

STRATEGIES FOR REDUCING RACIAL AND ETHNIC DISPARITIES IN HEALTH

ISSUE BRIEF NO. 5

BASED

ON A

GRANTMAKERS

IN HEALTH

ISSUE DIALOGUE

WASHINGTON, DC



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Foreword

On May 18, 2000, Grantmakers In Health (GIH) convened a select group of grantmakers along with officials from the U.S. Department of Health and Human Services and other experts in research and practice for an Issue Dialogue on racial and ethnic disparities in health. Intended to both share lessons learned and stimulate new ideas, the Issue Dialogue proved to be a rich, although difficult, discussion about the conditions that give rise to health disparities. Among the ideas discussed were the respective roles of race and socioeconomic status in affecting health, and the complexities of working with different racial and ethnic groups. At the same time, the forum focused on what health funders can do to support the development of programs to improve the health of minorities.

This Issue Brief brings together key points from the day's discussion with factual information on racial and ethnic disparities in health, and grantmaker activities drawn from a background paper prepared for Dialogue participants.

Special thanks are due to those who participated in the Issue Dialogue but especially to presenters and discussants: Thomas Aschenbrener, Mary Chung, Karen Scott Collins, Regan Crump, Yvette Joseph-Fox, Thomas LaVeist, Nicole Lurie, Len McNally, Peggy Shepard,

Charlie Stokes, Henrie Treadwell, and David Williams. Malcolm Williams of GIH's staff planned the program and wrote the background paper with editorial assistance from Anne Schwartz and Lauren LeRoy. Anita Seline skillfully synthesized the background paper with points made at the meeting. GIH also gratefully acknowledges the support and advice of Karen Scott Collins from The Commonwealth Fund in developing the program.

This report is the fourth in a series of programs made possible by a grant to GIH from The Commonwealth Fund. The goal of the Issue Dialogue series is to bring grantmakers together with experts in policy, practice, and research to exchange information and ideas about key health issues facing the nation.

About GIH

Grantmakers In Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the nation's health. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness. Formally launched in 1982, GIH is known today as the professional home for health grantmakers, and a resource for grantmakers and others seeking expertise and information on the field of health philanthropy.

GIH generates and disseminates information about health issues and grantmaking strategies that work in health by offering issue-focused forums, workshops, and large annual meetings; publications; continuing education and training; technical assistance; consultation on programmatic and operational issues; and by conducting studies of health philanthropy. Additionally, the organization brokers professional relationships and connects health grantmakers with each other as well as with those in other fields whose work has important implications for health. It also develops targeted programs and activities, and provides customized services on request to individual funders. Core programs include:

- **Resource Center on Health Philanthropy.** The Resource Center monitors the activities of health grantmakers and synthesizes lessons

learned from their work. At its heart are staff with backgrounds in philanthropy and health whose expertise can help grantmakers get the information they need and an electronic database that assists them in this effort.

- **The Support Center for Health Foundations.** Initially established in 1997 in response to the rising number of transactions that produced new health foundations, the Support Center now provides hands-on training, strategic guidance, and customized programs on foundation operations to organizations at any stage of development.
- **Building Bridges with Policymakers.** GIH helps grantmakers understand the importance of policy to their work and the roles they can play in informing and shaping public policy. It also works to enhance policymakers' understanding of health philanthropy and identifies opportunities for collaboration between philanthropy and government.

GIH is a 501(c)(3) organization, receiving core and program support from health foundations and corporate giving programs throughout the country.

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Introduction

Over the last century, advances in medical science have led to substantial improvements in the nation's health. But minority health status continues to lag behind that of whites. In general, African Americans, Hispanics, Asian or Pacific Islanders, and American Indian or Alaska Natives have poorer health and shorter lives than whites.

Minorities suffer disproportionately from many illnesses, even after controlling for socioeconomic status. The impact of these disparities becomes even more profound when the projected growth of the population of Americans who are racial and ethnic minorities is taken into account. In 1998, minorities comprised 28 percent of the population. By 2030, it is expected that minorities will make up 40 percent of the population, with Hispanics comprising almost half of the entire minority population (Figure 1).

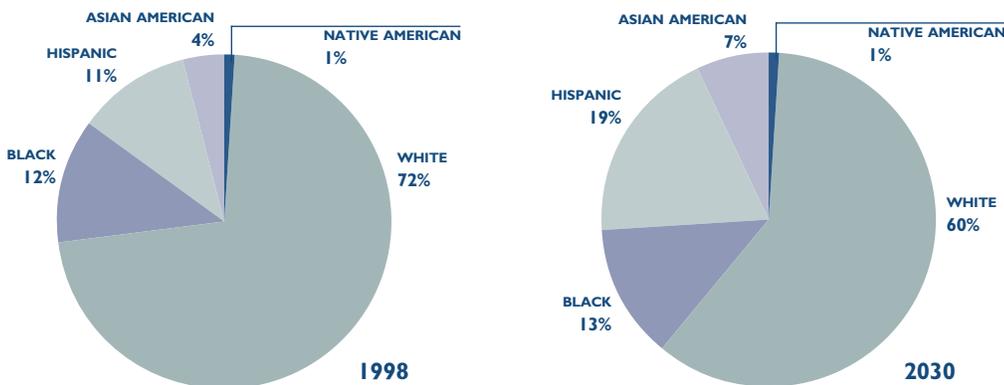
Developing strategies for reducing health disparities is a complicated task. Addressing them will not only require work in health promotion to reduce unhealthy behaviors among minorities, but will also depend on thoughtful explo-

ration of the other factors that affect health including:

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

On May 18, 2000, Grantmakers In Health (GIH) convened an Issue Dialogue, *Strategies for Reducing Racial and Ethnic Disparities in Health*, with support from The Commonwealth Fund. Drawing on the expertise of researchers, foundation leaders, and government officials, the discussion focused on how philanthropy can intervene to reduce disparities in health, particular strategies and practices for addressing disparities, and advice on how to make the most of limited resources. The dialogue gave participants an overview of the root causes of these disparities – such as racism and socioeconomic status – and reviewed government efforts to eliminate them. It also challenged those present to continue this

Figure 1. *Projected Resident Population of the United States, 1998 and 2030*



critical dialogue to raise the population’s awareness of these pressing problems. As one participant put it, “You cannot build a strong nation on the backs of sick people. If we are to be strong economically, socially, spiritually, and militarily, all of our citizens – all of our people – must be healthy.”

This Issue Brief begins by documenting disparities for six health conditions targeted by the federal government. It then explores some of the underlying causes of the disparities including the issue of racism. Also presented are examples of grantmaking strategies currently employed by private foundations and corporate giving programs in the health field, recent state initiatives, and the work of the federal government which, since 1998, has focused its health agenda on eliminating racial and ethnic disparities. Finally, the report offers conclusions about some of the challenges foundations are likely to face in working to eliminate health disparities.

Documenting the Problem

Data regarding the health status of minorities for the six health areas targeted by the federal government show that disparities in health affect individuals across the life span. They also provide an illustration of how profound disparities in health among minorities have become and highlight where grantmakers can focus their efforts to coordinate with work under way by the federal government.¹

HIV/AIDS

In 1998, the absolute number and rate of AIDS cases were higher among black, non-Hispanic men than white men. Black, non-Hispanic and Hispanic women comprised about 80 percent of new AIDS cases. The rate of AIDS among black, non-Hispanic children was more than four times that of white children (NCHS 1999).

Although death rates for HIV infection among men and women are declining, disparities in death rates continue. In 1997, the age-adjusted death rate for HIV was higher among non-Hispanic black and Hispanic men than other racial and ethnic groups, and deaths from HIV in 1997 were highest among non-Hispanic black and Hispanic women (NCHS 1999).

Cancer Screening and Management

Deaths from cancer were higher for black, non-Hispanics than other racial and ethnic groups in 1997 (NCHS 1999). Black men have significantly higher incidence and death rates than their counterparts in other racial and ethnic groups from three leading types of cancer (colon and rectum, lung, and prostate). Black women have the highest incidence rates of

¹ In 1998, Grantmakers In Health produced *Eliminating Racial and Ethnic Disparities in Health: A Chartbook* which documents in greater detail these and other disparities.

colon/rectum and lung cancers. Black women also lead all racial and ethnic groups in deaths due to colon/rectum and breast cancers even though the incidence of breast cancer is higher among white women. In 1994, the use of mammography was lowest among Hispanic and Asian or Pacific Islander women, and the rate of receiving a Pap test was lowest among Asian or Pacific Islander women (NCI 1996).

Coronary Heart Disease

Although the death rate for heart diseases has decreased for all racial and ethnic groups, the death rate for blacks remained consistently higher than that of any other racial or ethnic group for the 12-year period ending in 1997 (NCHS 1999). The death rate among African Americans for stroke is almost twice that of whites. African Americans lead all racial and ethnic groups in deaths due to stroke (NCHS 1998).

Diabetes

Black, non-Hispanics suffer disproportionately from Type 2 diabetes relative to the population at large (NIDDKD 1995). Type 2 diabetes is the most preventable form of diabetes when early and regular attention is paid to weight, diet, and exercise. The incidence of end-stage renal disease, one complication of diabetes, is almost twice as high for American Indian or Alaska Natives, blacks, and Hispanics as for whites (HHS 2000a). In addition, African Americans, American Indian or Alaska Natives, and persons of Hispanic origin have substantially higher death rates due to diabetes than all other racial and ethnic groups (NCHS 1998).

Immunization

The black immunization rate is lower than that of any other racial or ethnic group (HHS 2000b). The rate of death from influenza and pneumonia is highest among blacks, and during the 12-year period ending in 1996, the mortality rate for influenza and pneumonia,

both of which are preventable through immunization, rose among Asian or Pacific Islanders (NCHS 1998).

The proportion of children receiving vaccinations increased among all racial and ethnic groups from 1994 to 1996. In 1996, however, Hispanic; black, non-Hispanic; and Asian or Pacific Islander children continued to lag behind their white counterparts in receiving vaccinations.

Infant Mortality

Among the industrialized nations, the United States ranks 25th in infant mortality. Black, non-Hispanic and American Indian or Alaska Native children have the highest infant mortality rates among all racial and ethnic groups. The infant mortality rate among black, non-Hispanics is more similar to that of Costa Rica, Kuwait, Poland, and the Russian Federation than to the U.S. national average (NCHS 1998).

There are also disparities in how children die. The leading killer among white and Hispanic infants is congenital anomalies, while black infants suffer more deaths from disorders relating to short gestation and unspecified low birthweight (NCHS 1997).

Disparities in health among minorities have been extensively documented. Even so, understanding the current state of health for minorities can be problematic for several reasons. First, data regarding the health of minorities are often taken from samples too small to allow for calculation of reliable estimates for subgroups. For example, much of what has been reported for Asian or Pacific Islanders is based on more established national origin groups (e.g., Japanese) and in selected locations (e.g., West Coast) and then extrapolated to represent the

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“The minority population in the United States is the fastest growing segment of the population. It’s the part of the population that’s often in the poorest health, and often has received the poorest service on the part of the health care system.”

KAREN SCOTT COLLINS,
THE COMMONWEALTH
FUND, MAY 2000

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*Race is more than a qualifier
 or descriptor – it is an
 underlying condition
 that restricts participation
 in society.*

health of all Asian or Pacific Islanders in the United States.

Looking at averages can also be limiting as they often only tell part of the story. From 1995 to 1997, for example, the overall average death rate for American Indian or Alaska Natives was lower than that of whites. This population, however, had a higher average death rate in a number of states including Arizona, Idaho, Minnesota, Montana, Nebraska, New Mexico, North Carolina, North Dakota, South Dakota, Utah, and Wyoming (NCHS 1999).

Second, by pooling data on the experiences of racial and ethnic categories, federal data collection often masks the variations in health status of subpopulations within the larger racial and ethnic groups. So while the overall infant mortality rate for Hispanics is lower than for whites, the rate for the Puerto Rican subpopulation of Hispanics is well above that of whites (NCHS 1999). Similarly, the smoking rates of some subpopulations of Asian or Pacific Islanders – but not the group as a whole – are well above the rate for whites (CDC 2000).

The Antecedents to Disparities

Health disparities exist within a broader social context. A variety of factors (both health and nonhealth related) have an impact on the health of minorities in America. Minorities face some disadvantages in gaining access to care. Health insurance coverage is lower among minorities, and their health status is poorer. But programs designed to address only these traditional health indicators will not solve the problem. A comprehensive approach that tackles the roots of these disparities must be adopt-

ed. This is because factors such as racism and discrimination (both current and historical); socioeconomic status including income, wealth, and education; exposure to environmental hazards and violence; and the individual's experiences with the health care delivery system are interrelated.

Discrimination and Racism

Discrimination has had a direct impact on the health of minorities. We know from The Commonwealth Fund Minority Health Survey (CMHS) that ongoing discrimination is a major health and health care problem for minority populations.² Analyses of the survey data showed that minority populations are more likely than whites to perceive discrimination in the delivery of their health services, and are less likely to have access to care, to attain care, and then to be satisfied with the care they receive (Hogue and Hargraves 2000).

While a large number of minorities in the survey also believed that they would receive better care if they were of a different race, discussions of health disparities have rarely explored racism as an antecedent to health status or access. Race, however, matters a great deal to the understanding of health disparities. Race is more than a qualifier or descriptor – it is an underlying condition that restricts participation in society. As 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 approach-

² The Commonwealth Fund commissioned this survey in 1994 to assess how differences in health insurance coverage, choice in selecting a health care provider, and other access barriers might affect the experiences of minority populations. The CMHS consists of a nationally representative sample of more than 3,700 African American, Hispanic, Asian American, and white adults. The survey attempted to report on the experiences of subpopulations by oversampling Asian Americans of Chinese, Korean, and Vietnamese descent.

es 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, rather than from established medical practitioners. Slaves on smaller plantations may not have received any formal health care. After the war, blacks and other minorities still had problems obtaining health care. Voluntary hospitals cared for the so-called deserving poor: those who were chronically ill, whose need for care had not resulted from substance abuse or sexual indiscretions, or who were otherwise regarded as not being a social failure. Certain racial, ethnic, and religious groups were also denied care in voluntary hospitals. Public hospitals, established by municipalities to care for those perceived as unworthy, also provided segregated services for blacks. Care and services from traditional organizations such as orphanages, private charitable hospitals, local almshouses, and state facilities generally only served whites (Smith 1999).

Discrimination also affected minorities wishing to practice medicine. Black doctors could only serve black patients, constraining both the opportunities for providers to practice and the supply of health care in black communities.

Few accredited medical schools accepted black students. Those that did often advocated for training black physicians as sanitarians in order to reduce the spread of diseases into white communities rather than training them as expert medical practitioners. These practices eventually led to the development of black hospitals and the separation of these hospitals and their physicians from their white counterparts.

The practice of medicine with regard to racial and ethnic minorities was not a problem of mere scarcity of resources, or even substandard treatment. Racism found its way into research and experimentation as well. Blacks have been used as subjects in scientific experiments since slavery. One of the most horrific and famous of these was the Tuskegee syphilis experiment which began in 1932 and lasted 40 years. Smith (1999) suggests that one reason for current disparities in treatment is that the attitudes that allowed for unethical experimentation on and inadequate treatment of blacks still exist in the health professions.

Today, minority patients continue to face differences in the treatments they receive. Blacks, Hispanics, and Asian Americans all report, in numbers higher than the overall population, having a major problem getting specialty care (Figure 2). This is especially true for Asian Americans among whom more than one-quarter have reported problems getting specialty

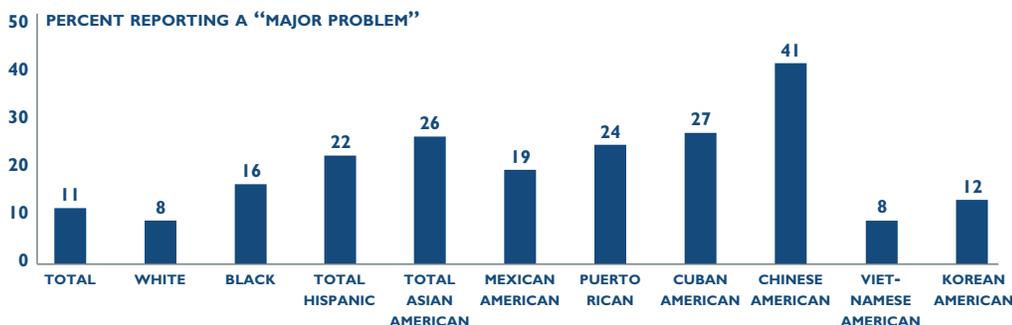
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After the Civil War, the development of separate institutions to educate and care for minority populations was not limited to blacks. At the same time, Russian Jewish, German Jewish, Irish Catholic, and Italian Catholic hospitals were also founded.

DAVID BARTON SMITH
1999

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Figure 2. Access to Specialty Care by Adults, by Race and Ethnicity, 1994



THE COMPLEXITIES OF RACE

When tackling the issues of racial and ethnic disparities in health, there are a number of complexities that foundations must be aware of. Above and beyond mere competition, for instance, tensions exist among different racial groups. And within a certain racial group, there often is conflict among organizations representing the needs of that segment of the population.

These tensions transcend the historic divide between whites and blacks, commented Henrie Treadwell, program director at the W.K. Kellogg Foundation. Treadwell reported that it is common for her foundation to choose one group to fund and then receive calls from others criticizing the decision. And because there is not that much money foundations can give to tackle racial disparities in health to begin with, these turns of events are painful. In a sense, it comes down to a foundation having to decide which group has the worst problem.

There are other complexities as well.

Relying on data to drive funding decisions is not necessarily the best approach, some participants warned, pointing to the many variations among different ethnic groups in racial categories. For instance, while Hispanics overall have little access to health care, it is most critical for the Mexican-American population, much of it located in states where social programs are at their most meager. Another example is the Asian population, parts of which are wealthier than whites and parts of which are poorer than blacks.

In the end, the tensions among racial groups reflect the segregated society in which we live, where whites are suspicious of African Americans. Black immigrants, recognizing that racial hierarchy, attempt to distance themselves from blacks. Data also suggest, said David Williams of the University of Michigan, that Hispanics are as negative as whites about having blacks as neighbors, while Asians are even more negative than whites to having blacks as neighbors. Williams described this phenomenon as different racial groups attempting to advance within the racial hierarchy anchored by whites at the top and blacks at the bottom.

“These are issues we will struggle with in the near and long-term future,” Williams concluded.

care. But African Americans were more than three times as likely to have a lower limb amputation, most likely reflecting a lack of preventive care in the early stages of diabetes (Collins 2000). There are also disparities in the use of other specialized procedures for breast cancer and hip fracture treatment for African Americans (Collins 2000). After suffering a heart attack, African Americans are less likely than whites to receive diagnostic, invasive, and therapeutic coronary procedures (LaVeist, Diala, and Jarret 2000). Other recent studies have shown that pharmacies are less likely to carry opiate-based medications when they are located in neighborhoods where minorities make up a higher percentage of the population (Morrison, Wallenstein, Natale, et al. 2000).

Perceptions about discrimination in the health care system can also be a powerful motive in preventing minorities from seeking care. Analysis of the CMHS study indicated that African Americans and Hispanics were more likely to report that they had been discriminated against. The survey also revealed that 30 percent of the respondents who perceived discrimination felt that they had been discriminated against at least in part because of their income. African Americans reported more often that they had faced discrimination because of their race, and a higher percentage of those reporting discrimination because of race felt that they would have received better care if they were of a different race (LaVeist, Diala, and Jarret 2000).

The effects of discrimination reach broadly into the culture in which disparities exist. These effects have not only 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 the substandard neighborhoods, housing, employment opportunities, education, and health care that many minorities face.

The experience of individual discrimination expands when one considers the larger picture of institutionalized racism. The clearest, most pervasive, and influential example of institutional racism is housing segregation. While the practice of legal segregation began to end more than 40 years ago, it has left longstanding marks on many communities. By 1970, the racial composition of black and white neighborhoods had changed little from the pre-civil rights era levels in 1940. Ten years later, there was still little change in the level of segregation and black isolation (Massey and Denton 1993).

Concentrating poverty through segregation dictates the quality of education people receive and their opportunities for attending college or for employment after leaving school. One study completed by the *Wall Street Journal* examined the numbers of jobs lost among the country's 35,000 largest companies that report to the Equal Employment Opportunity Commission. It found that, during the economic downturn of 1990 and 1991, African Americans suffered a net job loss of more than 60,000 jobs reflecting the movement of employment facilities from neighborhoods where African Americans lived to other areas, illustrating not individual cases of discrimination but a wider problem (Williams 2000).

Socioeconomic Status

Socioeconomic status also plays a key role in determining the health of minorities and access to health care, though participants at the Issue Dialogue debated whether or not racism was the root cause of health disparities. David Williams, senior associate research scientist at the Institute for Social Research at the University of Michigan, said that just focusing

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Evidence of health disparities in this country is striking and beyond dispute.... poverty, lack of education and health insurance; poor access to health care; and discrimination and inadequate information about disease risks, treatment, and prevention [are] the causes for racial disparities.

RUTH KIRSCHSTEIN,
NATIONAL INSTITUTES OF
HEALTH, JULY 2000

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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.” As an example, Williams said that the gap in health between high-income African Americans and low-income African Americans is larger than the overall gap between African Americans and whites. In addition, low-income whites have rates of heart disease that are twice that of high-income African Americans. Williams further noted that socioeconomic differences between races are the result of successful implementation of specific policies that were designed to, in fact, produce socioeconomic differences between the races.

Researchers have long debated the question of race, socioeconomic status, and their effect on health. In the end, this question about whether one or the other causes disparities in health cannot be decided, as each are critical components in explaining why minorities are less healthy, have poorer access to quality care, and die sooner than whites.

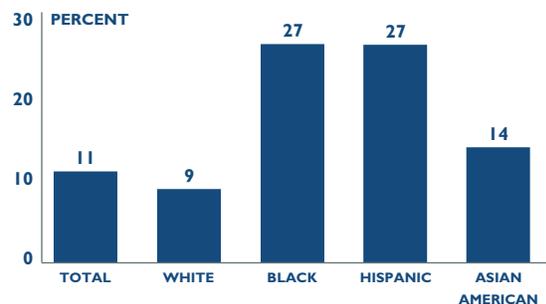
On a consistent basis, minorities in the CMHS fared less well on a variety of socioeconomic indicators. Minorities were poorer and less educated, had more financial barriers to care, and were more likely to delay care. Further analysis of socioeconomic status for Hispanic, African-American, and Asian subgroups showed that wealthier and more educated minorities are

more likely to be insured and to have a regular health care provider (Hogue and Hargraves 2000). Moreover, African-American households earn 59 cents for every dollar earned by whites in median family income. More dramatically, white households are generally 10 times more wealthy than African-American households – taking into account real estate, stock portfolios, and inherited wealth. This is true at all equivalent levels of income (Williams 2000). At the same time, a greater percentage of minorities make up a disproportionate part of the population living below the federal poverty level – \$16,400 for a family of four (Figure 3).

Minorities have also attained less education. In 1998, 83.7 percent of whites 25 years and older had attained at least a high school diploma. By contrast, only 76 percent of blacks and 55.5 percent of Hispanics had followed suit. In the same year, one-fourth of whites 25 years and older had attained at least a bachelor’s degree, but only 14.7 percent of blacks and 11 percent of Hispanics had done the same (Day and Curry 1998).

Minorities have fewer employment opportunities as well. While unemployment rates continue to decrease, the rates of unemployment for blacks and Hispanics are higher than for whites. In fact, black unemployment remains about twice that of white unemployment (U.S. Bureau of Labor Statistics 2000).

Figure 3. *Percentage of Persons Living Below Poverty, by Race and Ethnicity, 1997*



Environmental Hazards

Minorities are also more likely to live in environments that are hazardous to their health, whether it's the condition of the air, the quality of housing, or the experience of violence in their communities. While environmental hazards that represent potential sources of risk affect all races, a higher percentage of African Americans and Hispanics live in communities with higher levels of air pollutants associated with respiratory symptoms such as asthma and the exacerbation of other ailments (IOM 1999). In 1996, 81 percent of Americans lived in counties that met standards for all pollutants. Only 56 percent of Hispanics and 64 percent of Asian Americans, however, lived in counties that met air quality standards for all pollutants (NCHS 1999).

Lead is another environmental toxicant that disproportionately affects people of color. A variety of health problems – including neurodevelopmental effects in infants and children and cardiovascular effects in adults – result from lead exposure. Blood lead levels are consistently higher for poor and minority children and residents of central cities (IOM 1999). In New York City, the highest number of lead poisoning cases can be found in the city's ten poorest neighborhoods, where residents also suffer from the highest asthma rates.

Environmental racism is not found exclusively in cities but in rural areas as well. American Indian or Alaska Native populations are affected by polluted waterways – where polychlorinated biphenyls (PCBs) from mining and industry runoff contaminate the same rivers where American Indian or Alaska Natives fish for survival.

Finally, minorities are more likely to be victims of violence. The disparities in violence are most prevalent among males. The homicide rate for all minority groups between 1995 and 1997

was higher than for whites. Among African Americans, the rate was more than ten times that of whites, and among Hispanics the rate was more than four times as high (NCHS 1999).

Healthy Behaviors

The health behaviors of minorities are also important to understanding health disparities. Behavior and lifestyle can be major contributors to the health of the individual. There is some evidence to suggest that minorities lead unhealthier lifestyles than whites; however, it is important not to overstate the case. Uninformed perceptions about the lifestyles of minority populations can lead to unrealistic assumptions that changes in health behaviors alone can reduce disparities. Nonetheless, there are some differences that should be explored.

Data on smoking among minorities are mixed. In the CMHS, for example, fewer minorities reported that they smoked compared to whites (Hogue 2000). Data from the National Center for Health Statistics, however, suggest that the prevalence of smoking for survey respondents in the month before being surveyed is highest among American Indian or Alaska Natives. Among men, the prevalence of smoking in the past month for American Indian or Alaska Natives is more than twice that for whites. Black men had the second highest prevalence of smoking (NIDA 1998). The percentage of women who reported smoking during pregnancy in 1997 was highest among American Indian and Alaska Natives. Women listed as Hawaiian or part Hawaiian had the third highest percentage behind whites (NCHS 1999).

Diet and exercise are closely related to obesity. African Americans are only 60 percent as likely as whites to eat a healthy diet at least four times a week, and African-American men are only 70 percent as likely as white men to report that they routinely and vigorously exercise (Hogue

WEST HARLEM ENVIRONMENTAL ACTION: P

Northern Manhattan is one of the most unhealthy places to live in America. It is a community that is historically significant yet disproportionately affected by pollution. Here one will find poor health status, poor housing maintenance, concentrations of polluting facilities, poor air quality from particulate pollution from buses and trucks, and schools with coal-burning furnaces.

It is here where one will find some of the country's highest rates of asthma, lead poisoning, and other ailments caused by living and working in these polluted conditions. It is also here where one will find West Harlem Environmental Action (WE ACT), directed and co-founded by Peggy Shepard, making strides to empower residents of this area to work and lobby for healthier, less polluted neighborhoods. More importantly, it is the type of action that can succeed in places other than New York City.

For Shepard, the issue is environmental racism. Just as segregation congregates people of color in certain communities, businesses target these same communities to locate their polluting facilities, and government acts slowly to clean up housing and schools in need of better maintenance and heating systems. Without strong voices raised in protest, the environmental degradation continues and increases.

"Millions of people of color and low-income persons are living in disproportionately polluted communities. These environmental exposures are leading to very negative outcomes whether it's asthma and respiratory disease, heart disease, cancer, or developmental disorders in children. We are seeing a range of impacts," Shepard said.

West Harlem Environmental Action's work focuses on building capacity in communities to stop more pollution from affecting their neighborhoods and to improve environmental health and quality of life. The organization uses a multipronged attack on these problems: empower communities, involve community-based organizations and academic institutions, take a broad view of health problems, network with other environmental groups, and make government accountable.

The foremost of these is empowering residents to fight for environmental justice. Through educational campaigns and training of youth and community leaders, the group helps raise awareness of healthy environments and healthy homes in New York City.

As an example, WE ACT is partnering with community representatives, researchers, and scientists to train residents and clinicians to identify concerns and potential interventions, and to prioritize an environmental health research agenda through a program sponsored by the National Institute of Environmental Health Services.

"We've got to get away from a social services model where we administer to certain people. We can train residents to understand environmental health issues and how they can take action to

PROTECTING AND BUILDING COMMUNITIES

safeguard their families and communities, and participate in community-based research that benefits communities," said Shepard.

In addition, the organization seeks out groups that may already be working in the community but are unaware of the environmental hazards that surround them. Building collaborations furthers progress on these issues and helps their respective communities. For instance, West Harlem Environmental Action has sought out Latino organizations already involved in social services, language, and immigration efforts in an attempt to provide stronger health and environmental advocacy in New York City.

When tackling a problem such as lead poisoning, West Harlem Environmental Action makes sure to reach out to key populations. As an example, the organization was awarded a grant from the U.S. Department of Housing and Urban Development to conduct a citywide lead campaign in which WE ACT trained the staff of a Haitian immigrant group on lead. The staff will translate materials into Creole for Brooklyn's Haitian residents, and a Latino group will do Spanish translations and outreach for South Bronx residents.

Just as the organization seeks to collaborate with local groups, it also works with other environmental justice organizations across the country, within a multiracial and multiethnic national movement that includes networks of farmworkers, American Indian or Alaska Natives, Asian or Pacific Islanders, and African Americans. There are also regional networks in the south, southwest, and the northeast. Ms. Shepard is, in fact, the co-chair of the Northeast Environmental Justice Network.

"In environmental justice, we have been able to work together in strong regional and ethnic networks to really make a difference, so that we are all advocating for each other and working in collaboration with each other to address healthy communities on a local and national level," Shepard said.

As the chair-elect of The National Environmental Justice Advisory Council to the U.S. Environmental Protection Agency, Shepard recognizes not only the role of government but also its responsibility in these efforts. As a result, the organization has helped establish an environmental justice advisory committee to the New York State Department of Environmental Conservation. This committee's first order of business is to develop a new statewide policy on environmental justice. One strategy is to encourage the state to develop health profiles of communities. The goal is to get the government to look closely at communities before granting permits to businesses wanting to locate polluting facilities in certain areas. The committee wants the government to realize that some of these neighborhoods already bear too much of the environmental burden.

"When you're looking to grant a permit for a polluting facility, there are some communities with such low health status that you've got to look at that health profile," she said. "And maybe we've got to decide that certain facilities can't go there because the health profile is so negative."

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about the lifestyles of minority
populations can lead to
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changes in health behaviors
alone can reduce disparities.*

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2000). The age-adjusted obesity rate between 1988 and 1994 was higher among non-Hispanic blacks and Mexican Americans than among non-Hispanic whites. This is especially true among women. The rate of obesity for non-Hispanic black and Mexican-American women is higher than for white women by 15 and 12 percentage points, respectively (NCHS 1999).

Even so, physicians often do not counsel all minority patients to stop or curb their unhealthy behaviors, according to results from the CMHS (Hogue 2000). While nearly similar percentages of African Americans and whites received this type of advice (about 60 percent), less than half of Hispanic male smokers did.

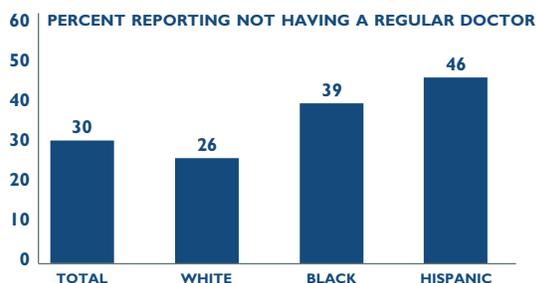
Barriers to Care

The CMHS revealed inadequacies in access to care to meet the needs of minority populations. Fewer Asian Americans and Hispanics reported seeing a doctor in the last 12 months than other racial or ethnic groups. African-American, Asian-American, and Hispanic respondents were more likely to self-report fair or poor health status than whites, and the percentage of respondents who needed medical care but did not get it was highest among Hispanics (Hogue and Hargraves, 2000).

Differences in willingness to seek care because of actual or perceived discrimination are exacerbated by the systemic lack of access that minorities face. The percentage of adults without health insurance is highest among Hispanics and African Americans (HRSA 1998). In 1995, at every family income level, the percentage of Hispanics lacking health insurance was higher than any other racial or ethnic group. This is also true among children. The percentage of Hispanic children lacking health insurance is greater than that of any other racial and ethnic group (Weinick, Weigers, and Cohen 1998).

Often, minority patients say they have little or no choice in where they go to receive their health care. Substantially fewer blacks and Hispanics have reported having a regular doctor than whites (Figure 4). Children of Hispanic origin are the most likely to lack a usual source of health care and the least likely to rely on office-based providers among all racial and ethnic groups (Weinick, Weigers, and Cohen 1998). Blacks are more likely than whites to receive care in the hospital outpatient department (including emergency rooms, outpatient clinics, and other hospital clinics), and whites are more likely than blacks to receive care in a physician's office (NCHS 1998). At every

Figure 4. *Percentage of Adults Age 18 and Over Without a Regular Doctor, by Race and Ethnicity, 1997*



income level, there are more Hispanics with a health problem who have not received care from a physician than whites or African Americans (HIRSA 1998). In addition, African Americans and Hispanics were less likely to have seen a dentist in the past year than whites (NCHS 1998).

Minorities are also more likely to face other barriers to care than whites. Hispanic families are more likely to report having a problem with receiving health care than all other families. In addition, Hispanic families report more often than black or white families that they could not afford care. On the other hand, although black families were less likely than whites to report a problem in receiving care, when they reported any problem at all, they were more likely to have problems with transportation, communication, and getting time off from work (Weinick, Zuvekas, and Drilea 1997).

Minorities are also less satisfied with the care they receive. In a study evaluating differences in attitudes toward primary care physicians, Asian patients rated the quality of care they received from their physicians lower than white patients. Within this population, Chinese and Filipino patients gave the lowest ratings of satisfaction with their physicians (AHRQ 2000).

Finally, for the American Indian or Alaska Native population, there are a number of circumstances and policies that pose particular barriers to care that other minority groups do not face. Disparities in this population are far worse than other racial and ethnic groups not only in health but in income, in employment, and in living conditions. Moreover, despite the growth in revenues to some tribes from casinos and the gaming industry, poverty remains high.

Cultural Competency

The ability of minorities to access the health care system is not the only important compo-

nent in understanding racial and ethnic disparities in care. Those who do enter the health care system may have difficulty in receiving culturally competent services. In order to be effective in the delivery of health services, health care providers must understand the impact that language and culture have on health and health care. The expected growth of the minority population means that many more families will speak a language other than English at home. Patients with limited English proficiency encounter many obstacles in the health care system including delays in making appointments and misunderstandings about their diagnosis and treatment. Without proper communication, patients may not be adequately prepared to undergo treatment. At the same time, it becomes difficult for patients to express their concerns, which may in turn lead to inappropriate tests, or even misdiagnosis (Diversity Rx 2000).

The growing minority population also faces cultural barriers in the delivery of health care services. Culture plays a role in how patients perceive their illness, who should be involved in the treatment, and the self-diagnosis of symptoms. There are cultural differences in beliefs about treatment including the use of machines, the nature of death and dying, and the appropriateness of invading the body. Patients may not recognize that similar episodes of an illness can point to a single chronic disease. They may expect that their family should be involved in managing the disease (Diversity RX 2000). Even widely accepted Western medical practices, such as informed consent, can have disastrous implications for the patient/professional relationship. Some cultures find it unacceptable for health professionals to discuss impending death with patients.

In some instances, minority groups must combat the perception that they do not have health problems. One critical example of this is in the

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*Citing personal preference
and language, about 25
percent of African Americans
and Hispanics who have
racially comparable
physicians said they
explicitly considered race or
ethnicity when selecting a
doctor.*

SAHA ET AL.
JULY 2000

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Asian-American community, says Mary Chung, president and chief executive officer of the National Asian Women's Health Organization. At the Issue Dialogue, Chung identified a common misperception of the community she represents being considered as the "model minority." "Asian Americans are not seen as a population that needs help," Chung said, despite statistics that illustrate a different story. In reality, many young, university women do not seek treatment for depression and other mental illness because they feel invisible and believe services are not available. The problem also affects elderly Asian women, who have the highest suicide rate of any other group (Chung 2000).

Supply of Minority Health Professionals

The number of minority health care professionals has a direct impact on the health of minorities. Having minority professionals can increase the comfort level of minority patients with the health care system. It can also increase the likelihood that the cultural needs of patients will be met. Nevertheless, minorities are underrepresented among physicians and other health professionals. African Americans and Hispanics comprised nearly 24 percent of the population in 1998 but made up less than 10 percent of physicians, dentists, and pharmacists (Kamat 1999). They also made up less than 15 percent of physician assistants and registered nurses. In addition, according to Williams (2000), these statistics have basically remained the same over the past 30 years – hardly a sign of progress.

The picture is bleak for the future, as well, as enrollment in health professional schools is also low among minorities. In some areas of the country, there have been actual dips in minority enrollment in medical schools. The profile of faculties is not much better. The Johns Hopkins University in Baltimore is considered one of the best in terms of African-American

faculty. Yet its School of Hygiene and Public Health has few tenure-track professors who are African American. "We're one of the best, and we only have three," said Thomas LaVeist, associate professor at Johns Hopkins.

Strategies to Reduce Racial and Ethnic Disparities in Health

Eliminating or reducing racial and ethnic disparities in health requires the combined efforts of the public and private sectors including government, foundations, providers, advocates, and individuals. While the federal government has taken the lead in tackling these complex problems, several states and some notable foundations have developed multilevel strategies to address these issues as well.

Federal Activities

In 1998, the U.S. Department of Health and Human Services (HHS) launched a major initiative to eliminate racial and ethnic disparities in health by 2010. The initiative focuses on six of the most important health areas affecting racial and ethnic minorities. The government selected these six areas for several reasons:

- they reflect the disparities that are known to affect multiple racial and ethnic minority groups at all life stages,
- there is good baseline data in these six areas which will enable HHS to monitor progress in reducing disparities, and
- the six priority areas represent health issues that account for a significant burden of disease but are also amenable to targeted improvement.

The effort is led by a senior-level steering committee in HHS, chaired by the Assistant

Secretary for Planning and Evaluation and the Surgeon General, which gives direction to the efforts of all agencies within the department.

The action plan for this effort involves three major steps:

- developing partnerships with other organizations that have the capacity to help eliminate racial and ethnic disparities,
- developing the capacity to collect data, and
- implementing new projects to eliminate disparities.

Every agency within HHS is working to eliminate racial and ethnic barriers to health.

Activities of these units include agenda setting; supporting communities in their efforts to mobilize and respond; research; and the direct delivery of health services.

Agenda Setting. The Office of Disease Prevention and Health Promotion in the Office of the Surgeon General administers Healthy People, a national health promotion and disease prevention initiative that brings together national, state, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve health, longevity, and the quality of life of Americans. Healthy People 2010 builds on initiatives pursued over the past two decades and was refocused in 2000 to emphasize the elimination of racial and ethnic disparities in health.

In 1997, HHS launched a department-wide Asian and Pacific Islander Initiative to identify and address the disparities in health status and access to health and human services for these communities. The initiative helps ensure that HHS is responsive to the health, mental health, and social service needs of Asian or Pacific Islanders and works to improve their quality of life.

Supporting Communities in Their Efforts to Mobilize and Respond. The Centers for Disease Control and Prevention (CDC) has awarded \$9.4 million to community coalitions in 18 states to help address racial and ethnic disparities in the United States. The awards are a component of CDC's new initiative, Racial and Ethnic Approaches to Community Health (REACH 2010), a demonstration project that targets the six health priority areas.

Thirty-two community coalitions were funded in 1999; three additional coalitions were subsequently funded by The California Endowment to participate in REACH 2010. Grantees spent the first year planning and developing activities to reduce the level of disparity in one or more of the priority areas. Now in its second year, all of these organizations will compete for funding to implement these plans, utilizing clearly defined interventions with a geographically defined minority population. The populations include African Americans, American Indian or Alaska Natives, Hispanic Americans, and Asian or Pacific Islanders. This collaboration between the government and The California Endowment has sparked interest at CDC in creating similar partnerships around the country to widen the impact of the REACH 2010 program.

In order to foster stronger community and institutional collaborations to address health disparities and increase its capacity to influence public health in minority and underserved communities, the National Institute of Environmental Health Sciences (NIEHS) is sponsoring regional meetings on health disparities and environmental justice. These meetings are planned to provide feedback to minority and low-socioeconomic status communities on the results of the Institute of Medicine Study on Environmental Justice.

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*Folks don't seem to realize
that there is a profound need.
There's an expectation that
the Indian Health Service is
going to meet 100 percent of
the tribe's needs.*

YVETTE JOSEPH-FOX,
NATIONAL INDIAN
HEALTH BOARD,
MAY 2000

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THE “MINORITY OF THE MINORITIES”: UNDERSTANDING THE UNIQUE PROBLEMS OF REACHING AMERICAN INDIANS AND ALASKA NATIVES

Racism and socioeconomic status are at the root of the health disparities that minorities suffer in this country. For Native Americans, one other factor has contributed to their poor health, short life expectancy, and incidence of disease: public policy.

For American Indian or Alaska Natives, there is a promise of a separate delivery system of health care through the Indian Health Service (IHS) and tribal health care providers. The health problems Native Americans suffer far outweigh these entities' ability to handle them, however. And while the IHS was a model in the provision of primary care for nearly two decades, the last several years have been marked by the federal government's decision not to provide increased funds to cover inflation, growing fixed costs, and population increases.

Public policy also contributes to other factors that complicate delivery of health care to this population.

State governments may feel threatened by tribes' sovereign status and their ability to tax state resources. At the same time, states also wield an enormous amount of power over the American Indian or Alaska Native population within their borders. For instance, for 10 years the Cheyenne River Sioux Tribe in South Dakota has attempted to get a certificate of need so it can open up a nursing home for the tribe's elderly, who suffer from diabetes, end-stage renal disease, heart disease, and ailments caused by smoking. The tribe wants to get Medicaid reimbursement but their efforts have been opposed in the state legislature.

In addition, despite qualifying financially, Native Americans generally are cut off from receiving Medicaid benefits. The thinking goes that the IHS should be picking up the costs and not the state or local governments.

To make matters worse, there is a growing perception that the booming gambling industry, centered on the success of Indian casinos, will take care of this population's income status and health status. In reality, only about 15 of the 558 tribes nationwide have casinos, and many of them are small operations that have had little impact and serve mostly as employment programs.

“American Indians and Alaska Natives are different from all other minorities in that our people enjoy a legal-political relationship with the United States government. It's what we secured, in terms of the exchange of our land,” said Yvette Joseph-Fox, executive director of the National Indian Health Board. But it is a promise that has not yet been kept in Indian country.

The Bureau of Primary Health Care within the Health Resources and Services Administration of HHS has developed an initiative to increase access to care to 100 percent and decrease disparities in health to zero. In the spring of 1998, the Bureau created the Center for Community Development to help identify partners and mobilize communities to provide access to primary health care. Partner organizations use the center to deliver the assistance communities need to build and sustain health systems for poor and vulnerable populations. For example, the Center disseminates information on model programs that can be replicated by other communities and will provide technical resources for identifying leaders committed to increasing primary health care access and eliminating disparities in health.

Research. The Agency for Healthcare Research and Quality (AHRQ) is currently supporting several research initiatives to develop new tools for improving the quality of care and new strategies providers can use to help them incorporate evidence into everyday practice. Several of these initiatives place a special emphasis on supporting research that can help address racial and ethnic disparities in health. For example:

- Funding has been approved for nine centers of excellence to develop practical tools in eliminating racial and ethnic disparities. The centers will conduct research to provide information on what factors affect quality, outcomes, cost, and access to health care for minority populations.
- AHRQ will support research that involves partnerships between academic researchers and health care providers who serve predominantly minority communities.
- AHRQ will also support training for minority health services researchers to address the priorities identified in the President's Initiative to Eliminate Racial and Ethnic Disparities in Health.

Past activities of AHRQ include convening an expert workshop in 1999, *Future Directions for Health Services Research Regarding Minority Populations*. Clinicians, health services researchers, and community leaders met to discuss the agency's future research agenda and identify appropriate priorities and questions for minority health services research, as well as strategies for building a minority health services research community.

The AHRQ also expanded its support for minority health services research in 1999 by allocating funds for projects that addressed the six conditions. Funded projects fall under one of three published AHRQ initiatives. The initiatives solicit the health services research community to develop new research, tools, and information to improve health care for priority populations and help build capacity in the field of health services research. They are:

- *Measures of Quality of Care for Vulnerable Populations.* This initiative seeks to develop and test new quality measures for use in the purchase or improvement of health care services for priority populations.
- *Assessment of Quality Improvement Strategies in Health Care.* This initiative seeks to expand the conceptual and methodological bases for improving clinical quality and to analyze the relative utility and costs of various quality improvement approaches.
- *Translating Research Into Practice (TRIP).* The initial TRIP solicitation aimed to generate new knowledge about approaches that effectively promote the use of rigorously derived evidence in clinical settings and lead to improved health care practice and sustained practitioner behavior change. In 2000, TRIP was continued as TRIP II. A major component of TRIP II is a focus on better understanding the reasons for health care disparities and ways to eliminate them. One priority is to determine the extent to which

general strategies need to be modified to improve quality of care for minority populations.

The Office of Research on Minority Health (ORMH) leads the efforts of the National Institutes of Health (NIH) to stimulate new research ideas for improving the health status of minority Americans. ORMH recently launched a new Web site to offer the public and scientific community information about the NIH Minority Health Initiative (MHI). This multi-year program supports biomedical and behavioral research aimed at improving the health of minority Americans and research training programs designed to increase the numbers of underrepresented minorities in all aspects of biomedical and behavioral research.

The MHI cofunds – in partnership with NIH institutes and centers, other federal agencies, and outside organizations – a variety of activities including:

- interventions to improve prenatal health and reduce infant mortality;
- studies of childhood and adolescent lead poisoning, HIV infection and AIDS, and alcohol and drug abuse;
- research in adult populations focused on cancer, diabetes, obesity, hypertension, cardiovascular disease, mental disorders, asthma, visual impairments, and alcohol abuse; and
- training for faculty and for students at all educational stages – from pre-college and undergraduate through graduate and post-doctoral levels.

Direct Services. The Substance Abuse and Mental Health Services Administration (SAMHSA) has several new programs that address the needs of minorities. Two of the programs are related to HIV/AIDS. The first offers \$9.15 million in grants to support community-based outreach and substance

abuse treatment programs targeted to minority populations at risk for HIV/AIDS. This grant initiative, funded by SAMHSA's Center for Substance Abuse Treatment, is designed to develop outreach projects that will provide HIV counseling and testing services, health education and risk-reduction information, tuberculosis testing, substance abuse treatment, primary care, mental health, and medical services for those who are HIV-positive or are diagnosed with AIDS.

The second program provides \$16 million to support 30 to 40 grants to expand substance abuse treatment in African-American, Hispanic, and other racial or ethnic minority communities affected by the twin epidemics of substance abuse and HIV/AIDS. The grants are designed to address gaps in services by increasing the accessibility and availability of substance abuse treatment and HIV/AIDS-related services.

HHS is also partnering with outside organizations in its efforts to eliminate racial and ethnic disparities in health. One such partnership, with the American Public Health Association, will address limitations in access to health care among racial and ethnic minorities and other aspects of life that contribute to good health, such as housing, education, faith, workplace conditions, and social welfare. The partnership will ultimately include a large number of organizations concerned with improving the health of the U.S. population.

The campaign has three phases or milestones. The first major milestone is the development of a blueprint of guidelines and end goals by a steering committee of 25 leaders representing business, labor, social welfare, housing, education, government, faith, and ethnic organizations. The second milestone is the development of the blueprint into a detailed, comprehensive plan by a larger coalition of similar national,

regional, and local organizations. Finally, the third milestone, made possible by public-private partnerships, will be the implementation of the comprehensive plan, the redirection of resources where necessary, and the evaluation of the campaign's success in eliminating racial and ethnic disparities in health by the year 2010.

State Activities

In addition to federal activities, several states are working to eliminate racial and ethnic disparities in health. A review of state legislative activities since 1998 shows a number of strategies that states are using to address the issue including convening advisory committees and task forces, developing grant programs to fund private organizations, and producing public education campaigns. In all, legislation to address racial and ethnic disparities has been proposed in 18 states. Although not all of these states have been successful in their efforts, examples of some state work follow.

A new initiative in North Dakota, North Dakota Delivers, outlines 21 primary goals for improving health and identifies key indicators to measure progress toward each goal. One of the goals of the initiative is to improve the quality of life for American Indians. Key indicators to measure progress toward reaching this goal include child mortality rates on reservations, life expectancy, suicide rates, the percentage of families living below 50 percent of the poverty level, high school graduation rates, and the percentage of high school graduates that enroll in postsecondary education.

The state of Nebraska created a blue ribbon panel to investigate the state's infant mortality rate. The panel will focus its efforts on determining the correctable and preventable causes of infant mortality in Nebraska, with a special focus on rising neonatal deaths. The panel will examine a number of factors including race and ethnicity. Likewise, the state of Oregon has cre-

ated the Racial and Ethnic Health Task Force. The purpose of the task force is to review, analyze, and recommend changes as needed in state agencies with the goal of improving the individual and community health status of people of color and ethnic populations.

In Florida, \$5 million was appropriated to create the grant program, Reducing Racial and Ethnic Health Disparities: Closing the Gap. The Indiana legislature is also giving consideration to using tobacco settlement funds in part for programs to eliminate racial and ethnic health disparities.

In both Maryland and Michigan, public education campaigns are being conducted. In Maryland, the media campaign is geared toward reducing infant mortality among African Americans. The campaign in Michigan is designed to promote healthy lifestyles in minority communities.

Foundation Activities

Tackling health disparities among minorities must be a multipronged effort. Foundations must strive to address specific health care problems while also combating the institutional roots of the causes of these disparities. There are some foundations that have adopted a broader vision in focusing on racial and ethnic disparities. They are highlighted here because they emphasize the kind of wide-ranging strategies that are needed to address disparities.

The Commonwealth Fund

The Commonwealth Fund has devoted significant resources for the purpose of addressing the health needs of minority populations. It has two strategic priorities: (1) improving the quality of care for an increasingly racially and ethnically diverse population; and (2) developing physician leaders in health policy who have a strong commitment to the needs of minority patients and their communities. The Fund

NURTURING YOUR BOARD – REI

The Northwest Health Foundation – a small, relatively new foundation based in Portland, Oregon – has set an example of educating its board of directors to be more sensitive to the disparities in health among minorities.

Thomas Aschenbrener, president of the foundation, said his board has recognized institutional racism as the root of these disparities and is working to eradicate it. Through the experience and efforts of some board members, the board has heightened awareness of preexisting notions they may hold of minority groups, and some of the board members have reexamined their own positions as members of white society. One successful training the board has undertaken is exploring what “white privileges” exist in our society. White privilege is another way of looking at racism, one that shifts the perspective from placing minorities at a disadvantage to examining the advantages that whites enjoy. Based on the work of Peggy McIntosh at Wellesley College, white privilege is described as what whites in society take for granted every day – that which is not earned but simply given to them because of the color of their skin. McIntosh describes this privilege as “like an invisible, weightless knapsack of special provisions, assurances, tools, maps, guides, code-books, passports, visas, clothes, compass, emergency gear, and blank checks.” Aschenbrener said that the Northwest Health Foundation is using the idea of white privilege as a framework for examining the board’s own attitudes.

The exercise has not been without its problems. “It’s hard to get a board to start addressing this kind of issue, especially when there are a lot of white men on the board,” he said.

Aschenbrener has also brought to his board a list of provocative books on the subject of race, among them: *The Measure of Our Success: A Letter to My Children and Yours* by Marian Wright Edelman, *Coyote Stories* by Mourning Dove and *Oh Freedom! Kids Talk About the Civil Rights Movement with the People Who Made it Happen* by Casey King and Linda Barrett Osborne.

DIRECTING YOUR FOUNDATION

Informing the board of directors is just one method that Northwest Health has taken in tackling the subject of racial disparities in health. It has eliminated funding preferences for ethnic and minority outreach, finding that many applicants did not take seriously their own commitment to diversity. Instead, each application is now reviewed from the standpoint of whether it reaches the minority communities it proposes to serve. "I am particularly delighted that I do not have a history to overcome with my board. So even though we have relatively small amounts of money, we have some real flexibility in using it effectively," said Aschenbrener.

In addition, the foundation has done a tremendous amount of listening to members of the community by convening meetings of direct service providers, health policy officials, and health education officials – in short, those who can detail what a foundation can do to make a difference.

"Some of our dialogues brought these people who may never have talked with each other together on issue areas. Suddenly, these people are talking in a way that they haven't before. So just the dialogues can make a real difference," Aschenbrener said.

Finally, the foundation has consciously become a resource for other foundations. As the largest Oregon-based foundation funding health care, Northwest Health has tried to expand its influence by engaging other foundations in these conversations. It accomplishes this by offering technical support and monitoring capacity to foundations that may receive a proposal from a community group on health care.

"What we're doing is building relationships with local foundations and giving simple messages such as "if you get a proposal from a community group on health care, we will use the expert staff of our foundation to assist you in reviewing it,"" Aschenbrener said. "I don't know of any other way that we can expand our impact in the community better than to help other funders come in and support health efforts important to the whole community," he said.

seeks to accomplish its objectives through a number of activities, including analytic work, publications, and direct intervention.

Research on minority health. Studies supported by the Fund have shed light on access to care, health care utilization, health status, and other issues affecting the health of minorities. For example, a recent paper prepared by Fund staff in collaboration with Sherry Glied, Ph.D., of Columbia University, documented comparatively low rates of employer-based health care coverage among racial and ethnic minority workers. Although workforce and sociodemographic characteristics explain some of the variation, the analysis showed that disparities persist even when factors such as industry type, firm size, job type, poverty level, and geographic location are considered (Hall, Collins, and Glied 1999).

The Fund also published *U.S. Minority Health: A Chartbook* which contains key facts on the health status and availability of health care to minority populations as well as a volume of papers based on analysis of The Commonwealth Fund Minority Health Survey (Collins, Hall, and Neuhaus 2000). The Fund is currently considering a second national survey of minority populations, with a focus on their experiences and quality of care within the U.S. health care system.

Quality of care. As an increasing number of studies continue to show that access to care is no guarantee for healthy outcomes, the Fund has begun to focus more on quality of care issues in underserved populations. One aspect of quality of care that the Fund is exploring is cultural competency. The Fund recently awarded a grant to Maren Monsen, a physician at Stanford and award-winning filmmaker, who will produce a film documenting the experiences of racial and ethnic minority patients in the health care system, with particular emphasis

on the relationships between patients and their providers. This film will be used both to inform public, patient, and provider audiences as well as to teach students in undergraduate medical education.

The Commonwealth Fund also provided a grant to the Center for Multicultural and Minority Health at Cornell University, headed by Joe Betancourt, for a project on cultural competence. The project has four goals: to define and operationalize the concept of cultural competence; to examine the roles of various stakeholders in this process; to look at current best practices; and to develop recommendations for integrating cultural competency into health care delivery.

The Fund is also supporting work that focuses on measuring and reporting the quality of care in minority populations. Ruth Perot, director of Summit Health Institute for Research and Education, Inc., was funded to assess current federal and selected states' policies and practices pertaining to racial and ethnic data collection. This project will focus on the collection of data on program enrollment, health care service utilization, and health outcomes.

David Nerenz at the Institute for Managed Care at Michigan State University was funded to lead a project entitled "Quality of Care for Minority Populations." In this project, now in Phase II, Nerenz is developing a report card for health plans that rate health plan performance in providing quality health care to minority patients. This report card includes existing quality measurement tools, such as those from the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Study (CAHPS). This report card also includes new tools for assessing cultural competency, provision of preventive services, and measures of appropriateness of care for clinical conditions that are highly associated with minority populations.

Commonwealth Fund/Harvard University Fellowship in Minority Health Policy. Now completing its fourth year, the objectives of this initiative are to prepare minority physicians for leadership positions in minority health policy. The program also seeks to improve the capacity of the health care system to address the needs of minority and disadvantaged populations; create a network of minority physician leaders capable of advancing in the public, nonprofit, and academic sectors; and enhance Harvard's health leadership training.

The fellowship program prepares participants in a one-year, full-time program of rigorous academic training, which leads to a master's degree in public health, and thorough instruction in leadership skills. Fellows are taught to identify, analyze, quantify, and develop solutions to public health problems through instruction in financial and organizational management, communications, politics, economics, and ethics. The fellowship includes courses, seminar series, leadership forums, site visits, national conferences, shadowing of public health leaders, and a practicum. It is expected that the fellowship will support the development of a cadre of leaders in minority health – well-trained academically and professionally in public health, health policy, health management, and clinical medicine – who are committed to pursuing careers in public service.

A corollary benefit of the program is that it has strengthened the focus and curriculum of the Harvard School of Public Health on minority health issues and attracted more minority students to the school.

The California Endowment

The California Endowment works to develop the field of multicultural health by promoting community-driven strategies that reduce socio-cultural barriers to health through both its responsive and strategic grantmaking programs

in the state of California. The Endowment's responsive grantmaking program, CommunitiesFirst, is rooted in two fundamental beliefs: that the role of community is central to health; and that inclusion, partnership, and community ownership, with a focus on local assets and resources, are critical to addressing local issues successfully. CommunitiesFirst responds to community proposals that address three objectives: access, health and well-being, and multicultural health. Projects funded under CommunitiesFirst are comprehensively addressing the public health concerns of every age group and region in California.

The strategic grantmaking program of the Endowment includes a number of projects that address the health needs of California's diverse communities. Last year, the strategic grantmaking program consisted of initiatives in the areas of cultural and linguistic competence, medical interpretation, health professions workforce diversity, and the elimination of racial and ethnic disparities in health. As part of the Disparities in Health program, the Endowment undertook a partnership with CDC and the CDC Foundation to fund three additional community coalitions as part of REACH 2010. Beyond collaboration with the CDC, The California Endowment awarded multiyear grants to three regional projects also focused on the elimination of racial and ethnic disparities in health. To date, the Endowment's Disparities in Health work covers all of California and addresses the African-American, Asian or Pacific Islander, and Latino populations. Its work also addresses four of the six identified health priority areas: cancer screening and management, cardiovascular disease, diabetes, and adult immunization.

Finally, in order to illustrate the opportunities and gaps in the field, The California Endowment commissioned an annotated bibliography on multicultural health, *Multicultural Health:*

Setting the Stage for Innovative and Creative Approaches (Murray-Garcia, Herd, and Smith 1999).

The Henry J. Kaiser Family Foundation

The Kaiser Foundation's activities in minority health are focused on efforts to reduce racial and ethnic disparities in health care access. Through both policy research and analysis, and media and public education activities, the Foundation seeks to develop more effective solutions to the problems contributing to the poorer health access and outcomes experienced by many racial and ethnic minority Americans. It also supports leadership and skills development programs for disadvantaged youth, through its Barbara Jordan Congressional Scholars program. In addition, the Foundation has a specific initiative on Native American health. This initiative supports a Native American health policy fellowship program for midcareer professionals as well as other efforts to develop more effective policy solutions for health problems facing American Indian or Alaska Natives. Recent activities of the Foundation have included:

- a forum to bring together leading public and private sector policymakers – including health professionals, educators, civil rights leaders, and consumer organizations – to review the evidence on race and medical care and discuss what can be done to address inequities in care;
- a survey of public perceptions and experiences regarding racial and ethnic disparities in health;
- focus groups designed to study perceptions of how race and ethnic background affect medical care; and
- a synthesis of the literature on racial and ethnic differences in access to medical care.

Recent publications produced by the Foundation include the following:

- *Racial and Ethnic Disparities in Access to Health Insurance and Health Care*. This report, produced in collaboration with the UCLA Center for Health Policy Research, examines health insurance coverage and access to physician services among African Americans, Latinos, Asian or Pacific Islanders, and American Indian or Alaska Natives. By pooling national survey data over two years, information about particular minority subgroups is also provided (Brown, Ojeda, Wyn, and Levan 2000).
- *Key Facts: HIV/AIDS and African Americans*. This publication provides an overview of recent data and research on the impact of the HIV/AIDS epidemic on African Americans. The document also presents trends in the HIV/AIDS epidemic over time, racial differences in the access to and quality of HIV/AIDS services, and the attitudes toward and perceptions of HIV/AIDS by race (Kaiser Family Foundation 2000).
- *Sources of Financing and the Level of Health Spending for Native Americans*. This study analyzes all sources of financing and the level of total health expenditures by and on behalf of Native Americans. It also includes a detailed analysis of the same data for each of the 12 Indian Health Service areas across the country and an estimate of per capita spending for health services to Native Americans overall (Cox and Langwell 1999).

The Kaiser Commission on Medicaid and the Uninsured has also produced new reports on immigrant health care, a chart pack highlighting statistics, and a policy brief discussing the legal status of Medicaid eligibility. Additionally, the Foundation has produced fact sheets examining health insurance coverage and access to physician services among racial and ethnic minority groups.

The Medtronic Foundation

The Medtronic Foundation provides grants to programs and projects that directly affect the lives of those most vulnerable in communities served by Medtronic, a medical device company. In health, the Foundation supports programs that enable patients and their families to participate confidently in their health care. Special consideration is given to projects or programs that address diseases or conditions for which Medtronic offers therapies or treatments. Priority is given to programs that benefit people who are socioeconomically disadvantaged.

For example, The Medtronic Foundation Patient Link Program is designed to improve the health and lives of patients with chronic diseases and conditions through support of patient associations that provide information and empower patients and their families. Medtronic has targeted survivor groups dealing with illnesses and diseases such as cerebral palsy, spinal cord injury, and brain injury. Medtronic has found that these associations are interested in outreach to minorities because, even though statistics show that minorities may suffer more from these diseases or types of injuries, the associations do not know the best approaches to reach these communities. Grants made under the initiative include \$5,000 to the Brain Injury Association for reaching minority communities; \$20,000 to the International Cancer Alliance for outreach to African-American communities; and \$50,000 to the National Stroke Association for its African-American Stroke Education Initiative. Medtronic also is working on a best practices book to help patient associations with these outreach efforts.

Northwest Health Foundation

As the largest Oregon-based grantmaker focusing on health, the Northwest Health Foundation has served the health needs of minority populations and sought to build non-

traditional collaborations with other foundations, applicants, and community-based organizations. Among its other priorities, the Foundation supports projects designed to improve the delivery of health care to culturally diverse communities, including those that address:

- health protection;
- quality of health care;
- access to health care;
- basic and applied biomedical, health, and sociobehavioral research;
- education for health professionals and consumers; and
- mental health.

For example, the Foundation recently made a grant to the Mental Health Center for Southeast Asian Children and Their Families to hire a bilingual interpreter for the health clinic which addresses the needs of children, adolescents, and families of Cambodian, Laotian, and Vietnamese origin. The Foundation also supported the Josephine County Mental Health Organization to recruit and train 20 culturally diverse trainers to conduct suicide intervention-skills training workshops for health professionals serving youth in the region. The Foundation also supports programs tackling HIV/AIDS in minority communities, diabetes among Hispanics, and prenatal care for American Indian or Alaska Natives.

Thomas Aschenbrener, president of Northwest Health, said that the work of the Foundation expands beyond simply funding health prevention programs. It offers three-part technical assistance training sessions (grant writing, evaluation, and sustainability) to grantees and other organizations interested in applying for grants. The Foundation board has tried to raise its own consciousness about minority health disparities. Proposals are reviewed from the standpoint of how they will reach minority communities. In

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*We believe that the
empowered patient is really
the wave of the future.*

PENNY HUNT,
THE MEDTRONIC
FOUNDATION,
MAY 2000

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addition, it has tried to sensitize other larger area foundations by offering expertise in grant reviews and technical assistance.

SmithKline Beecham

In partnership with the University of Pennsylvania's Institute on Aging, SmithKline Beecham is sponsoring a \$4.5 million initiative, The SHARE Awards, to reward community-based nonprofit organizations that address issues of human diversity in improving access to quality health care for older adults. Two types of awards will be given:

- leadership awards for organizations that have had a positive, measurable impact on the well-being of diverse groups of elders through culturally competent approaches to health care. Up to ten \$50,000 awards will be made annually.
- innovation awards for organizations proposing new approaches to improving access and outcomes for racial, ethnic, and cultural minority elders. Up to five awards of \$200,000 will be awarded on a biannual basis.

The program will be conducted over three years. Through a transnational nominating process that includes an advisory board, the Institute on Aging will select community-based nonprofit organizations to be funded each year.

Funding Strategies

Much of the work of foundations to reduce or eliminate racial and ethnic disparities can be categorized into four main areas: cultural competency, recruiting minority physicians and other health professionals, eliminating racism, and health promotion.

Cultural competency. The California Endowment has made a number of grants in the area of cultural competency. For example, several CommunitiesFirst grants support the

incorporation of alternative and complementary health practices in community health clinics and the establishment of culturally appropriate clinics incorporating native traditional healing practices and western medicine. One grant provides cross-cultural training programs for Hmong shamans and western physicians working with the Hmong population in Merced, CA.

The Endowment has also awarded a series of grants to support the development of the field of medical interpretation within the state. This series of grants supported a train-the-trainers model; a standardization proposal for the California Health Interpreters Association that included certification processes and infrastructure development; a research program to assess the impact of professional interpretation on improved quality of care, service delivery, and cost savings; and policy and advocacy work for cultural and linguistic competency in health.

Finally, the Endowment supports the development and incorporation of cultural competency curricula and training into existing health professions education programs.

The Northwest Health Foundation is active in this area as well. It provided \$65,000 to the Urban League of Portland to support salaries for expansion of culturally relevant outreach and health education programs to promote the wellness of the African-American community, especially the organization's health initiatives on HIV/AIDS, childhood lead poisoning, and breast and cervical cancer. The Foundation has also supported culturally appropriate health education and breast and cervical cancer screenings for Latina women ages 30 and older, in addition to the use of anti-smoking messages to Hispanic communities.

Recruiting minority physicians and other health professionals. Several national foundations have

focused on building the supply of minority physicians and faculty. For example, The Robert Wood Johnson Foundation's (RWJF) programs include the Minority Medical Education Program, a summer enhancement program designed to help minority students compete for medical school acceptance. In 1998, this program was expanded from 8 to 12 sites and funded at \$300,000 annually. RWJF also sponsors the Minority Medical Faculty Development Program, which offers four-year, postdoctoral research fellowships to minority physicians who have demonstrated superior academic and clinical skills and who are committed to careers in academic medicine. Each of the Fellows selected (up to 12) will receive an annual stipend of up to \$50,000, and a \$25,000 annual grant toward support of research activities. Fellows will study and conduct research in association with a senior faculty member located at an academic center noted for the training of young faculty and conducting research that is of interest to the Fellow. Fellows are expected to spend up to 70 percent of their time in pursuit of research activities.

The W.K. Kellogg Foundation and RWJF co-sponsor Project 3000 by 2000: Health Professions Partnership Initiative, which challenges educators in medical, nursing, and other health professions schools to join together and partner with local school systems and colleges. The goal of the initiative is to enhance the academic preparation of minority students and nurture their interest in health careers, thereby increasing minority participation in all health professions, including medicine. The third round of funding for this initiative began in 1999, with ten grants of \$350,000 each. Five are for partnerships led by schools of public health; five are for partnerships led by medical schools. Partnerships undertake activities to improve academic performance and ensure students' progress through the health professions pipeline, such as:

- establishing formal partnership councils;
- developing and implementing joint plans for curricula and educational strategies;
- establishing or enhancing existing programs in high schools;
- developing performance benchmarks that facilitate progression of minority students from one partnership institution to the next;
- actively involving families of students, especially those in middle or high school;
- strengthening the math and science skills of elementary and secondary teachers;
- administering after-school and summer enrichment programs;
- improving student understanding of health career opportunities;
- developing internships for high school and college students; and
- implementing strategies to enable more underrepresented minority college students to maintain interest in the health professions and complete preprofessional studies.

The W.K. Kellogg Foundation also sponsors a number of other initiatives designed to recruit and train minorities for the health professions. One is a \$1.5 million grant to Hampton University to address underrepresentation of ethnic minorities as pharmacists. Kellogg also awarded a \$1.7 million grant to National Medical Fellowships, Inc. to support graduate study leading to the Ph.D. in health policy for minorities. The goal of this grant is to increase the diversity of voices that research and formulate policy options.

Josiah Macy, Jr. Foundation has also sponsored a number of initiatives including minority summer research fellowships; neurology fellowships for minority physicians; a program to improve the qualifications of minority students who narrowly missed acceptance to a specific medical school; a program to recruit and train minority students in providing primary care in under-

served communities; and substance abuse training for minority medical students.

At the state level, the Hogg Foundation for Mental Health sponsored the Minority Professionals in the Fields of Mental Health Services and Research program. It funded Prairie View A&M University to develop the George R. Ragland Scholars Program. The Scholars Program seeks to train minority professionals in the fields of mental health services and research.

Eliminating racism. The Charles Stewart Mott Foundation has made a major commitment to addressing racism. The Mott Foundation is funding the ERASE Initiative which is being carried out by the Applied Research Center. The initiative is an effort designed to foster collaborative strategic approaches to challenge racism in public schools and promote academic excellence and equity for all students. This program is designed to address inequality in public schools which creates structural barriers for people of color, limiting their access to quality education, information, jobs, and economic opportunities. Funding supports a national program to encourage community, parental, and student involvement in addressing issues of racism in public education. Program goals include amplifying public awareness of and discourse about racism in public education; deepening the political and racial analysis of community-based organizations; strengthening the capacity of community organizations to engage in strategic anti-racist organizing; promoting more ideological and infrastructural cohesion among social justice organizations; and creating racial justice and academic excellence for all students.

Another major program supported by Mott is the eRacism Research Project. The project assesses organizations that claim to be engaged in anti-racism work in low-income communi-

ties and hopes to shape future thinking among practitioners, funders, and policymakers on how to develop projects aiming to counter racism.

The Ford Foundation is also working with Mott and various community foundations to promote community-wide efforts to counter institutional racism. Ford and Mott are cofunding the Community Foundations/Intergroup Relations Program, which is a three-year, \$5.1 million initiative to emphasize the importance of community-based efforts that combine honest dialogue about racial and ethnic differences with action that focuses on shared neighborhood concerns. Five community foundations and a private community-focused foundation have received grants ranging from \$460,000 to \$510,000. During a yearlong planning phase, the organizations will form advisory committees comprised of diverse groups of community, neighborhood, and philanthropic leaders to help determine the kinds of projects each will support during the subsequent two-year regranting phase. Participating organizations are: Community Foundation of Greater Atlanta; Community Foundation of Greater New Jersey; Dade Community Foundation, Inc.; the Eugene and Agnes E. Meyer Foundation; The Minneapolis Foundation; and The San Diego Foundation. Ford and Mott are contributing \$3 million; local foundations are required to raise the remaining \$2.1 million.

Health promotion. Foundations have also been active in promoting health among minorities. The Paso del Norte Health Foundation has supported a number of health promotion activities for the largely Hispanic population of its community, including providing \$3 million over four years for Life is Delicious! (Que Sabrosa Vida!). This is a program that includes 20 community-based organizations throughout El Paso, Texas, southern New Mexico, and Ciudad Juarez, Mexico, in efforts to change the

way area residents choose the food they eat by promoting moderation and providing culturally positive and realistic ways of selecting and preparing healthy foods. This initiative will include a foundation-designed public awareness campaign for mass media, restaurants, and grocery stores. Also, a community mobilization effort characterized by interactive classes aimed at disadvantaged families – focusing on planning, budgeting, purchasing, preparing, saving, and sharing family meals – will be emphasized. Finally, a community gardens program will be implemented in an effort to reconnect city dwellers with the land and teach children about food sources.

The California Endowment has provided more than \$800,000 over three years to the Ventura County Health Care Agency to develop a comprehensive heart disease and diabetes prevention and early intervention program for underserved residents. Program services will be delivered by various community organizations and administered by the Public Health Department. The grant funds will go towards developing and implementing a community-driven program that will seek to promote healthy eating and regular physical activity in four selected communities where heart disease and diabetes disproportionately affect the residents. Latinos represent the ethnic group in most of the selected communities. The Health Department plans to seek additional funding to expand the program to reach other areas of the county.

Many foundation activities fall into one of the four areas described above. There are a number of other foundations, however, whose programs fall outside of these areas and may either directly or indirectly work to improve the health of minority populations. For example, the Jewish Healthcare Foundation provided a grant of \$139,000 to AIDS Action Plan to implement the recommendations of a community advisory

committee convened by the Foundation in response to the rising AIDS epidemic. The grant will support the implementation of major recommendations including:

- cross-training outreach workers who have a focus other than AIDS,
- minority outreach,
- convening an ethics forum,
- technical assistance,
- community consensus/action meetings, and
- application to The Ford Foundation's National Community AIDS Partnership.

The New York Community Trust is currently assessing the barriers to care and the health needs specific to minority populations in New York. Together with other funders in New York, it will develop a coordinated grantmaking program to address these needs. More broadly, a group of community foundations has also gathered to work collaboratively in designing a program that jointly addresses access to care and racial and ethnic disparities in health.

Challenges for Grantmakers

The range of factors that affect both the health status of minorities and their experiences in the health care system show that racial and ethnic disparities in health are an extremely complex problem. Much remains to be done. The need for better data remains despite public and private efforts to enhance what we know about minority health. For example, the development of new programs to provide culturally specific services to minorities would benefit from data regarding their impact on minority access and health. In addition, many communities lack the capacity to deliver culturally competent services to their diverse populations. Foundations can help communities build the capacity to deliver services to minorities, foster new coalitions to achieve shared goals, and provide guidance on evaluating programs.

Grantmakers face many internal challenges to prepare for addressing health disparities among minorities. Foundation boards of directors may not be fully sensitized to the needs of these communities, if they have had little social or work experience with them. Diversity must be promoted on these boards – and not by selecting just one person of color to serve. The same is also true among foundation staff.

Foundations must be prepared for challenges to their funding decisions by groups in the minority community. Grantmakers described awarding funds to a particular group and then receiving phone calls from similar organizations not funded, questioning why one group was funded over another. In short, foundations must be cognizant of the complexity of race and racism and attempt to make their funding decisions clear.

Finally, foundations must strive to think more broadly about how to tackle these health problems – moving outside traditional health care boundaries to form partnerships with groups working on environmental, poverty, and housing issues. Dialogue must be initiated and sustained for there to be real progress in the future.

Finding the Right Niche

Foundations' role in reducing disparities in health among minorities is a daunting task, especially as grantmakers are strapped with precious resources and faced with many valid needs. But with so many avenues to explore in both traditional programming and nontraditional measures, foundations are positioned to quickly fill a niche that can help them have an impact on the problem. Ideas culled from successful foundations working in this area and other experts include:

- *Initiate public education campaigns.* Target a specific segment of the population as well as highlighting health disparities to a wide audience. Address unhealthy behaviors or better publicize health prevention. A Sudden Infant Death Syndrome campaign among certain American Indian or Alaska Native populations, for instance, could combat a specific public health problem by disseminating well-documented information on how to prevent these deaths. Publicizing a low-sodium and high-vegetable diet may help prevent heart disease and cerebral vascular disease among African Americans.
- *Create programs that expand insurance coverage or enroll eligible participants.* African Americans, Hispanics, and Asian or Pacific Islanders are all disproportionately uninsured. Make sure these programs include distribution of public health information.
- *Focus on quality of care.* While access to care remains a critical issue for minorities, quality of care plays an equally important role in creating or eliminating health disparities. Just as

critical are programs that can measure the quality of care being provided. For instance, are patients who speak little English receiving appropriate translation services when visiting a physician? Are providers culturally competent to serve patients in their community? Are minorities receiving the same care as their white counterparts?

- *Highlight access and quality of care to specialty services.* These areas are where disparities are most profound, even among groups of Medicare patients who are similarly insured.
- *Address disparities through less popular avenues.* Convene meetings that help build coalitions throughout the community. Consider legislation at the state level or programs that empower individuals and communities to give them a voice.
- *Determine whether nonprofit hospitals are acting for the community benefit.* Enlist the help of attorneys general to determine whether poor patients are actually getting the care that they are supposed to from these organizations. Empower local communities to provide political weight to these efforts.
- *Fund data collection.* Consider studies that look more deeply into subgroups of minorities within the larger minority community. For example, collect health statistics for Vietnamese, Chinese, and Cambodians within the Asian-American population.
- *Take on universities.* Press for more minority students in medical schools and public health schools. Advocate for permanent curriculum changes that address minority health issues and cultural competency for all students who are future health care providers. Emphasize the importance of the sustainability of these changes.
- *Dedicate grant dollars to fund studies and clinical trials that include minorities.* Compel grant applicants to include people of color in their proposed work before awarding money.
- *Seek nontraditional partners in collaborative efforts.* Is there an environmental, social ser-

vice, or housing group in the community whose work overlaps the health field?

Overcome mistrust by initiating and sustaining a dialogue.

- *Offer technical assistance and grant monitoring to potential future grantees.* Help prepare them to apply for larger grants offered by federal programs.
- *Collaborate with like-minded others.* For example, the Ford Foundation's group on women's reproductive health meets regularly with the Intercultural Cancer Council to discuss minorities and the underserved. Such work will be even more critical in the coming decades as the American population continues to diversify.
- *Engage corporate America.* Our future decisionmakers are attending college today, and they must be made aware of the importance of health care to a strong society and sensitized to the unique problems that minorities face in this arena. Programs that expose these students to all areas of health care by visiting public health clinics, school-based health centers, hospitals, and nursing homes may result in a better health care system in the future.

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