RACE matters

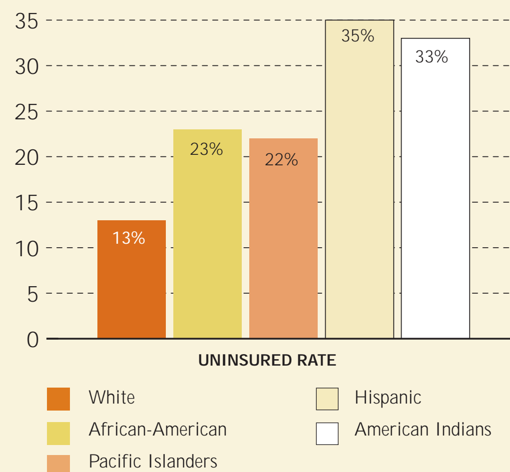
Unequal Opportunities for HEALTH AND WELLNESS

Why Equal Opportunity is Important

- We know how to promote good health. Good nutrition, healthy environments, adequate health care coverage, access to preventive care, and timely diagnosis and treatment of illness are key components of optimal child and adult health.
- The consequences of poor health are far-reaching. Poor nutrition, inadequate preventive care, poor environmental conditions, and delayed and inadequate diagnosis and treatment are linked to reduced income for adults, poorer school attendance and performance by children, and reduced well-being for children whose parents are ill.
- Embedded inequities produce unequal opportunities for health and wellness. Systematic policies, practices, and stereotypes work against the health of families, children, and communities of color. These can undermine their strengths, deplete their resilience, and compromise their health and other outcomes. We need to understand the consequences of embedded inequities, how they are produced, and how they can be eliminated to ensure opportunities for all in health and wellness.

Barriers to Equal Opportunity

- Poverty and access to health and wellness. Income is highly related to health care access and insurance coverage. Because African-American, Latino, and Native American families are more likely to be poor than others, they are less likely to have adequate insurance coverage and access to quality health care. Most studies show that even when income is similar across groups, racial and ethnic disparities remain.[1] Workers of color, especially Hispanics,[2] are more likely to be relegated to low-wage jobs and labor market sectors that offer minimal if any health benefits.
- Insurance coverage. For low-income populations specifically, the percent of the uninsured rises and gaps still remain, mostly for immigrant and Native American populations. Whites are most likely to obtain health insurance through their employers (73%), compared to African Americans (53%), Hispanics (44% — with Cubans highest at 65%) and "Others" (59%).[3]



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1. Institute of Medicine (IOM), Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academy of Sciences: Washington, D.C., 2002, p.5.

2. Michelle M. Doty and Alyssa L. Holmgren, "Unequal access: Insurance instability among low-income workers and minorities." Issue Brief, The Commonwealth Fund, April, 2004, www.cmwf.org.

3. IOM, p. 67.

Barriers to Equal Opportunity (cont'd)

- Differential access to available resources. The rate of uptake and utilization of available governmental supports is often higher for Whites than for other groups. Reasons include language and cultural differences between the provider and potential user, as documented in Medicaid health plans,[4] mistrust of government systems or institutional providers,[5] which is compounded for undocumented and non-English speaking residents, lack of knowledge about available services and supports, and removal of coverage for recent immigrants, such as the Welfare Reform Act's prevention of the use of federal dollars for this group for health insurance coverage.[6]
- Spatial segregation and its link to vulnerability. The de facto residential segregation experienced particularly by African American and Latino lower income families translates into limited access to healthful resources and vulnerability to a wide range of toxic environmental conditions. Low income neighborhoods of color are differentially exposed to air, water, and soil pollutants, lead hazards, and dust molecules and fail to meet EPA standards for air quality. These neighborhoods are also disproportionately located near contaminated sites ("brownfields").[7]
- Lack of culturally competent services. Up to 1 in 5 Spanish-speaking Latinos do not seek medical care because of language barriers.[8] The promotion of managed care for Medicaid recipients may displace culturally familiar minority providers.[9] And Western health care organizational models that fail to understand and build upon the health beliefs of immigrants and refugees are designed to produce disparate outcomes. While patient-provider racial similarity is associated with greater treatment adherence and higher patient satisfaction,[10] experts believe that differential behaviors and attitudes of patients toward treatment are not major sources of healthcare disparities.[11]
- Health care system discriminatory practices. Survey research documents that minority patients perceive higher levels of racial discrimination in health care than non-minorities.[12] Other studies show that these perceptions are accurate: racial and ethnic minority patients receive a lower quality and intensity of health care than Whites.[13]
- Neighborhood resources. Residents of disinvested low income neighborhoods of color are less likely to have access to safe local recreational spaces for exercise. Rates of physical activity are lowest among African Americans and Hispanics.[14] They are also less likely to have nearby supermarkets offering quality fresh produce, which impacts nutritional intake,[15] and less likely to have adequately stocked pharmacies for health care needs.[16]

The Consequences of Unequal Opportunity

- Access to a usual source of health care. Preventive care is more likely to be received by people who have primary care physicians. Yet, 30% of Hispanics, 21% of Asian Americans, 20% of African Americans, and 19% of American Indians do not have primary care doctors, in comparison to 16% of Whites. Hispanic children are three times more likely than White children to have no primary care physician. African Americans and Hispanics are twice as likely as Whites to rely on hospitals and clinics rather than personal physicians for primary care. Almost 1/3 of low-income Latinos had no health care visits in the past year.[17]
- Quality of diagnosis and treatment. Health care providers' diagnostic decisions are influenced by a patient's race/ethnicity.[18] Certain characteristics of the diagnostic setting – time pressures, resource constraints, and the need to draw inferences from limited data – set the stage for stereotyping and biases.[19] In addition, minorities are more likely to be treated in settings that have fewer diagnostic technologies to allow for optimal on-site assessments.[20] Studies of cardiovascular care, cancer treatments, HIV infection, diabetes care, renal disease, pediatrics, maternal and child health, mental health, rehabilitative and nursing home services, and certain surgical procedures document that racial and ethnic minority patients receive a lower quality and intensity of health care than Whites.[21] Among children aged 1–5, African American children were half as likely to receive prescription medication compared to White children, even after controlling for health factors.[22] Lower quality of treatment is associated with poorer medical outcomes and higher mortality rates that disproportionately impact patients of color.

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4. Leatherman & McCarthy, Quality of Health Care for Children and Adolescents: A Chartbook, 2004. The Commonwealth Fund.
5. IOM, p.109.
6. O. Carrasquillo et.al., "Eligibility for government insurance if immigrant provisions of welfare reform are repealed," American Journal of Public Health, October, 98 (10), 2003:1680–82.
7. Council for Urban Economic Development cited on www.policylink.org/EquitableDevelopment/.
8. IOM, p.23.
9. IOM, p.22.
10. IOM, p.20.
11. IOM, p.7.
12. IOM, p.10.
13. IOM, p.5.
14. Ibid.
15. The California Campaign to Eliminate Racial and Ethnic Disparities in Health, Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities: Summary. Prevention Institute, www.preventioninstitute.org/healthdis.html.
16. IOM, p.8.
17. www.ahrq.gov/research/disparit.htm (AHRQ); www.kff.org/minorityhealth.
18. IOM, p.9, AHRQ.
19. IOM, p. 23.
20. IOM, p.61.
21. IOM, p. 5.
22. IOM, p.54.

The Consequences of Unequal Opportunity (cont'd)

- Life expectancy. For persons born in the U.S. in 2001, the greatest gaps in life expectancy occur between Whites and African Americans. White females' life expectancy is 80 years compared to 75 years for African American females; the gap is greater for males, with White males expected to live to 75 and African American males to 68.[23] In 2000 African Americans had the highest mortality rates — 1.6 times higher than Whites, the same as it was in 1950. While other groups' deaths per population are close to or lower than Whites, these overall data mask group variations and elevated risk for specific causes of death. For example, diabetes deaths are disproportionate in African American, Hispanic, and Native American populations; Korean Americans and Japanese American males have the highest deaths from colon and rectal cancers; Vietnamese American women have the highest death rates from cervical cancer.[24] In 2000 Whites had an infant mortality rate of 5.7% compared to a rate of 8.3% for American Indians and 13.6% for African Americans. The rate for Hispanics was 5.6% and for Asian and Pacific Islander infants was 4.9%.[25]

- Childhood vulnerabilities. Asthma, which is a leading cause of school absences, differentially affects African American children (8%), compared to 6% of White children and 4% of Hispanic children. Two percent of all pre-schoolers have enough lead in their blood to reduce intelligence and attention span, cause learning disabilities, and permanently damage a child's brain and nervous system.[26] These preschoolers are disproportionately low-income children of color: 9% Black, 6% Hispanic, 4% Asian or Pacific Islander, 2% White, and 1.5% Native American.[27] Over 90% of all lead poisoning cases in New York City involve children of color living in only 10 neighborhoods.[28]

- Adult chronic diseases. Conditions of disinvested, racially isolated, low-income communities can produce chronic stress, which is linked to cardiovascular disease and some cancers[29] and expose residents to environmental hazards, which contribute to African Americans in low-income urban areas being at greater risk of morbidity and mortality due to asthma.[30] A link has been reported between high blood pressure and exposure to racism when it is left unchallenged.[31] Foreign-born residents are over 8 times more vulnerable to tuberculosis than U.S.-born residents[32] African American adults have a death rate from cardiovascular disease that is 30% higher than Whites. While the prevalence of diabetes for American Indians and Alaska Natives is double that of the total population, African Americans have a 70% higher rate than Whites, and Hispanics have a 100% higher rate than Whites. Although African Americans and Hispanics comprise 25% of the population, they are 55% of adult AIDS cases and 82% of pediatric AIDS cases.[33]

23. www.cdc.gov/nchs/data/hus/tables/2003/03hus027.pdf.

24. IOM, p.64.

25. Kids Count 2003, The Annie E. Casey Foundation, Figure 2, p. 41.

26. www.scorecard.org/about/txt/new.html.

27. www.childtrendsdatabank.org/indicators/81BloodLead.cfm.

28. "Erasing the Color Line: A Closer Look at Racial and Ethnic Health Disparities," Grantmakers in Health, November, 2003, www.gih.org/usr_doc/Erasing_the_Color_Line_Report.pdf.

29. The California Campaign.

30. IOM, p.50.

31. Erasing the Color Line.

32. Keppel, K.G., Pearcy, J.N., Wagener, D.K., "Trends in racial and ethnic specific rates for the health status indicators: Unites States, 1990–98." Healthy People Statistical Notes, No. 23. National Center for Health Statistics.

33. Erasing the Color Line.

Strategies to Promote Equal Opportunity

- Systematic attention to disparities reduction. The Commonwealth Fund has produced a comprehensive state policy agenda for disparities elimination that contains a wide range of recommendations and promising practices for states to consider to improve their performance on minority health.[34]
- Regulatory attention to gaps. Federal and state performance standards for Medicaid managed care could include (1) stable primary care coverage, which is associated with better prevention and earlier intervention, and (2) reasonable patient loads and time per visit, which can reduce the inclination to make medical decisions on the basis of stereotypes.[35]
- Racial equity impact analysis. Available benefits should be monitored for the effectiveness of their distribution to eligible populations. Because 94% of all uninsured kids in families up to twice the poverty level are eligible for SCHIP/Medicaid coverage, active efforts to reach under-enrolled communities should be given high priority. Using community residents to sign up eligible families — as Health Care for All in New Orleans does — is an effective strategy for closing the coverage gap.[36]
- Use of community health workers/promotoras/cultural case managers. The use of community health workers has been shown to improve patient access to services and adherence to treatment regimens and has improved provider understanding of community needs and community culture.[37] Community House Calls in Seattle employs bilingual, bicultural outreach workers in partnership with community leaders to mediate between immigrant community members and the biomedical system. This approach achieved 82% treatment completion among refugees, compared to 37% completion using a clinic-centered approach.[38]
- Promotion of culturally competent provider/system features. Experts propose that practices such as the availability of interpreter services, coordination of health care with indigenous or traditional healers, strategic inclusion of family members in treatment, recruitment and retention of minority staff, and cultural skills training for all staff can reduce health care and health outcome disparities.[39] The Kaiser Family Foundation and the Robert W. Woodruff Foundation have launched an initiative to raise physician awareness and promote dialogue about care disparities through www.kff.org/whythedifference.
- Interventions that eliminate health hazards. Numerous best practices at the state, city, and local level for addressing lead hazards in distressed communities are detailed on the website of the Alliance for Healthy Homes (www.afhh.org). These include model state and local laws mandating lead safety in rental property, code enforcement efforts, and community organizing for political impact and hazard control.[40] PolicyLink (www.policylink.org) offers strategies and tools for promoting healthy neighborhoods and redeveloping brownfields.
- Development of successful coalitions that mobilize political power for change. In response to alarming rates of asthma and other respiratory illnesses in inner city neighborhoods, youth of Boston have been mobilized under the initiative Cleaner Buses for Boston to advocate for reduced hazardous emissions from idling buses that frequent their neighborhoods.[41] Latino, African American, and Hasidic Jewish organizations united successfully under the New York City Community Alliance for the Environment to oppose a 55 story incinerator in their neighborhood, which would have emitted a half ton of lead yearly and be the area's largest producer of nitrogen oxide, a component of smog.[42]

34. John E. McDonough et. al., "A state policy agenda to eliminate racial and ethnic health disparities." The Commonwealth Fund, June, 2004, www.cmwf.org.

35. IOM, p. 64.

36. DeCourcy Hinds, M., "Health care for all: Medicaid and CHIP outreach in New Orleans," Advocasey 2, 1 (2000). Baltimore, MD: The Annie E. Casey Foundation.

37. IOM, p. 15.

38. Bill Rust, "Inconspicuous consumption," Advocasey 2, 1 (2000). Baltimore, MD: The Annie E. Casey Foundation.

39. AHRQ, Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model, USDHHS, PHS, AHRQ.

40. Alliance to End Childhood Lead Poisoning, Innovative Strategies for Addressing Lead Hazards in Distressed and Marginal Housing: A Collection of Best Practices. Available on www.afhh.org under Alliance Publications.

41. Erasing the Color Line.

42. Maya Wiley, "Structural racism and multicultural coalition building." Institute for Race and Poverty, University of Minnesota, 2000.

The Annie E. Casey Foundation