

UNEQUAL LIVES

Health Care Discrimination Harms
Communities of Color in Maine

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Health Care Discrimination Harms Communities of Color in Maine

Rapidly escalating medical costs and insurance premiums, rising numbers of people without coverage, and rip-offs by monopolistic private insurers have dominated the Maine political dialogue surrounding President Barack Obama's plans for comprehensive health reform. On Capitol Hill, the American public is witnessing an historic clash of Washington special interest groups fighting to protect their revenue streams. Yet no one has more at stake than the 103 million people of color in the U.S.,¹ including the 59,000 in Maine.² Throughout the nation's history, communities of color have been forced to accept health care that bears little resemblance to what is experienced by members of more advantaged groups. For people of color in Maine and nationwide, life is shorter, chronic illness more prevalent and disability more common. These are predictable side-effects of a health care system that provides these communities in Maine with narrower opportunities for regular health services, fewer treatment options and lower-quality care.

Despite growing evidence of racial disparities in health status and medical services, no system exists in Maine for collecting state and local data on disparities. As a result, many questions about the health of minorities in state remain unanswered. Life expectancy for African Americans in Maine is 6 to 10 years shorter than that of whites.³

Maine Disparities

- In Maine, about 8.8 percent of Latino adults have been diagnosed with diabetes, more than 10 percent higher than the rate for whites.⁴
- Almost 17 percent of adult Latinos in Maine have asthma, compared to 10 percent of whites.⁵
- In Maine, 30 percent of African American women received no early prenatal care, compared to 18 percent of Latinas and 12 percent of whites.⁶
- The U.S. Bureau of Labor Statistics estimates that 8.3 percent of Maine's labor force is unemployed.⁷
- In Maine, 118,935 people were uninsured in 2007.⁸
- Health insurance premiums for Maine working families have skyrocketed, increasing 90 percent from 2000 to 2007.⁹
- The full cost of employer-sponsored health insurance in Maine is projected to grow at an annual rate of 9.3 percent, compared to a 1 percent increase in income.¹⁰
- About 70,000 working non-elderly adults in Maine do not have health insurance. That comprises 72 percent of the total non-elderly uninsured population.¹¹
- In Maine, the AIDS case rate per 100,000 population is 59.8 for African Americans, compared to 25.5 for Latinos and 3.3 for whites.¹²

Endnotes

¹ US Census Bureau, "USA QuickFacts," 2008. Accessed at <http://quickfacts.census.gov/qfd/states/00000.html>.

² Ibid.

³ National Center for Health Statistics, "Health, United States, 2008 With Chartbook" Hyattsville, MD: 2009.

⁴ Department of Health and Human Services, Office of Public Health and Science, Office of Women's Health. Quick Health Data Online, 2008.

⁵ Ibid.

⁶ National Center for Health Statistics, "Health, United States, 2008 With Chartbook" Hyattsville, MD: 2009.

⁷ Bureau of Labor Statistics, "Local Area Unemployment Statistics." Accessed at <http://www.bls.gov/web/lauhsthl.htm>.

⁸ Kaiser Family Foundation, "Health Insurance Coverage of the Total Population, states (2006-2007), U.S. (2007)." Accessed at <http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3>.

⁹ Families USA, "Premiums versus Paychecks," September 2008. Accessed at <http://www.familiesusa.org/resources/publications/reports/premiums-vs-paychecks-2008.html>.

¹⁰ New America Foundation, "The State of State Health: The Cost of Failure (2007)" Accessed at <http://statehealth.newamerica.net/>.

¹¹ Peter Harbage, Ben Furnas, "Health Care in Crisis," Center for American Progress, May 4, 2009. Accessed at http://www.americanprogress.org/issues/2009/05/working_uninsured_map.html.

¹² The Henry J. Kaiser Family Foundation, "Key Health Indicators by Race/Ethnicity and State," 2009 update. Accessed at <http://www.kff.org/minorityhealth/7633.cfm>.

Executive Summary

NO ONE HAS MORE AT STAKE in the political debate over how best to shape health care reform legislation than the 103 million people of color. After hundreds of years of unequal treatment in this country, communities of color are forced to continue accepting health care and health outcomes that fall short of the quality and availability of medical services provided to more advantaged groups.

Heart disease, diabetes, and cancer account for two-thirds of all U.S. health care costs. African Americans, Latinos, Asian Americans, Native Americans and others who tend to live in neighborhoods with limited opportunities for healthful lifestyles have higher rates of all these diseases, and they fare worse in treatment. Were racial disparities absent from our society, the deaths of more than 880,000 African Americans would have been averted from 1991 to 2000, according to a recent analysis of mortality data. The implications for the country are profound when one considers the demographic trends at work today. The Census Bureau projects that 62 percent of the U.S. population will consist of people of color by 2050, when the U.S. population is expected to reach 439 million, up from 302 million today.

Compared to non-Latino whites, African Americans and Latinos are more likely to go without health care because they can't afford it. A larger share of African Americans and Latinos lack a usual place of health care, and they are less than half as likely as whites to have a regular doctor. Low-income residents and people of color always score lower in measures of preventive health, such as frequency of cancer screenings and well-visit checkups. Inequities in health are accompanied by disparities in health insurance coverage. People of color have the highest rates of uninsurance. The lack of quality,

affordable coverage makes these populations less likely to receive medical care and more likely to fall into poor health and die early, according to government analysts. Even when their insurance, income and diagnoses are comparable to those of whites, people of color with heart disease, cancer, diabetes, HIV/AIDS and other serious ailments often receive fewer diagnostic tests and less sophisticated treatment, according to a landmark 2002 report by the Institute of Medicine.

The effects are devastating to a multicultural society. They include shorter life expectancy, higher infant mortality rates, lower quality care, greater risk of diabetes, higher likelihood of death from cancer, less access to life-extending high-tech procedures, and increased risk of receiving undesirable treatments, such as limb amputations. In areas like the highly segregated city of Washington, D.C., the harsh effects of racial and ethnic health disparities are startling. The rates of infant mortality, asthma, high blood pressure, various cancers and numerous other health conditions are sharply higher in the predominantly African-American neighborhoods than in areas populated mostly by whites.

The medical establishment bears a major share of responsibility for the institutionalized racism that has led to persistent health disparities in the U.S., and the American Medical Association, the largest physician group, has publicly acknowledged it. The negative impact of discrimination on the health of communities of color was profound and continues to this day, primarily because these actions left these populations with too few doctors to treat people of color in a culturally competent manner, according to the predominantly black National Medical Association. The extent of the health

insurance industry's contribution to health disparities is unknown because good data are unavailable about the effects of insurers' marketing practices, provider networks and treatment decisions made for people of color.

Recommendations

The health care reform legislation under consideration in Congress offers one of the best opportunities since the creation of Medicare and Medicaid in 1965 to change public policy and erase persistent health disparities. Health Care for America Now (HCAN), a coalition of more than 1,000 organizations, urges Congress and the Obama administration to take advantage of this rare convergence of economic and political forces.

HCAN believes:

- Everyone should have access to an **affordable benefit package** that provides a **defined set of comprehensive services** to promote good health for all, including the millions who don't speak English, in a linguistically and culturally competent manner.
- Coverage should be backed by **adequate reimbursement rates** and effective **performance incentives** that promote provider participation, change the inefficient behavior of doctors and hospitals and

- promote improved health for people of color.
- Substantial improvements in health and life expectancy will be achieved by **addressing the social determinants** of health, including a clean environment, occupational safety, safe neighborhoods and access to nutritious food.
- The nation must address chronic shortages of **health professionals in communities of color and marginalized populations.**
- Congress should implement mechanisms to **support safety-net institutions** and **drive quality-improvement initiatives** in all health care settings.
- Stakeholders and the public should be given **good data** by insurers and health care providers on race, ethnicity and ethnic sub-population, socioeconomic position, primary language, age, gender and gender identity.

A high-performing health system must deliver quality care to everyone, regardless of race, ethnicity, sex, income, or any other demographic characteristic. A reformed and uniquely American system will be able to address a long history of discrimination in medical treatment by reorienting the way doctors, hospitals, drug makers, medical device makers, insurance companies and government programs provide care.

Health Care Discrimination Harms Communities of Color in U.S.

PEOPLE OF COLOR across the United States are more likely than non-Latino whites to receive inferior medical care, develop life-threatening chronic diseases, and die at a younger age. They also are more likely to be among the 45.7 million people without health insurance coverage,¹ and this comes at a high cost. Experts have estimated that 22,000 people die each year because of conditions that worsen as their lack of health insurance blocks them from routine access to physicians and hospitals.²

Heart disease, diabetes, and cancer account for two-thirds of all U.S. health care costs.³ African Americans, Latinos, Asian Americans, Native Americans and others, who tend to live in neighborhoods with limited opportunities for healthful lifestyles, have higher rates of all these diseases, and they fare worse in treatment. Even when their insurance, income and diagnoses are comparable to those of whites, people of color with heart disease, cancer, diabetes, HIV/AIDS and other life-changing ailments often receive fewer diagnostic tests and less sophisticated treatment, according to a landmark 2002 report by the Institute of Medicine.⁴

The U.S. has the world's richest health care system, a \$2.5 trillion-a-year⁵ juggernaut that caters to the affluent while remaining relatively indifferent to the fact that communities of color are disproportionately affected by serious diseases. As a result people of color are trapped in a vicious cycle of disease, poor quality of care and insufficient access to non-emergency and preventive services. This comes at a terribly high cost.⁶ Were racial disparities absent from our health care, the deaths of more than 880,000 African Americans would have been averted from 1991 to 2000, according to a recent analysis of mortality data.⁷ The implications are

profound when one considers the demographic trends at work today. The Census Bureau projects that 62 percent of the U.S. population will consist of people of color by 2050,⁸ when the U.S. population is expected to reach 439 million, up from 302 million today.

"Minorities and low-income Americans are more likely to be sick and less likely to get the care they need," Health and Human Services Secretary Kathleen Sebelius said last month. "These disparities have plagued our health system and our country for too long. Now it's time for Democrats and Republicans to come together to pass reforms this year that help reduce disparities and give all Americans the care they need and deserve."⁹

Inequities in health are accompanied by disparities in health insurance coverage; Native Americans and Latinos have the highest rates of uninsurance in the country.¹⁰ The lack of quality, affordable coverage makes these populations less likely to obtain medical care and more likely to fall into poor health and die early, according to government analysts.¹¹

The health care reform legislation under consideration in Congress offers one of the best opportunities since the creation of Medicare and Medicaid in 1965 to erase persistent health disparities. Health Care for America Now (HCAN), a coalition of more than 1,000 organizations, urges Congress and the Obama administration to take advantage of this rare convergence of economic and political forces and adopt health policies that will enable people of color to enjoy equal access to doctors and hospitals, higher quality of care, and more equitable geographic and socioeconomic distribution of treatment and research resources.

HCAN believes that everyone should have access to an affordable benefit package that provides a defined set of comprehensive services to promote good health to all, including the millions who don't speak English. Whether through public or private plans, coverage should be backed by adequate reimbursement rates and effective performance incentives that change the inefficient behavior of doctors and hospitals, eliminate wasteful spending and promote improved health for people of color.

Health and social scientists are moving toward a consensus that health disparities between non-Latino whites and other groups arise from psychosocial and cultural factors related to the social definition of groups, as opposed to genetic differences at the population level. This emerging framework is premised on the understanding that racism has more of an impact on health than race does.¹²

Disparity in care does not only take a human toll; it drives up costs for everyone. When people lack access to health insurance that would provide more primary and preventive care, they are more likely to require expensive visits to emergency rooms that aren't intended to ensure continuity of care. Without health insurance, patients enter the medical system with illnesses that are more advanced and complications that require costlier interventions. If everyone has good, comprehensive health care coverage—a goal greatly advanced by an affordable public health insurance plan option available nationwide—patients would have improved access to preventive care, earlier diagnoses and better disease management, reining in costs and saving lives. Coverage is only one important step, however. Meaningful reform ought to invest in prevention and wellness, and ensure that people of any race or ethnic background have access to high-quality, affordable care.¹³

A World of Difference

Compared to non-Latino whites, African Americans and Latinos are more likely to go without health care because they can't afford it.¹⁴ A larger share of African Americans and Latinos lack a usual place of health care, and they are less than half as likely as whites to have a regular doctor.¹⁵ Low-income residents and people of color always score lower in measures of preventive health, such as regular cancer screenings and other well-visit checkups.¹⁶

The contrast is stark for health care providers who treat wealthy and low-income patients, according to family practitioner Ranit Mishori, who works both at Georgetown University Medical Center in Washington, D.C., and at a community clinic in suburban Maryland, a 25-minute drive away. "My patients in northwest Washington not only have education and insurance going for them, they also are people who have been seeing doctors all their lives," Mishori wrote. "Most come in when they are perfectly healthy with the goal of staying that way. They ask questions, take notes, and look up medical information on the Internet. In other words, they are full participants, often the main driving force in their own care. By contrast, the patients in my community clinic may be unemployed or working multiple jobs to make ends meet. They may skip regular visits to save money or because getting time off to see a doctor is not an option. As a result of language barriers or lack of education, they may not fully understand medical instructions or even what conditions they have. Patients in this world also tend to seek medical help late."¹⁷

Clinic patients tend to visit a doctor only when they know they are sick, and often when medical conditions that might have been treated easily if diagnosed early instead have advanced and become complicated, said Luis Padilla, medical director of the Upper Cardozo Clinic in Washington, D.C. "Things that could have been caught earlier have been missed," Dr. Padilla

said. Patients show up with advanced diabetes, advanced cancer, and kidneys damaged beyond repair, he said.¹⁸

Yet the lack of access to timely care does not fully explain the inequality that persists in America, according to researchers. Even when their insurance, income and diagnoses are comparable to those of whites, people of color with heart disease, cancer, diabetes, HIV/AIDS and other serious ailments often receive fewer diagnostic tests and less sophisticated treatment, according to a landmark 2002 report by the Institute of Medicine.¹⁹

“Stereotyping, biases, and uncertainty on the part of health care providers can all contribute to unequal treatment,” the IOM report said. “The conditions in which many clinical encounters take place—characterized by high time pressure, cognitive complexity, and pressures for cost containment—may enhance the likelihood that these processes will result in care poorly matched to minority patients’ needs. Minorities may experience a range of other barriers to accessing care, even when insured at the same level as whites, including barriers of language, geography, and cultural familiarity. Further, financial and institutional arrangements of health systems, as well as the legal, regulatory, and policy environment in which they operate, may have disparate and negative effects on minorities’ ability to attain quality care.”²⁰

In one study of doctors who viewed videotaped presentations of patients from different racial groups with identical medical histories and symptoms, the physicians overwhelmingly referred more whites for advanced treatment. The doctors were far less likely to refer black women for aggressive treatment of cardiac symptoms than white women. When asked to give their impression of the actors, whom they were told were real patients, doctors routinely said they perceived the black “patients” as less intelligent, less likely to comply with doctor’s treatment recommendations, and more likely to miss appointments.^{21,22}

Irrefutable Data

In the IOM study and more recently in work for the Service Employees International Union and the National Conference of Black Mayors, researcher Brian Smedley demonstrated that across a range of measures of health care access and quality, communities of color receive a lower intensity and quality of care than white patients.²³

“Racial and ethnic health disparities are real and persistent,” Smedley wrote. “Although today’s problems may be deeply rooted in the past, what’s important is that they threaten our future health and well-being. Simply put, many people of color live shorter lives and suffer poorer health than white Americans.”²⁴

The effects are devastating to the fabric of our multicultural society:

- **Shorter life expectancy.** African-American men on average are 6.1 years younger than white men at the time of death. The life expectancy of black men is 69.6 years, compared to 75.7 years for white men. African-American women, on average, are 4.3 years younger at death than white women (76.5 years vs. 80.8 years), and black women face higher rates of illness and mortality.²⁵
- **Higher infant mortality rates.** Even as infant mortality rates declined for all races from 1980 to 2000, the gap in infant mortality rates between blacks and whites widened.²⁶
- **Higher rates of uninsurance.** Disproportionately large percentages of people in communities of color and of immigrant communities are uninsured. About 21 percent of white Americans lacked health insurance at some point in 2002, compared with 28 percent of African Americans and 44 percent of Latinos.²⁷
- **Lower quality care.** Economic and geographic segregation has resulted in separate and unequal care for patients from low-income groups and communities of color.

Institutions that serve communities of color are more likely to be deficient in quality of care and have fewer resources for patient care than those serving white communities.²⁸

- **Reduced likelihood of having a regular doctor.** African Americans, Latinos, and low-income families are more likely than non-poor whites to face barriers to a regular source of health care, a resource necessary to maintaining good health and managing chronic diseases.²⁹
- **Higher likelihood of diabetes.** The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States.³⁰
- **Higher likelihood of different treatments and death from cancer.** Among African Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for white Americans.³¹ Among patients with similar types and stages of cancer, blacks do not receive the same combinations of surgical and chemotherapy treatments as whites.³²
- **Less access to standard tests, procedures and drugs regardless of income and insurance status.** African-American heart patients are less likely than white patients to receive diagnostic tests, coronary artery-opening procedures, and blood-clot dissolving drugs, even when they have similar incomes, insurance, and other characteristics.³³ Black and Latino patients are less likely than whites to receive aspirin when leaving a hospital after a heart attack, to receive appropriate care for pneumonia, or to be given appropriate medications for pain.³⁴
- **Less access to life-extending high-tech procedures.** Insured African-American patients are less likely than insured whites to receive many potentially life-saving or life-extending high-tech procedures, such as

cardiac catheterization, heart-bypass surgery or kidney transplantation.³⁵

- **Higher likelihood of undesirable treatments.** People of color are more likely than whites to receive undesirable treatments, such as limb amputations for advanced diabetes.³⁶

Health Disparities Provide a Window on American Society

Disparities in health reflect inequalities in American society as a whole. Members of disadvantaged population groups are burdened by segregation, substandard housing conditions, inadequate education, exposure to environmental toxins, and occupational hazards. Even before seeking health care, people of color carry an excess burden of disease. African Americans suffer from higher incidences of chronic diseases, including asthma and diabetes, and suffer higher mortality rates. Latinos received equivalent care to whites in only 17 percent of measures.³⁷ Many of the factors perpetuating the social and economic disparities among people of color are the same that have led to the absence of health care equality, such as lack of educational opportunity, segregated housing in neighborhoods without convenient access to healthy food, exposure to environmental hazards and employment in low-paying, dangerous jobs.³⁸

Racial disparities have been shown to exist in all corners of the health care industry, including hospitals, physician offices and nursing homes. Due partially to the limited resources of facilities that serve the poor and disadvantaged, these institutions provide a lower level of care and reach fewer patients.³⁹ A paper published in the *New England Journal of Medicine* showed that a relatively small number of physicians care for black patients and that those who did were less likely to be board-certified and less likely to report they can provide quality care.⁴⁰ These disparities occur over a wide variety of measures, such as the prevention and treatment of chronic disease, maternal and infant health, and death rates for diseases such as cancer.

Fewer Hospitals in Neighborhoods of Color

Hospitals often are located outside communities of color and serve their populations less frequently.⁴¹ Community health centers that tend to serve patients of color face labor shortages,⁴² and patients at these clinics often have difficulty getting referrals to obtain services outside these clinics, including specialty care, diagnostic testing, and mental health and substance-abuse treatment.⁴³ Institutions that care for under-served and lower-income people do not have the resources to compete for staff or to provide what they would consider an effective level of care.⁴⁴ These communities are also challenged by the lack of preventive treatment. Providing quality health care is not merely treating illness. Caring for the healthy and providing preventive services and health-based education are essential to promoting long-term wellness.

Even when people of color gain access to health services, they are more likely than whites to receive inadequate care. Wait times to see a doctor are longer for people of color.⁴⁵ They are less likely to be given tests to determine risk of heart attack or stroke.⁴⁶ Asians and Latinos are more likely to die from complications during hospitalization.⁴⁷

Stereotypes and biases can interfere with effective communication between patients and doctors and other health care staff. More than 50 percent of Asians and more than 40 percent of Latinos have reported that their doctors do not listen to them. Almost 40 percent of African Americans have reported not entirely trusting their specialist physician.⁴⁸

Linguistic Barriers to Good Care

Nearly 20 percent of people in the U.S. speak a language other than English at home,⁴⁹ yet health care facilities often fail to provide interpretation and translation services.⁵⁰ Less than half of people with limited English-speaking skills have a usual source of care that offers language assistance.⁵¹ When hospitals

and clinics refuse to provide language services, they are shutting their doors to patients with limited English and increasing the possibility of misdiagnosis and treatment.

Under-representation of women, people of color, disabled persons, and rural populations in the vast majority of research studies is being recognized as a contributing factor to health disparities. Without adequate representation of diverse patient populations, researchers cannot learn about potential differences among groups and cannot ensure the generalization of results.⁵²

Barriers to Wellness

Wellness promotion, a concept that has taken hold in much of American society, is a huge challenge in disadvantaged neighborhoods. Many studies have found that a lack of supermarkets adversely affects dietary patterns in these areas and increases the risk of obesity and diabetes. Supermarkets are associated with more fruit and vegetable intake, more healthful diets and lower rates of obesity. Shopping at supermarkets versus independent grocers has been linked with more frequent fruit and vegetable consumption.⁵³ A study conducted in Washington, D.C., by the National Urban League found that 81 percent of food options in a predominantly African-American area of the city were convenience stores or fast-food outlets. Until a chain supermarket opened there in December 2007, there was no full-service grocery store in an area with 70,000 residents. Anyone who wanted to obtain fresh produce but had no car had to take a long bus ride across town.⁵⁴

Communities of color have fewer parks and green spaces than white neighborhoods. They have fewer safe places to walk, jog, bike or play. Their neighborhoods are less likely to be walkable, with homes located near stores and jobs, and more likely to be unsafe after dark. Rather than allow their children to play on unsafe streets, cautious parents in poor neighborhoods keep youngsters indoors after school, where they are more likely to watch TV, play video games and eat.⁵⁵ These sedentary activities create the

conditions for unhealthful patterns of adult health behavior.

The most significant challenge, however, is access to consistent, quality, affordable care. For the past 19 months the U.S. has been mired in the worst economic downturn since the Great Depression of 1929 to 1940. In June 2009 alone, 467,000 jobs were lost, many from industries that employ high numbers of people in communities of color, such as construction and manufacturing.⁵⁶ Unemployment among African Americans has climbed to almost 14 percent, with the rate for Latinos not far behind. Thus as unemployment rises generally, communities of color are disproportionately punished through the loss of access to employer-based health insurance.⁵⁷ Even among those lucky enough to hold onto their jobs, people of color are more likely to be employed in low-wage industries that do not offer health benefits even in good economic times.⁵⁸

Barriers to Good Care Resulting From State Budget Deficits

Public health care programs that rely on state funding face severe budget shortfalls.⁵⁹ The current fiscal crisis has inflicted budget shortfalls on 48 states for the 2010 fiscal year, totaling \$166 billion, or an average of 24 percent of state budgets. Combined budget gaps for the remainder of this fiscal year and state fiscal years 2010 and 2011 are estimated to total more than \$350 billion.⁶⁰ An analysis of unemployment data by the Kaiser Family Foundation found that a 1 percentage point rise in the national unemployment rate would increase Medicaid and State Children’s Health Insurance Plan enrollment by 1 million people (600,000 children and 400,000 non-elderly adults) and cause the uninsured population to grow by 1.1 million. That would increase Medicaid and SCHIP costs by \$3.4 billion, including \$1.4 billion in state spending. This represents a 1 percent increase in total Medicaid and SCHIP expenditures.⁶¹ Each percentage-point increase in the unemployment rate causes state general fund revenue to drop 3 to 4 percent below

States with Projected Fiscal Year 2010 Budget Gaps That May Affect State Health Programs

Ranked by Percentage of Shortfall

| | Total FY2010 Budget (in billions of dollars) | Projected Revenue Shortfall as a % of FY2010 Budget |
|----------------------|---|---|
| California | 53.70 | 58.2 |
| Arizona | 4.00 | 41.1 |
| Nevada | 1.20 | 37.8 |
| Alaska | 1.30 | 30.0 |
| Illinois | 9.20 | 33.0 |
| New York | 17.90 | 32.3 |
| New Jersey | 8.80 | 29.9 |
| Oregon | 4.20* | 29.0* |
| Vermont | 0.28 | 24.8 |
| Washington | 3.60 | 23.3 |
| Connecticut | 4.10 | 23.2 |
| Wisconsin | 3.20 | 23.2 |
| Florida | 5.90 | 22.8 |
| Kansas | 1.40 | 22.6 |
| Georgia | 3.90 | 22.3 |
| North Carolina | 4.60 | 21.9 |
| Louisiana | 1.80 | 21.6 |
| Maine | 0.64 | 21.4 |
| Minnesota | 3.20 | 21.0 |
| Utah | 1.00 | 19.8 |
| Rhode Island | 0.59 | 19.2 |
| Hawaii | 0.98 | 19.1 |
| Colorado | 1.40 | 18.6 |
| Pennsylvania | 4.80 | 18.0 |
| Massachusetts | 5.00 | 17.9 |
| Delaware | 0.56 | 17.6 |
| Alabama | 1.20 | 16.7 |
| Idaho | 0.41 | 16.4 |
| New Hampshire | 0.25 | 16.2 |
| Maryland | 1.90 | 13.6 |
| Iowa | 0.78 | 13.2 |
| District of Columbia | 0.80 | 12.7 |
| South Carolina | 0.73 | 12.5 |
| Ohio | 3.30 | 12.3 |
| Michigan | 2.40 | 12.0 |
| Kentucky | 1.10 | 11.3 |
| Virginia | 1.80 | 10.9 |
| Oklahoma | 0.60 | 10.5 |
| Missouri | 0.92 | 10.3 |
| Tennessee | 1.00 | 9.7 |
| Mississippi | 0.48 | 9.6 |
| Texas | 3.50 | 9.5 |
| Indiana | 1.10 | 7.5 |
| New Mexico | 0.35 | 6.3 |
| West Virginia | 0.20 | 5.3 |
| Nebraska | 0.15 | 4.3 |
| Arkansas | 0.15 | 3.2 |
| South Dakota | 0.32 | 2.9 |
| Wyoming | 0.32 | 1.7 |

*Oregon has a two-year budget.

Source: Center on Budget and Policy Priorities.

expected levels.⁶² By law, states must balance their budgets, so a drop in revenue must be met by a corresponding drop in spending or increase in taxes.

The economic downturn and rising unemployment are expected to increase demand for state-sponsored medical services, but state tax revenue is falling short of what will be needed to fund them. People of color rely on the social and medical services provided by these programs more heavily than non-Latino whites. In the last recession, 34 states made cuts in public health programs and 23 states limited access for children.⁶³ As the table above shows, states are facing shortfalls of up to 58 percent of their budgets.

Congress has responded with the American Recovery and Reinvestment Act, also known as the economic stimulus package, aimed at reducing the crushing burden on states.⁶⁴ Unfortunately, the stimulus is devoting about \$135 billion to \$140 billion to help states maintain current activities, less than half of the total projected shortfalls. Most of the money is targeted for increased Medicaid funding and a “Fiscal Stabilization Fund.” While this added money has reduced the depth of state cuts and moderated state tax and fee increases,⁶⁵ it hasn’t closed the gaps, and states are unable to afford enrollment of more people in already strained state health programs.

One City, Two Worlds

The harsh effects of racial and ethnic health disparities in care are starkly visible in Washington, D.C., the nation’s capital. The population of Washington’s Ward 3 in the affluent northwestern quadrant of the city is 84 percent white, 7 percent Latino, and 6 percent African-American.⁶⁶ A few miles away, across the Anacostia River in the southeastern neighborhoods, the population of Ward 8 is

92 percent African American, 6 percent white and 2 percent Latino.⁶⁷ Health providers are concentrated in the northwestern area of the city, far from low-income residents in the southeastern neighborhoods who rely on public transportation.

The differences are startling, according to a 2008 RAND Corp. report:

- The infant mortality rate was 1.3 per 1,000 live births in Ward 3, compared to a staggering 18.8 in Ward 8.⁶⁸
- In Ward 3, the premature death rate was 140 per 100,000 people, far below the 789 in Ward 8.⁶⁹ This rate is a measure of unfulfilled life expectancy.
- The rate of HIV infection in Ward 3 is 4 per 100,000 residents, compared to 104 in Ward 8.⁷⁰ About 3 percent of District of Columbia residents are infected with HIV, a prevalence on par with west African countries.⁷¹
- The rate of diabetes is 3 percent in Ward 3 and 11 percent in Ward 8.⁷²
- The rate of high blood pressure is 14 percent in Ward 3 and 36 percent in Ward 8.
- In Ward 3, about 38 percent of the population is obese or overweight, compared to 71 percent in Ward 8.⁷³ Among the city’s children, 18 percent of those in Ward 3 are obese or overweight, well below the 52 percent in Ward 8.⁷⁴
- The asthma rate among children in Ward 3 is 3.9 percent and 12 percent in Ward 8.⁷⁵
- Among women in Ward 3 the incidence of breast cancer is 118 per 100,000 compared with 145 in Ward 8.⁷⁶
- The rate of cervical cancer per 100,000 women is 7 in Ward 3 and 23 in Ward 8.⁷⁷
- In Ward 3, the incidence of prostate cancer is 97 per 100,000 men, compared with 151 in Ward 8.⁷⁸
- The colon cancer rate in Ward 8 is 31 per 100,000 men and only 15 in Ward 3.⁷⁹

Infant Mortality

Many experts deem the infant mortality rate as one of the best available indicators of a society's overall health and well-being, and view it as the gold standard for delineating racial and ethnic health disparities. The infant mortality rate shows the number of babies per 1,000 live births who die before their first birthday is considered a vital indicator of public health,⁸⁰ directly related to sanitation, health care, medical technology, and economic security.⁸¹ There is a consensus among experts that infant mortality reflects not only the health of infants, but of the entire population, and that it is an early indicator of the next generation's overall health.⁸² Infant mortality rates also serve as a measure of pregnant women's access to high-quality primary care and quality follow-up care.⁸³

Among nonwhite Americans, inequalities exist from early in life. African-American mothers give birth to the highest percentage of babies with low birthweights,⁸⁴ and black infants are more than twice as likely as white children to die within a year.⁸⁵ Native American infants die at a rate almost 25 percent greater than the national average.⁸⁶

Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity, 2003-2005

Ranked by African-American Rate

| | White | African American | Latino |
|----------------------|------------|------------------|------------|
| United States | 5.7 | 13.6 | 5.6 |
| District of Columbia | 3.4 | 17.2 | 7.2 |
| Delaware | 6.5 | 16.8 | 6.2 |
| Michigan | 6.2 | 16.4 | 7.6 |
| Wisconsin | 5.1 | 16.4 | 6.1 |
| Colorado | 5.2 | 16.3 | 7.0 |
| Tennessee | 7.0 | 16.3 | 6.5 |
| North Carolina | 6.3 | 15.8 | 6.6 |
| Mississippi | 7.0 | 15.6 | – |
| Ohio | 6.4 | 15.6 | 6.5 |
| Hawaii | 4.0 | 15.5 | 7.9 |
| Illinois | 6.0 | 15.3 | 6.2 |
| Indiana | 7.1 | 15.1 | 6.8 |
| Kansas | 6.7 | 14.3 | 6.2 |
| South Carolina | 6.4 | 14.2 | 7.3 |
| Nebraska | 5.1 | 14.0 | 5.7 |
| Louisiana | 7.1 | 13.9 | 5.6 |
| Missouri | 6.6 | 13.8 | 6.6 |
| Virginia | 6.0 | 13.7 | 5.4 |
| Maryland | 5.2 | 13.7 | 5.8 |
| Alabama | 6.8 | 13.6 | 7.7 |
| Arkansas | 7.2 | 13.6 | 6.0 |
| Pennsylvania | 5.8 | 13.6 | 7.6 |
| Georgia | 6.1 | 13.3 | 5.5 |
| Oklahoma | 7.5 | 13.0 | 6.0 |
| Florida | 5.8 | 12.9 | 5.2 |
| Connecticut | 3.9 | 12.7 | 7.4 |
| Texas | 5.9 | 12.4 | 5.6 |
| Nevada | 5.6 | 12.2 | 4.5 |
| West Virginia | 7.5 | 12.0 | – |
| New Jersey | 3.7 | 11.9 | 5.2 |
| New York | 4.6 | 11.8 | 5.5 |
| California | 4.6 | 11.4 | 5.0 |
| Arizona | 6.0 | 11.2 | 6.7 |
| Iowa | 5.1 | 11.0 | 5.2 |
| Kentucky | 6.4 | 10.9 | 7.6 |
| Rhode Island | 4.5 | 10.8 | 7.4 |
| Massachusetts | 4.0 | 10.0 | 6.5 |
| Washington | 5.0 | 9.0 | 4.9 |
| Minnesota | 4.3 | 8.9 | 4.2 |
| Oregon | 5.5 | 8.6 | 5.5 |
| Alaska | 5.3 | – | – |
| Idaho | 6.1 | – | 6.2 |
| Maine | 5.8 | – | – |
| Montana | 5.7 | – | – |
| New Hampshire | 4.8 | – | – |
| New Mexico | 6.9 | – | 5.3 |
| North Dakota | 6.0 | – | – |
| South Dakota | 6.2 | – | – |
| Utah | 4.5 | – | 5.8 |
| Vermont | 5.3 | – | – |
| Wyoming | 6.8 | – | – |

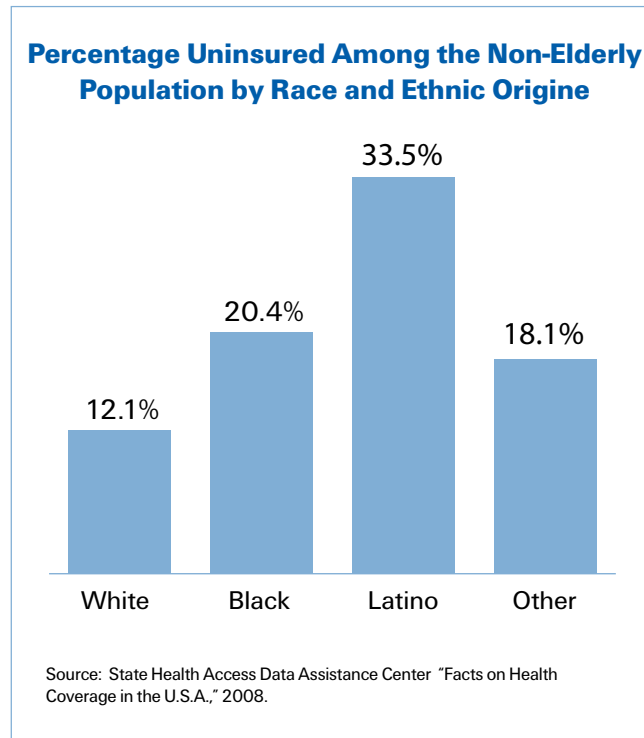
Note: - denotes insufficient data in state.

Source: Kaiser Family Foundation, StateHealthFacts.org, 2008. Data from the Center for Disease Control and Prevention, Division of Vital Statistics.

Lack of Health Insurance

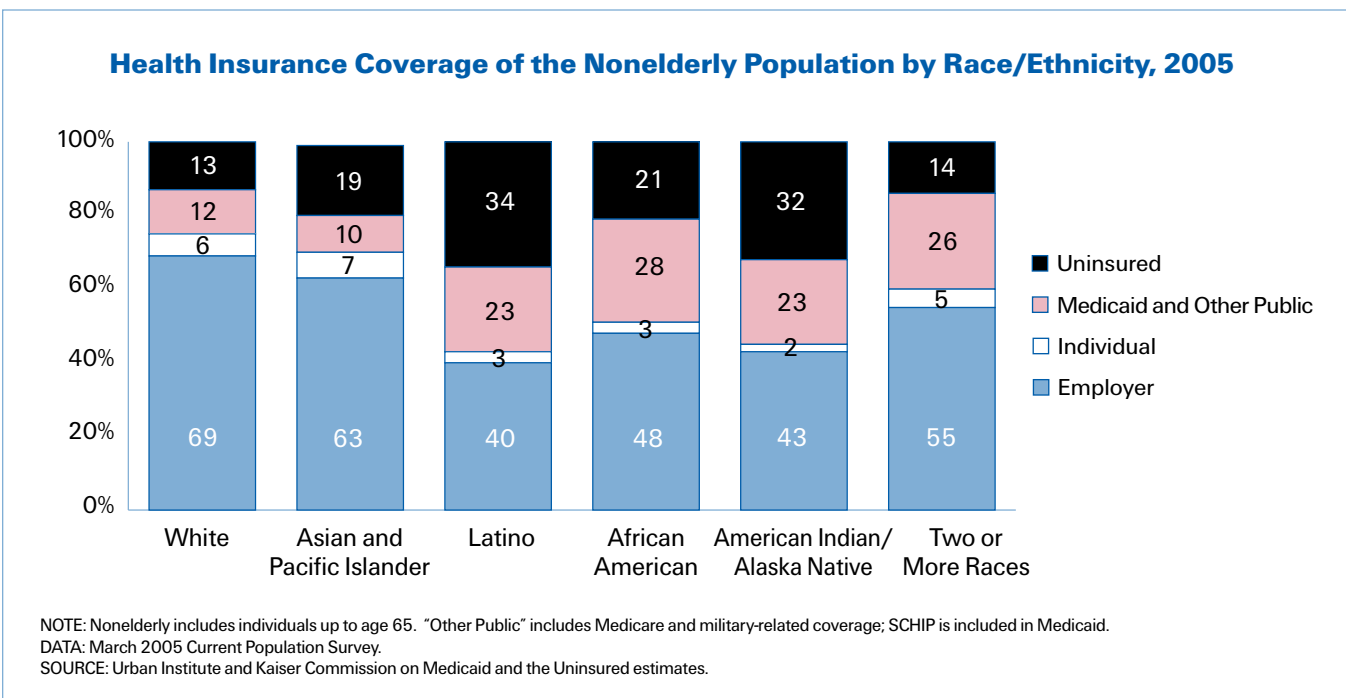
Insurance status is a reliable indicator of health inequities. Immigrants and people in communities of color are disproportionately uninsured.⁸⁷ While 21 percent of white non-Latino Americans were uninsured at some point in 2002, the share among communities of color

was higher: 28 percent of African Americans, 44 percent of Latinos, 24 percent of Asian Americans and Pacific Islanders, and 33 percent of Native Americans and Alaska Natives. Members of these communities are thus more likely to depend on public sources of health insurance.⁸⁸



While Latino children constitute less than one-fifth of children in the United States, they represent more than one-third of uninsured children.⁸⁹ Among the 570,000 children in fair or poor health who lacked insurance in 2002, more than two-thirds were Latino.⁹⁰

Lack of health insurance disproportionately hurts low-income families and communities of color because health insurance in the United States remains linked to employment. Higher-paying jobs tend to offer more comprehensive medical coverage, while lower-paying jobs—disproportionately occupied by people of color—tend to offer limited, if any, health benefits. Even when low-paying jobs do offer benefits, they are often accompanied by expensive cost-sharing arrangements with employees.⁹¹ These trends are more pronounced for women than men in communities of color.



Percentage of Women without Health Insurance Coverage, Ages 18-64, by State and Race/Ethnicity

Ranked by Uninsured Percentage for All Women of Color

| State | Disparity Score* | All Women | White | All Women of Color** | Black | Hispanic | Asian and NHPI | American Indian/ Alaska Native |
|----------------------|------------------|-----------|-------|----------------------|-------|----------|----------------|--------------------------------|
| All States | 2.18 | 17.7 | 12.9 | 27.9 | 22.5 | 37.3 | 18.3 | 33.8 |
| Montana | 2.61 | 20.1 | 17.7 | 46.1 | - | - | - | 56.1 |
| Texas | 2.43 | 27.8 | 16.0 | 39.0 | 26.8 | 45.4 | 24.4 | - |
| Utah | 2.63 | 18.4 | 14.6 | 38.2 | - | 41.0 | 28.5 | - |
| Arizona | 2.84 | 22.3 | 12.9 | 36.5 | 26.3 | 40.3 | - | 37.5 |
| Louisiana | 1.84 | 25.9 | 19.7 | 36.3 | 36.9 | - | - | - |
| Oregon | 2.11 | 20.1 | 17.0 | 35.8 | - | 50.4 | 21.4 | - |
| Idaho | 2.34 | 17.8 | 15.2 | 35.6 | - | 42.5 | - | - |
| North Dakota | 4.59 | 10.4 | 7.5 | 34.6 | - | - | - | 41.0 |
| Colorado | 2.72 | 18.0 | 12.6 | 34.4 | 19.2 | 39.1 | 27.6 | - |
| Oklahoma | 1.64 | 24.0 | 20.5 | 33.6 | 21.3 | 51.1 | - | 49.7 |
| Florida | 1.91 | 23.6 | 17.5 | 33.4 | 30.8 | 37.7 | 21.0 | - |
| New Mexico | 1.84 | 25.6 | 17.4 | 32.1 | - | 28.5 | - | 49.7 |
| Arkansas | 1.48 | 23.3 | 21.1 | 31.0 | 30.4 | 38.1 | - | - |
| South Dakota | 2.57 | 13.3 | 11.4 | 29.4 | - | - | - | 34.4 |
| California | 2.40 | 20.9 | 11.9 | 28.5 | 17.5 | 35.4 | 18.9 | - |
| Mississippi | 1.84 | 20.9 | 15.5 | 28.5 | 27.0 | - | - | - |
| Nebraska | 2.90 | 12.8 | 9.8 | 28.4 | 29.7 | 30.8 | - | - |
| New Jersey | 3.08 | 16.2 | 9.0 | 27.9 | 22.7 | 38.3 | 18.5 | - |
| North Carolina | 1.99 | 18.4 | 13.9 | 27.7 | 21.7 | 50.3 | 26.9 | 36.8 |
| Georgia | 1.93 | 19.7 | 14.3 | 27.6 | 22.6 | 55.7 | 22.0 | - |
| Nevada | 1.74 | 20.4 | 15.9 | 27.6 | 19.0 | 37.6 | 12.4 | - |
| Alaska | 1.60 | 19.8 | 16.9 | 27.1 | - | 23.5 | 18.6 | 35.8 |
| Missouri | 1.99 | 15.8 | 13.5 | 26.9 | 28.7 | 33.3 | - | - |
| Indiana | 1.92 | 15.6 | 13.8 | 26.5 | 21.8 | 44.8 | - | - |
| Kentucky | 1.66 | 17.0 | 15.9 | 26.3 | 23.3 | - | - | - |
| Illinois | 2.33 | 15.7 | 11.0 | 25.5 | 24.7 | 34.1 | 10.6 | - |
| Kansas | 2.13 | 13.9 | 11.7 | 24.9 | 21.6 | 31.7 | - | - |
| Tennessee | 2.03 | 14.7 | 11.8 | 24.1 | 18.0 | 58.4 | - | - |
| Virginia | 2.24 | 14.7 | 10.6 | 23.8 | 20.7 | 42.5 | 16.8 | - |
| Iowa | 2.24 | 11.5 | 10.3 | 23.1 | - | 30.8 | - | - |
| Alabama | 1.45 | 18.1 | 15.8 | 22.9 | 21.1 | - | - | - |
| West Virginia | 1.12 | 20.1 | 20.0 | 22.4 | - | - | - | - |
| South Carolina | 1.23 | 19.1 | 17.6 | 21.8 | 20.2 | 45.3 | - | - |
| Wisconsin | 2.34 | 10.8 | 9.2 | 21.5 | - | 29.3 | - | - |
| Connecticut | 2.36 | 12.1 | 9.1 | 21.4 | 20.1 | 25.9 | 14.7 | - |
| New York | 1.94 | 15.1 | 10.9 | 21.2 | 17.0 | 24.5 | 23.3 | - |
| Maryland | 1.97 | 15.1 | 10.6 | 21.0 | 19.2 | 38.0 | 15.7 | - |
| Minnesota | 2.94 | 8.7 | 7.0 | 20.6 | 11.7 | 46.0 | 10.9 | - |
| Ohio | 1.89 | 12.2 | 10.6 | 20.0 | 20.1 | 28.4 | - | - |
| Washington | 1.64 | 13.9 | 12.2 | 19.9 | - | 29.6 | 14.4 | - |
| Delaware | 2.09 | 12.6 | 9.4 | 19.7 | 15.2 | 37.5 | 21.5 | - |
| Pennsylvania | 1.97 | 11.6 | 9.9 | 19.5 | 18.9 | 23.7 | 16.1 | - |
| Rhode Island | 1.91 | 11.7 | 10.0 | 19.0 | 11.5 | 22.9 | 21.7 | - |
| Michigan | 1.63 | 13.2 | 11.5 | 18.8 | 18.7 | 21.2 | 13.6 | - |
| Massachusetts | 1.82 | 11.2 | 9.6 | 17.5 | 12.9 | 25.8 | 14.2 | - |
| Maine | 1.65 | 10.6 | 10.3 | 17.0 | - | - | - | - |
| Vermont | 1.37 | 12.3 | 12.1 | 16.5 | - | - | - | - |
| New Hampshire | 1.23 | 12.4 | 12.2 | 15.0 | - | - | - | - |
| District of Columbia | 1.98 | 11.5 | 7.1 | 14.0 | 12.0 | 29.0 | - | - |
| Hawaii | 0.92 | 10.1 | 10.8 | 9.9 | - | 11.8 | 9.8 | - |

Note: - denotes insufficient data in state.

*Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women.

Disparity score equal to 1.00 indicates that minority and White women are doing the same.

** All women of color includes African-American, Asian-American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Source: Current Population Survey, 2004-2005.

Source: Kaiser Family Foundation.

Racism in the Medical Profession

The oldest institutions of the medical profession bear a major share of responsibility for the institutionalized racism that led to persistent racial and ethnic health disparities in the U.S., and the American Medical Association, the largest physician group, has publicly acknowledged it. White medical leaders began as early as the 1870s to reject nonwhite physicians from professional societies, denying them equal status and marginalizing their capacity to care for their own people.⁹² The impact on the health of communities of color was profound and continues to this day, primarily because these actions left minority groups with too few doctors to treat them in a culturally competent manner, according to Nedra Joyner, M.D., board chairwoman of the predominantly black National Medical Association.⁹³ Today blacks represent about 2.2 percent of physicians and medical students, compared to 13 percent of the overall population, according to the American Medical Association.⁹⁴ Last year, in a study and an accompanying editorial published in the *Journal of the American Medical Association*, the organization took the extraordinary step of taking full responsibility for its actions, apologizing to African-American doctors and their communities and pledging to expand the population of physicians of color.

According to a Bloomberg News account from July 10, 2008:

From 1906 to 1939, the AMA directory labeled African-American doctors as 'colored' even though black physicians asked that the practice be stopped, [an independent panel commissioned by the AMA] said. The designation made it difficult or impossible to obtain liability insurance and bank loans, the panel said.

After World War II, Americans unfavorably compared Adolf Hitler's "brand of racism" to the kind practiced by white supremacists in the U.S., creating a "moral crisis" that spurred new attempts to end racial discrimination at home, the panel said.

Still, the AMA did little in the 1950s, and it took no public position on the landmark Civil Rights Act of 1964. The group ignored repeated requests from black doctors to lobby lawmakers to stop federal funding for construction of segregated hospitals under the 1946 Hill-Burton Act, the report said.

The AMA instead focused on trying to prevent the creation of the Medicare program for the elderly and disabled, legislation that effectively ended hospital segregation. The AMA termed the federalization of control over hospitals "socialized medicine." The [predominantly black] National Medical Association was a "champion" of the Medicare program, which was passed in 1965.

The AMA's apology does not mean all doctors were or are racist; it recognizes that all complex systems and institutions are shaped by their histories. The AMA's acknowledgment of its failure to eradicate discrimination and racism has led it to adopt policies promoting diversity and cultural competency in the medical work force and doctors within reach of more people who need them.

Barriers to Good Care for Women and Rural Families

Women of all races and ethnicities often find quality affordable health coverage beyond their reach. Health issues specific to women, such as pregnancy and childbirth, are not covered by all health plans, and limitations on coverage of family planning resources leads to unsatisfactory levels of prenatal health and counseling. Fewer than half the states require insurers to cover important preventive measures for women, such as annual mammograms.⁹⁵

Because of the affordability gap in health insurance, and because twice as many women as men rely on their spouses for health coverage,⁹⁶ women increasingly find themselves uninsured, underinsured, or with unstable coverage. Given that women generally use more health services than men, women are more likely to delay necessary care because it is unaffordable or difficult to find, and that leaves them vulnerable

to greater medical debt than men.⁹⁷ The number of uninsured women is growing almost three times faster than the rate for men.⁹⁸

Though inequities affect women of all races and ethnicities, more than 19 percent of women in communities of color report poor or fair health status, compared with about 12 percent of white women. For Latina women, more than 27 percent report fair or poor health.⁹⁹ Such disparities exist in every state. African American women have higher rates of obesity, cancer, and strikingly higher levels of HIV/AIDS infections.¹⁰⁰ Among Native Americans and Alaska Natives, 30 percent of women do not receive prenatal care, about three times the rate for white women.¹⁰¹

People in rural areas also are burdened by structural barriers that lead to poorer health outcomes. Levels of poverty in those regions combine with a scarcity of medical services to create worse outcomes than in metropolitan areas. Rural residents have higher rates of infant mortality, pulmonary disease, chronic disease, cardiac disease, and trauma deaths.¹⁰² Rural residents are more likely to be uninsured or underinsured, and more likely to suffer from poor health.¹⁰³ One study showed that rural residents paid more out-of-pocket health costs than people in urban or suburban areas.¹⁰⁴ One important reason for this disparity is that rural residents are more often forced into nongroup coverage than urban residents, increasing their premiums and deductibles, while shrinking their benefits. Fewer rural residents have prescription drug coverage, but their rates of prescription drug use are higher.¹⁰⁵

Structural inequalities, economic hardship, and distance from population centers combine to deprive rural Americans of access to quality health care. Rural residents tend to be poorer than urbanites and often live in areas experiencing shortages in necessary resources, such as primary care physicians. One study found that 40 percent of non-metropolitan residents lived in primary-care shortage areas, compared to 12 percent of the city residents.

Almost 75 percent of non-metropolitan counties are designated as medically underserved areas.¹⁰⁶

A Public Health Insurance Plan Will Reduce Health Disparities

Disparities in health access and health outcomes are the consequence of hundreds of years of systemic discrimination against communities of color, women and rural areas. An important tool in combating disparities is to create a national public health insurance program modeled on the Medicare program for the elderly and disabled. The only way to ensure that the private health insurance industry adopts practices aimed at eliminating disparities is by introducing a competitor with a broad provider network available to everyone, regardless of race, ethnicity, sex or age, and with treatment protocols that are subject to public scrutiny.

As the nation's largest purchaser and regulator of health care, Medicare is a leader in reducing racial and ethnic health disparities. Its leverage was first demonstrated in 1966 when hospitals desegregated as a condition for receiving Medicare reimbursement. Since then, Medicare has contributed to dramatic improvement in the health of elderly and disabled people of color, although disparities between people of color and white beneficiaries remain.¹⁰⁷

Medicare is well-suited to address health care disparities. It is available to all elderly Americans.¹⁰⁸ While large gaps in coverage exist between non-Hispanic whites and other populations earlier in life, much of the differential is erased by the program's universality starting at age 65. Although Medicare coverage can't address every social determinant of health, people with Medicare benefits experience smaller disparities than before entering the program.¹⁰⁹

As a system with about 45 million enrollees, Medicare has collected the world's most extensive health care data set. Medicare has launched pilot programs and tested innovative ideas to improve care and control costs. These assets enable Medicare to develop strategies and programs

that address current disparities in the system. As a federal program sensitive to civil rights law, Medicare has historically made positive advances towards equal access and is continuing to do so. In 1966, hospital participation in Medicare became conditional on desegregation, and that occurred in more than 1,000 hospitals in less than four months. These advances continue as necessary under the full enforcement of Title VI of the Civil Rights Act of 1964. Today, race- and ethnic-conscious programs are being pursued to target and address factors that contribute to racial, ethnic, and rural disparities, and guidelines have been implemented to improve care for those with limited English proficiency.¹¹⁰

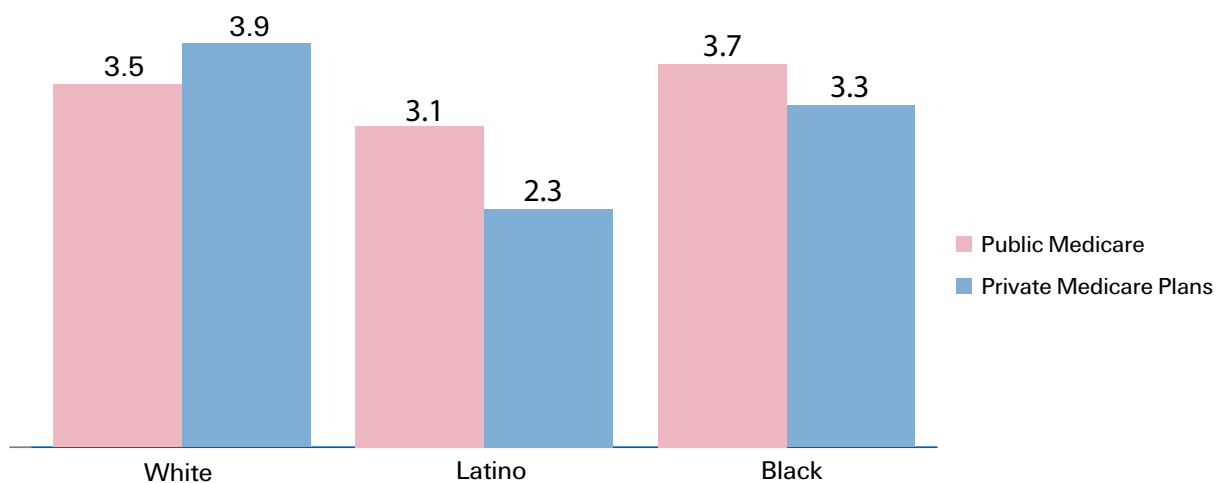
Medicare has tremendous potential to close the health care gap. Because people of color are often among the lowest-income beneficiaries in the system, they would benefit disproportionately from health policies that increase affordability, expand coverage areas, and reduce co-payments and deductibles.¹¹¹ In terms of quality of care, people of color may benefit the most from evidence-based medicine that Medicare intends to require.¹¹² Medicare has

systemic strengths that put it in a good position to deliver good care to people of color, including the proposed creation of a medical-homes plan relying on primary care providers to coordinate primary and specialty care. New payment incentives could be created to address diseases that disproportionately affect racial and ethnic populations, such as diabetes, or to monitor key health indicators that can help reduce disparities.¹¹³

A recent study found that the traditional public Medicare plan is more effective at eliminating racial and ethnic health disparities than private managed care/HMO plans.¹¹⁴ The differences in the structures of each program were the reason the traditional public Medicare program is more effectively reducing racial and ethnic disparities. Often managed care plans have a financial incentive to under-treat patients;¹¹⁵ unfortunately the most likely to be under-served are people of color, women, and marginalized populations. The public Medicare plan more effectively eliminates racial and ethnic disparities in health than do managed care plans.¹¹⁶ In the same way, a voluntary public

Racial and Ethnic Disparities in Medicare Private Health Plans and Public Medicare Program

Self-rated health status by race on a scale of 1 to 5 (5 being the best health) among people earning less than \$10,000 per year and diagnosed with diabetes or high blood pressure.



Source: Noah Webster, "Medicare Managed Care and Racial/Ethnic Health Disparities," 2008.

insurance plan for Americans under age 65 would diminish racial and ethnic disparities in health care access and outcomes.

It is no secret that private insurers actively market to people with high incomes and in good health and that people of color tend to have low incomes, more health problems and greater difficulty gaining access to care. It is also well documented that insurers devote significant resources to evaluating whether an applicant's health status is likely to create higher medical expenses than the insurer wants to risk

paying.¹¹⁷ The desire to avoid risk combined with the fact that communities of color are burdened by inequities in health status and medical services raises crucial questions about whether private insurers are unwilling or unable to meet the needs of people of color. Insurers reveal little data on whether they actively market to people of color or actively avoid them; whether they form provider networks that are geographically distant from communities of color; and whether insurers create networks that are adequate for people who don't speak English as a first language.^{118,119,120}

HCAN Recommendations to Erase Racial and Ethnic Health Care Disparities

Health Care for America Now is a national grassroots campaign of more than 1,000 organizations in 46 states representing 30 million people dedicated to winning quality, affordable health care we all can count on in 2009. Our organization and principles are supported by President Obama, and more than 190 Members of Congress. HCAN believes that a centerpiece of health reform must be equity in health care access, treatment, research and resources to people and communities of color.

Closing the gap in health outcomes requires an affordable benefit package that provides a defined, comprehensive set of age- and gender-appropriate services that promote health in a linguistically and culturally competent manner. Through public or private plans, coverage should be backed by adequate reimbursement and financial incentives to promote provider participation. Only with robust provider networks can we ensure meaningful access to services in communities of color and among marginalized populations. In addition, reform initiatives should be designed to address the complex health care challenges faced by American Indians and Alaska Natives and should be

consistent with and responsive to the federal government's trust responsibility to Indian Tribes.

Substantial improvements in health and life expectancy will be achieved by addressing the social determinants of health, including a clean environment, occupational safety, access to nutritious food, and safe neighborhoods. A strong public health system invests in health planning, undertakes prevention strategies, conducts disease surveillance and management, increases health literacy, and fosters a health care safety net through community health care workers and clinics.

HCAN believes health reform should include all of our nation's residents. The SCHIP expansion approved by Congress in January demonstrated support for providing coverage to everyone legally residing in our country. The election last fall was a display of strong public support for equitable treatment of immigrants. Health care reform is an opportunity to build on that support by extending coverage to all who are here with permission, to identify ways to bring as many others as possible under comprehensive coverage, and to provide a safety net for

everyone who lives within our borders and may temporarily lack coverage. In addition, no one should have to wait to be eligible for coverage. It is critically important that no actions be taken that in any way weaken or limit access to coverage or care that is currently available.

To ensure effective communication between consumers and providers and prevent medical errors that cost lives and money, culturally-competent language services must be guaranteed as a covered service and financially supported. HCAN believes appropriate standards and training methods should be developed.

Concrete strategies must be developed and supported to address chronic shortages of health professionals in communities of color and marginalized populations. Pipeline incentives as well as reimbursement reform should be aimed at training, attracting, supporting and retaining a diverse, culturally competent work force.

HCAN urges Congress to implement mechanisms to support safety-net institutions and quality improvement initiatives in all health care settings. These include expanding and strengthening safety-net and community-based providers; prioritizing investment in the primary care infrastructure, including facilities, equipment and health IT; and promoting the adoption of “medical home” models.

Congress should authorize the federal government to regulate the marketing practices of private insurance companies to make sure they aren’t discriminating against racial and ethnic groups or marketing products in ways that lead to favorable risk selection, both of which would contribute to disparate treatment and health status. The public should have access to this data to help people make informed choices about which health plans meet their needs. The data should include information on race, ethnicity and ethnic sub-population, socio-economic position, primary language, age, and gender.

Community-based and qualitative research should be supported to determine what’s working and what’s not. To document effectiveness, funding must be adequate and linked to integrated evidence gathering. Best practices in treatment, services and medications must be grounded in empirical data based on the actual populations involved. Research and development must be cognizant of and linked to disparity factors, and medical research must include adequate representation of women, people of color, and other populations.

Programs to enforce anti-discrimination laws in health care should receive sufficient resources to monitor, prosecute, and ensure active compliance with all civil rights laws, and must integrate and prioritize the health issues of communities of color in relevant federal agencies. In order to foster transparent policy-making, government decisions affecting the health of a community should be evaluated, and the findings publicly released, on the potential positive and negative health effects of these decisions.

Service delivery and quality improvement programs targeted to under-served communities should be flexible, recognize the needs, language, culture, infrastructure and practices of the local population and rely on local people and institutions to address community health-care deficiencies.

A high-performing health system must deliver quality care to everyone, regardless of race, ethnicity, gender, income, or any other demographic characteristics. A reformed and uniquely American system will be able to address a long history of discrimination in medical treatment by reorienting the way doctors, hospitals, drug makers, medical device makers, insurance companies and government programs provide care.

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