to meet the Environmental Protection Agency's standards for air quality.
- Cancer rates are much higher in New York's predominantly Dominican and African-American neighborhoods (Washington Heights and Harlem, respectively) than in more affluent parts of Manhattan.
- Nationwide, asthma death rates are three times higher in African Americans, as compared to whites. Moreover, African-American children have been found to be three times more likely than white children to be hospitalized for asthma and asthma-related conditions, and four to six times more likely to die from asthma.

Source: Shepard, Peggy, West Harlem Environmental Action, remarks at Grantmakers In Health 2002 Annual Meeting on Health Philanthropy, February 27, 2002.

THE ENVIRONMENTAL JUSTICE MOVEMENT

The term, environmental justice, refers to the fair treatment and meaningful involvement of all people with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. Despite overall gains in environmental quality since the 1970s, mainstream environmental policy has neglected, and even exacerbated, environmental health problems in low-income communities of color that often lack the political and economic resources to defend themselves. For example, when ocean dumping was banned in New York, the city transported its sewage sludge (much of which was contaminated or laden with heavy metals) to Sierra Blanca, a small town in Texas that is 80 percent Latino. In essence, the town became the new dumping ground for New York City's trash. In the last 10 years, 200 such sites have been created in the state of Texas (Faber and McCarthy 2001).

Despite these injustices, the overall movement has achieved impressive results over the past 20 years. In low-income towns and communities of color, hazardous waste sites are now being cleaned up, brownfields are being redeveloped, incinerators are being shut down, parks and conservation areas are being established, local pollution threats are being eliminated, cleaner and more accessible means of public transportation are being adopted, and unique habitats and wild lands are being protected. At the national level, the creation of the National Environmental Justice Advisory Council and other federal actions have significantly improved the performance of the Environmental Protection Agency with regard to policy design, implementation, and enforcement.

OPPORTUNITIES FOR GRANTMAKERS

Strategies that focus on improving environmental conditions in communities can have a meaningful effect on eliminating racial and ethnic health disparities by addressing the problem at one of its roots. Grantmakers have supported activities that promote safe housing, improvements in air and water quality, reduced exposure to pesticides and other toxins, and environmental justice.

➤ **Supporting activities that address poor and unsafe housing** – In 2002, the Northwest Health Foundation funded the Josiah Hill Clinic to hire a Spanish-speaking

community outreach coordinator to educate and mobilize Hispanic communities in north and northeast Portland, Oregon, to address lead poisoning hazards in their homes. It funded the Urban League of Portland for similar activities targeting the African-American community. The Moses Cone-Wesley Long Community Health Foundation in Greensboro, North Carolina provided $25,000 to the Greensboro Housing Coalition to identify homes with unsafe and unhealthy conditions that posed health and safety risks, such as lead paint poisoning, rodents, asthma triggers, and carbon monoxide poisoning. Community and volunteer outreach workers were trained to inspect and evaluate 800 homes of low-income residents in Greensboro and then facilitate access to necessary housing repairs. Plans for correction were filed for 75 percent of the homes visited.

Environmental health is one of The California Wellness Foundation's priority areas. Grants are awarded to organizations that provide environmental health education and awareness activities, community organizing to promote environmental health, screening and testing for environmental health exposure, leadership development, and partnerships between public health departments and community-based health programs to improve environmental health. The foundation also funds efforts to inform policymakers and advocate for policies that could improve environmental health among underserved populations. In 2002, the foundation awarded $130,000 to the Inner City Law Center in Los Angeles for core operating support to continue the work of the *Housing for Healthy Families* program, which conducts outreach, health education, leadership development, and community organizing to reduce environmental health hazards related to poor housing.

- **Supporting activities that reduce exposure to pesticides and other toxins** – Pesticides and toxic waste are particularly dangerous to those with high exposure, such as agricultural workers and farmers, a majority of whom are recent immigrants. The California Wellness Foundation awarded $90,000 to the Organización en California de Lideres Campesinas (OCLC) to train women to educate their families and peers about pesticide poisoning, its symptoms, and legal protections for farm workers. Once the women complete the training, they take on the role of promotoras de salud (health promoters) and share pesticide information with their peers through house meetings and other local outreach efforts. To help ensure that participants attend trainings, OCLC provides child care, lodging and food, and a small stipend to help cover lost wages.

- **Supporting activities that promote access to clean air and water** – In response to alarming and increasing rates of asthma and other respiratory conditions in several inner-city neighborhoods, The Boston Foundation provided funding for the *Clean Buses for Boston* initiative, which advocates for the conversion of diesel buses to cleaner alternatives. The initiative mobilized inner-city youth to develop a campaign to reduce hazardous emissions from idling buses that frequent their neighborhoods.

  The Paso del Norte Health Foundation funded a $1.7 million initiative to improve the quality of local drinking water. The program, *When Water Works for Health*, provides school-based education and community-based outreach efforts to address problems with sanitation and purification of drinking water. This initiative was one of several investments the foundation has made to improve conditions in communities lacking access to running water and sanitation. Others include funding for the installation of water tanks in homes without running water; outreach workers to teach community members how to purify and protect their drinking water; and collaborative efforts with local officials to connect unincorporated areas.

- **Supporting activities that promote environmental justice** – Sometimes, the most effective environmental health advocates are those who come from the affected communities themselves. Often, these individuals are not trained as environmental scientists, policymakers, or lawyers. In fact, more than 70 percent of the people in local environmental justice groups have never been involved in the community before. Foundations can offer credibility and confidence by partnering with these individuals to develop the skills they need. The San Francisco Foundation is doing this through its *Environmental Health and Justice Initiative*, a five-year project that focuses on critical environmental health and justice concerns in the San Francisco Bay Area. The initiative consists of informational briefings and events, an annual round of grantmaking, and technical support services. Similarly, through its *Environmental Justice Fund*, the Liberty Hill Foundation in Los Angeles, California has partnered with Communities for a Better Environment, an environmental health organization that empowers inner-city residents to participate in the local policymaking process. Funding supported work that successfully closed a toxic chrome-plating facility located next to an elementary school and mitigated the respiratory health impacts of concrete rubble in a residential neighborhood.

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IMPROVING Access

Millions of Americans – disproportionately those of color – do not have access to needed health care services. Racial and ethnic minorities are less likely than whites to have a usual source of care, less likely to make visits to any provider, more likely to receive late prenatal care, and more likely to postpone care for HIV/AIDS. The impact of racial and ethnic disparities in access to care will become more profound as the nation becomes more diverse. Today, racial and ethnic minorities make up approximately one-third of the U.S. population. By 2050, it is estimated that almost half of the population will be African American, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native (Kaiser 2003).

INSURANCE DISPARITIES EXIST

Much of the public debate has focused on lack of insurance coverage as a barrier to access. The uninsured are more likely to report not having a usual source of health care and, as a result, often do not receive regular preventive and primary care. Uninsured adults, for example, are less likely than those with insurance to be screened for cancer, cardiovascular disease, and diabetes. The uninsured also tend to receive smaller amounts of therapeutic care, including prescription drugs and surgical interventions (Families USA 2003).

According to the Census Bureau, 43.6 million Americans did not have health coverage in 2002. Although public coverage for low-income children and families expanded during the 1990s, some populations, such as adults with no dependents and undocumented immigrants, remain largely uncovered. The recent economic downturn also raised concerns due to losses of employer-sponsored coverage, as a result of both unemployment and rising premiums; and state budget crises that are leading to limits on the scope and availability of Medicaid and State Children's Health Insurance Programs.

Racial and ethnic minorities are less likely than whites to have health insurance. In 2002, 52 percent of Hispanics and 39 percent of African Americans did not have health insurance, compared to 23 percent of whites (Families USA 2003). Overall, people of color account for a little over half of the uninsured, even though they comprise only 33 percent of the nonelderly population (Kaiser 2003).

DIFFERENCES IN ACCESS TO DIAGNOSIS, TREATMENT, AND SERVICES

Disparities in access cannot be wholly explained by differences in income and health insurance coverage. In an analysis of nationally representative medical expenditure panel surveys, researchers at the federal Agency for Healthcare Research and Quality (AHRQ) found that one-half to three-fourths of the disparities observed remained even after controlling for insurance and income status (Weinick et al. 2000).

Results from The Commonwealth Fund's 2001 Health Care Quality Survey (2002) reveal access barriers across a number of measures. For example, minority adults are more likely to receive care in a hospital or health center and less likely to have a regular doctor. Specifically, the survey found that 13 percent of African Americans and 14 percent of Hispanics usually visit the emergency room for care or that they do not have a usual source of care. They are also less likely to feel that they have a choice in where they receive care. The survey found that 28 percent of Hispanics, 24 percent of Asian Americans, and 22 percent of African Americans said they have very little or no choice in their source of health care, compared to 15 percent of whites.

Racial and ethnic minorities are less likely to receive appropriate diagnostic interventions and also less likely to receive appropriate treatment. For example, research funded by AHRQ found that the length of time between abnormal mammogram results and follow-up tests is more than twice as long for African-American, Hispanic, and Asian-American women than white women. Another study reported that African Americans are 13 percent less likely to undergo coronary angioplasty and one-third less likely to undergo bypass surgery than are whites (AHRQ 2000).

Minority patients report having problems accessing specialty medical care. For example, while 11 percent of the total population reports having a major problem getting specialty care, 16 percent of African Americans, 22 percent of Hispanics, and 26 percent of Asian Americans report major problems. Disparities also exist in the use of specialized procedures, such as those for hip fracture, among African-American patients (GIH 2000).

OPPORTUNITIES FOR GRANTMAKERS

Grantmakers can play an important role in increasing access to health services for racial and ethnic minorities. By focusing support on programs that break down barriers to care, foundations can help enhance understanding of how and why disparities occur, improve the health status of racial and ethnic minorities, and advocate for an improved and culturally competent health care delivery system. Following are a few of the many examples

of what foundations are doing to improve access to care.

- **Funding research and dissemination of findings** – Working at the national level, The Commonwealth Fund awarded a $155,000 grant in 1995 to Columbia University's Health Services Division for research on disparities in the use of health services and in health status among diverse groups of elderly Americans. Using data from the Medicare Current Beneficiary Survey, researchers analyzed indicators of access to high-quality preventive and primary care, including screening, mammograms, and preventable hospitalizations. The findings demonstrated that the inability to pay a share of the costs of care limits the extent to which women take advantage of Medicare's coverage of mammograms. Factors affecting avoidable hospitalizations among the insured and whether the duration of provider-patient relationships influenced the cost and use of health care services were also assessed.

  More recently, The Commonwealth Fund awarded an $86,265 grant to the National Hispanic Medical Association to bring together leaders from business, health care, government, and nonprofits to learn about findings from the latest research in the area of racial and ethic disparities in health. The meeting also helped the foundation reach new audiences and provided a venue for exploring public-private initiatives to improve Hispanics' health coverage and access to culturally appropriate care.

  At the state level, the Endowment for Health supported the New Hampshire Area Health Education Center and Dartmouth Medical School to develop and analyze a series of economic, social-cultural, and geographic indicators for access barriers to primary care services within New Hampshire primary care service areas (geographic areas directly related to primary care utilization patterns in the state). Results were disseminated through the New Hampshire Department of Health and Human Services and in research papers to assist in reducing disparities in the availability and utilization of primary care services.

- **Improving delivery of health care services** – Whether providing core support or funding new programs, foundations can play an important role in increasing access to health care services for diverse populations. In 2000, Kaiser Permanente – Mid-Atlantic States awarded $25,000 to support a bilingual Hispanic outreach coordinator at The Women's Center in Vienna, Virginia. The coordinator is the first point of contact for Hispanic persons seeking health and other services. An additional grant of $12,500 was awarded in 2001 to support the coordinator. Healthcare Georgia Foundation, Inc. provided $80,000 in operating support to the Good News Health Center. The grant was used to improve the center's ability to absorb a 25 percent annual increase in the multicultural, multiracial, and multilingual patient population in Gainesville and Hall County, Georgia.

  As part of its larger body of work to break down racial and ethnic barriers to care, The California Endowment supported the Los Angeles Eye Institute, an organization seeking to address the eye health needs of residents of South Central Los Angeles. Grant funds were used in the planning phase of a new eye care clinic. The foundation also supported a demonstration project through the institute's diabetes center, which utilizes mobile vans and clinic-based screenings to detect and treat diabetes-related vision problems. The foundation's grants have helped the institute increase the number of patient visits to 20,000 annually and to reduce the waiting period for an eye care appointment.

- **Supporting advocacy and consumer education/ navigation** – There are opportunities for funders of all types to support patient education and empowerment. For example, Blue Cross and Blue Shield of Minnesota Foundation awarded $85,300 to ARC Hennepin-Carver to support multicultural outreach. The program links people from diverse cultures who have mental retardation or related conditions with services to meet their health care, housing, and employment needs. The grant enabled ARC to develop tools in Spanish, Somali, and Hmong describing services available under the state's Mental Retardation and Related Conditions Medicaid Home and Community-based waiver program for children and adults.

  The California Wellness Foundation provided a $200,000 grant to the California Pan-Ethnic Health Network (CPEHN) to support efforts to advance policies that improve health care access and utilization among underserved ethnic communities. Representing health-focused organizations serving communities of color, CPEHN works to ensure that the state's Medi-Cal and Healthy Families programs provide culturally and linguistically competent care to enrollees and to ensure that commercial health plans pay for and provide appropriate care to their members.

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PROMOTING
Healthy Behaviors

Healthy behaviors – such as eating a nutritious diet, getting regular exercise, and avoiding tobacco – can prevent or delay the development of many chronic diseases, including heart disease, lung disease, some cancers, and type 2 diabetes. Chronic diseases are the leading causes of death and disability in the United States, accounting for 7 out of every 10 deaths and untold amounts of pain and suffering for individuals and their families (HHS 2000).

Many chronic diseases affect members of racial and ethnic minority populations at rates that exceed those for whites. For example, African Americans are more likely to die from heart disease, stroke, and cancer than are whites. Deaths from diabetes are also significantly higher for African-American, American Indian/Alaska Native, and Hispanic populations than for whites (HHS 2000).

These differences stem from disparities in insurance coverage and access to medical care, as well as differences in behavioral risk factors among populations. Rates of physical activity are lower among African Americans and Hispanics, for example. Tobacco use is also higher among minorities. American Indians and Alaska Natives have the highest rate of smoking of all racial and ethnic population groups and are almost 50 percent more likely to smoke than the population generally. Cultural differences in dietary patterns can also contribute to the development of chronic disease (HHS 2000).

Obesity, which raises the risk of developing chronic disease, is also more common among members of racial and ethnic minority groups. Almost 30 percent of African-American adults and about one-quarter of Hispanic adults are obese, compared to 18 percent of white adults (HHS 2000).

OPPORTUNITIES FOR GRANTMAKERS

Health grantmakers can play an important role in encouraging the adoption of healthy behaviors across the lifespan. Chronic illnesses often have their roots in behavior patterns that are established in childhood, making children and youth a prime target for programs aimed at instilling healthy habits and behaviors. Even for adults, however, prevention programs, health promotion programs, and other interventions are important: the adoption of healthier behaviors by adults with or at risk for chronic disease can prevent or delay disease development and enhance quality of life. Regardless of the age group targeted, interventions will be more effective if they are tailored to the cultural and social contexts in which people live.

- **Funding programs targeting children and youth** – Grantmakers can achieve a substantial return on their investment by reaching children and youth early, before unhealthy behaviors are adopted. This strategy is particularly important in targeting such issues as tobacco use, as most people who become regular smokers first try a cigarette by the age of 20 (HHS 2000). Among the grantmakers that work to keep youth tobacco-free are: the American Legacy Foundation, which funds a wide range of prevention and tobacco cessation programs for underserved populations, including racial and ethnic minorities; and the Moses Cone-Wesley Long Community Health Foundation, which funded a local chapter of the NAACP to incorporate a tobacco use prevention program into after-school programs and summer camps.

  Other foundations target physical activity and nutrition to get young people started on the road to a healthy adulthood. The California Endowment, The California Wellness Foundation, and The Robert Wood Johnson Foundation fund the *California Adolescent Nutrition and Fitness (CANFit) Program*, which works with communities to build their capacity to improve the nutrition and physical activity status of low-income youth from California's African-American, American Indian, Hispanic, and Asian and Pacific Islander populations. Among the efforts supported by *CANFit* are ethnic group-specific community assessments, a Cambodian recipe book, an American Indian surf camp, and activity leagues for African-American and Asian and Pacific Islander girls, as well as culturally and linguistically appropriate social marketing campaigns.

- **Supporting programs that motivate adults** – By adulthood, many behaviors and habits are well-ingrained. As a result, grantmakers interested in fostering healthier behaviors among adults need to focus on helping them develop the skills and motivation to change their unhealthy behaviors. The Mary Black Foundation, Inc. supported *HeartWise*, a program designed to improve cardiovascular health by helping people become more physically active. The program provided mini-grants to African-American churches in South Carolina to support the organization of physical fitness programs for their congregations. To address the

disproportionate toll that diabetes takes on minority communities, the Northwest Health Foundation funded a diabetes program aimed at the Paiute tribal community in Oregon that included a prevention and health promotion component, along with disease management and other services. With a focus on prevention and wellness, this program will integrate mainstream medical practices with elements of traditional Paiute culture.

Health grantmakers are also supporting tobacco cessation programs aimed at adults. Along with the American Legacy Foundation, grantmakers supporting community-based tobacco cessation programs aimed at adults include the Blue Cross and Blue Shield of Minnesota Foundation and the Columbus Medical Association Foundation. The Blue Cross and Blue Shield of Minnesota Foundation supported a tobacco reduction and prevention program targeting that state's Vietnamese community, while the Columbus Medical Association Foundation collaborated with Ohio's Commission on Minority Health to help community-based agencies serving African Americans to develop smoking cessation models.

- **Supporting programs for older adults** – Health grantmakers know that it is never too late to adopt healthy behaviors. In one example, the Michael Reese Health Trust provided funding to promote healthy, independent living for vulnerable Chinese seniors through therapeutic activities; support services; and monitoring of nutritional, physical, and mental well-being. In another example, the Palm Healthcare Foundation supported the *Each One, Reach One* program, which seeks to identify African-American seniors at risk for diabetes, educate the community about the risk of diabetes and its effects, and provide appropriate interventions. The grantee is collaborating with a network of churches to accomplish the project's objectives.

  Obesity among older adults is a growing concern. While rates of overweight and obesity are climbing for all age groups, the rate of obesity among adults ages 51 to 69 is the highest of any age group (Center on an Aging Society 2003). Older adults who are obese are more likely to experience serious disabilities and activity limitations than those who are not obese. Health grantmakers are tackling this and related issues, and are working to promote active and healthy lifestyles among older adults. The Missouri Health Foundation, for example, supported an exercise program for disadvantaged elderly to improve their health and decrease heart risk factors. The California Endowment provided funding to adapt a successful exercise promotion program developed by the National Institute on Aging to an ethnically diverse community of seniors in San Francisco and San Mateo counties. The project was designed to increase awareness about the benefits of physical activity while motivating and helping older adults to create exercise regimens for themselves.

- **Supporting multigenerational initiatives** – Recognizing that promoting behavior change requires multifaceted and sustained intervention, many foundations have implemented major initiatives targeting populations across the lifespan. To help primary care providers address unhealthy behaviors among their patients, The Robert Wood Johnson Foundation, working with the federal Agency for Healthcare Research and Quality, has launched a five-year initiative to support strategies of changing unhealthy behavior through primary care. *Prescription for Health* will award grants to primary care practices for identifying ways in which primary care physicians and their staff, including nurse practitioners and physician assistants, can help their patients avoid or quit smoking, become more physically active, eat better, and use alcohol in moderation. Several of the grants awarded through this initiative focus on reaching underserved populations with education about healthy behaviors, as well as counseling and support for behavior change.

  The Kate B. Reynolds Charitable Trust in Winston-Salem, North Carolina is another foundation that implemented a major initiative, *Project SELF Improvement*, focused on preventing chronic disease. The initiative is targeting low-income communities, including racial and ethnic minority populations, with information about the importance of smoking prevention, exercise, and improved nutrition. Grants have funded a range of activities, including school-based education efforts, peer health educators, and lay health advisors in churches. The foundation intends to create low-cost replicable models for community-based prevention programs built through collaborative efforts.

  Other foundations are also taking a multigenerational approach. For example, The Rapides Foundation in Alexandria, Louisiana is supporting an initiative that funds community groups, service providers, and academic or faith-based institutions to implement projects that promote healthy behaviors. Funded projects utilize health education curricula, peer education, teen advocacy, and behavioral alternatives. The GlaxoSmithKline Foundation in Philadelphia supports the Health Promotion Council of Southeast Pennsylvania to operate health education programs focused on youth and adults in African-American, Latino, and Asian communities. The program supports health communications, prevention, and disease management activities. The program has achieved a 65 percent reduction in illegal tobacco sales to teens and an 85 percent graduation rate in its program to combat hypertension and diabetes.

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RESPONDING

to Mental Health Needs

Mental disorders are among the most common of the chronic diseases affecting the U.S. population, affecting an estimated one in five people. Racial and ethnic minority communities have similar rates of mental disorders as the general population. And like the population as a whole, the most common conditions among racial and ethnic minorities include depression, bipolar disorder, schizophrenia, and anxiety disorders (HHS 2001).

For any particular individual, the likelihood of developing a mental disorder depends on the presence and interplay of risk factors and protective factors, both of which may be biological, psychological, or social in nature (HHS 1999). Although individuals from racial and ethnic minority groups frequently benefit from protective factors such as spirituality and strong family support, they disproportionately face social and economic environments that expose them to higher levels of stress and other deleterious experiences due to poverty, unemployment, violence, trauma, and discrimination (HHS 2001). Minority groups are also overrepresented in populations vulnerable to mental health problems, such as the homeless, immigrants and refugees, incarcerated individuals, and children in foster care.

The cultural contexts in which people live influence the way they define and experience mental health and mental illness. Cultural factors can influence whether people seek care for their symptoms; what kind of care they seek; and whether they seek care from primary care providers, specialty mental health providers, clergy, or traditional healers. Cultural factors can also influence how symptoms are reported, as people seek to express or present symptoms in culturally acceptable ways. For example, Asian patients are more likely to report physical symptoms associated with mental health problems, while not reporting emotional symptoms unless questioned further.

Because of cultural factors and the significant barriers to care that they face, racial and ethnic minorities are less likely to seek mental health treatment, and some groups are more likely to delay treatment until symptoms are more severe. Studies also suggest that members of most minority groups typically receive poorer quality of care (Smedley et al. 2002). For example, African Americans with schizophrenia are less likely to receive appropriate care and medications than their white counterparts (Lehman 1999). As a result, racial and ethnic minorities bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity (HHS 2001).

CULTURALLY COMPETENT MENTAL HEALTH CARE

According to the *Diagnostic and Statistical Manual of Mental Disorders*, providing culturally competent mental health services means that providers must:

- inquire about patients' cultural identity;
- explore possible cultural explanations of the illness;
- consider cultural factors related to the patient's psychosocial environment and levels of functioning;
- critically examine cultural elements in the patient-clinician relationship to determine differences in culture and social status and how those differences affect the clinical encounter; and
- synthesize all of the information to render an overall cultural assessment for diagnosis and care.

Source: U.S. Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General* (Washington, DC: 2001).

OPPORTUNITIES FOR GRANTMAKERS

America's racial and ethnic minority communities are diverse, and each group and subgroup has its own history, language, religious beliefs, spiritual practices, and cultural beliefs. This growing diversity is challenging the mental health system and its providers to adapt and reduce barriers to appropriate and timely mental health care for members of racial and ethnic minority groups. A landmark report on mental health and culture, race, and ethnicity issued by the U.S. Surgeon General in 2001 outlined strategies for eliminating mental health disparities, including improving access, reducing barriers to treatment, and building the system's capacity to serve minority populations (HHS 2001). There are opportunities for grantmakers in advancing each of these strategies.

➤ **Improving access** – Mental health services and mental health providers are frequently scarce in minority neighborhoods. Health grantmakers are working to address this by increasing the number of mental health programs designed specifically for minority populations. As a foundation focused solely on mental health issues, the Hogg Foundation for Mental Health has

funded a wide array of projects aimed at increasing access to mental health services for Texas' Hispanic and other minority populations. Grants have ranged from funding for mental health outreach to minority groups to case management services for vulnerable populations to new program development tailored to the needs of minority communities. In another example, the Endowment for Health helped initiate a program in Nashua, New Hampshire to increase mental health care for the Latino community. The program, an expansion of services provided in a neighboring town, provided outreach and education about mental illness and incorporated cultural competency outreach to mental health providers. In response to the move to managed behavioral health care by both public and private insurance plans, The New York Community Trust funded the operation of a Latino behavioral health managed care plan, giving people access to qualified, culturally competent mental health providers.

Other grantmakers are building on existing programs and service providers to improve access to mental health services for minority communities. In California, the Alliance Healthcare Foundation supported a program that enhanced the capacity of public and private mental health facilities and their staffs to provide appropriate mental health services to immigrants and refugees from East Africa. The Fan Fox and Leslie R. Samuels Foundation participated in a public/private partnership between the New York City Department of Aging and two local mental health organizations to help local senior centers offer a range of therapeutic mental health services either on-site, at nearby mental health clinics, or in the seniors' homes.

- **Reducing barriers to treatment** – Members of racial and ethnic communities, particularly those new to this country, can face significant language and cultural barriers to mental health care. To reduce language barriers, the William T. Grant Foundation funded the development of a Spanish language version of the *Child and Adolescent Psychiatric Assessment*, an interview-based survey that allows a trained interviewer to make developmental and cultural judgments about psychiatric symptoms, while the Hogg Foundation for Mental Health funded the translation of a mental health screening tool for use with refugees speaking Arabic, Serbo-Croatian, Spanish, and Vietnamese.

  In other efforts to remove language barriers, the Northwest Health Foundation supported a bicultural, bilingual interpreter for an Oregon university's mental health clinic to improve services to children, adolescents, and families of Southeast Asian origin, while the Michael Reese Health Trust supported a program that expanded access to comprehensive bilingual mental health services in Chicago and created a unified service delivery system for Spanish-speaking individuals with severe and persistent mental illness. Brandywine Health & Wellness Foundation provided support that enabled a community health center to enhance its counseling services by providing a master's level bilingual/bicultural Latino counselor to work one full day a week.

  Other grantmakers are removing barriers by supporting mental health outreach and education efforts tailored to specific communities. For example, Kaiser Permanente – Mid-Atlantic States supported efforts to educate elderly African Americans about mental health issues and mental illness and improve their access to mental health services. The John Muir/Mt. Diablo Community Health Fund supported outreach and mental health services for Latino families, focusing on issues arising out of unemployment, parenting challenges, loneliness and depression, drug and alcohol abuse, and cultural and linguistic isolation. The program was designed to combat a cultural taboo against sharing personal issues outside the family.

- **Building the capacity of the mental health system to serve minority populations** – Because diagnosis and treatment of mental disorders depends on verbal communication to a greater degree than for physical disorders, differences between providers and clients in culture, language, beliefs, and life experiences create a greater risk of miscommunication and misunderstanding (Smedley et al. 2002). One way to address this is to develop a more diverse workforce, drawn from populations that share the socioeconomic, cultural, and language backgrounds of patients. To encourage minorities to consider careers in mental health, The Healthcare Foundation of New Jersey supported internships for minority graduate students at a mental health clinic. To increase the number of Hispanic providers, the Northwest Health Foundation supported a coordinator to recruit, mentor, and tutor Hispanic persons studying to become mental health/chemical dependency professionals.

  In another approach to capacity building, the Hogg Foundation for Mental Health worked to increase minority voices in the governance of organizations providing mental health and related services. The foundation awarded funds for a program to help recruit and train minority volunteers to serve on the boards of community-based organizations, especially those serving people with mental illness.

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INCREASING

Workforce Diversity

The supply, mix, and competency of the health workforce are important ingredients in maintaining and improving the health of individual patients and broader populations. One measure of inequity between the current workforce and population need is the lack of racial and ethnic diversity among health professionals. While minorities make up one-quarter of the nation's population, with this share projected to grow to nearly a third by 2010, they account for less than 10 percent of the health workforce.

- In 2002, underrepresented minorities (defined as African Americans, Mexican Americans, and mainland Puerto Ricans) accounted for only 11.2 percent of enrollees in allopathic medical schools (AAMC 2002).
- While the number of minority nurses has nearly tripled since 1980, only 13.4 percent of all registered nurses are minorities (Spratley et al. 2000).

THE ISSUE

Increasing diversity in the health workforce matters for reasons of access, quality, and equity. Minority populations are more likely to live in areas with chronic workforce shortages. Although the notion of training minorities primarily to treat minorities is problematic, a consistent body of research indicates that African-American and Hispanic physicians are more likely to provide services in underserved and minority communities and are more likely to treat low-income and sicker patients (Smedley et al. 2001). Second, a more diverse workforce may help ensure that minority populations receive care in settings they trust and in ways that respect cultural values and beliefs. Although the link between diversity and health outcomes is unclear, for some minority patients, having a minority physician results in better communication, greater satisfaction with care, and greater use of preventive services (Smedley et al. 2001). A diverse educational environment also builds the strength and understanding of nonminority students and better prepares them to become successful professionals in a diverse society (Cohen et al. 2002). Finally, fairness and equity demand that minorities be afforded equal access to economic and professional opportunities, and that the vehicles for gaining access to these opportunities recognize personal aptitude for performance as clinicians.

Progress to improve minority representation has been slow for several reasons, including inadequate preprofessional education; the high costs of tuition; and institutional policies and environments, such as inflexible admissions policies, lack of mentors, and lack of faculty. The length of the professional training is another limiting factor; changes in K-12 and professional education are both desperately needed, but reforms will take years to pay off.

OPPORTUNITIES FOR GRANTMAKERS

Health grantmakers are taking a variety of steps to improve diversity in the health professions.

➤ **Strengthening and expanding pipeline programs** – Pipeline programs focus on expanding the pool of potential applicants and on strengthening academic preparedness. These strategies may require partnership with school systems and private funders focused on education. The California Wellness Foundation, for example, is providing support for the *Stanford Medical Youth Science Program* (*SMYSP*), an intensive residential program for high school students. During a five-week period, participants take classes in basic sciences, public health, and preventive medicine, as well as gain internship experience. The Columbus Medical Association Foundation has funded the work of the Blue Chip Training Academy, which provides at-risk, African-American teens with role models to encourage interest in medical careers. The Robert Wood Johnson Foundation (RWJF) has long supported the *Minority Medical Education Program*, a six-week preparation course for high school students at 12 medical school sites. Core elements include: academic enrichment in premedical courses, such as chemistry, biology, physics, and math; coursework in problem solving and critical reading and writing; test-taking techniques and preparation for the Medical College Admission Test; and clinical experiences. An evaluation of the program found that it enhanced the probability of medical school acceptance for both those with high and low grades and test scores.

➤ **Providing financial incentives for minority students and to institutions committed to minority advancement** – The California Wellness Foundation is supporting an effort

by the California Rural Indian Health Board to recruit and retain Native American students; the grantee is offering scholarships, building relationships with educational systems, assessing program staffing needs at its member clinics, and building an Internet database of qualified Native American health providers as a recruiting tool. Other foundation-funded efforts include grants from The HealthCare Foundation for Orange County to the University of California at Irvine to increase the diversity of students in the family nurse practitioner program, and from the Lancaster Osteopathic Health Foundation to fund scholarships for students interested in careers in osteopathic medicine.

- **Supporting the professional development of those already in the health workforce** – The term, pipeline, suggests one entry point to training with a terminal point at which one is discharged into practice. In fact, the pipeline can be conceived of as having multiple entry points. Allied health workers, for example, are a potential pool for registered nurses. The HealthCare Foundation for Orange County made its largest grant ever for an effort to tap into this pool, after a community needs assessment indicated that cultural and linguistic factors present a barrier to care. Under the grant, the Anaheim Memorial/St. Joseph Hospital project teamed with the Regional Health Occupations Resources Center and colleges countywide to place existing entry-level minority health workers in local training programs, to upgrade their skills, and to prepare them for positions as technicians and emergency nurses. The hospitals committed to offering the workers work release time and mentoring. The Commonwealth Fund and the W.K. Kellogg Foundation are both supporting major efforts to improve minority representation in public health, health policy, and health services research, funding individual scholars and providing institutional support to universities and colleges.

- **Promoting faculty development** – Minority faculty have an important influence on both the number and quality of minority students. But current numbers (only 4.8 percent of full-time medical faculty members are minorities) are insufficient. RWJF's *Minority Medical Faculty Development Program* seeks to increase the number of minority faculty within the senior ranks of academic medicine who will encourage and foster development of succeeding classes of minority physicians. The program offers postdoctoral research fellowships to minority physicians who have demonstrated superior academic and clinical skills and who are committed to careers in academic medicine. A 1995 evaluation found that the program has played a "seminal role" in developing the careers of talented minority medical school faculty members.

- **Implementing multifaceted strategies** – Several funders are combining strategies to maximize their effectiveness in improving diversity. Under its workforce diversity priority area, The California Wellness Foundation is funding: pipeline programs, scholarships, mentoring, and internships and fellowships that advance career opportunities for people of color, including allied health and public health professions. Grants are also available to organizations that support minorities in the health professions through strategic partnerships, leadership development, continuing education, and networking activities, as well as organizations that educate policymakers about public and institutional policies that promote health workforce diversity. The California Endowment has committed $10 million over three years to an effort to address the nursing shortage in the state's Central Valley. The initiative includes funding for scholarships, an effort to build the capacity of the region's nursing education programs, advocacy efforts, a regionally focused communications and marketing campaign to promote positive images of the nursing profession, and intensive technical assistance on cultural competency issues to all initiative grantees.

Projects funded by The Josiah Macy, Jr. Foundation include efforts with eight medical schools in New York to improve the qualifications of minority students who narrowly missed medical school acceptance; to strengthen training efforts at the City University of New York that prepare students for careers providing primary care in the city's underserved communities; and to study the impact of public and institutional policies on diversity in U.S. medical schools. Finally, the W.K. Kellogg Foundation has committed $3.6 million to an initiative that includes a blue ribbon commission chaired by former Health and Human Services Secretary Louis Sullivan; a study by the Institute of Medicine; and an effort to galvanize communities around efforts to make medical education more responsive to communities in terms of admissions, curriculum, and service.

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STRENGTHENING
Cultural Competence

The demographics of the nation are changing. People of color make up nearly a third of the U.S. population (Kaiser 2003). Over the past decade, the foreign-born population increased 44 percent, and over 300 languages are now spoken in the United States (U.S. Census Bureau 2002). This growing diversity is challenging health professionals and institutional providers with how to address the needs of populations with diverse languages and distinct cultural perceptions of health; the body; the nature of certain diseases; and relationships among patients, families, and healers. Public policy and private efforts by nonprofit organizations, health care systems, and foundations have made some progress in confronting these problems and providing resources for action, but more remains to be done.

The term, cultural competence, has been used broadly to describe an array of activities that improve the ability of health systems and clinicians to deliver appropriate services to all patients. Although the literature linking specific actions to improvements in health outcomes is still developing, strong patient-provider relationships are known to increase patient satisfaction and a patient's willingness to access health care services. For example, a consistent relationship with a primary care provider may alleviate minority patient mistrust of health care systems and providers, particularly if the provider is able to address cultural and linguistic needs. This results in higher patient satisfaction, stronger understanding of treatment guidelines, and potentially better health outcomes (Smedley et al. 2002).

Brach and Fraser (2000) offer a conceptual model suggesting that improved cultural competence in health care could overcome barriers to care by improving clinician/patient communication, increasing trust between clinicians and patients, creating greater knowledge of differences among racial and ethnic groups in epidemiology and treatment efficacy, and enhancing understanding of patients' cultural behaviors and environment. For example, interpreter services could result in more accurate medical histories and lead to a reduction in diagnostic errors and unnecessary testing. Also, harmful interactions between prescribed drugs and folk or home remedies could be avoided by training clinicians to ask patients whether they use such remedies. Finally, health promotion and education materials that reflect culture-specific attitudes and values could result in more successful patient education and increased adherence to treatment regimens.

Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency (Betancourt et al. 2002).

OPPORTUNITIES FOR GRANTMAKERS

Brach and Fraser (2000) identify nine major cultural competence techniques in health care:

- providing interpreter services,
- having recruitment and retention policies for minority staff,
- offering training,
- coordinating with traditional healers,
- using community health workers,
- practicing culturally competent health promotion,
- including family/community members in caregiving,
- immersing health care providers into another culture, and
- making administrative and organizational accommodations.

Health grantmakers can play an integral role in supporting these approaches, as well as other promising programs and interventions. While the research linking cultural competence to improvements in health outcomes continues to grow, grantmakers are supporting various activities that help inform the health care community of the importance of cultural competence.

➤ **Supporting activities to promote cultural competence among health care providers** – Blue Cross Blue Shield of Massachusetts Foundation provides grants to Massachusetts health delivery organizations through its *Pathways to Culturally Competent Health Care* program. Implementation grants range from $15,000 to $50,000, and planning grants for early-stage initiatives range from $5,000 to $15,000. Grantees were chosen for their ability to successfully collaborate with community-based organizations, elicit strong

organizational commitment at various management and staff levels, and effectively serve culturally diverse populations. In 2002, the foundation awarded Carney Hospital $30,000 to launch a multifaceted plan for integrating culturally competent practices and programs into the hospital's delivery of care model. The hospital partnered with the Vietnamese Civic Association, Haitian Multi-Service Center, and Churches Organized to Save Tomorrow. Similarly, the Connecticut Health Foundation made a grant to the Saint Francis Hospital and Medical Center to improve the cultural competence of its staff and other providers in the Hartford area. Providers were educated through grand rounds and similar forums on how to increase patient trust, decrease the likelihood of miscommunication, and positively affect the health outcomes of children with asthma, lead poisoning, and other health concerns.

Grantmakers are funding efforts to improve cultural competence among other types of health service providers. The Medtronic Foundation in Minneapolis funded the Lao Family Community of Minnesota for the *Hmong Outpatient Chemical Dependency* program. Many older Hmong adults abuse opium and other substances to deal with the frustrations that accompany resettlement and assimilation into modern America. The grant supports a bilingual, bicultural outpatient treatment program that blends nontraditional Hmong treatment methods, such as spirituality and acupuncture, with more traditional Western chemical dependency therapies. Similarly, The Health Foundation of Greater Cincinnati made a grant to Sojourner Recovery Services, Inc. to provide culturally competent and bilingual services to Hispanic/Latino individuals and their families in need of substance abuse services. The grant will help hire a bilingual clinical assistant and provide staff training, develop Spanish-language substance abuse treatment materials, and translate existing agency materials.

- **Supporting activities to integrate cultural competence training into the medical curriculum** – The Commonwealth Fund made a grant to researchers at Massachusetts General Hospital to survey resident physicians in their final year of training to determine characteristics that predict greater preparedness to provide care to minority patients. The study will assess cross-cultural education at the residents' graduate medical education training sites. Survey findings will inform efforts by key leaders in medical education to incorporate cross-cultural education into current training. The project will also include self-assessment tools for residency programs. The foundation also made a grant to the Association of American Medical Colleges to help medical schools assess and develop curricula related to cultural competence by providing guidelines on what should be taught, how it should be taught, and how students are to be evaluated.

- **Supporting activities that raise awareness of the availability of culturally competent services** – One of The California Endowment's four programmatic priority areas is to improve cultural competence in health care, which includes initiatives that promote language access, cross-cultural communication, and integrative medicine. A specific goal is to advance the field of cultural competence until culturally responsive and linguistically accessible health care is considered a basic right for consumers and an integral part of quality health systems. In the area of language access, The California Endowment has invested over $15 million to ensure equal access for limited English proficient (LEP) consumers. In 2003, it embarked on a public engagement campaign in partnership with New California Media, a nationwide association of over 600 ethnic media organizations. The $2.5 million initiative will support the development, placement, and tracking of an integrated advertising and editorial campaign targeting LEP groups. Specific campaign activities include: informing consumers about the issue of language access through 200 print, radio, television, and on-line ethnic media outlets that target 12 linguistic groups; administering pre- and post-campaign surveys monitoring the level of awareness of these issues among the top 12 linguistic groups; and forming linkages to ongoing advocacy and systems change efforts.

- **Engaging in efforts to assess your own cultural competence** – When the Connecticut Health Foundation initiated funding for its *Eliminating Racial and Ethnic Health Disparities Initiative* in September 2002, it decided to take a look at itself to see whether the foundation was actually practicing what it was preaching to potential grantees. The foundation has contracted with the National Center for Cultural Competence at Georgetown University to conduct a cultural competence assessment of its board, staff, and grantmaking policies and procedures. Additionally, the foundation is working to educate its board on the importance of diversity and cultural competence.

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FOCUSING on Men of Color

Men of color have been characterized as the invisible population, overlooked by public and private efforts to improve health status that have primarily focused on women, children, and the elderly. Moreover, even those efforts specifically targeted to men have focused more on the influence that men have on the health and well-being of women and children than their own physical and mental health.

A significant number of men, and a disproportionate share of men of color, lack health insurance, forgo routine and preventive health visits, disregard health counseling, and ignore symptoms or delay seeking medical attention when sick or in pain. In a survey supported by The Commonwealth Fund, three times as many men as women had not seen a doctor in the previous year, and one in three men (compared with one in five women) had no regular doctor. More than half of men had not had a physical exam or blood cholesterol test in the previous year, and among men age 50 or older, 60 percent had not been screened for colon cancer and 41 percent had not been tested for prostate cancer. Men of color fared even worse. Hispanics, for example, were twice as likely as other men to not have seen a physician in the past year (Sandman et al. 2000).

In comparison to all women and white men, men of color have a lower life expectancy and are more likely to die from serious chronic conditions. Consider that:

- While the life expectancy for white men in the United States is 74.5 years, African-American men can expect to live to 67.6 years; Latino men live an average of 69.6 years; and Native American men fare the worst, living an average of 66.1 years (Meyer 2003).
- While 21 percent of white men die prematurely from heart disease, the rate is almost double for African-American men (40 percent), 37 percent for Latino men, 31 percent for American Indian and Alaska Native men, and 26 percent for Asian and Pacific Islander men (Meyer 2003).
- African-American men have a higher incidence of cancer than other groups of men (Meyer 2003).
- In 2000, HIV/AIDS was the third leading cause of death for African-American men between the ages of 25 and 34 and the fourth leading cause of death for Latino men in the same age group (Satcher 2003).

Violence has a disproportionate effect on minority men, as compared to white men. In 1998, men of color accounted for 70 percent of all deaths due to homicide in the United States. Homicide is the leading cause of death for African-American men ages 15 to 34 and the second leading cause of death for Latino men in the same age group. The death rate from homicide for young African-American men is 17 times the rate for white males, while the rate for young Latino males is seven times that of similarly aged white males (Rich and Ro 2002).

MEN AND MASCULINITY: TOO STRONG FOR THEIR OWN GOOD

Societal and cultural ideals that define men may account for disparities in health care system utilization and health outcomes between men and women. Rich and Ro (2002) argue that from their early years and well into manhood, men in our society are taught to be emotionally and physically strong and are valued when they possess a high tolerance for physical and emotional pain. This idea of manhood can greatly influence how men view and access the health care system. This may be especially true in the case of mental health. The stigma associated with mental disorders often prevents individuals from seeking appropriate care. In particular, men of color often come from communities where acknowledging mental or emotional distress is associated with being weak or "not acting like a man" (Satcher 2003).

Marginalized men of color may also be more likely to engage in risky behaviors that result in adverse health outcomes. Many men, at some point in their lives, feel social pressure to be fearless and prove their manhood through excessive drinking, reckless driving, and unsafe sexual exploits. For men of color, the added burden of feeling powerless in mainstream society may cause them to assert their manhood through increased risk-taking (Rich and Ro 2002). Without positive mechanisms and models for displaying their manhood, men of color are stuck in a revolving door characterized by a lack of power, risky behavior, and poor health.

OPPORTUNITIES FOR GRANTMAKERS

Funding for men's health has traditionally focused narrowly on interventions related to sexual health, pregnancy prevention,

and responsible fatherhood. While these initiatives are needed, keeping men healthy requires a broader approach. Special attention must be given to men of color, many of whom are marginalized and in need of services that take into account their unique economic, social, and cultural situations.

The W.K. Kellogg Foundation has made several major investments to raise awareness about the health needs of men of color and to improve the delivery of services to this vulnerable population. For example, the foundation has funded the Center for the Advancement of Health in Washington, DC to coordinate a three-year, nearly $3 million program to deliver health services to African-American men and develop an action plan for both government and health providers. Beginning in 2002, the center was tasked with convening meetings and providing guidance for community health programs for African-American men in Atlanta, Georgia; Baltimore, Maryland; Boston, Massachusetts; Clarksdale, Mississippi; Denver, Colorado; and Miami, Florida. In each city, providers will target men where they congregate, such as churches, barbershops, and day labor offices. At the end of the demonstration project in 2005, the center will convene a national summit on the health of African-American men, allowing the six programs to share findings, learn about innovative and successful models, and educate stakeholders and policy leaders.

Other grantmakers are supporting efforts to expand health care services to underserved men, many of whom are men of color. Grantmakers are also supporting efforts to encourage prevention and provide appropriate health education.

- **Supporting activities that increase access to health care services** – The New York Community Trust funded the Columbia University Center for Population Health to hire two additional nurses for direct patient care and a social worker for individual and group counseling, enabling the program to serve an additional 500 young men, the majority of whom are Latino. The center is the first primary care center in New York City designed specifically for young men and boys. It is available two evenings per week and provides physical exams, screening and treatment for sexually transmitted diseases, family planning and mental health counseling, and referrals. Similarly, the Fannie E. Rippel Foundation in New Jersey provided $300,000 to Wheeling Hospital to establish a men's health center in the hospital that would focus exclusively on serving and reaching out to underserved men in the community.

- **Supporting activities to encourage prevention and health education** – The Jessie Ball duPont Fund in Florida provided $150,000 to the University of Pennsylvania School of Nursing to develop a program that would encourage young, African-American men to use preventive health services, including primary care, mental health assessments, relationship counseling, and assistance with obtaining health insurance. The Wellmark Foundation in Des Moines, Iowa funded the project *Better Health, Better Men, Better Hardin County*, a program to improve the health of 19- to 64-year-old men in the county. The initiative provides three tiers of services, including preventive screening assessments, initial primary care, and referral to a doctor or clinic for underserved men. The Sierra Health Foundation in California made a $100,000 grant to the *OK Program* to provide health education and prevention services through workshops to African-American males between the ages of 12 and 18. Finally, Healthcare Georgia Foundation, Inc. granted $140,000 to the Taylor Regional Hospital to provide health screenings and education to men in rural counties in Georgia.

- **Supporting activities to prevent male violence** – The California Wellness Foundation provided $75,000 in core operating support to Men Overcoming Violence (MOVE), an organization working to prevent violence perpetrated by adult and youth males. The organization works to foster a sense of responsibility among male offenders, providing counseling and other services to prevent violence among males and toward women and children. MOVE's services include: individual, family, and group therapy for men who complete a batterer intervention program; student-run support groups; teen dating violence prevention for youth ages 12 to 20 in public schools and in community-based service centers; mentoring and training for high school peer educators; and regular workshops for young men at San Francisco's juvenile hall. With more than 20 years of experience on this issue, MOVE has found the use of role-playing and drama therapy to be highly effective in helping program participants examine gender roles and create change based on personal transformation. MOVE serves an ethnically diverse clientele, each year serving approximately 400 adult men and 50 young men through its workshops and outreach to schools and community-based organizations.

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FOCUSING on Women of Color

By virtually every measure, women of color are in worse health than white women. They are more likely to report being in fair or poor health, experience higher rates of mortality and disability, and are less likely to have access to appropriate diagnostic and therapeutic services. Consider that:

- While cardiovascular disease is the leading cause of death for women (except for Asian and Pacific Islander women for which it is second), African-American women are almost twice as likely as white women to die from heart disease (Leigh and Jimenez 2002).
- Women of color ages 60 to 74 are twice as likely to have diabetes as white women of the same age (Jacobs Institute and Kaiser 2002).
- In 1987, 60 percent of all American Indian women on reservations and 63 percent of urban American Indian women were obese. Similarly high rates were found among Native Hawaiian and American Samoan females, 63 percent and 66 percent, respectively. By contrast, the rate for white women was only 31 percent (Leigh and Jimenez 2002).
- Maternal mortality rates for African-American women are more than three times higher than for whites (20.1 deaths per 100,000 live births, compared with 6.2 per 100,000). Rates for Hispanic women also substantially exceeded those for whites at 9.0 per 100,000 live births (NWHIC 2003).
- Although the overall rate of unintended pregnancies has been declining, minority teens are more likely to have an unintended pregnancy. The pregnancy rate for white teenagers aged 15 to 19 is 94 per 1,000, while the rates for African Americans and Latinas are 170.4 and 148.7, respectively (Kaiser 2002).
- In 2000, 80 percent of new AIDS cases in women occurred in African-American and Hispanic women (Kaiser 2003).

Minority women also fare worse in terms of their use of preventive health services. One study found that two-thirds of Asian immigrants in California had never had a Pap smear, and 70 percent had never had a mammogram (Leigh and Jimenez 2002). Another study found that although African-American women are less likely to have breast cancer, they have higher breast cancer mortality rates than white women, perhaps because these cancers are detected at a later stage when treatment is less effective (Jacobs Institute and Kaiser 2002).

It is important to note the profound differences in indicators of women's health and well-being across the various racial and ethnic minority groups. For example, Vietnamese women are five times more likely than white women to have cervical cancer. Rates for other women of Asian origin (such as Koreans, Filipinos, and Japanese Americans) are similar to those for whites. African-American women are substantially more likely to suffer from sexually transmitted diseases. Among Hispanic women, there are profound differences among the various subgroups (for example, Mexican Americans, Puerto Ricans, and Dominicans), as well as significant differences between the newest immigrants and those whose families have been in the U.S. for many years. For example, less acculturated, first-generation Mexican-American women have a lower incidence of low birthweight infants (4 percent of live births) than white non-Hispanic women (6 percent of live births), and than second-generation Mexican-American women (6 percent of live births) (NWIHC 2003).

OPPORTUNITIES FOR GRANTMAKERS

Women of color have different life experiences that ultimately affect how they access health care services, where they obtain health information, and their ability to communicate effectively with service providers. Grantmakers are finding that women's health initiatives must be broadened to take into account the unique beliefs and life experiences of minority women. Foundations are supporting activities that reach out to women of color in their communities and provide linguistic and cultural support in accessing health care services.

➤ **Supporting activities to educate women about health issues in community settings** – The Bristol-Myers Squibb Foundation, Inc. in New York, New York funded The Johns Hopkins School of Public Health to evaluate the effectiveness of a community-based intervention to control high blood pressure and avert hypertension-related cardiovascular disease in African-American women. Specifically, the project involved working with a network of churches to document the impact of various behavioral approaches to controlling blood pressure. Similarly, the Boston Foundation funded the Dana Farber Cancer Institute for a church-based wellness

program targeting African-American female church congregants and their families. The program offered cancer prevention education and screening at local churches. The United Hospital Fund in New York, New York made a grant to the Arthur Ashe Institute for Urban Health for the project *Training Hair Stylists to Become Advocates for Breast Health*, which trained hair stylists in underserved African-American communities in Brooklyn to become breast health advocates and encourage their clients to have regular clinical breast exams and practice breast self-examination. The grant primarily supported the development of a training curriculum, *Breast Cancer 101*. The National Cancer Institute subsequently awarded a $1.2 million grant to conduct a case-control evaluation of the 18 participating salons to assess changes in women's self-care practices.

- **Supporting activities that encourage reproductive health and well-being** – The Alliance Healthcare Foundation funded the Maternal Outreach Management System Resource Center in support of its *Madrina Program*, which uses volunteers and full-time lay persons to assist indigent Latinas with high-risk pregnancies and to improve access to prenatal health care services. To address HIV/AIDS and other sexually transmitted diseases, The Columbus Medical Association Foundation provided funding for the *Sisters Healing Sisters Program*, which uses a culturally specific methodology to promote responsible sexual behavior among African-American women. Program objectives include increasing women's knowledge, attitudes, and awareness about HIV transmission and promoting risk reduction techniques to avoid the spread of HIV. Similarly, The California Wellness Foundation funded the Lao Family Community of Stockton, Inc. to implement the *Hmong Women's Circle*, a program that provides sexuality education to middle and high school students in Stockton, California.

- **Supporting activities that address women's health needs in culturally and linguistically appropriate settings** – Lack of English proficiency, cultural or religious beliefs about health and wellness, and distrust of the health care system can impede women of color from seeking health services or complying with the advice and instructions provided by health professionals. Examples of grantmaker activities to break down these barriers are numerous. For example, the John Muir/Mt. Diablo Community Health Fund in Walnut Creek, California granted $60,000 to a local battered women's agency to hire translators who were specifically trained to address domestic violence issues, as well as cultural issues specific to the target population. The Kate B. Reynolds Charitable Trust in Winston-Salem, North Carolina funded the North Carolina Coalition Against Domestic Violence, Inc. in support of *Project Esperanza: Addressing Domestic Violence Within the Hispanic Community*, an outreach program serving victims of domestic violence within the Hispanic community. Members of the coalition were finding that their services were being underutilized by the increasing Hispanic population. Through this project, a manual on understanding and addressing domestic violence within Hispanic communities was distributed to member agencies. Community workshops on addressing linguistic and cultural barriers were held and attended by attorneys, health and social services providers, and law enforcement personnel across the state. These workshops were then supplemented by one-on-one technical assistance for agencies in attendance. *Project Esperanza* also included a grassroots volunteer training program that recruited Hispanic women to serve as translators for domestic violence agencies that lacked bilingual services.

- **Supporting activities that promote policy and advocacy** – In 1994, the James Irvine Foundation launched the *Women's Health Initiative*, allocating $6.3 million over a five-year period to improve the availability and accessibility of culture- and gender-appropriate health information and health services for women, with an emphasis on low-income women and women of color. The initiative's goals were to develop and promote the adoption of policy recommendations that address the unique health needs of women; provide leadership development for women who work at the grassroots level and within communities of color; support community organizations to inform, educate, and empower women about health issues and to address barriers to the effective utilization of health care services; and enlarge and strengthen the network of advocates for women's health. An evaluation of the initiative found that several of its grantees were successful in increasing awareness and understanding of key women's health policy issues among policymakers, health plans, providers, and the general public.

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FOCUSING on Minority Elders

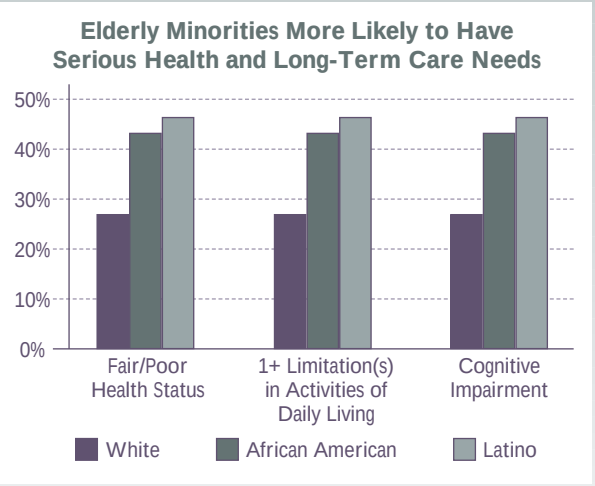
The elderly comprise the fastest growing segment of our population, with the number of people over the age of 65 expected to double over the next 40 years. The number of those over the age of 85 is expected to triple over the same time period (HHS 2000). Although the vast majority of the current elderly population is white (85 percent), this percentage is expected to decrease to 67 percent by 2050. The percentage of elderly minorities, including African Americans, Hispanics, Asian and Pacific Islanders, and American Indians, is expected to increase to more than 33 percent by 2050 (Friedland and Summer 1999).

Providing services to an increasingly diverse elderly population will create challenges for the health care system. Disparities in access to care and health insurance coverage can be compounded by cultural differences, which can affect how and when patients seek medical care and the vital interactions between patients and providers.

MEDICARE AND MINORITY ELDERS

Medicare is the backbone of the nation's health care system for the elderly, now serving almost 35 million Americans over the age of 65. Although now only a small portion of the Medicare population, the number of minority beneficiaries is expected to grow at a faster pace than the total Medicare population. According to The Henry J. Kaiser Family Foundation (2001), the share of Medicare beneficiaries from ethnic and racial minority groups is projected to increase from 14 percent in 1995 to 35 percent by 2025. In 2025, 18 percent of beneficiaries will be Hispanic; 10 percent will be African American; and 7 percent will be Asian or Pacific Islanders, American Indians, Eskimos, and Aleuts.

As an insured population, Medicare beneficiaries tend to report fewer problems with access to care than younger Americans. Minority Medicare beneficiaries, however, are more likely to encounter problems accessing needed care than white beneficiaries. For example, African-American beneficiaries are less likely to undergo specific surgical procedures, such as heart bypass and angioplasty. They also receive less primary and preventive care services, have fewer outpatient physician encounters, and have lower immunization and mammography rates. On the other hand, these beneficiaries are as likely as their white peers to receive inpatient hospital care and more likely to receive home health care services (Kaiser 2000).



Source: The Henry J. Kaiser Family Foundation, *The Faces of Medicare: Medicare and Minority Americans* (Menlo Park, CA: 2000).

HEALTH AND ECONOMIC STATUS OF MINORITY ELDERS

Minority elders tend to report poorer health status than whites. Forty-six percent of Latino Medicare beneficiaries and 43 percent of African-American beneficiaries rate their health as fair or poor, compared to 26 percent of white beneficiaries (Kaiser 2000). In addition, 1 out of every 6 minority elders has at least one functional limitation affecting his/her ability to perform activities of daily living, such as bathing, toileting, and eating, compared to 1 out of every 10 white elders.

Minority elders are also more likely than whites to live in poverty. Thirty-three percent of elderly African Americans and 30 percent of elderly Latinos live in poverty. Only 10 percent of white elders live in poverty (Kaiser 2000). Poverty can be an important barrier to care, even for this insured population. Lower-income beneficiaries have fewer resources to pay for cost sharing and for services not covered by Medicare, such as outpatient prescription drugs. According to the Center for Studying Health System Change (2003), elderly Medicare beneficiaries with incomes below 100 percent of the federal poverty level (FPL) are three times as likely as beneficiaries with incomes above 200 percent of the FPL to report not filling at least one prescription because of cost.

Due to their lower incomes, minority elders are less likely to have supplemental Medicare coverage, an important source of protection against high out-of-pocket costs related to Medicare premiums, deductibles, and copayments, as well as to non-covered services. According to The Henry J. Kaiser Family Foundation (2000), approximately 25 percent of African-American and Latino Medicare beneficiaries have no supplemental coverage, compared to 10 percent of whites. The foundation also reports that only 33 percent of African Americans and 25 percent of Latinos have Medigap or employer-sponsored retiree coverage, compared to two-thirds of whites.

OPPORTUNITIES FOR GRANTMAKERS

Grantmakers can play an important role in reducing racial and ethnic disparities in health and health care for the aging population.

- **Supporting research and dissemination of findings** – Foundations can support research and dissemination of findings in order to enhance the knowledge base needed to improve care for minority elders. For example, Blue Cross Blue Shield of Massachusetts Foundation awarded a $15,000 planning grant to Jewish Memorial Hospital & Rehabilitation Center to conduct a community assessment and identify potential cultural barriers to visiting the hospital. The hospital partnered with two other organizations in the assessment: Action for Boston Community Development and the National Caucus and Center on Black Aged. A plan for training physicians and staff on culturally appropriate care is under development.

- **Supporting community-based programs** – Grantmakers can support community-based programs that reach out to specific racial or ethnic elderly populations. The California Endowment has funded *Project CHASE* (Community Health Alternative Services for the Ethnic Elderly) through a grant to the Union of Pan Asian Communities. *Project CHASE* is a three-pronged program that includes the implementation of a mobile health team for the frail and homebound elderly; senior services advocates who will provide case management, patient advocacy, and translation services; and a fully licensed adult day health care center, located in the heart of north central San Diego, that will provide health services and therapies for 75 seniors per day who are under a physician's supervision for chronic conditions such as diabetes, hypertension, stroke, congestive heart failure, and dementia.

  The Retirement Research Foundation funded the White Crane Wellness Center, a community-based social service agency in Chicago. The center's outreach program works to reduce the incidence of risk factors for preventable disease; motivate and educate seniors to take control of their health; and make primary health care services accessible to low-income, disadvantaged, at-risk elderly. Its team of medical professionals and community partners offers a comprehensive array of services, including blood pressure, blood sugar, and cholesterol exams; clinical breast exams; dental screenings; flu shots; foot care education; mammography screenings; and mental health workshops. White Crane has also developed a model of health outreach that brings culturally and linguistically appropriate health and wellness services directly to at-risk, underserved, low-income elderly. The foundation's three-year, $75,000 grant supports expansion of health and wellness services to at-risk, low-income minority, immigrant, and refugee elderly in the center's service area.

- **Enhancing cultural competency** – Foundations can enhance the cultural competency of health care providers serving the elderly. In the area of long-term care, The Commonwealth Fund provided a $106,116 grant to the Foundation for Long-Term Care to develop best practice guidelines for culturally appropriate care. Project staff performed a literature search, conducted focus groups with families of nursing home residents and with nursing home staff, and surveyed 500 long-term care providers in 10 states to learn about successful practices and training programs.

  The Fan Fox and Leslie R. Samuels Foundation, Inc. in New York City awarded a $40,000 grant to New York University's Downtown Hospital to support the use of bilingual peer advocates to facilitate discussion between physicians and Chinese immigrant patients and their families about end-of-life decisions, specifically as they pertain to the use of health care agents. This project built on a successful intervention to increase the number of Chinese-American New Yorkers appointing health care agents. In 2001, the project approached the issue of health care agents from the perspective of culturally specific challenges facing the Chinese-American agent and sought to provide information, support, and help in performing the task of making health care decisions for someone else. In 2002, an additional award of $160,000 was given to support the program for another 18 months.

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FOCUSING on Children of Color

Racial and ethnic disparities in health are found across the lifespan. Although the causes of morbidity and mortality for children differ dramatically from those affecting adults, minority children, like minority adults, experience greater barriers to health care and have worse health outcomes than whites.

INFANT MORTALITY

Infant mortality rates are frequently cited in comparisons of health and well-being across populations and nations. In 2000, infant mortality among African Americans occurred at a rate of 14.1 deaths per 1,000 live births, more than twice the national average of 6.9 deaths per 1,000 live births. American Indian/Alaska Natives also experience high infant mortality rates (CDC 2003a). Such disparities hold across all socioeconomic levels, as measured by educational attainment. Interestingly, Hispanic infants, despite higher poverty and lower parental education, have higher birth weights and lower infant mortality rates than those of white infants. Cultural practices (including family sleeping practices), social support, selective migration, diet, and genetic heritage are possible contributing factors (Kaiser 2003).

OVERWEIGHT AND OBESITY

In the past two decades, the prevalence of children who are overweight or obese has nearly tripled. In 1999, 13 percent of children aged 6 to 11 years and 14 percent of adolescents aged 12 to 19 years in the United States were overweight, with minority children more likely than white children to be overweight. For example, in the federal National Health and Nutrition Survey conducted between 1988 and 1994, overweight was found to be more prevalent among Mexican-American boys than African-American and white boys. Among girls, African Americans were more likely to be overweight than white and Mexican Americans (HHS 2001).

IMMUNIZATION

Significant progress has been made in closing the gap in immunization rates between minority children and whites. For example, in 1970, the rate of measles immunization for minority children between the ages of one and four was 20 percentage points lower than the rate for white children. By 2001, the gap between African-American and white children had narrowed to 2.6 percentage points, while the measles immunization rate for Hispanic children 19 months to 35 months of age actually exceeded that of white children in the same age group by 0.4 percent (CDC 2003b).

INSURANCE COVERAGE

Insurance coverage is often seen as necessary, although not sufficient, to secure access to health services and ultimately better health outcomes for children and others in need. Over the past 15 years, state and federal policymakers have made substantial efforts to decrease the number of uninsured children with striking progress, particularly for minorities. Between 1999 and 2002, for example, gains in public coverage were greater for African-American and Hispanic children (9.2 percent and 10.8 percent, respectively) than white children (3.9 percent). Even so, the uninsurance rate for African-American children continues to be 2.4 percent higher than for white children, and Hispanic children remain nearly three times as likely to be uninsured as white children and more than twice as likely to be uninsured as African-American children (Kenney et al. 2003).

OPPORTUNITIES FOR GRANTMAKERS

Health grantmakers are supporting a wide range of programs that have the potential to reduce racial and ethnic disparities in health among children. Foundations have long supported efforts to reduce infant mortality, increase childhood immunization, and promote healthy childhood development. More recently, health funders have also focused their attention on increasing enrollment in public health insurance programs and promoting efforts to address the growing epidemic of childhood obesity, with a particular focus on reaching out to communities of color.

- **Supporting activities to reduce infant mortality** – The Jewish Healthcare Foundation in Pittsburgh, Pennsylvania conducted a three-part study on black infant mortality in the greater Pittsburgh area that included a review of previous community efforts to address black infant mortality, information from professional experts, and focus groups with teen

parents and their mothers in six communities with the worst infant mortality rates. The final report, *Ear to the Ground*, included action recommendations related to school/health partnerships, family centers, substance abuse prevention, outreach, infant mortality registry, and tracking of sudden infant death syndrome (SIDS). In San Jose, California, The Health Trust provided funding to support the *Healthy Opportunities for Babies* program, which provides case management services to women of color who are at high risk for having babies that develop serious health issues and/or die due to lack of prenatal care, substance abuse, lack of immunizations, and/or sexually transmitted diseases. The program's activities center around providing health education and case management outreach services to minority women and teens in Santa Clara County in order to reduce infant mortality and SIDS; increase knowledge of prenatal, neonatal, and perinatal care; and increase the number of minority women and teens receiving prenatal, neonatal, and perinatal services.

- **Supporting activities to increase childhood immunization and use of other preventive services** – As part of a broader effort to improve the health and dental care access for children and adolescents in the state, the Blue Cross and Blue Shield of Minnesota Foundation developed *Growing Up Healthy in Minnesota*. This multiyear program funds planning and demonstration programs with an emphasis on preventive care for underserved communities, including Native Americans, people of color, and foreign-born populations. The program places special emphasis on increasing access to and appropriate use of child and adolescent preventive services, including immunization. It also fosters creation of youth-friendly preventive care environments, addresses barriers to preventive care through education and outreach, and promotes culturally and linguistically appropriate preventive care services.

- **Supporting activities to curb overweight and obesity** – Baptist Community Ministries in New Orleans, Louisiana provided over a half million dollars to fund the project *Healthy Lifestyle Choice*, an age-appropriate, interactive curriculum for grade school students. The curriculum teaches children about healthy eating habits and physical activity, as well as self-esteem, decisionmaking, goal setting, communications skills, and stress management. Classroom teaching is reinforced with media messages, an interactive exhibit at the Louisiana Children's Museum, and a health bus for school visits. The California-based HealthCare Foundation for Orange County funded a collaborative effort involving a community hospital, Latino Health Access, and four local elementary schools to build on existing relationships and modify policies and practices in the schools, community, and at home to address and prevent serious overweight problems in children.

- **Supporting activities to increase the number of minority children enrolled in public insurance programs** – Several foundations have made significant outreach efforts to eligible children and their families, with a targeted focus on racial and ethnic minority children, including children of immigrants, many of whom are U.S. citizens by birth. For example, Kaiser Permanente – Mid-Atlantic States provided $25,000 to the Asian Pacific Islander Partnership for Health to raise awareness among the greater Washington, DC area's Asian and Pacific Islander community about existing public health programs. Efforts specifically focused on increasing the enrollment of eligible children into the *DC Healthy Families* program. Similarly, the Paso del Norte Health Foundation in Texas funded a bilingual media campaign to promote enrollment in the State Children's Health Insurance Program with the goal of registering an estimated 68,000 eligible children in the El Paso area.

- **Supporting research to explore the physician's role in racial and ethnic disparities in children's health** – In 2002, The Commonwealth Fund in New York funded the Boston Medical Center to explore the effect of children's race and ethnicity on physicians' clinical decisions. This study broadens the literature on physician decisionmaking, which previously focused primarily on adults. The project, an extension of a larger government-funded study of physician behavior and clinical discretion, will include a four-state survey of pediatricians and family practitioners to help uncover the underlying reasons for these differences in care. At the conclusion of the study, project staff will convene a national conference to discuss study results and identify areas where actions to eliminate disparities could be directed. The federal Agency for Healthcare Research and Quality and The California Endowment also provided funding for this project.

SOURCES

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U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (Rockville, MD: 2001).

GRANTMAKERS IN HEALTH

ERASING the Color Line:

RESOURCES *on Racial and Ethnic Health Disparities*

PUBLICATIONS FROM GIH

Grantmakers In Health, *In the Right Words: Addressing Language and Culture in Providing Health Care* (Washington, DC: August 2003).

Grantmakers In Health, "Lost in the Translation: The Role of Language and Culture in the Health Care Setting," *GIH Bulletin*, May 5, 2003.

Grantmakers In Health, *Access to Better Health Care: A Universal Language*, Findings from the Grantmakers In Health Resource Center (Washington, DC: February 2002).

Grantmakers In Health, *Race and Aging: Meeting the Needs of A Diverse Population*, Findings from the Grantmakers In Health Resource Center (Washington, DC: February 2002).

Grantmakers In Health, *Underserved Men: The Invisible Health Crisis*, Findings from the Grantmakers In Health Resource Center (Washington, DC: February 2002).

Grantmakers In Health, *The Newcomer Challenge: Responding to the Health Care Needs of Immigrants*, Findings from the Grantmakers In Health Resource Center (Washington, DC: November 2001).

Grantmakers In Health, "Promoting Diversity in the Health Workforce," *GIH Bulletin*, November 19, 2001.

Grantmakers In Health, *Hecho en Mexico: The Growing Issue of Border Health*, Findings from the Grantmakers In Health Resource Center (Washington, DC: February 2001).

Grantmakers In Health, *Strategies for Reducing Racial and Ethnic Disparities in Health* (Washington, DC: October 2000).

Grantmakers In Health, "Strategies for Reducing Racial and Ethnic Disparities in Health," *GIH Bulletin*, May 29, 2000.

Grantmakers In Health, *Social Inequalities in Health: Keynote Addresses from the Annual Meeting on Health Philanthropy* (Washington, DC: February 1999).

Grantmakers In Health, *Chartbook: Eliminating Racial and Ethnic Disparities in Health* (Washington, DC: September 1998).

U.S. Department of Health and Human Services, and Grantmakers In Health, *Call to Action: Eliminating Racial and Ethnic Disparities in Health*, conference proceedings (Washington, DC: 1998).

GENERAL RESOURCES

ORGANIZATIONS

The Arthur Ashe Institute for Urban Health
Brooklyn, NY
718.270.3101
www.arthurasheinstitute.org

The Arthur Ashe Institute for Urban Health works to reduce morbidity and mortality from disease among the most vulnerable populations in urban areas through improved access to care and increased health knowledge. The Web site features information on general health topics of interest to minority populations, community programs addressing health concerns, and news.

National Center on Minority Health and Health Disparities
National Institutes of Health (NIH)
Bethesda, MD
301.402.1366
http://ncmhd.nih.gov

The mission of the National Center on Minority Health and Health Disparities is to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. The Web site provides information on NIH programs addressing health disparities, relevant conferences and meetings, and links to related government agencies.

Office of Minority Health
U.S. Department of Health and Human Services
Washington, DC
800.444.6472
www.omhrc.gov

The Office of Minority Health's Web site includes information on conferences and publications, as well as a resource center where users can find information on health topics that include substance abuse, cancer, heart disease, violence, diabetes, HIV/AIDS, and infant mortality.

PUBLICATIONS

The Commonwealth Fund, *U.S. Minority Health: A Chartbook* (New York, NY: 1999).

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

LaVeist, Thomas, ed., *Race, Ethnicity, and Health: A Public Health Reader* (Indianapolis, IN: Jossey-Bass, 2002).

PolicyLink, *Reducing Health Disparities Through a Focus on Communities* (Oakland, CA: November 2002).

Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, produced by the Institute of Medicine's Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (Washington, DC: National Academy Press, 2002).

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

POVERTY

ORGANIZATIONS

Institute for Research on Poverty
University of Wisconsin-Madison
Madison, WI
608.262.6358
www.ssc.wisc.edu/irp

The Institute for Research on Poverty (IRP) is a national, university-based center for research on the causes and consequences of poverty and social inequality in the United States. Its Web site contains information on related conferences, seminars, IRP publications, and links to external resources.

The National Center for Children in Poverty
Mailman School of Public Health at Columbia University
New York, NY
646.284.9600
www.nccp.org

The National Center for Children in Poverty conducts research on the necessity and impact of public investment as part of the national debate on addressing the nation's economic disparity. It also identifies and promotes strategies to prevent child poverty and improve the lives of low-income children and their families. Its Web site contains links to the organization's publications, fact sheets, and newsletter.

PolicyLink
Oakland, CA
510.663.2333
www.policylink.org

PolicyLink is a national organization whose mission is to advance a new generation of policies to achieve economic and social equity from the wisdom, voice, and experience of local constituencies. Its Web site includes many publications focused on creating economic opportunities for low-income communities and communities of color.

PUBLICATIONS

Jargowsky, Paul A., *Stunning Progress, Hidden Problems: The Dramatic Decline of Concentrated Poverty in the 1990s* (Washington DC: The Brookings Institution, 2003).

Wilson, William Julius, *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy* (Chicago, IL: University of Chicago Press, 1990).

RACISM

ORGANIZATIONS

Philanthropic Initiative for Racial Equity
Washington, DC
202.466.4281
www.civilrights.org

Funded by the Charles Stewart Mott Foundation, this three-year project is intended to increase the amount and effectiveness of resources aimed at combatting institutional and structural racism in communities. Its activities include capacity building, education, and convening grantmakers and grant seekers. Its Web site provides information on grantmakers funding anti-racism work, as well as nonprofits working in the areas of race relations and/or racial equity.

The People's Institute for Survival and Beyond
New Orleans, LA
504.241.7472
www.thepeoplesinstitute.org

The People's Institute has developed a training workshop, *Undoing Racism*, that is designed to educate, challenge, and empower people to undo the racist structures that hinder social change. The Web site provides information on the organization's trainers and organizers, as well as its schedule of upcoming trainings.

The Praxis Project
Washington, DC
202.234.5921
www.thepraxisproject.org

This organization partners with communities to achieve health justice by providing resources and capacity for policy development, advocacy, and leadership. It serves community groups and both public and private institutions interested in examining social problems through its root causes. The Web site offers tool kits for advocates, presentations, and publications, as well as information on conferences and Webcasts.

Racial Justice Collaborative
New York, NY
212.764.1508
www.racialjusticecollaborative.org

This collaborative of national and regional foundations and individual donors funds partnerships among lawyers and community organizations that are using legal and other tools to achieve

equity and fairer policies for communities marginalized by race, ethnicity, and immigrant or citizenship status. The Web site provides information on donors and on how to apply for funding for projects focusing on education, voting rights, land use policies, immigrant access to welfare benefits, and labor rights for immigrants and low-wage workers, among others.

PUBLICATIONS

Blackwell, Angela Glover, Stewart Kwoh, and Manuel Pastor, *Searching for the Uncommon Common Ground: New Dimensions on Race in America* (New York, NY: W.W. Norton, 2002).

Jones, Camara Phyllis, "Race, Racism, and the Practice of Epidemiology," *American Journal of Epidemiology* 154(4): 299-304, 2001.

West, Cornel, *Race Matters* (New York, NY: Vintage Books, 1994).

Williams, David, and Chiquita Collins, "Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health," *Public Health Reports* 116(5):404-416, September/ October 2001.

ENVIRONMENTAL HEALTH

ORGANIZATIONS

Center for Health, Environment, and Justice
Falls Church, VA
703.237.2249
www.chej.org

The Center for Health, Environment, and Justice provides technical assistance, information, and training to community groups interested in organizing to address environmental threats. Its campaigns include *Stop Dioxin* and *Childproofing Communities.* The Web site includes links to publications in English and Spanish.

Environmental Justice Fund
Oakland, CA
510.267.1881
www.ejfund.org

The Environmental Justice Fund is a national membership organization dedicated to strengthening the environmental justice movement. It helps to build the capacity of environmental justice networks – groups of community-based organizations led by communities of color – to strengthen their funding and programs. The Web site provides links to regional networks around the United States.

Office of Environmental Justice
U.S. Environmental Protection Agency
Washington, DC
202.564.2515
www.epa.gov/compliance/environmentaljustice/index.html

The Environmental Protection Agency's (EPA) Office of Environmental Justice oversees the integration of environmental justice into all the EPA's activities, coordinates environmental justice outreach and educational activities, and provides technical and financial assistance. The office also leads the Interagency Working Group on Environmental Justice, which coordinates environmental justice work across several federal agencies. The Web site provides access to reports, policy guidance, and links to environmental justice newsletters and listservs.

PUBLICATIONS

Faber, Daniel, and Deborah McCarthy, *Green of Another Color: Building Effective Partnerships Between Foundations and the Environmental Justice Movement* (Washington, DC: Aspen Institute, 2001).

Foreman, Christopher, *The Promise and Peril of Environmental Justice* (Washington, DC: The Brookings Institution, 2000).

ACCESS

ORGANIZATIONS

Health Resources and Services Administration
U.S. Department of Health and Human Services
Bethesda, MD
301.443.0530
www.hrsa.gov

One of HRSA's four missions is providing medical care to underserved areas. Through its *Health Disparities Collaboratives* initiative, for example, community health centers are implementing population-based care models to improve delivery of services for racial and ethnic minorities related to asthma, depression, and diabetes. The agency Web site includes a wealth of publications on access issues for different racial and ethnic groups, with materials in English; Spanish; and Tagalog, as well as several other Asian languages.

PUBLICATIONS

The Access Project, *Immigrant Access to Health Benefits: A Resource Manual* (Boston, MA: 2002).

The Commonwealth Fund, *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans, Findings from The Commonwealth Fund 2001 Health Care Quality Survey* (New York, NY: 2002).

Ku, Leighton, and Timothy Waidmann, *How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

Schulman, Kevin A., Jesse A. Berlin, William Harless, et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *The New England Journal of Medicine* 340:618-626, February 25, 1999.

Weinick, Robin M., Samuel H. Zuvekas, and Joel W. Cohen, "Racial and Ethnic Differences in Access to and Use of Health Care Services, 1977 to 1996," *Medical Care Research and Review* 57(Suppl. 1):36-54, November 2000.

HEALTHY BEHAVIORS

ORGANIZATIONS

Food and Nutrition Information Center
U.S. Department of Agriculture
Beltsville, MD
301.504.5719
www.nal.usda.gov/fnic

The Food and Nutrition Information Center collects and disseminates information about food and human nutrition. Its Web site provides access to information on topics including child and adolescent nutrition, dietary guidelines for the United States and other countries, ethnic and cultural food guide pyramids, food safety, weight management, and public policy. It also serves as a portal to other work on diseases that have links to poor nutrition, including work targeting disease in racial and ethnic population groups.

National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
Atlanta, GA
800.232.1311
www.cdc.gov/nccdphp

The CDC's National Center for Chronic Disease Prevention and Health Promotion conducts public health surveillance, epidemiologic studies, and behavioral interventions; disseminates guidelines and recommendations; and assists state agencies in increasing their capacity to prevent chronic diseases and promote healthful behaviors. The Center's *Chronic Disease Prevention Databases* (available at www.cdc.gov/cdp) provide bibliographic citations and abstracts of various types of materials, including journal articles, monographs, book chapters, reports, curricular materials, fact sheets, and proceedings. Database users can identify materials specific to racial and ethnic minority populations.

National Latino Council on Alcohol and Tobacco Prevention
Washington, DC
202.265.8054
www.nlcatp.org

The National Latino Council on Alcohol and Tobacco Prevention concentrates its efforts on informing public opinion and promoting changes in local, state, and federal policies that affect advertising, access, enforcement, and consumption of these products by Latino youth. The Web site includes a directory of Hispanic/Latino professionals involved in alcohol and tobacco prevention, as well as information about publications in English and Spanish.

Office on Smoking and Health
Centers for Disease Control and Prevention
Atlanta, GA
404.639.3311
www.cdc.gov/tobacco

The Office on Smoking and Health leads and coordinates strategic efforts aimed at preventing tobacco use among youth, promoting smoking cessation among youth and adults, protecting nonsmokers from environmental tobacco smoke, and eliminating tobacco-related health problems. Its Web site includes access to reports, publications, and data on tobacco use in specific populations; a searchable database of journal abstracts; and educational materials targeted to multiple audiences.

PUBLICATIONS

Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs* (Atlanta, GA: 1999). The book can be ordered on-line at www.cdc.gov/tobacco/bestprac.htm.

The Robert Wood Johnson Foundation, *Patient Education and Consumer Activation in Chronic Disease* (Princeton, NJ: 2000).

U.S. Department of Health and Human Services, *Physical Activity Fundamental to Preventing Disease* (Washington, DC: 2002). Available at http://aspe.hhs.gov/health/reports/physicalactivity.

U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (Washington, DC: 2001).

MENTAL HEALTH

ORGANIZATIONS

Association for Multicultural Counseling and Development
American Counseling Association
Alexandria, VA
703.823.9800 or 800.347.6647
www.bgsu.edu/colleges/edhd/programs/AMCD/

The Association for Multicultural Counseling and Development (AMCD) supports research and provides training materials and opportunities to counseling professionals with a focus on racial and ethnic issues. Publications available include the *Journal of Multicultural Counseling* and *Operationalization of the Multicultural Counseling Competencies*, a monograph that discusses multicultural competencies applicable to different counseling environments and specializations. The Web site includes AMCD publications, as well as information on its multicultural training and standards tools.

National Alliance for Multicultural Mental Health
Immigration and Refugee Services of America
Washington, DC
202.797.2105
www.refugeesusa.org/who/prog_info_sp.cfm

The National Alliance for Multicultural Mental Health provides culturally appropriate mental health technical assistance to those working with newly arrived refugees. Among the issues addressed by the alliance's technical assistance are special adjustment issues of refugee children and adolescents, managing family conflict, models for working with refugee women, and programs to serve elderly refugees. The Web site includes answers to frequently asked questions regarding refugees, as well as information on how to become involved in efforts to help refugees settle in the United States.

National Alliance for the Mentally Ill
Arlington, VA
800.950.6264
www.nami.org

The National Alliance for the Mentally Ill (NAMI) is a grassroots, self-help support and advocacy organization for people with serious mental illness, as well as their families and friends. With more than 1,000 affiliates, it advocates for nondiscriminatory and equitable policies; research into causes, symptoms, and treatments for brain disorders; and education to remove the stigma of severe mental illness. NAMI's Web site includes a Spanish language section that provides information on mental illness, support groups, mental health organizations in other countries, and mental health resources.

National Mental Health Association
Alexandria, VA
703.684.7722
www.nmha.org

The National Mental Health Association works to improve the mental health of Americans through research, policy, advocacy, and service. Its Web site provides data and other information on advocacy and effective prevention programs in child and adult mental health for health professionals, policymakers, and individuals and families living with mental illness. Among the information on the Web site is a publication on ending treatment disparities for women of color.

Substance Abuse and Mental Health Services Administration
Rockville, MD
301.443.8956
www.samhsa.gov

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) seeks to reduce mortality, morbidity, and cost resulting from substance abuse and mental illness. SAMHSA's National Mental Health Information Center provides access to information about mental health prevention and treatment services for underserved populations, including racial and ethnic minority groups. The information center also provides links to professional associations and organizations serving specific racial and ethnic populations. The information center can be accessed at www.samhsa.gov/centers/cmhs/cmhs.html.

PUBLICATIONS

American Psychological Association, *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (Washington, DC: 1990).

Koslow, Diane R., and Elizabeth Pathy Salett, eds., *Crossing Cultures in Mental Health*, second edition (Washington, DC: National MultiCultural Institute, 2001).

Sue, Derald Wing, Robert T. Casas, J. Manuel Fouad, et al., *Multicultural Counseling Competencies in Individual and Organizational Development* (Thousand Oaks, CA: Sage Publications, 1998).

U.S. Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General* (Washington, DC: 2001).

U.S. Office of Refugee Resettlement, *Promoting Mental Health Services for Refugees: A Handbook on Model Practices* (Washington, DC: U.S. Department of Health and Human Services, 1991).

WORKFORCE DIVERSITY

ORGANIZATIONS

Association of American Medical Colleges
Washington, DC
202.828.0400
www.aamc.org

The Association of American Medical Colleges is a national organization representing medical schools, teaching hospitals, faculty, students, and residents. Its Web site includes a page on diversity and affirmative action, with links to the organization's various initiatives to strengthen minority presence in medicine and an extensive "recommended reading" page.

Bureau of Health Professions
U.S. Department of Health and Human Services
Rockville, MD
301.443.2100
http://bhpr.hrsa.gov/diversity/default.htm

The federal government's efforts to diversify the health workforce are housed within the Health Resources and Services Administration's Bureau of Health Professions. Key activities include: the *Health Care Careers Opportunities*, *Centers of Excellence*, and *Minority Faculty Fellowships* programs. The

Web site includes information on funding opportunities, contact information, and current data describing the nation's health workforce.

Community Catalyst
Boston, MA
617.338.6035
www.communitycatalyst.org

Funded by the W.K. Kellogg Foundation, Community Catalyst's *Physician Diversity Project* is exploring how to use a community benefit approach to address inequity and quality of care as they pertain to racial and ethnic minorities' underrepresentation in the physician workforce. The two initial sites are Massachusetts and New York. Local partners are the Boston-based consumer health advocacy organization, Health Care For All; and the Public Policy and Education Fund of New York and its grassroots organizing affiliate, Citizen Action of New York. An initial briefing paper is posted on the Web site, along with more detailed project site descriptions.

PUBLICATIONS

Cohen, Jordan J., Barbara A. Gabriel, and Charles Terrell, "The Case for Diversity in the Health Care Workforce," *Health Affairs* (21)5:90-102, September/ October 2002.

Dower, Catherine, Gale Berkowitz, Kevin Grumbach, and Carrie Wong, *From Affirmative Action to Health: A Critical Appraisal of the Literature Regarding the Impact of Affirmative Action* (San Francisco, CA: Center for the Health Professions, 1999).

Dower, Catherine, Tina McRee, Bram Briggance, and Edward H. O'Neil, *Diversifying the Nursing Workforce: A California Imperative* (San Francisco, CA: Center for the Health Professions, 2001).

National Advisory Council on Nursing Education and Practice, *A National Agenda for Nursing Workforce Racial/Ethnic Diversity* (Rockville, MD: Health Resources and Services Administration, 1999).

Smedley, Brian D., Adrienne Y. Stith, Lois Colburn, and Clyde Evans, *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions* (Washington, DC: National Academy Press, 2001).

CULTURAL COMPETENCY

ORGANIZATIONS

Center for Cultural and Linguistic Competence in Health Care
U.S. Department of Health and Human Services
Washington, DC
800.444.6472
www.omhrc.gov/cultural

An arm of the federal Office of Minority Health, the Center for Cultural and Linguistic Competence in Health Care develops and evaluates models, conducts research, and provides technical assistance on removing cultural and linguistic barriers to health care services. The Web site includes information on the center's national standards for culturally and linguistically appropriate health services, as well as information on federal policies, initiatives, and laws.

National Center for Cultural Competence at Georgetown University
Washington, DC
800.788.2066
www.georgetown.edu/research/gucdc/nccc

The main activities of the National Center for Cultural Competence include: promoting policy development, assisting with organizational self-assessments, and developing strategic approaches to systematically incorporating cultural competence into organizations. The center's Web site contains several publications and tools, as well as an on-line database of cultural competence resource materials.

PUBLICATIONS

Betancourt, Joseph R., Alexander R. Green, and J. Emilio Carrillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (New York, NY: The Commonwealth Fund, 2002).

Brach, Cindy, and Irene Fraser, "Reducing Disparities Through Culturally Competent Health Care: An Analysis of the Business Case," *Quality Management in Health Care* 10(4): 15-28, 2002.

Brach, Cindy, and Irene Fraser, "Can Cultural Competence Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model," *Medical Care Research and Review* 57(Suppl. 1):181-217, November 2000.

The California Endowment, *A Manager's Guide to Cultural Competence Education for Health Care Professionals* (Los Angeles, CA: 2002).

Fadiman, Anne, *The Spirit Catches You and You Fall Down* (New York, NY: Farrar, Straus, & Giroux, 1998).

The Henry J. Kaiser Family Foundation, *Compendium of Cultural Competence Initiatives in Health Care* (Menlo Park, CA: 2003).

MEN

ORGANIZATIONS

Men's Health Network
Washington, DC
202.543.6461
www.menshealthnetwork.org

The Men's Health Network (MHN) is committed to improving the health and wellness of men through education campaigns, data collection, and work with health care providers. A major activity of MHN is the annual Men's Health Week, held each June to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys. The Web site includes information on the organization's initiatives and programs, as well as links to additional men's health resources.

National Women's Health Information Center
U.S. Department of Health and Human Services
Washington, DC
800.994.9662
www.4woman.gov/mens/index.cfm

The National Women's Health Information Center is housed in the U.S. Department of Health and Human Services' Office on Women's Health and provides information on men's health because women play a key role in helping men adopt healthy lifestyles and obtain preventive screenings. This section of the center's Web site focuses on issues such as exercise, good nutrition, and mental health, with a special focus on the health of college age, minority, and older men.

PUBLICATIONS

American Public Health Association, [Special Issue on Men's Health] *American Journal of Public Health* 93(5), May 2003.

Barnett, Elizabeth, Michele L. Casper, Joel A. Halverson, et al., *Men and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality* (Atlanta, GA: Centers for Disease Control and Prevention; and Office for Social Environment and Health Research, West Virginia University, 2001).

Rich, John A., and Marguerite Ro, *A Poor Man's Plight: Uncovering the Disparity in Men's Health* (Battle Creek, MI: W.K. Kellogg Foundation, 2002).

W.K. Kellogg Foundation, *Saving Men's Lives* (Battle Creek, MI: 2003).

W.K. Kellogg Foundation, *What About Men? Exploring the Inequities in Minority Men's Health* (Battle Creek, MI: 2002).

WOMEN

ORGANIZATIONS

Jacobs Institute of Women's Health
Washington, DC
202.863.4990
www.jiwh.org

The mission of the Jacobs Institute of Women's Health is to identify and study women's health care issues involving the interaction of medical and social systems; facilitate informed dialogue and foster awareness among consumers and providers alike; and promote problem resolution, interdisciplinary coordination, and information dissemination at the regional, national, and international levels. Its Web site provides access to fact sheets and additional publications on women of color.

Office on Women's Health
U.S. Department of Health and Human Services
Washington, DC
202.690.7650
www.4woman.gov

This Web site, created by the federal Office on Women's Health, seeks to provide free, reliable health information for women everywhere. One section contains specific information on the most common health risks and concerns of minority women and includes fact sheets on the four major racial and ethnic groups (African Americans, Hispanics, Asian Americans and Pacific Islanders, and American Indians/Alaska Natives). The site also provides additional publications that document the disparities between women of color and white women.

PUBLICATIONS

Agency for Healthcare Research and Quality, *Health Care for Minority Women: Program Brief*, AHRQ Publication No. 03-P020 (Rockville, MD: May 2002).

American Medical Women's Association, [Special Issue on Disparities in Women's Health] *Journal of the American Medical Women's Association*, 56(4), Fall 2001.

American Public Health Association, [Special Issue on Women of Color] *American Journal of Public Health* 92(4), April 2002.

National Women's Health Information Center, *Violence and Minority Women* (Washington, DC: 2003).

AGING

ORGANIZATIONS

Center on Ethnic and Minority Aging
Philadelphia, PA
215.477.5719
www.cemainfo.net

The Center on Ethnic and Minority Aging, Inc. provides research, consultation, training, development of practice models, and the creation of alternative service delivery approaches for ethnic and minority elderly. Its Web site offers publications on minority aging, as well as links to additional resources on minority and elderly health issues.

Resource Centers for Minority Aging Research
National Institute on Aging
Bethesda, MD
301.496.1752
www.rcmar.ucla.edu/

The Resource Centers for Minority Aging Research were funded by the National Institutes of Health to decrease the disparities in health and their social consequences for older people through research on health promotion, disease prevention, and disability prevention. The Web site, run by a coordinating center at the University of California, Los Angeles, includes links to more information on the work of the centers, disparities information at the National Institute on Aging, and other resources.

PUBLICATIONS

The Henry J. Kaiser Family Foundation, *How Do Patterns of Prescription Drug Coverage and Use Differ for White, African American, and Latino Medicare Beneficiaries Under 65 and 65+* (Menlo Park, CA: 2003).

The Henry J. Kaiser Family Foundation, *The Faces of Medicare: Medicare and Minority Americans* (Menlo Park, CA: 2000).

Schneider, Eric C., Alan M. Zaslavsky, and Arnold M. Epstein, *Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care* (New York, NY: The Commonwealth Fund, 2002).

U.S. Department of Health and Human Services, *Growing Older: Health Issues for Minorities* (Washington, DC: Office of Minority Health, 2000).

CHILDREN

ORGANIZATIONS

American Academy of Pediatrics
Elk Grove Village, IL
847.434.4000
www.aap.org/nach/activities.htm

The American Academy of Pediatrics' Committee on Native American Child Health is working to increase awareness of the major health problems facing Native American children and monitoring legislation affecting Native American child health. The committee also conducts pediatric consultation visits to Indian Health Service and tribal health facilities and works to strengthen ties with tribes throughout the United States. The Web site includes information on the committee's activities, as well as links to relevant publications and other resources.

Children's Defense Fund
Washington, DC
202.628.8787
www.childrensdefense.org

The Children's Defense Fund is a national advocacy organization working, among other things, to ensure every child a healthy start in life. The Web site includes a wealth of data documenting disparities in child health, as well as information on other Children's Defense Fund activities, such as the *Black Community Crusade for Children*.

National Black Child Development Institute
Washington, DC
202.833.2220
www.nbcdi.org

The National Black Child Development Institute (NBCDI) is a nonprofit organization supporting programs, workshops, and resources in early health and education, general health, elementary and secondary education, child welfare, and parenting for African-American children, their parents, and communities. Its Web site includes information on NBCDI's history, programs, and affiliate network.

PUBLICATIONS

The Annie E. Casey Foundation, *KIDS COUNT Pocket Guide: African-American Children, State-Level Measures of Child Well-Being from the 2000 Census* (Baltimore, MD: 2003).

The Annie E. Casey Foundation, *KIDS COUNT Pocket Guide: Latino Children, State-Level Measures of Child Well-Being from the 2000 Census* (Baltimore, MD: 2003).

Hughes, Dana C., and Sandy Ng, "Reducing Health Disparities Among Children," *The Future of Children* 13(1):153-167, Spring 2003.