



Community-Campus
Partnerships for Health
A POLICY AGENDA FOR HEALTH
IN THE 21ST CENTURY



TRACK 7

*Racial and Ethnic Disparities in Health Status:
Framing an Agenda for Public Health
and Community Mobilization*

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PREFACE

From Community-Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century April 29-May 2, 2000 ~ Washington, DC

Creating healthier communities and overcoming complex societal problems require collaborative solutions that bring communities and institutions together as equal partners and build upon the assets, strengths and capacities of each. Community-campus partnerships involve communities and higher educational institutions as partners, and may address such areas as health professions education (i.e. service-learning), health care delivery, research, community service, community-wide health improvement, and community/economic development. Founded in 1996, Community-Campus Partnerships for Health is a non-profit organization that fosters community-campus partnerships as a strategy for improving health professions education, civic responsibility and the overall health of communities. In just four years, we have grown to a network of over 700 communities and campuses that are collaborating to achieve these goals.

Community-Campus Partnerships for Health's 4th annual conference was designed to broaden and deepen participants' understanding of the policies, processes and structures that affect community-campus partnerships, civic responsibility, and the overall health of communities. The conference also aimed to enhance participants' ability to advance these policies, processes and structures.

These nine papers, commissioned for discussion at the conference – played an integral role in the conference design and outcomes and would not have been possible without the generous support of the Corporation for National Service and the WK Kellogg Foundation. On the conference registration form, participants chose a track that interested them the most in terms of contributing to the development of recommendations and possibly continuing to work on them after the conference. Participants were then sent a copy of the commissioned paper corresponding to their chosen track, to review prior to the conference. At the conference, participants were assigned to a policy action team (PAT). Led by the authors of that track's commissioned paper, each PAT met twice during the conference to formulate key findings and recommendations. These key findings and recommendations were presented at the conference's closing session and are reflected in the conference proceedings (a separate publication). These will be considered by CCPH's board of directors as part of its strategic planning and policy development process, and are expected to shape CCPH policies and programs in the coming years.

The complete set of nine commissioned papers is available on CCPH's website at <http://futurehealth.ucsf.edu/ccph.html>

1. Integrating student learning objectives with community service objectives through service-learning in health professions schools curricula – Kate Cauley
2. Working with our communities: moving from service to scholarship in the health professions – Cheryl Maurana, Marie Wolff, Barbra J. Beck and Deborah E. Simpson
3. Promoting collaborations that improve health – Roz Lasker
4. Public policies to promote community-based and interdisciplinary health professions education – Janet Coffman and Tim Henderson
5. Building communities: stronger communities and stronger universities – Loomis Mayfield
6. Community-based participatory research: engaging communities as partners in health research – Barbara Israel, Amy J. Schulz, Edith A. Parker, and Adam B. Becker
7. Racial and ethnic disparities in health status: framing an agenda for public health and community mobilization – Gerard Ferguson
8. Social change through student leadership and activism – David Grande and Sindhu Srinivas
9. Advocating for community-campus partnerships for health – Charles G. Huntington

Introduction: Mapping Racial and Ethnic Disparities in Health

Racial and ethnic minority populations are among the fastest growing of all communities in America. Yet, Blacks, Hispanics, American Indians/Alaska Natives, Asian Americans, Native Hawaiians and other Pacific Islanders, in many respects, have poorer health and remain chronically underserved by the health care system.

- United States Department of Health and Human Services, Office of Minority Health, *Eliminating Racial and Ethnic Disparities in Health: Report to Congress*, April 1, 1999

Public debate about differential morbidity and mortality among various cultural and racially-defined communities is at least as old as our historically fragmented infrastructure for collecting vital statistical and epidemiologic data about health and social status in the United States (Krieger 1999; National Academy of Sciences, 1981). Critical attention to racial and ethnic disparities in health status in recent years has challenged policy and community leaders, health care researchers, public health officials, anthropologists and sociologists of health care, historical epidemiologists, social justice advocates. A proliferation of interdisciplinary social science and epidemiological analytical frameworks in the health research literature continue to invite answers to core dilemmas: What is the meaning of race and ethnicity in health? What value does ethnic and racial categorization have for our strategies to reduce and eliminate social disparities in access to quality preventive and primary health services? How do we build systems and networks of care that are sensitive to difference and the multiple identities of health care consumers? And finally, how do we translate current research about racial and ethnic disparities in health status into effective community-based strategies for public health intervention?

A federal investment in the health of historically-marginalized “minority” communities increased during the mid to late 1960s (Farley 1987; Sparer, 1996). Federal appropriations directed to health and social safety nets, such as Medicaid, the state and

federal sponsored insurance program for the poor and medically needy, drew attention to differentials in health status between poor and nonpoor (Cooper 1981). These policy discussions would culminate in an examination of minority health twenty years later with a comprehensive, federally-sponsored study of black and minority health. With an explicit call for a public health agenda to address health disparities between whites and various minority populations, the 1985 *Report of the Secretary's Task Force on Black and Minority Health* presented new threshold questions about health care access, social disparities in health, civil rights, and accountability in public health and medicine in its declaration that there were identifiable "excess deaths" for African Americans, Hispanics, Native Americans, and Asian and Pacific Islander communities (Nickens 1986; US DHHS 1985). Excess deaths were defined as the difference between minority deaths and age- and sex-specific deaths for whites. At bottom, the report – the result of a Task Force on Black and Minority Health convened in 1984 by US Department of Health and Human Services Secretary, Margaret Heckler- identified six areas for special attention: (1) cancer (2) cardiovascular disease and stroke (3) chemical dependency (link with cirrhosis) (4) diabetes (5) homicide, suicide, and unintentional injuries (6) infant mortality. The 1985 report also recommended several core strategies for implementation to narrow these differentials. Among the actions recommended were improved access to preventive health education, health professions investments, better research efforts targeted at minority groups, and more collaborative approaches with a focus on community-based supportive services.

Fifteen years after the release of the 1985 *Report on Black and Minority Health*, public health officials, researchers, and community activists are faced with some of the same health issues and similar dilemmas about strategy to eliminate gaps in access, care, and health

status (Bayne-Smith 1996; US DHHSa) . Stark racial and ethnic disparities continue to be reflected in epidemiologic data outlining the health status of the Nation. In some cases, an emphasis on aggregate societal declines over the last half century in the incidence of certain conditions has also masked the ways in which the production of social disparities and patterns of disproportionate impact have occurred alongside these larger trends. This is perhaps best represented in racial disparities in infant mortality, where rates for African Americans are almost three times as high as those for Whites (Hogue 2000).

On February 21, 1998, the launch of President Clinton's and the United States Department of Health and Human Services' *Racial and Ethnic Disparities in Health Initiative* to reduce and eliminate disparities in six new areas affirmed the chronic problem of social disparities in health. Though there is some overlap with the areas identified earlier in 1985, the Administration's priorities now include a focus on infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS, and childhood and adult immunizations.

Strategic discussions at the federal level are also largely anchored in the context of the Nation's public health targets identified in the United States Public Health Services' *Healthy People 2000/2010* framework. In general, more aggressive policy and research initiatives centered on minority health both inside and outside of government over the past twenty years have stemmed from a recognition that different communities have experienced a disparate impact from many preventable conditions, even as shifts in the scientific and technological base of medicine and public health have introduced improvements in prevention, treatment, and diagnosis. Life expectancy, a measure of long-term health status, has also shown a stark racial and ethnic disparity. Although life expectancy has risen for all groups in the U.S.

population over the past century, there has been a consistent disparity in life expectancy in terms of race and ethnicity. In 1996, life expectancy at birth for black men was 66.1 years- the lowest for any group- and 73.9 for white men (OMH 1999).

The federal Office of Minority Health has also presented these data to highlight disparities among several of the leading categories of death in the United States:

- **Diabetes.** African Americans experience diabetes at a rate that is 70 percent higher than white Americans. The prevalence of diabetes among Hispanics is double that of white Americans. Data from 1994-1996 reveal that American Indian and Alaska Natives experience a diabetes death rate that 3.5 times greater than the rest of the U.S. population.
- **HIV/AIDS.** Minority communities, which account for 25% of the total U.S. population in official estimates, make up 50% of all AIDS cases. AIDS is the leading cause of death for African Americans between the ages of 25 and 44 and the second leading cause of death for Hispanics in the same age group. It is also the fourth leading cause of death for African Americans and the fifth leading cause of death for Hispanics. African American and Hispanic women, who represent less than 25% of all U.S. women, account for 76% of AIDS cases among women through 1997.
- **Infant mortality.** In 1998, the overall U.S. infant mortality rates was 7.2 deaths per 1,000 live births. African Americans experience a rate that is 13.7 per 1,000 live births, while Hispanics experience a rate of 6 deaths per 1,000. Between 1985 and 1996, infant mortality rates by 33.7% for infants born to white mothers and declined by 22.6% for black infants during the same period.

There are also racial and ethnic gaps in births to low birthweight infants, which constitute a risk for infant mortality.

- **Cancer screening and Management.** In terms of mortality for men and women, African Americans have a cancer death rate that is 35% higher than whites. African American women, who are less likely to be diagnosed with breast cancer than white women, have a higher mortality rate. The lung cancer death rate is 27% higher for African Americans than for whites.
- **Cardiovascular disease.** In comparison to whites, coronary heart disease mortality is 40% below the rate for whites. African Americans, however, experience a rate that is 40% higher than that of whites.

Over the past decade, there has been an unprecedented federal commitment to the health of underserved and vulnerable populations, including poor and minority populations that experience a disproportionate impact from preventable diseases. In September of 1999, the federal Centers for Disease Control and Prevention awarded \$9.3 million to 32 community coalitions who were addressing some aspect of the six targeted health conditions. The United States Congress authorized \$156 million in 1998 for a special HIV/AIDS Initiative to address the devastation of this disease among African Americans. Health and Human Services Secretary Donna Shalala also made a formal budget request for \$5 billion this past February to establish a Coordinating Center for Research on Health Disparities at the National Institutes of Health to foster a more coordinated and collaborative research and policy framework focused on minority health.

Although special initiatives and appropriations at the federal level has focused attention to the problem of racial and ethnic disparities outlined in aggregate terms for certain

conditions, there are still gaps in public policy related to epidemiologic trends adjusted for age and gender differences. Although they have not been singled out in the current priority areas identified in the present federal *Race and Health Initiative*, violence (including homicide and suicide) and unintentional injury were mentioned in the 1985 report on black and minority health. Accidents and unintentional injuries were identified, in 1996, as the fifth leading cause of death for Whites (non Hispanic), but ranked as the third leading cause of death for Latinos and Native Americans and the fourth for Asian Americans (OMH 1999). In terms of intentional injury, age-adjusted firearm injury death rates for Black males increased 23.2 percent compared to 7.2 percent for White males between 1985 and 1996. In 1996, Black males aged 15 to 24 and for whom death from homicide and legal intervention is the leading cause of death, experienced a death rate from this cause of 123 per 100,000 compared to 49 per 100,000 for Hispanics, 27 per 100,000 for Native Americans, 16 per 100,000 for Asian Americans, and 14 per 100,000 for Whites. Given the specter of gun control as a public health intervention and policy option to stem incidence (Ferguson 1998). Domestic violence, an area which has recently been profiled in the core of injury discussions, reflects similar disparities. Between 1992 and 1996, the average annual rate of nonlethal violent victimization by an intimate partner occurred at a rate of 8 per 1,000 for whites, in comparison to 12 per 1,000 for blacks and 7 per 1,000 for Hispanics.

Even as attention to racial and ethnic disparities in health is sustained in prominent local, state, and federal public health campaigns, a host of problems relate to the measurement of racial and ethnic disparities (Cunningham 2000). Chief among these problems is the lack of consistency in the use and meaning of the terms race, ethnicity, and culture. These include the inconsistency in definitions of race and ethnicity, the lack of

consistent state and federal data, and a general homogenization of cultural, class, and ethnic experiences within these diverse communities. Some of our foremost national surveys measuring health care access, utilization, and status, including the *Current Population Survey* (CPS), the *Medical Expenditure Panel Survey* (MEPS), the *National Health Interview Survey* (NHIS), and the *Behavioral Risk Factor Surveillance System* (BRFSS), for example, do not reflect the complex demographic and cultural experiences of communities that continue to be homogenized as black, white, or Hispanic (Bolen et.al 2000). Nor do these surveys commonly ask about or affirm ethnic group identities, such as Puerto Rican, Dominican, or Mexican, which underlie the broad cultural category Hispanic.

In spite of the ongoing debates about definitional inconsistencies and the epidemiological significance of race, several scholars continue to note that there are complex social phenomena and inequalities that are often ignored in a reliance of broad racial and ethnic group identification (Nazroo 1998; Park 1997). Health care researchers who continue to rely on race without adequate controls that measure the impact of other social and economic variables fail to capture the ways in which race and ethnicity exist as proxies for social class and related socioeconomic factors (Feldman 1999; Guralnik 1997; Harrison 1994). Public health efforts to reduce and eliminate disparities must journey beyond simple categorization to affirm the ways in which race, as most geneticists and social scientists now affirm, is not a valid biological category or predictor but a culturally-constructed social reality. In this context, researchers and community activists must constantly search for the diverse variables, such as income, education, transnational experience, acculturation, etc...that often mask the cultural contexts, social status, and historical experiences with discrimination that underlie racial and ethnic group categorization (Ma 1999; Bollini 1995;

Harwood 1981). This should also entail a sensitivity to the historical reality of how racial categorization has been used simultaneously to stigmatize and discriminate, at the same time that it has been invoked to critique and fight discrimination and oppression.

Race and Ethnic Differentials in Health: An Assessment of Contributory Factors

A voluminous health research and social science literature has identified some of the financial and economic factors that produce social disparities, including disparate impact for certain conditions among socially-defined ethnic and racial groups (Guralnik 1999; Davis et.al 1987). Disparities in health status for these groups has been traced to several variables, including socioeconomic factors (e.g., income, poverty, educational level, employment, acculturation, etc...), racism and gender discrimination, and other contextual factors, such as lack of insurance coverage and inadequate access to high quality networks of preventive and primary care (Muntaner, et.al 1997). Poverty has been recognized a major barrier to access among racial and ethnic groups, given its disproportionate impact on communities of color. As health researchers and other social scientists have turned their attention to a study of the intersection of race and place, new perspectives on barriers to health status have also emerged. This has largely entailed a recognition that the spatialization of racialized communities in urban environments has produced a set of unique nonfinancial and financial barriers. These include concentrated poverty in the core of cities, a shortage and maldistribution of primary care providers, a hesitancy among providers to accept Medicaid, lack of indigent or charity care facilities, variability in quality of services and choice of care options, as well as demands on ailing health care and hospital systems faced with problems stemming from an indigent population (Parchment 1996; McCaughrin 1995; Ford 1995). In

addition, health researchers and social scientists have just begun to unravel the ways in which the issue of expanding devolution of federal public health and social service programs in the context of welfare and immigration reform is impacting access to care among spatialized and racially-segregated racial and ethnic communities.

Financial Barriers

Poverty is a major factor in the experience of racial and ethnic groups in the United States, as well as a significant financial barrier to health care access. In 1998, the U.S. Census Bureau reported that 12.7% of the population lived below the poverty level. It reported that 10.5% of Whites, in comparison to 26.1% of Blacks, 25.6% of Hispanics, and 12.5% of Asian and Pacific Islander communities lived under the poverty level. The poor lack insurance coverage at higher levels, producing disparities in access to coverage. Health care coverage is an important issue determining access and has been associated with the maintenance of a regular source of care, access to after hours emergency care, and sustained contact with a physician or comprehensive system of preventive and primary care services (Targanski, et.al 1994; Crump, et.al 1999). The Medicaid program, in this context, has been a major factor in the provision of comprehensive services to poor and marginalized communities of color since 1965, particularly in terms of narrowing racial and ethnic gaps in prenatal care and infant mortality. Still, it is estimated that eligibility significantly lags behind enrollment. Approximately 4 million children in the United States, for example, are eligible for Medicaid but not enrolled. This fact continues to inhibit access to much-needed quality health and social services.

Recognized as a major financial variable for health care access, insurance status is key to the eradication of social disparities in health (Weinick 1998). Several prominent data sets reveal inadequate access to insurance coverage among racial and ethnic minorities. The March 1999 Supplement to the *Current Population Survey* reports that 15.5% of Whites, 22.2% of Blacks, 21.1% of Asian and Pacific Islanders, and 35.3% of those of Hispanic origin went without health insurance for the entire year of 1998. In terms of the experiences of children, 14.4% of White children, 19.7% of black children, 30.0% of Hispanic children, and 16.8% of Asian and Pacific Islander children went without coverage for 1998. These findings are also consistent with other national surveys.

While the U.S. Census Bureau affirms that 70.2% of Americans are covered by private insurance through employers, Medicaid enrollment data reveals that public insurance is an important primary source of coverage for the poor and communities of color (HCFA 2000). According to a recent report from the California-based Kaiser Family Foundation, one-half of Medicaid's 1997 beneficiaries were white and half were minority (Kaiser 1999). Of those living under 200% of the federal poverty level, Medicaid covered 39% of African Americans and 36% of Native Americans. Medicaid also covers approximately 1 in 5 nonelderly African Americans, Latinos, and Native Americans, in comparison to less than 1 in 10 nonelderly whites. The same report also found that minority Medicare beneficiaries were more likely to use Medicare as a sole source for insurance protection. The Kaiser analysis also found that 25% of African American and Latino beneficiaries had no supplemental coverage, in comparison to 10% of whites.

Disparities in access to health care coverage are also found among members of poor and minority communities who work full-time. A recent Commonwealth Fund survey on the

availability of employer-sponsored coverage found racial and ethnic gaps in access to coverage (Hogue 1999). Twenty-nine (29%) of Hispanic full-time, low-wage workers lacked an opportunity to participate in employer-sponsored plans, in comparison to 14% of Blacks and 12% of Whites who were also not afforded an opportunity for coverage. This is an especially troubling fact, given the growth in the number of the uninsured to 44.6 million, the increasing gap in insurance coverage between low-wage and high-wage workers, and the rates of erosion of employer-based coverage in general. Newacheck (1997) and Long and Marquis (1999), have also identified that Hispanics constitute approximately 30% of those who experienced the erosion of employer-based during the mid 1990s. In terms of comparisons between low-wage and high-wage workers, Cooper and Schone (1997) also found that, in 1996, 55% of low-wage workers (defined as those earning \$7 or less an hour) had access to employer-sponsored health insurance, in comparison to 96% of high-wage workers (those earning \$15.01 or more an hour).

Nonfinancial: Cultural and Contextual Barriers

In addition to the financial factors stemming from poverty and lack of insurance coverage, there are crucial nonfinancial barriers bearing on access to health services and utilization patterns. These factors include social and economic assets, cultural competency of health care providers, racism, classism, sexism, xenophobia, linguistic diversity, acculturation, and other factors bearing on interactions with health care providers and institutions (Krieger 1999; Berger 1998; Gamble 1997). These various nonfinancial variables can inhibit access to health care, even when insurance coverage is not the chief barrier. For example, numerous studies of access and utilization patterns among minority children have

found that transportation is a key variable determining utilization of ambulatory services among minority children (Kaiser 1999; Targanski 1994). Such studies have also found that these children experience longer wait times when seeing a health care provider. At bottom, a refined understanding of these cultural and contextual factors has helped to understand barriers to access preventive and primary care services. These contextual factors have implications for the studies of asthma hospitalization rates, for instance, where African American and Latino children are two to three times more likely to die from asthma than white children, even when they share similar profiles in socioeconomic status and insurance coverage (Kaiser 1999; Lozano 1995). Asthma remains a leading chronic condition in childhood and has been highlighted as a cause of death that is up to six times greater for African American children in comparison to white children.

Cultural and linguistic background, as well as acculturation, also bear heavily on interactions with the health care system and perceptions of health status among ethnic and racial minorities (Ma 1999b; Ferguson 1998; Berger 1998). Numerous health services researchers, particularly those with methodologies that incorporate ethnographic processes, have linked patterns of health care access and delivery, quality, and utilization to cultural differences and diversity among consumers in the health care seeking process. An analysis of selected health indicators among a sample of 60,719 Latinos who answered the *National Health Interview Survey* between 1992 and 1995 found differences for selected health care indicators among ethnic groups (National Center for Health Statistics 2000). Among those asked to assess their health status, 40% of Non-Latino Whites rated their health as excellent, in comparison to 28% of Non-Latino Blacks, 28.3% of Mexican/Mexican Americans, 37.8% of Cubans, and 27.8% of Puerto Ricans. In terms of physician contact, 79.9% of Non-Latino

Whites reported contact with a physician within the past year, while 79.2% of Non-Latino Blacks, 69.2% of Mexican/Mexican Americans, 78.3% of Cubans, and 82.8% of Puerto Ricans answered that they had seen a physician during the same period. These ranges in perceptions of health status also underscore differences among smaller cultural and ethnic communities commonly aggregated in studies of race and ethnicity.

A lack of culturally competent providers, racism, discrimination, and xenophobia are also at the heart of interactions with the health care system, as revealed in a series of recent surveys and scholarly analyses (Cheng 1997). The Commonwealth Fund's *Comparative Survey of Minority Health* found that language differences were a problem for 21% of minority Americans in seeking care. Researchers found that 26% of Hispanic adults and 22% of Asian American adults who did not speak English as a first language needed an interpreter when seeking care. Similar studies of consumers by the Kaiser Foundation found that there were issues of distrust of the health care system by African Americans, some of whom carried the historical memory of the Tuskegee Syphilis Study (1932-1972) and the racism and classism that shaped this unethical episode of medical experimentation upon African Americans (Gamble 1999). In the Kaiser study, consumers expressed through perceptions that African Americans, Native Americans, and Hispanics were all poor, ideas that African American women were all unmarried, and beliefs that Asians were deferential, among other common and offensive stereotypes.

In addition to the research that cultural perceptions and stereotypes influence access and utilization patterns, it is evident that some percentage of racial and ethnic disparities can be linked to compelling evidence that racism and ideas about racial and ethnic difference impact not only the view of patients by providers, but also pattern of treatment (Ford 1995;

Blustein 1995). Fifteen percent (15%) of minority participants in the recent Kaiser study expressed a belief that they would have received better care during the previous year if they were of a different race who echo other surveys, at the same time that they were more likely to report that their health was poor in comparison to whites (Kaiser 1999). A series of recent epidemiologic studies over the past decade have given more credibility to these perceptions, with research citing race (and gender) as important variables in the process of medical judgement and decision-making. Most recently, studies of access to cardiac catheterization raise questions about whether physician referral patterns of treatment may stem from a conscious or unconscious belief about race. A study by Schulman et.al (1999) is particularly illuminating for cardiovascular disease management in its finding that blacks and some women were less likely to be referred for cardiac catheterization or coronary-artery bypass graft surgery when presenting chest pains or myocardial infarction. Findings also note that this occurs after one controls for insurance status and other interactions with health care providers.

The study of cultural competency in health care settings is among the most promising aspects of research bearing on racial and ethnic disparities (Carrillo 1999; Galloway 1999; Pachter 1994). The American Medical Association's Consortium on Minority Affairs, the National Medical Association, the National Hispanic Medical Association, the Association of American Indian Physicians, and the American Academy of Family Physicians, among other professional organizations, have issued guidelines calling for attention to culturally competent health care. Many of these efforts promote efforts for interdisciplinary, cross-cultural understanding of patients and advocate transformations in the core curriculum of medical schools and allied health schools. There is a lack of consensus among researchers

and policy officials about how to operationalize standards to define and measure cultural competency, but the use of culture-based tools such as Kleinman's "typology of health sectors" to gauge sociocultural determinants of health and wellness, sociocultural risk factors, and cultural assumptions is yielding valuable data about the influence of culture on health (Marks 1997). Medical anthropologists and sociologists of health care have also proposed models of cross-cultural primary care, which are patient based and teach medical students, residents, and staff physicians to appreciate cultural understanding of the "patient's explanatory model," including attention to intersecting identities stemming from race, gender, class, and sexuality (Kleinman 1990, 1978; Erickson 1997). At bottom, many of these assessments of cultural competency stress that an understanding of culture and its importance for health status cannot expand until medical schools and other allied health institutions invite and operationalize more integrated discussions of anthropological and ethnographic studies of health care delivery.

An Agenda for Public Health and Community Action

An agenda to address social disparities and racial and ethnic disparities in health cannot rely solely on medical or scientific factors that influence the incidence of disease. While there is certainly a need for disease-specific strategies to narrow racial and ethnic disparities, there are broader policy options that go beyond traditional public health policy and strategies (Institute of Medicine 1987; Brooks 1997; Krieger 1999). These initiatives must address the social, economic, community, and cultural contexts in which people live and function (Emanuel 1997). And as a recent group of social scientists have pointed out in studies of urban poverty, such explorations of strategy and policy options must incorporate

attention to community-based assets as well as deficits. I will focus in this next section on community action and themes bearing on the production of social disparities that are necessary to deal with current trends in health care delivery and financing.

- **Social Justice.** Community and health care activists must mobilize to promote public policies which are just and fair. This implies that they are free from the effects of discrimination. This also implies an end to punitive xenophobic policies that exclude newly-arrived immigrants and certain classes of citizens from comprehensive systems of care. There are powerful historical examples, in terms of the exclusion of blacks and early twentieth century Catholics and Eastern, Central, and Southern European immigrants from segregated and nativist health care institutions. Legal challenges to segregation in health care waged through *Simkins v. Cone* (1963) and other cases presented compelling evidence that racial covenants excluding certain classes of patients, as well as the maintenance of segregated health care institutions (e.g., Hill-Burton hospital construction funds, etc...), undermined the health status of marginalized groups.

The denial of publicly-sponsored health care to newly-arrived immigrants and certain classes of citizens under welfare and immigration reform should be addressed from an ethical perspective. The implementation of the *Personal Responsibility and Work Reconciliation Act of 1996* (PRWORA), in this context, has had dramatic implications in urban areas for racialized and spatialized communities. Diversion practices instituted for potential Medicaid and food stamp populations have been pointed out in documents from the U.S. Department of Health and Human Services and the Justice Department's Office

of Civil Rights (see www.hcfa.gov for “Dear State” letters from Center for Medicaid and State Operations).

Strategy: Health care advocates and community-based organizations should work together to insure that discriminatory policies are not implemented on the federal, state, or local level. Discriminatory practices should be tracked and reported to the U.S.

Department of Justice and the U.S. Department of Health and Human Services, Office of Civil Rights.

- **Health Professions Development and Training.** Attention to the problem of racial and ethnic disparities has historically been framed by minority physicians, who disproportionately serve in neighborhoods where the poor and racialized minorities live. Programs for loan forgiveness and other incentives to attract a broader range of physicians and health professionals are needed to anchor health care delivery in underserved areas. The role of the Health Resources and Services Administration, the federal health agency with an explicit mandate calling for health safety nets for vulnerable populations has been invaluable in terms of meeting the needs for workforce development through its Bureau of Health Professions.

Strategy: Support for physicians and other allied health professionals can be increased through the reauthorization of the *Health Professions Partnership Act (P.L. 105-392)* and the *Disadvantaged Minority Health Improvement Act (P.L. 101-527)*. The research finding that minority physicians are more apt to serve in areas where the poor live must be translated into effective policy action which strengthens those already in place and

creates additional incentives for all of those who may seek to practice in underserved and poor areas.

- **Development of cultural competency assessment instruments and materials for Outreach.** A voluminous social science and epidemiologic literature has provided evidence that nonfinancial barriers to health care stem from low levels of cultural competency among providers and problems of translation stemming from linguistic and cultural diversity. Developmental models of ethnosensitivity, which measure ethnocentrism, can help to assess an institution's effectiveness in dealing with various populations and quality of care.

Strategy: An important model of this process has been implemented at the New York Academy of Medicine, where an interdisciplinary and multisectoral network of health providers, researchers, and community activists convene in a Racial Disparities in Health Workgroup share advice and experiences related to cultural competency and institutional practices. These discussions have implications for the delivery of services. At the Sunset Park Health Center and the Downtown Family Care Center in New York, for example, there are social and cultural assessments of Latino immigrants, which measure acculturation and various other cultural beliefs and practices. This information is gathered at the Downtown Family Care Center and integrated in medical school curricula.

- **Insurance coverage: Medicaid/XIX and SCHIP/Title XXI.** Medicaid and the State Children's Health Insurance Program represent important opportunities to sustain gains

in minority health status, as well as options to narrow racial and ethnic disparities in the future (Ferguson 1997a; Weinick, et.al 1998). The continued devolution of authority and oversight in public health and social welfare programs to the states coupled with welfare reform represents a dilemma for access in some states. SCHIP, in particular, where states can expand Medicaid or create their own state-only child health insurance programs, gives states extreme flexibility in the determination of eligibility criteria, including the use of geography/residence. States may also exercise extreme autonomy in the creation of benefit packages in their new state-only programs, a fact reflected in the wide variation of services currently offered among the states that participate in Title XXI. States have the option to include additional and optional services, such as substance abuse prevention, mental health services, and translation assistance.

Strategies: (1) Health advocates, providers, and community-based organizations should aggressively maintain educational programs about continued eligibility for Medicaid in the aftermath of PRWORA's passage. Welfare reform de-coupled eligibility for Medicaid based on welfare enrollment, and current declines in Medicaid caseloads parallel, in some instances, dramatic declines in welfare caseloads. The federal Administration for Children and Families (ACF), the agency responsible for oversight of the new Temporary Assistance to Needy Families (TANF) program, reports that the number of families receiving TANF declined from 4,114,000 to 2,536,000 during the period between January 1997 and June 1999. While state experiences differ in many respects, Medicaid participation rates declined. One study by Ellwood and Wu (1998) found that Medicaid cases dropped by almost 30% in Wisconsin and 20% in New York

between January 1995 and January 1998. Given the importance of Medicaid as a financing mechanism for the poor and minority communities, Medicaid and SCHIP enrollment monitoring is important strategies to preserve access. Advocates should encourage states to use the \$500 million Medicaid/TANF outreach fund to educate communities and hire eligibility workers to enroll people who are Medicaid-eligible in the aftermath of welfare reform. (2) Specifically in the case of SCHIP, health care providers and community-based organizations should monitor their State Plan development processes to determine the services that are being inserted in benefits packages (as well as potential fees and fines). This should also imply a monitoring of the decision about whether to expand Medicaid under Title XXI or to restrict benefits. The flexibility to establish eligibility based on geography also has implications for the politics of race, place, and health.

- **Policy leadership development among health care providers.** Collaborative frameworks are needed to foster policy leadership at the local, state, and federal level. The lack of participation of minority physicians and other health care professionals on review and expert panels and other leadership positions reflects a marginalization from many decision-making venues.

Strategy: Initiatives that support leadership development can bring physicians to the policy table as informed advocates on behalf of an agenda for quality health care for racialized minorities. The Health Resources and Services Administration and the Office of Minority Health within the United States Public Health Service have

supported numerous leadership development institutes, including a recent initiative launched as the National Hispanic Medical Association Policy Leadership Development Institute. This institute meets twice a year, first, at New York University's Robert F. Wagner Graduate School of Public Service for a summer institute in public policy analysis, and, in the fall, in Washington, D.C., where the fellows are exposed to health services researchers and other policy officials.

Research. Quality research must always parallel good policy development and implementation. Research is needed about the complex composition of various identified racial and ethnic groups, including subgroups and cultural communities within the commonly invoked broad racial categories. We must investigate the range of sociocultural and financial factors that produce disparities within heterogeneous cultural and ethnic communities. The sharply divergent experience with asthma hospitalization patterns of Puerto Rican and Mexican American children (Puerto Rican children experience a prevalence of 11% in comparison to 3% among Mexican American children) provides just one example of how current racial and ethnic categories may serve as a proxy for more complicated sociocultural and socioeconomic factors.

Strategy: (1) Promote more interdisciplinary research frameworks that bring together a diverse network of scholars and practitioners from varied backgrounds. (2) Establish special journal issues that highlight dilemmas related to race and ethnicity. (3) Refine data on specific under-represented communities, such as

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Asian and Pacific Islander communities and Native American communities, in research and evaluation.

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