CLOSING the GAP

Solutions to Race-Based Health Disparities

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Contents

Maria Jimenez* works in a discount chain store on Seattle's north side. She earns just above a minimum wage, enough to feed her two daughters but not enough to purchase health insurance on the private market. Her employer does not provide or offer health benefits. Maria had not seen a primary care provider for nearly ten years when she went to Seattle's 45th Street Clinic, a federally funded health care facility for the indigent and underinsured. Her pap test revealed a horrible reality. She had cervical cancer that was now in an advanced stage. She is now undergoing debilitating and expensive chemotherapy treatment for a potentially terminal condition that could have been treated easily if detected during a routine doctor's visit.

Korey Wilson,* an 11-year-old living in Oakland, California, was recently hospitalized during an asthma attack. Korey and his three siblings are crammed into a two-bedroom apartment alongside an interstate highway. Passing trucks belch pollutants into the neighborhood, which has the highest levels of air pollution in the city. "Now they are talking about building an incinerator in the neighborhood," his mother says worriedly. She has reason to be concerned. According to the Alameda County Public Health Department, Oakland, which is 35 percent African American, 22 percent Latino, and 15 percent Asian American, has much higher mortality rates than the rest of the county.

The unhealthy neighborhoods and lack of access to health care that Wilson and Jimenez face are not unique to Seattle, Oakland, or urban areas. Rather, they illustrate dimensions of a persistent but rarely discussed crisis that afflicts a racially stratified U.S. society. While health in the U.S. has improved overall, people of color still suffer higher rates of mortality and illness from asthma, diabetes, cancer, heart disease, and a range of other diseases compared to white Americans. A recent report from the Institute of Medicine, *Unequal Treatment,* reveals that African Americans experience the highest mortality rates from cancer, heart disease, cerebrovascular disease, and HIV/AIDS of any race or ethnicity. Diabetes kills a higher proportion of Native Americans than any other group, while stomach, liver, and cervical cancers afflict some groups of Asian Americans at disproportionate levels.

Racial disparities in health constitute a national crisis. Equalizing mortality rates between African Americans and whites alone would have saved five times as many lives as all advances in medical technology saved between 1991 and 2000, according to a recent study by Dr. Steven Woolf. Woolf argues that policymakers should "reconsider the prudence of investing billions of dollars in the development of new drugs and technologies, while investing only a fraction of that amount in the correction of racial disparities in health." (Woolf, 2004) On a national scope, the response to this crisis has been ineffective at best. At worst, public policies have only served to exacerbate health disparities. Within the health care field, national conversations have focused on prescription drugs for seniors, tort reform, and cuts to critical public health care programs such as Medicaid, rather than eliminating inequities in access and quality of care. Policies that favor businesses have sought to ease environmental protections and eliminate workplace safety regulations, and school funding has focused more on mandatory testing than physical and health education. The health implications of such government priorities are considerable for all Americans, particularly people of color.

Racial disparities in health constitute what is perhaps the nation's greatest public health challenge, and real solutions must target these disparities at their roots. The experiences of Jimenez and Wilson, the people mentioned in the examples above, highlight two fundamental causes of health disparities: failures of the health care system and persistent economic, environmental, and social inequities.

Like Jimenez, many people of color are underserved by the health care system because the system 1) is inaccessible, due to financial or geographic barriers, 2) provides a lower quality of care to people of color, due to discrimination, cultural incompetence, a focus on individuals rather than communities and families, or financing constraints, 3) is unable to meet the needs of limited-English speakers, and 4) disregards or misunderstands the role and benefits of alternative medicine.

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* Names have been changed.

The health care system must demonstrate improvements in each of these areas if it is to reduce racial disparities in health outcomes. The lack of quality health care for many Americans, particularly for people of color, presents a public challenge. Yet, as the pollution and deteriorated housing that contribute to Korey Wilson's respiratory ailments attest, other primary causes of disparate health outcomes stem from environmental, social, and economic conditions. People of color experience job and wage discrimination; environmental pollutants in workplaces and housing; health-related risk factors in neighborhoods such as poor transportation, lighting, and access to parks and nutritious food; and less safe working conditions. All of these factors contribute to disparate health outcomes. Even when controlling for access to insurance, income, education levels, and health care, people of color still suffer disproportionately from a range of illnesses.

These disparities are a function of historical and present-day injustices. A movement to acknowledge and explicitly research and address health disparities is growing. These efforts may lead to a willingness to address some of the profound effects of racism on people's health, whether within health care institutions or within the social and economic structures of a racially stratified society.

Identifying the causes of health disparities is an important step; how to eliminate them is another matter. This report assesses best practices from around the nation that address root causes of health disparities, both from inside and outside of the health care system.

- Bellevue Hospital has combined technology with standard practices to provide interpretation and translation services to New York City's diverse immigrant communities.

- In Anchorage, Alaska, the Southcentral Foundation has demonstrated dramatic health improvements among Alaska Natives and Native Americans through a cost-effective, high-quality health care system.

- Washington, D.C. and Santa Clara County, California have found ways to improve health care access by expanding public health programs to include more people of color.

This report also analyzes innovative approaches to community health outside of the health care system.

- In Arizona, the Tohono O'odham tribe is addressing diabetes through a return to agricultural traditions; in Berkeley, California, school gardens are reinventing health education and school nutrition programs.

- In New Orleans, Louisiana, St. Thomas Health Services demonstrates the role that health care institutions can play in addressing community issues such as housing and education from a health perspective.

Improving health outcomes for Wilson, Jimenez, and other people of color throughout the U.S. will require proactive policies and practices that are rooted in understanding of the relationship between racism and health. The promising practices that are analyzed in this report may serve as models for institutions, government agencies, and community-based organizations as they develop health-related programs. In addition, the policies and practices profiled here will serve as a guide for organizers, legislators, and advocates as they work toward public policies that emphasize equity in opportunity structures and improving the health care system and people's health in general.

METHODOLOGY

This report identifies practices that successfully address racial and ethnic disparities in health. This requires a clear understanding of the root causes of health disparities, which may differ for different communities. The research for this report includes three components: a review of data and literature on race, racism, and health; field research and interviews with people and institutions nationwide; and a series of in-depth best practices case studies.

Data and Literature Review: To assess the primary causes of health disparities, the research team conducted a review of data, articles, and research studies on health disparities related to race, ethnicity, and socioeconomic status. This research can be grouped in three categories:

- Research detailing the scope of disparities in health across races and ethnicities, genders, and income groups.

- Research that identifies the causes of these disparities.

- Research that assesses proactive solutions.

There is extensive research documenting the scope of health disparities. Many studies have taken this research further to identify the causes of those disparities, whether they are rooted in the health industry or broader social and economic inequities. There are fewer studies, however, which identify or assess proactive approaches to minimizing racial disparities in health. This report will help to fill that gap.

Field Research: The assessment of the causes of health disparities, as well as best practice solutions, is grounded in extensive field research. The research staff interviewed more than 100 individuals from around the nation whose personal experiences reveal the true nature of the health crisis for people of color. In addition, 40 interviews with experts in health and related fields—including academics, community-based organizations, policy makers, funders, and health care professionals—helped the research team frame key questions and identify promising practices and policies.

Case Studies: This study includes in-depth case studies of policies and organizations that have demonstrated a successful

and/or innovative approach to reducing racial or ethnic disparities in health. Within the health care system, health disparities result from a range of factors, such as a lack of access to primary care, language access barriers, lack of traditional healing and alternative medicine, or culturally inappropriate care. Outside of the health care system, factors that influence health include economic opportunity, access to nutrition and exercise, segregation, housing, pollution, education, and workplace health and safety. The case studies reflect what the research staff, in consultation with a range of experts in the field, identified as the most promising, innovative, and effective policies or programs that address the root causes of racial disparities in health. The institutions and policies highlighted in each of these case studies reveal one or more best practice models that could be replicated elsewhere around the nation.

In addition to this fundamental criterion, case studies were also chosen to include:

1. different racial and ethnic groups, for whom the primary barriers to health and health care vary;

2. geographic diversity, urban and rural settings, and language differences; and

3. both model health care institutions and community-based organizations that address the root causes of poor health.

REPORT STRUCTURE

This report, consisting of seven chapters, identifies best practices for addressing racial disparities in health and assesses the root causes of those disparities.

Chapter 1: The Causes of Inequities, focuses on understanding health disparities and explores the connections between racism and health. It answers three fundamental questions. First, what do we know about racial disparities in health? Second, how does this corroborate our experiences and perceptions at a community level? And finally, how are these disparities connected to the various forms of racism—interpersonal, institutional, and structural—that pervade our society?

The chapters following Chapter 1 profile institutions, policies, and organizations from around the nation that are proactively addressing racial disparities and improving health for people of color.

Chapter 2: Reducing Health Disparities: Southcentral Foundation, Anchorage, AK. The Southcentral Foundation integrates primary care with urgent and hospital care to serve 45,000 Alaskan Native and Native American residents in Anchorage, AK and its surroundings. Its focus on integrated services and accessibility, as well as its emphasis on cultural competency and alternative medicine, have led to measurable health improvements for the entire Alaska Native and Native American population.

Chapter 3: Language Access for All: Bellevue Hospital, New York, NY. Belleview Hospital serves people from every corner of the world, in hundreds of distinct languages. Bellevue is exceptional in its ability to meet the language needs of this diverse patient population. The hospital has employed a three-tiered system of language services, offering traditional interpretation as well as an innovative system that provides high-quality interpretation while building the patient-doctor relationships and trust that are often compromised in the presence of an interpreter.

Chapter 4: Access to Quality Health Care: Washington, D.C. and Santa Clara County, CA. Health care financing is a fundamental barrier to access to health care institutions, particularly for people of color. This case study looks at attempts to expand health coverage programs, such as Medicaid and CHIP, to cover low-income families and immigrants. It also provides an empirical basis for further expansions of these programs and discusses the promise of a comprehensive health care financing system.

Chapter 5: Community-Based Approaches: Sells, AZ and Berkeley, CA. Most health disparities result from socioeconomic inequities and other derivatives of past and present-day racism in the U.S. This chapter identifies promising practices that lie outside of the health care system in improving health within communities of color. In Arizona, Tohono O'odham Community Action has sought a return to a traditional diet to counter extreme rates of diabetes. In Berkeley, a typical inner-city middle school has replaced less nutritional processed foods in its school lunch program with produce grown in a school garden.

Chapter 6: An Anti-Racist Approach: St. Thomas Health Services, New Orleans, LA. While the effects of public decisions related to community development, safety, affordable housing, and neighborhood design all have profound health implications, few health-focused institutions engage in such policy discussions. St. Thomas Health Services illustrates the role that a health care institution can play in addressing community-level health risks. The clinic also recognizes that racism and its manifestations pose an independent health risk that cannot be mitigated through health care alone.

Chapter 7: Improving Health: Key Findings and Recommendations. This chapter reviews the root causes of health disparities and highlights promising, replicable practices for addressing the health crisis for people of color.

The report also includes excerpts of interviews with experts from a range of professions; a contact list for organizations, academics, health professionals, and organizers; and a resource list for accessing relevant research and useful supporting documents for model policies and practices. ∎

THE CAUSES OF INEQUITIES
Overview

Juan Zavala* is the smallest kid in his 5th grade class and has hardly grown in three years due to an undiagnosed medical condition. Now, his mother, Elena, worries about her son's inability to gain weight, her daughter Mayra's repeat trips to the emergency room, and her own lack of health insurance. Elena thinks the organic foods they ate in El Salvador were healthier than the pesticide-laden produce and processed foods that she can afford to buy. She wonders if they are healthier here or in El Salvador. "Back home, kids don't get sick like they do here," she says. "Here, my kids are always suffering from a cold or something worse."

While the existence of racial disparities in health is undisputed, there is often confusion about their causes. Two myths dominate how people talk about health and race: 1) biological and genetic differences are primarily responsible for difference in health, and 2) health disparities are entirely attributable to socioeconomic status. Neither is true. Karen Williams and Veronica Johnson write in the *Harvard Health Policy Review*, "The concept of 'race' has been found to be largely psychological and sociopolitical, rather than biological, as human genome research indicates that all human beings carry 99.9 percent of the same genetic material (DNA) regardless of race." The Human Genome Project, which has greatly advanced an understanding of the role of genetics in health disparities, has demonstrated that differences in the remaining 0.1 percent of genetic material cannot explain differences in rates of any of the most serious diseases, such as heart disease, cancer, diabetes, or asthma. As Francis Collins of the National Human Genome Research Institute writes, "In many instances, the causes of health disparities will have little to do with genetics, but rather derive from differences in culture, diet, socioeconomic status, access to health care, education, environmental exposures, social marginalization, discrimination, stress and other factors." (Collins, 2004)

The fact that biological and genetic differences within racial and ethnic subgroups are much greater than differences across races precludes their responsibility for most differences in health outcomes. Yet Williams and Johnson continue to write that

"False constructs of racial effects on health must be studied in order to eliminate health disparities that are largely psychosocially, historically, and economically driven." (Williams, 2002) The myth that health disparities result from biological or genetic differences can in itself become a barrier to addressing the true causes of those disparities.

The second myth about health disparities is that they are entirely attributable to socioeconomics. It is true that income and wealth are directly proportional with health outcomes—the better off people are, the healthier they tend to be. This is largely due to environmental factors. People with lower incomes face many environmental barriers to health, including substandard housing, lack of access to parks or nutritious food, air and water pollution, and hazardous working conditions. However, even when income, age, and education level are the same, people of color experience different health outcomes.

Analysis by leading scholars, including Dr. David Williams from the University of Michigan and Dr. Camara Jones from the Centers for Disease Control and Prevention, demonstrates that living within a racially stratified society has profound health effects. Longer work hours, multiple jobs, more dangerous work environments, poor access to transportation, and overt discrimination all affect physical, mental, and emotional health. Their research demonstrates that racism and its associated outcomes cause people of color to experience diseases with a greater frequency and at an earlier age than their white counterparts. (Center for the Advancement of Health, 2003)

Health disparities are not about race or ethnicity in a cultural or biological sense; rather, they result from racism and its social and institutional manifestations. Addressing them requires an understanding of the ways in which racism affects people of color in the U.S. Racism in U.S. society exists on interpersonal, institutional, and structural levels. On one level, racial disparities in health can result from bias, discrimination, and stereotypes on the part of individual health care professionals, such as doctors or nurses. Differential treatment by individuals is *interpersonal* racism, which is driven and reinforced by ingrained beliefs and media stereotypes.

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* Names have been changed throughout this chapter.

On a second level, multiple forms of racism are embedded within the institutions that constitute the health care system. For example, a hospital may close a clinic in a low-income, African American neighborhood because of the high cost of emergency care to mostly uninsured families. The result is longer travel times for critical care in what may be life and death circumstances. Such a policy may not explicitly intend to discriminate against a particular racial or ethnic group, but the outcome of that policy may be devastating. Institutional racism is often masked underneath layers of bureaucracy or financial decision-making but can have dire consequences, both intended and unintended. Translation and interpretation services, access to health care for people of color, and the quality of care that is available are all connected to institutional priorities and decisions. Several of the case studies in this report exemplify organizations that have directly addressed such institutional barriers to health equity.

While inequities within the health care system are a significant cause of health disparities, most determinants of health lie outside the scope of health care institutions. *Structural* racism in the U.S. is the normalization and legitimization of an array of dynamics—historical, cultural, institutional, and interpersonal—that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color. (Applied Research Center, 2003) Structural racism lies beneath social and economic inequities that are at the root of the vast majority of health disparities. Health is mostly determined by where people live, what we eat, where we work, how we exercise, what we breathe, what we drink, how we perceive our life options, and how well informed we are of issues related to our own health. Addressing social and economic inequities is critical to developing healthy communities. The following analyses will highlight the role of interpersonal, institutional, and structural racism in creating and perpetuating the health crisis for people of color.

INTERPERSONAL RACISM WITHIN HEALTH CARE SETTINGS

Tamisha Williams* recently had a stroke. Williams, an African American woman in her 50s, was referred by her doctor to a cardiologist. Her doctor and cardiologist, both of whom were white, treated her through cardiac catheterization, a standard procedure for anyone demonstrating her symptoms.

The fact that Williams' doctors responded to her condition with a basic standard of care should be nothing out of the ordinary. But for many African Americans, and particularly African American women, such a standard cannot be taken for granted. In 1999, Dr. Kevin Schulman, a cardiologist, showed fellow cardiologists photos of patients demonstrating identical symptoms that would require cardiac catheterizations. What he found was that cardiologists were 40 percent less likely to recommend African Americans, particularly African American women, than white men for this basic care. (Schulman, 1999)

Why was Williams lucky to receive care that would be almost assured for a white man in her identical situation? Culturally imbedded and media-propagated racial and ethnic stereotypes affect the way all people are perceived and treated by other individuals. Whether it occurs on a conscious or subconscious level, interpersonal racism affects the way people of color are treated within health care institutions.

Several studies have documented the role of bias, discrimination, and stereotyping between health care providers and their patients. In a 2001 survey, 20 percent of Asian Americans, 19.4 percent of Latinos, 14.1 percent of African Americans, and 9.4 percent of white people said they were treated with disrespect or looked down on in their patient/provider relationship. (Blanchard and Lurie, 2004) That study reveals that African Americans, Latinos, and Asian Americans, along with people who spoke a primary language other than English, are more likely than whites to believe they would have received better treatment if they were of a different race.

The discrimination that these patients felt is more than just perception. People of color who reported disrespectful treatment were less likely to have had a physical exam in the prior year,

Interpersonal Causes of Health Inequities

ROOT CAUSE OF DISPARITY	POTENTIAL POLICY RESPONSE
Individual biases in doctor/patient relationships	• Standards for care and treatments for common diseases/illnesses • Minimize barriers to relationship-building between patients and doctors

and those with diabetes, hypertension, or heart disease were less likely to have received optimal care. (Blanchard and Lurie, 2004) Moreover, people who reported that they were treated unfairly or with disrespect because of their race were less likely to follow their doctor's advice and were more likely to put off needed care. When doctors have limited time to spend with patients or are under pressure to prescribe lower-cost treatments, conscious and unconscious biases are even more likely to lead to differential treatment.

INSTITUTIONAL RACISM WITHIN THE HEALTH CARE INDUSTRY

While discrimination in the patient/provider relationship is an undeniable factor in health disparities, institutions perpetuate most inequities in health care. Ever since her family fled from southern Vietnam to escape persecution in the late 1970s, Nguyen Minh* has acted as a bridge between her parents and the people of the small town chosen for them by refugee resettlement agencies. By 11 years old, still not quite caught up

The myth that health disparities result from biological or genetic differences can in itself become a barrier to addressing the true causes of those disparities.

to her American classmates at reading and writing, Nguyen was forced to do something not expected of any of her peers. When her father developed a respiratory infection, Nguyen had to learn medical terminology and talk him through his doctor's visits. Doctors determined that his condition, which he attributed to long hours spent sweeping up dust and cleaning offices with toxic chemicals, was cancer. With no interpreters who spoke Vietnamese, it was 11-year-old Nguyen who doctors asked to give him the news. The fact that the hospital did not have a trained interpreter not only created a traumatic situation for Nguyen, but also jeopardized clear communication about diagnoses and treatment instructions between her father and his doctor.

Whether it involves language services, accessibility, or quality of care, health care institutions often provide unequal treatment to people of color. Health care institutions perpetuate health disparities through deficiencies in four key areas: 1) financial and geographic access to health care; 2) language services for Limited English Proficient (LEP) patients; 3) culturally appropriate, quality health care; and 4) understanding and facilitation of the use of alternative medicine.

Financial and geographic access to health care: Lack of health insurance is the major barrier to the health care system for many people of color. More than one in three Latinos, one in four Native Americans/Alaska Natives, and one in five African Americans and Asian Americans lack health insurance, as compared to one in nine whites. (Current Population Survey, 2001) Even when employed full time, African Americans are less likely to have employer-based health care than whites. Without public health programs such as Medicaid, the gap in health insurance would be greater. Location of health services also poses an access barrier. In 2001, the closure of D.C. General Hospital, the only hospital on Washington's southeast side, reduced access to emergency services for most of the city's low-income immigrant and African American residents. Budget crises in California led to the closure of 23 hospitals between 1995 and 2000, mostly in urban areas with predominantly people of color. A survey of pharmacies in New York City found that two-thirds of all pharmacies with inadequate supplies were in nonwhite neighborhoods. (Morrison et al, 2000) As a result, people of color often suffer longer wait times for emergency care and have limited access to preventive and primary care.

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The variable we call race is a rough proxy for socio-economic status, an even rougher proxy for culture, and doesn't work at all for genes. Race is just the social interpretation of how we look, which in turn governs our life experience and opportunities. And racism is at the basis of all of that.

Racial disparities arise at all levels within the health care system and in access to the health care system. But the most profound impacts are at the structural level, the differences in life experience and life opportunities that result from racism.

Quality health care: Quality health care for people of color is an issue of resources and priorities. Often, clinics that do operate in low-income communities of color are understaffed, operate with limited resources, and may provide a lower quality of care. (Bach et al, 2004) Only 57 percent of Latinos and 50 percent of Asian Americans, as compared to 70 percent of whites, say they spend enough time with their doctors. (Commonwealth Fund, 2002) Continuity and culturally appropriate interactions between health care institutions and their patients are also components of quality care. An institutional culture that acknowledges, respects, and responds appropriately to diverse populations is critical. While staff diversity alone does not guarantee culturally appropriate care, a study by Dr. Brian Smedley and others demonstrates that increasing diversity in professions results in more professionals in underserved communities. (Institute of Medicine, 2004)

Language Access: According to the 2000 Census, more than 26 million adults (13 percent of the population) live in households in which no one speaks English. As Nguyen's situation attests, trained medical interpreters are necessary to effectively communicate symptoms and treatment instructions across this language barrier. Yet failure to address the needs of non-English speaking patients is a common occurrence. In a 16-city study of uninsured patients, more than half of limited-English proficient patients did not receive interpretation services—either the wait for someone who spoke their language was too long, or a friend or family member had to interpret for them. (Andrulis et al, 2002) Even when an interpreter is present, they often lack training in medical terminology.

Alternative Medicine: Many people of color rely on non-Western medicine. Twelve percent of African Americans, 22 percent of Latinos, and 27 percent of Asians, as compared to four percent of whites, are likely to use alternative care for religious or cultural reasons. (Commonwealth Fund, 2002) If such care were available or covered under insurance plans, those numbers might be higher. Health care institutions need to understand or have access to information about alternative forms of medicine and healing. For example, there may be serious adverse effects when prescription drugs interact with other remedies that a doctor is unaware of or unfamiliar with. Yet only 55 percent of African Americans, 50 percent of Latinos, and 63 percent of Asian Americans reported telling their doctor about their use of alternative medicine, as compared to 70 percent of white patients.

STRUCTURAL RACISM THAT AFFECTS THE HEALTH OF COMMUNITIES AND INDIVIDUALS

Located within a 97 percent African American community in Memphis, Tennessee, the Defense Depot of Tennessee has been processing hazardous military waste since 1946, when a leaking container of mustard gas was buried on the site. Since then, workers at the Depot have handled nuclear waste materials, asbestos, and other chemicals. Children and pets suffered from

Institutional Causes of Health Inequities

ROOT CAUSE OF DISPARITY	POTENTIAL POLICY RESPONSE
Inaccessible health care for people of color due to financial and geographic barriers	• Universal health care • Expand employer contributions and responsibility for health care • Expand Medicaid, SCHIP, Medicare coverage • Community-based primary care clinics
Lower quality or culturally inappropriate care for communities of color	• Increased funding for understaffed hospitals/clinics • Access to specialized or urgent care • Resource support and incentives for building relationships • Recruitment and on-the-job training programs for people of color
Lack of comprehensive interpretation and translation services within hospitals and clinics	• Provide access to highly trained medical interpreters • Translate written materials and signage into multiple languages • Implement federal CLAS standards
Lack of understanding or integration of alternative and traditional medicine	• Insurance coverage for appropriate alternative health care • Training of doctors to understand alternative treatments.

a variety of inexplicable ailments, and subsequently neighbors were made aware of the dangers of being near the site. For workers at the Depot, it was worse. People developed facial rashes, lesions, and respiratory problems, and were not given proper safety equipment when handling toxic substances. Black and white workers received different treatment—white workers were sent to the hospital for full examinations once a year, while African American workers were only offered a blood and urine test on site. (Applied Research Center, 2001)

The experiences of the residents near the Defense Depot of Tennessee are not unique. African American children are more likely than white children to live in highly polluted urban areas and

Racism and its associated outcomes cause people of color to experience diseases with a greater frequency and at an earlier age than their white counterparts.

are far more likely to suffer from asthma. Diabetes, which is linked to diet and exercise, is more prevalent in communities that are targeted by fast food advertising, have little access to parks and physical recreational activities, and have poorly funded schools with few after-school activities. Stresses related to racism and discrimination have also been connected to other poor health outcomes such as cardiovascular disease and some forms of cancers. (Vitaliano, 2003)

Holding the health care system accountable to standards of quality and equitable care is an important component of a long-term effort to negate health disparities. Yet the health of a community is determined by a myriad of interconnected social, economic, and historical factors. Many of these are related to discrimination, segregation, and broader social and economic inequities. For example, a study published in the journal *Social Epidemiology* demonstrates that people with higher incomes generally have better health and live longer than people with lower incomes. (Lynch and Kaplan, 2000) Income levels are strongly correlated with race and ethnicity. Median income for white households in 2000 was $45,910, as compared to $30,436 for African American households and $33,455 for Latinos. (U.S. Census 2000) While 26 percent of whites are low-income, 29 percent of Asians, 49 percent of African Americans, 54 percent of Native Americans, and 61 percent of Latinos are low-income. (Steveteig and Wigton, 2000) As a result of this racial and economic stratification, many healthy life choices are not available to people of color, such as time for exercise, buying healthy foods, attending quality schools, living near parks and green spaces, and working in stable, safe conditions.

For people of color, economic inequality, limited educational opportunity, and housing discrimination restrict access to healthy communities and choices. These inequities are indirectly culpable for many social and economic causes of health disparities. There are several related factors that have a direct and disproportionate impact on the health of communities of color: environmental hazards and pollution; community design and segregation; and workplace health and safety.

Environmental Hazards and Pollution: Environmental racism contributes to disparities in health outcomes. People of color tend to be segregated in neighborhoods characterized by greater exposure to environmental-based health hazards.

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Many communities have their own folk theories or explanations about why there are so many social problems. For example, within certain subgroups of American Indians a theory called historical trauma is very big right now. The theory is that many social problems are a result of the breakdown of religious, economic, social, family, and cultural systems because of the policies of colonization. People experience higher mental health problems and alcohol and substance abuse rates due to intergenerational historical trauma.

It will be very hard to prove that this exists on a physiological level. But if this theory resonates with people and unites people and brings people together to solve problems, then the theory is important. The importance of a theory about the origin of a disease is how much it motivates people to do something about the problem.

Structural Causes of Health Inequities

ROOT CAUSE OF DISPARITY	POTENTIAL POLICY RESPONSE
Income inequality	• Quality public education • Job opportunities
Housing and segregation	• Lead paint removal • Affordable housing • Public transportation • Health impact assessments
Workplace health and safety	• Employer-based health care • Government enforcement of environmental standards • Union right to organize
Access to healthy food and exercise	• Physical and health education in schools • Healthy school lunch programs • Healthy local groceries and markets • Traditional agriculture

(Smedley et al, 2003) This includes incinerators, dumps, and industrial pollutants, as well as highways, train stations, docks, and other emitters. The Environmental Defense Fund found that nearly twice as many toxic waste Superfund Sites per square mile are in neighborhoods of color, along with more than twice as many facilities emitting air pollutants. As a result, people of color experience 27 percent more exposure to toxic chemicals and 32 percent more cancer risk from hazardous air pollutants. (Environmental Defense Scorecard) Children living and attending school near highways with higher levels of motor vehicle pollution have higher rates of asthma and bronchitis symptoms. (Kay, 2004)

Community Design and Segregation: Segregation of neighborhoods by race and income has myriad implications for housing, education, and employment opportunities, all of which affect health outcomes. Housing in low-income neighborhoods where people of color live is more likely to contain lead paint, insect dust, and other harmful contaminants. (PolicyLink, 2002) As a result, African American children in the United States have 80 percent higher blood lead levels than white children. (Environmental Justice and Health Union, 2005) Segregation also limits access to goods and services. Many communities of color lack adequate public transportation systems, offer few parks or safe walking spaces for exercise, and lack supermarkets

that sell affordable, healthy foods. (Morland et al, 2000) Poor public transportation often increases time spent commuting to work, time that could be spent getting exercise or cooking a nutritious meal. In California, African Americans and Latinos were more likely than white respondents to say that their neighborhood was not a good place to buy healthy foods, nor was it "a place that promotes the overall health and well-being of its children and teens." (Field Research Corporation, 2003)

Workplace Hazards: In the workplace, people of color have higher exposure to industrial hazards. Research has shown that disparities in cancer risk may reflect the disproportionate exposure of African American men to carcinogens at work. (Briggs et al, 2003) Health risks in the workplace are not limited to pollutants and carcinogens. Historically, some employers in the United States reserved the most dangerous jobs for African American workers; in some documented cases the workers suffered horrific mortality rates. For example, in North Carolina between 1977 and 1991, African American workers were 30 to 50 percent more likely to be fatally injured on the job than other workers. (Loomis and Richardson, 1998) The ten occupations with the most Latino workers are almost three times as dangerous as the ten occupations with the most white workers. (Matsuoka, 2003)

Confronting inequities in treatment and access to health care and the social and economic roots of health disparities will require proactive strategies. For example, environmental standards, translation and interpretation services, immigrant access to health care, physical education and nutrition in schools, and myriad other issues are all part of a critical, long-term struggle for healthy communities. Many organizations and institutions have effectively addressed health inequities and improved health outcomes for people of color in particular. The case studies in the following chapters provide lessons for addressing health disparities and improving health for all. ■

Racial and Ethnic
DISPARITIES IN HEALTH

CANCER

African Americans are ten percent more likely to suffer from cancer and 30 percent more likely to die from cancer than whites. Low-income people and people of color are less likely to receive cancer screenings; without screening, cancers are more likely to be detected in later stages.

U.S. Department of Health and Human Services, 2003

INFANT MORTALITY

Infant mortality rates are nearly two times higher for African Americans and one times higher for Native Americans than for white children. Latinos, African Americans, and Native Americans/Alaska Natives are at least three times as likely as whites to receive late or no pre-natal care.

Kaiser Family Foundation, 2003

DIABETES

African Americans, Native Americans, and Hispanics have higher rates of death from diabetes. Low-income people and people of color are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and related complications.

U.S. Department of Health and Human Services, 2003

ASTHMA

One in four Native American and Alaska Native children suffers from asthma, as does one in five African American child. Between 1990 and 1997, African American children in California died of asthma at seven times the rate of white children. Many respiratory diseases can be prevented through management and vaccination, but many people of color and low-income people are less likely to receive recommended immunizations.

California Endowment, 2004
U.S. Department of Health and Human Services, 2003

MORTALITY

During the 1990s, mortality rates for white men and women were an average of 29 percent and 24 percent lower, respectively, than those for African Americans. Equalizing these mortality rates could have saved 886,202 lives.

Woolf, 2004

LIFESPAN

While average lifespans increased overall, the difference in life expectancy between African American men and white men increased from 7 years to 8 years between 1960 and 1996. In some parts of the country, **Native American men can only expect to live until their mid-50s.**

Collins, et. al., 1999

REDUCING HEALTH DISPARITIES

The Southcentral Foundation

Growing up on the Blackfeet reservation in Browning, Montana, DeAnn Shooner learned, like most others, to tough it out when she felt sick. On the reservation, appointments to see a doctor often required a month's wait or more. But years after moving to Anchorage, Alaska, Shooner, an energetic, 36-year-old mother and successful small business owner, began to experience fatigue and pain throughout her body, particularly in the mornings. She didn't want to admit she was not well, until one day the pain became so intense that she couldn't stop violent shakes in her arms and legs.

She drove herself to the emergency room at a private hospital in Anchorage. "They said they didn't know what I had," she recalls. "They told me it was just in my head." A year later, she began shaking so badly that her mother called an ambulance. As a Native American, Shooner was eligible for care at the Alaska Native Medical Center (ANMC) in Anchorage, a world-class health facility for Native Americans and Alaska Natives.

Doctors at ANMC were still unable to diagnose her problem, but they recognized that Shooner was in extreme pain. The Southcentral Foundation (SCF), a nonprofit Native health corporation and co-owner of both ANMC and a primary care center, honored Shooner's request for specialized services and offered her $10,000 to attend a private pain clinic. A specialist at the clinic finally discovered that Shooner suffers from fibromyalgia, a musculoskeletal pain and fatigue disorder.

Shooner is one of 85,000 Alaska Natives and Native Americans who rely on ANMC and SCF for care. Since taking over the management of all Native health care services from the federal government in 1999, SCF has been improving people's health in cities and villages statewide. Under the leadership of Katherine Gottlieb, an Alaska Native woman born to Aleut and Filipino parents and recent winner of a MacArthur Foundation "genius" award, SCF has demonstrated remarkable success in increasing access to primary and preventive care, and mitigating racial and ethnic disparities in asthma and other illnesses.

SCF's approach to primary care and its integration of specialty care and alternative medicine have led to a decrease in hospitalizations and urgent care usage among Alaska Natives and Native Americans. Since her diagnosis, Shooner has never had to go back to the emergency room; when she needs to see her primary care provider, she is guaranteed a same-day visit. She also has access to an array of complementary services, from acupuncture and chiropractic care to mental health and counseling. Counseling services have been a critical support for Shooner, who was at first resistant to taking her pain medication. "I didn't want to be a 'pill popper'," she says. "They taught me that it's okay to take medication. I take it so I am functional."

Since assuming control of health care for Alaska Natives and Native Americans, SCF has achieved dramatic improvements in screenings and preventive testing, a reduction in hospitalization rates, and overall health improvements. Three core components of SCF's model are primarily responsible for improving the health of Alaska Natives and Native Americans. These components include 1) its innovative approach to primary care and prevention, 2) the focus on quality assurance and monitoring, and 3) its emphasis on Native culture, traditions, and empowerment.

INTEGRATED, ACCESSIBLE CARE

Shooner's experience with health care in Alaska was dramatically different from the care available to her on the reservation in Montana, but it hasn't always been that way. Before SCF assumed control, Indian Health Service (IHS), a federal agency, was legally responsible for providing health care to Native populations in Alaska. The services provided by IHS were characterized by long wait times, bureaucratic mismanagement, and impersonal or culturally inappropriate services or treatment. Since SCF assumed control of health services, it has focused on reducing traditional access barriers such as long wait times for appointments, addressing a person's health holistically instead of treating individual symptoms, and building long-term relationships with patients and families. "We work with the whole person, the family, and the community," explains Dr. Douglas Eby, vice-president of Medical Services for SCF. "We must get to issues of diet, nutrition, family violence, depres-

sion, and substance abuse. To do that, we must build trusting, long-term relationships."

The process of relationship-building started with improving access to primary care physicians. Not long ago, people with non-urgent medical needs had to wait a month to visit with their doctor. Now, patients can call SCF and schedule an appointment with their primary care physician that same day, even if they call as late as 4 p.m. Doctors had to work overtime for six months to clear the patient backlog, but now, by estimating demand and increasing efficiency, they are able to honor their commitment to see all patients who call each day.

Same-day access is just one component of an innovative approach to primary care. SCF is also able to improve preventive care and maximize patient visits through coordinated teams of doctors, nurse practitioners, and case managers. Case managers are the key to maintaining a relationship with patients and fulfilling the commitment to their long-term health. Case managers take a proactive approach to patient care, calling to remind patients of necessary screenings or prescription renewals and handling many issues over the phone that might otherwise require a visit.

> *"Our approach is different, because we're the culture. We live it. We're Native, and we're putting the health care into it. It's also in the buildings; it's how we do complementary care and mental health. The culture is here in our hearts."*
>
> Katherine Gottlieb
> Southcentral Foundation President/CEO

"In six months, we'll call you to follow up on your diabetes labs, etc. If your florist can send you an email to remind you of your mother's birthday, then we should be able to do this for diabetes," says Dr. Steve Tierney, who has practiced as a primary care physician at SCF for eight years. "We've stopped using meds to hold people hostage. We know that people are diabetic. They need to keep taking their meds for the rest of their lives. We take it as our job to make sure they get the meds and then also to follow up when we need to do appropriate tests." Mental health clinicians are also available to meet with patients and their doctors, conduct evaluations, and set up ongoing appointments. When appropriate, SCF also offers on-site access to an array of complementary care options, including chiropractic care, acupuncture, and traditional healing.

The holistic approach to health is reflected in the care patients receive during a typical visit. When possible, patients are offered multiple services in one visit; it is common for mammograms, blood pressure checks, cholesterol screenings, and annual physicals to be conducted in conjunction with a visit for a cold or a minor injury. While maximizing patient visits and saving time for both doctors and patients, this approach also maintains continuity of treatment and prevents unnecessary hospitalizations or emergency care. "There used to be a lot of repeat ER visits. That's usually an indication that you're not getting good care, before or after the visit," says Mike Thompson, a case manager and registered nurse. "Now we're managing patients, stabilizing them so they don't need to go into the ER."

What may be most surprising about this system is that while it improves access to doctors, it also provides cost savings. Case managers such as Thompson are trained nurses but cost less than doctors. They handle much of the paperwork and ongoing patient contact, saving doctors' time for patient interaction and treatment. Due to the emphasis on addressing multiple issues in one visit, primary care appointments among the same population of patients have dropped by 20 percent. Same-day appointments also increase efficiency. At the start of a typical workday, a doctor at SCF may have four appointments on her or his calendar. By the end of the day, that doctor will have seen a full patient load, usually 10-15 patients in 30-minute segments. Before patients could schedule same-day appointments, 28 percent of scheduled patients did not show up. Now, only ten percent of scheduled appointments are no-shows, saving doctors' time and opening slots for others.

Data have begun to show remarkable results. Since she began treatment at SCF, DeAnn Shooner has not needed urgent care for pain associated with fibromyalgia. Overall, urgent care visits to the hospital have dropped by 50 percent since SCF began its same-day visit policy. In addition, the number of mammograms and Pap tests has tripled, indicating a marked increase in preventive care.

Between 1999 and 2002, the Alaska Department of Health and Social Services studied asthma hospitalization rates and the prescription rate for inhaled corticosteroid among Medicaid patients under the age of 20. For asthmatics, the use of corticosteroid inhalers prevents the type of severe asthma attacks that might cause hospitalization. In Anchorage in 1999, the first year that SCF's same-day service was implemented, 15 percent of asthmatic Alaska Natives were admitted to a hospital. By 2002, only six percent required hospital care. This is attributable to improvement in the number of people who received inhalers: in 2002, 85 percent of Alaska Native asthmatics received inhalers, as compared to only 35 percent in 1999. By comparison, only 60 percent of non-Native Alaskan asthmatics received the inhalers in 2002. In other words, the primary care provided through Southcentral Foundation did not just reduce the disparity in asthma treatment between Native populations and white Alaskans, it reversed it. Hospitalizations for asthma decreased overall for the Alaska population between 1999 and 2002. The most sig-

The primary care provided through Southcentral Foundation did not just reduce the disparity in asthma treatment between Alaska Natives/Native Americans and white Alaskans, it reversed it.

nificant cause for the decrease was high-quality preventive care for Alaska Natives and Native Americans.

QUALITY ASSURANCE

While integrated teams and case management facilitate quality care, SCF is also unique in the way it holds doctors accountable to performance standards. The health care provided by each primary care provider and her or his team is tracked through a robust system developed by Dr. Tierney. Physicians receive monthly charts detailing the percentage of their patients who have had immunizations, mammograms, Pap tests, lipid checks, and a range of other screenings and tests. Alongside this percentage is the clinic average, and when possible the numbers are compared to state and national averages. Doctors are shown the number and age of their patients who received cholesterol screenings and cancer screenings, people with overdue tests, and kids who have received immunizations. They are also scored for the number of patients who are referred to mental health services and the number who are hospitalized each month. Annual charts compare each provider's performance on a month-to-month basis with the clinic average, as well as showing the percentages of the best provider for each month in each category (see appendix).

Such quality assurance systems are rare within the health care field. "We don't check provider performance, usually, in health care. It's a mystery," says Dr. Tierney. "You go in, you see a provider, something secret happens, there's patient/provider privilege, and nobody talks about it. It's a secret black box interaction between the patient and provider, and no one knows what happened. We don't believe in that. We think the patient shouldn't disappear from your radar screen just because they're not physically in front of you."

The system allows the clinic to track the performance of each of its primary care providers and structure institutional priorities to meet the needs of the community. "Your efficiency as a provider should be rated against your peer group," says Dr. Tierney. "Many doctors might be resistant at first. But you learn quickly how much better it is to work in a team, how much more time you get to spend with your patients, and you know when you are doing a good job."

The commitment to assuring quality is a part of SCF's philosophy that extends beyond the clinical encounter. Most changes

DOUGLAS CHUNG, MSW, MA, PH.D.

President of The Asian Center in Grand Rapids, Michigan.

There are a lot of barriers for Asian immigrants in Michigan who choose to access traditional Chinese medicine (TCM), including acupuncture, herbal medicine, and qigong (a meditative practice and exercise). In Michigan, unlike other states such as California and Washington, there is still no licensure for acupuncturists, so they have to practice under the supervision of an M.D. who is not trained in this area and lacks knowledge of TCM.

Additionally, people often travel to Chicago, New York, or even return to their birth country after a diagnosis to get access to traditional treatments. Our solution is to create a culturally sensitive Asian clinic in Grand Rapids, which we hope to open in 2005. We will integrate medicine from the East and West, thereby providing culturally sensitive services to our Asian communities as well as the general public.

that happen within the hospital are a result of client requests or complaints, says President/CEO Katherine Gottlieb. After same-day services were implemented, for example, the most common patient complaint was long wait times on the phone to set up appointments. Now the hospital closely tracks how long patients wait on the telephone when they call, how long they wait before seeing a doctor, and how they are treated when they arrive. "We started to focus on the call wait time because several patients commented on it," says Gottlieb. Now the wait time averages less than a minute.

The clinic's commitment to responding to patient needs runs deep. DeAnn Shooner remembers when she was frustrated about her doctors' inability to diagnose her condition. Despite the workload associated with directing a $118 million dollar organization, Katherine Gottlieb called Shooner directly to see how they could serve her better. "That really struck me," says Shooner. "To get a call from Katherine herself really shows how much they care."

"We are constantly asking our customers how things are going," says Gottlieb. "We do measurement. We collect everything. We try to measure how we're doing compared to people around the state. But number one, we know from our customers. We know if they stay with us or go to another hospital. And we follow up with our customers to see how we can do better."

NATIVE CULTURE, TRADITIONS, AND EMPOWERMENT

Relationships and community health are core values of SCF, and they grow out of the Native culture. The physical space of the clinic and hospital, its traditional healing programs, and its outreach efforts reflect Native culture because SCF is Native, says Gottlieb. She rejects the notion of cultural competency. "Our approach is different, because we're the culture. We live it. We're Native, and we're putting the health care into it. It's also in the buildings; it's how we do complementary care and mental health. The culture is here in our hearts."

SCF recognizes the importance of creating a physical space that honors the culture of Alaska Natives. Its award-winning architecture is welcoming to its patients and creates space for cultural expression and social interaction. "My aunt comes here most days," says Connie Irrigoo, public relations director at Southcentral Foundation. "It's a place for her to meet relatives and connect with friends." The facilities are designed to resemble traditional native structures and meeting places. Throughout the hospital and the clinic are displays of artwork from the state's different tribal groups. On the clinic's entry floor, a health education center provides information, and health education specialists are on hand to discuss health issues. Next to the education center, Alaska Native artists often sell beadwork and other traditional crafts.

TRADITIONAL HEALING

Native culture extends into healing practices. Dr. Ted Mala, the first Alaska Native man to receive an M.D., is the director of the traditional healing program. Dr. Mala is the former health commissioner for the state of Alaska, past president of the National Association of Native American Physicians, and works on minority health issues as a board member for the National Institute of Health. At SCF and ANMC, Dr. Mala's department treats approximately 80 people each month, after they are referred by their primary care provider.

To Dr. Mala, one of the significant aspects of traditional healing is that it is not the quick fix that Western medicine promises. "We as Americans have become accustomed to instant gratification. Traditional healing is very slow and methodical," he says. "It's not just perhaps taking a plant and using it to heal something. There could be a ceremony involved, there could be prayer involved. There could be a number of things that as a whole contribute to healing." One example is the resistance of many Alaska natives to western medicine's ways of dealing with alcohol abuse. "Traditional programs have bridged that gap, whether through tribal circles, through sweats, through different medicine people," Mala says.

"Traditional healing is not for everyone," Dr. Mala explains. "It depends on how you're brought up. For Native people who come from a village and are in tune with their elders, this is very important. We have patients who have four, five, six problems in their charts, and who only found resolution through traditional healing." While most traditional healing referrals are people who grew up in villages without access to Western medicine, Dr. Mala will often see urban Alaska Natives and Native Americans as well. "We use elders, a tribal council, who teach people about their culture. A lot of people are searching for their roots, looking for something that will help them in their journey, mentally or physically." Dr. Mala believes that the biggest problem facing Alaska Natives and all people is mental health. "If you don't integrate mental, physical, and spiritual, you're not a total healer. And traditional healing kind of does that in a good way," explains Dr. Mala. "We empower individuals to take more responsibility for their own health, and we do it in a cultural way that uses cultural knowledge, elders, prayer, a lot of things all together. It's a component that's missing from Western medicine."

Developing traditional healing into a core component of the services available to Alaska Natives and Native Americans requires education and an institutional commitment. The Anchorage Native Primary Care Center is the only center in Alaska that has traditional healers on staff. Traditional healers spend time educating and training doctors about their role, and communicating with those doctors as the healing process continues. Neither private insurance nor Medicaid reimburses for the services of Dr. Mala's eight-person department, so SCF must find other means of supporting the services. "It's a big investment for our people," says Dr. Mala.

DEVELOPING NEW STAFF

SCF also invests in the development of Native health practitioners. Among the 100 doctors who practice at SCF and ANMC, 15 to 20 are Alaska Native or Native American, says Dr. Mala. While this is perhaps a greater number than any other hospital in the state, if not the nation, it is a number that SCF hopes to increase. Only 63 percent of Alaska Natives have a high school diploma, as compared to over 75 percent of Alaskans of all races ages 25 and over. Improving educational attainment for Alaska Natives has to start at a young age.

SCF operates Head Start programs and runs an internship within ANMC to encourage young Alaska Natives to pursue health-related professions, says Connie Irrigoo, public relations specialist. The RAISE program, which offers summer internships for Native high school students, started in 1997 with 20 participants. "High school students come and work here during the summertime so they learn about health care jobs," says Irrigoo. "It's not just nurses and doctors. There are administrators, technology people, so they get the exposure." There are now 11 full-time SCF staff who completed the RAISE program, Irrigoo says. SCF also partners with the University of Alaska-Anchor-

DR. JOSEPH P. GONE

Assistant Professor in the Department of Psychology and the Program in American Culture at the University of Michigan in Ann Arbor

For the American Indian population in particular (and people of color more generally), there is a dearth of evidence-based knowledge regarding what mental health interventions actually work. Even one good scientific study that tried to assess therapeutic outcomes in Indian country would be groundbreaking.

We should start cautiously and experimentally. Mental health scientists and researchers need to make it clear that we are doing something new, but that we have reasonable expectations that these proposed therapeutic interventions might prove effective. Then we must proceed in the context of a rigorous evaluation of intervention outcomes. Then when the project is completed all of Indian country will have learned something from the effort.

age to implement the Native nursing program, which regularly sends nurses-in-training to work at ANMC and SCF.

FAMILY WELLNESS WARRIORS

SCF also uses cultural traditions and symbols as a way to combat domestic violence and child abuse and neglect. The Family Wellness Warriors Initiative is an effort to target the significant problem of domestic violence within the Alaska Native community. Don Shugak has participated in the program for the past three years. "More than 80 percent of villages had seen abuse," Shugak says. "It's horrific, the abuse that still goes on." When Katherine Gottlieb first approached the elders about starting a program to address domestic violence, she got negative responses from the older men in the room. "It was a challenge to get men to talk about domestic violence," she says. "But then we had the idea to call out the warriors in the community." The program seeks to revitalize the traditional role of Alaska Native men as providers and protectors, making them less inclined to fall into a pattern of domestic violence. Thus far, 500 to 600 people have gone through the program. "When they called us out as protectors of the family, that's when I got into it," says Shugak. "Now, we want to stop abuse in our generation."

"We empower individuals to take more responsibility for their own health, and we do it in a cultural way that uses cultural knowledge, elders, prayer, a lot of things all together. It's a component that's missing from Western medicine."

Dr. Ted Mala,
the first Alaska Native man to receive an M.D.

CONCLUSION

Since entering under Native management, SCF has become a model for accessible, quality care, one that has attracted the attention of national health care programs in England, the Netherlands, and elsewhere around the world. "We're trying to provide the best care anywhere, but in a Native way, built on Native priorities and principles," explains Dr. Douglas Eby. "It's not a tradeoff. You can be Native, and you can be the best."

Three elements of the SCF model are particularly useful as best practices for reforming the health care system to eliminate disparities and improve overall health. They include integrated health care systems, accountability and measurement, and complementary care and traditional healing.

Integrated health systems offer potential for improvements in quality, accessibility, and cost of care.

SCF has demonstrated that access to primary care can reduce emergency room visits, increase the frequency of screenings and preventive testing, and provide ongoing drug treatments that will prevent life-and-death consequences of asthma, diabetes, or other illnesses that disproportionately affect people of color. Meanwhile, SCF demonstrates a model of integrated primary care that incorporates mental health services and case management, while ensuring accessibility by offering same-day service. These practices improve relationships between doctors and patients, increase usage of primary care by patients, maximize patients' time and the range of services they receive, and provide opportunity for cost savings. By prioritizing access and quality, SCF is able to demonstrate substantial improvements in the health of Alaska Natives and Native Americans, and displays practices that could be replicated around the nation.

The integration of primary care, urgent care, hospitals, mental health, and other specialty care permits SCF to take a holistic approach to community health, while providing a high quality of care, reducing costs, and improving health outcomes. Yet while integrating health care systems can provide substantial benefits, there are considerable challenges that must be overcome to implement such systems on a broad scale. Most doctors in the U.S. receive payment and insurance reimbursements per patient visit; there is little incentive to address multiple health issues or provide a series of screenings or physical exams during a single visit. Emergency room personnel, often the only medical professionals that many people see, lack the time, resources, or incentive to look beyond urgent health needs. Emphasis on acute care, weak incentives, and insufficiently developed communication and information sharing across facilities and providers all pose challenges to the development of integrated systems such as that of SCF.

For health care institutions to address disparities in health, they must be accountable to the communities of color that they serve.

Accountability to the health of the community is a critical element of SCF's accomplishments. Within most health systems, even if people have access to primary care through Medicaid, private insurance, or a new form of comprehensive coverage, the quality of care people of different racial and ethnic groups receive may vary. Underfunded health care institutions, less-trained doctors, or insufficient patient/doctor interaction, as well as conscious and subconscious racial bias on the part of medical professionals, all affect the quality of care available to people of color. Holding institutions and individual doctors accountable to high standards requires moving beyond "secret" interactions between patients and doctors. SCF demonstrates how data collection and evaluation can be used to measure performance, target areas for improvement, and hold

people accountable to quality assurance measures. This process allows SCF to set and achieve standards that improve the health of the Alaska Native and Native American communities as a whole.

SCF holds itself accountable to the health of the community, rather than a financial bottom line. The system creates incentives for doctors, receptionists, and all health professionals to improve their services, rather than to cut costs or raise revenue. Despite its successes, SCF faces considerable funding challenges, particularly as the Alaska Native community continues to grow. SCF relies on a variety of funding sources, including billing to private insurance and Medicaid, foundations, and federal funding through Indian Health Services. Since IHS funding is capped in future years, SCF may have to look to other funding streams in the future.

Traditional healing and alternative medicine have proven to be effective at addressing various illnesses and require more consideration and research.

People from non-Western racial, ethnic, or religious backgrounds may find more appropriate and effective approaches to mental, spiritual, and physical illnesses that are unique to their history and traditions. There are three components to insuring access to such care: knowledge and acceptance, financing, and outreach. Often, alternative medicine, whether it is acupuncture, chiropractic care, herbal healing, or SCF's traditional healing program, is not understood by or integrated within mainstream medical institutions. Doctors must be encouraged to ask patients about their use of alternative medicine and to understand potential reactions to combinations of Western and non-Western medical practices. Ideally, alternative healing should be available as a complement to Western medical practices and accessible when it is appropriate, as is the case at SCF. In addition, states and private insurers should seek out ways to reimburse alternative practices, particularly in the field of mental health. Health care institutions that are committed to addressing health disparities need to train medical staff and make alternative medicine accessible when necessary, regardless of insurance coverage or ability to pay. ■

BRIAN SMEDLEY

Project Director of the Opportunity Agenda, a think tank devoted to improving public debate on issues of opportunity and human rights.

One of the keys to addressing health care disparities is data collection. Data collection and monitoring for disparities in health care quality will allow us to determine when and where disparities occur. Some insurers are already collecting data on language status, income, and education, as well as race/ethnicity of their enrollees. If data is publicly available, it will empower consumers when choosing health plans. Data collection could also expose private insurers that are "cherry picking," or avoiding insuring the sickest applicants.

Data could be used to compare health plans by how well they serve patients after adjusting for race and economic status. Insurer performance could be compared to a gold standard, such as evidence-based clinical practice guidelines; for certain diseases, the standards should require certain treatments, tests, or check-ups. We can judge how well we are dealing with diabetes and asthma, for example, based on this kind of standard. That information can empower communities to demand better treatment.

LANGUAGE ACCESS FOR ALL
Bellevue Hospital

"My client base is kids with chronic disabilities. So for the most part, nothing is simple; there are no one-word answers. The majority of my patients are Spanish-speaking, and I don't speak Spanish. You can't see a patient unless you can communicate in the same language. And people do it. It's malpractice! I could not survive here without an interpreter service."

— Betty Keating, Pediatrician
Bellevue Hospital, New York City

"When I've gone to the doctor with my son, if the doctor doesn't speak Spanish and I don't have an interpreter, I just have to keep asking the same questions over and over, to make sure I understand. Sometimes I've had to ask my daughters to come along and help me. It is very important to have good interpreters available because then the patient can be sure of what's really happening."

— Mother of a child whose chronic illness
is being treated at Bellevue Hospital

New York City's Bellevue Hospital is the nation's oldest public hospital and its most diverse. With over 100 languages spoken within the hospital, Bellevue is a reflection of the immigrant community that it serves. Thirty-five percent of New York City's residents are immigrants; 46 percent of New York City residents five years old and older speak a language other than English at home. (U.S. Census, 2003) Bellevue is also home to the Bellevue/NYU Program for Survivors of Torture, which since 1995 has served over 1,500 men, women, and children from more than 70 countries around the world. "If you want to know what's going on around the world, you can see by just looking around the hospital," said Irene Quinones, who runs Bellevue's volunteer Interpreter Services department. At a hospital with patients as culturally and linguistically diverse as Bellevue, the challenges to clear communication between a doctor and a patient can be substantial. Yet despite these challenges, Bellevue hospital has been exemplary in its commitment to providing language access within all of its services. In 2003, three different sources of interpretation—TEMIS (Team/Technology Enhanced Medical Interpreting System), volunteer Interpreter Services, and the Language Line, a commercial, for-profit service—served Bellevue's limited English proficiency patients

in over 35,000 encounters. The volunteer interpreters at Interpreter Services handled 42 percent of those calls, TEMIS served eight percent of the requests, and the remaining 50 percent of requests went to the Language Line.

Despite federal regulations requiring language interpretation services, few medical facilities around the nation have matched Bellevue's success. An assessment of Bellevue's three language service mechanisms offers a glimpse of the challenges and benefits of a comprehensive language access program.

REMOTE INTERPRETATION:
TEMIS AND THE LANGUAGE LINE

Half of all language interpretation needs at Bellevue Hospital are served by the Language Line, an international telephone service that offers interpretation in 150 languages. With the diversity of languages at Bellevue Hospital, this is a critical component to quality care. The Language Line is a popular and important alternative to on-site interpreters, due both to its breadth of languages and its ease of use. The service provides training for users, operates 24 hours a day, and also offers written document translation. Moreover, some people believe that the physical presence of an interpreter hinders doctor/patient communication; phone interpretation avoids this problem.

Yet while the Language Line provides an important option, it may not be the ideal model for a language access program. First, the system is designed to provide general interpretive services; interpreters are not trained in medical terminology, which can pose serious communication problems. Unlike TEMIS, interpretation through the Language Line is not simultaneous, which both takes more time and limits communication between doctors and patients. In addition, the Language Line can be an expensive service, costing around $2 per minute. Still, this is a small cost considering the importance of communication between a doctor and a patient.

The Language Line offers a baseline of interpretation services that all health care facilities should offer. Yet because of its drawbacks, the Language Line is the last option that providers are encouraged to use at Bellevue Hospital. The first option is TEMIS, an innovative remote simultaneous interpretation sys-

tem that holds promise for language access nationwide. The idea behind TEMIS is to pool trained simultaneous interpreters in one place and connect them to providers anywhere—in New York, around the country, even internationally. Currently, TEMIS serves Gouverneur Health Care Services and Bellevue Hospital, both members of the South Manhattan Healthcare Network, one of six networks in New York City's Public Hospital System.

HOW TEMIS WORKS

Each room equipped for TEMIS has two wireless headsets, one for the provider and one for the patient. Attached to each headset is a small cell-phone-sized transmitter that can hook onto a belt. The initial technology supporting TEMIS is the same technology that is often seen on football fields to facilitate communication between coaches and players. Medical professionals and football coaches share the same requirements for excellent sound quality and equipment that can compete with a noisy environment.

To use TEMIS, a provider enters a code that indicates what language is required. As the patient and provider speak, the interpreter can hear them both. Each of them, however, can only hear the interpreter. Simultaneous interpretation means that the patient hears the interpreter speaking as the provider speaks, but in her or his own language and with only a few seconds of delay. During the encounter, the interpreter tries to convey the patient's mood and tone through the interpreter's own voice. The provider can see the patient's expressions and body language but not hear the patient's voice because of the headsets. The interpreters attempt to fill that gap with their voices.

By removing the interpreter from the room, TEMIS allows (or, in some cases, forces) the provider and patient to communicate directly, without any "culture brokering" by the interpreter. "What you find in the other methods is that both the doctor and patient relate to the interpreter, but with simulating a conversation with TEMIS you get a rapport," explains Dr. William Bateman, organizer and director of TEMIS. "With so much of medical care being about a relationship, we think that's going to prove to be really important."

Some providers state a preference for a live interpreter in the room who can bridge cultural divides and provide moral support for the patient. Dr. Bateman and the TEMIS staff disagree with this view. Requiring an adult patient to depend on another adult who is not a trained medical interpreter, as often happens in clinical settings, is not appropriate. Nor is it acceptable, they argue, to assume that doctors and providers should be able to rely on interpreters to translate cultural differences. "TEMIS does require that the doctor become culturally competent," says Dr. Bateman. "It means the patient doesn't come in with a guide who hopefully understands their culture because they understand the language." Providing quality care requires building

a relationship with a patient and learning about their habits, living and working conditions, and health history. "Individuals within a culture vary more than people between cultures,' says Dr. Bateman. "A doctor's job is to understand and learn about that patient."

HOW TEMIS BEGAN

Inspiration from unexpected sources—the Nuremberg trials, the United Nations, and professional football—came together to create TEMIS. In 1995, the Executive Director of the Gouverneur, Alan Rosenblut, asked Medical Director William Bateman why no one in health care was copying the United Nations, using wireless headsets to provide simultaneous interpretation. Dr. Bateman thought that such a system would be the perfect solution to the problem of providing language access to patients, so he embarked on a quest to find the money and expertise to make it possible. He turned to Dr. Francesca Gany, Founder and Director New York University's Center for Immigrant Health, who was able to direct him to the technology he was looking for and supply the method to recruit, select, train, and quality control the interpreters.

The technology had already been developed and tested in a pilot project at the Valley Medical Center in Santa Clara, California. The idea of bringing a remote simultaneous medical interpretation system into a medical setting had occurred to the late Dr. Count Gibson, a prominent community health figure. Dr. Gibson was a staff physician at the Nuremberg war crimes tribunals after World War II, where he watched remote simultaneous interpretation in use. Many years later, while working in a clinic in a predominately Spanish-speaking community, he decided to try to bring the technology he saw at Nuremberg to patients like his. Dr. Gibson worked with William Wood, founder of Simulmed and developer of remote medical interpreting systems like TEMIS.

Dr. Gibson's model demonstrated improvements in doctor/patient communication. Following this initial promise, in 1999, Gouverneur Diagnostic and Treatment Center implemented TEMIS as a two-year pilot project. The initial funding came when New York State's application for a Medicaid waiver to move to a mandatory managed care system was accepted. The waiver resulted in federal money being made available for projects that would make the health care system more effective and more efficient. South Manhattan Health Networks Executive Director and Senior Vice President Carlos Perez approved the use of these funds to start TEMIS and later increased support to allow the successful TEMIS pilot project to expand to Bellevue Hospital.

RESULTS

Dr. Bateman expected resistance from patients to headset technology and to working with a remote interpreter, and assumed that doctors, who were accustomed to new technologies, would adapt quickly. Instead, they found that patients readily accepted

the new system. Patients have overwhelmingly reported that they preferred TEMIS to other systems; 98 percent of patients surveyed had utilized other interpretation programs and preferred TEMIS. Almost unanimously (108 out of 109 people surveyed), they said they would like to use TEMIS every time they saw a doctor who did not speak their language. (Innovations Application, 2001)

Contrary to Dr. Bateman's expectations, many doctors were initially reluctant to use TEMIS. Over time, however, providers have begun to utilize the system, and those that use it report substantial benefits as compared to other language services. One general internist who had been using existing interpretation services in treating her patients was able to identify 51 cases in a three-month period where using TEMIS resulted in clinically significant improvement in her care of patients; she was able to change or add a diagnosis, or counsel them more effectively. For example, using TEMIS improved her ability to communicate with a patient to provide advice about an abusive relationship. (Innovations Application, 2001)

TEMIS can also save time for the provider, the patient, and the interpreter. Compared to consecutive interpretation, simultaneous interpretation can cut the encounter time by as much as 50 percent. Moreover, with TEMIS, patients and providers can begin their conversation within minutes of entering the room, rather than waiting for an interpreter to travel to their location.

QUALITY AND SCALABILITY

One of the challenges for implementing TEMIS is building a competent team of interpreters. TEMIS has a very rigorous screening process and training program for its interpreters, who must demonstrate an aptitude for both another language and simultaneous interpretation. The training, a 60-hour introduction to medical simultaneous interpreting, consists of theoretical and practical components. In the theoretical component, they discuss the code of ethics of the medical interpreter, the role of the interpreter, and linguistic and cultural competency. The practical component includes role playing and is taught in the target language.

Following the initial training, there is a three-month, on-the-job training period and continuing education. Interpreters meet with supervisors to discuss issues that arise, such as new vocabulary, medical concepts, and ethical dilemmas. Currently, interpreters are largely recruited through the New York State Commission for the Blind and Visually Handicapped, which provided training money from the start of the program. This partnership has brought needed funding to TEMIS and provided a new source of employment for the Commission's blind clients. To date, 100 people have entered the training program.

According to its developers, TEMIS is not a project to be replicated in every community around the country. TEMIS is not

IRA SENGUPTA

Executive Director of the Cross Cultural Health Care Project and co-founder and former president of the Society of Medical Interpreters (SOMI)

Providing language interpretation does not always ensure cultural competency. Cultural competency is a complex mix of self-awareness and self-assessment, acceptance of the intricate diversity that we encounter in each and every human interaction, and developing appropriate knowledge to navigate and negotiate successful individual and community partnerships. Maintaining cultural competency requires a process of understanding through training, self-reflection, and organizational support.

Cultural competency in health care takes a holistic view of health and the individual. It also includes maintaining and fostering respectful interpersonal relationships within the organization and the understanding that internal function precedes external function. The CLAS standards developed by the Office of Minority Health provide an excellent benchmark for providing culturally competent services.

financially viable on a small scale, and maintaining a staff of highly trained interpreters is costly. A nationwide network, they believe, is the most feasible way of providing many interpreters speaking a wide array of languages, with 24-hour availability. Currently, six interpreters work at TEMIS, providing interpretation in Spanish, Cantonese, Mandarin, Fukkien, and Ben-

gali. In contrast, the Language Line provides interpretation in 140 languages, far more languages than TEMIS or the volunteer services can provide. But the Language Line does not have interpreters who are trained in medical terminology, nor is the interpretation simultaneous. TEMIS has invested $1.5 to $2 million to start up and maintain the project, but once it is running on a larger scale with more users, they expect to charge rates that are competitive with the existing Language Line service. The California Endowment and the Commonwealth Fund are jointly funding an ongoing evaluation of TEMIS that will provide further information about its relative costs and the extent to which it affects medical outcomes.

While creating a TEMIS-like center is not viable in a small community, hooking into the existing system is feasible within any facility, Dr. Bateman explained. Bellevue's TEMIS system uses Voice Over Internet Protocol technology that allows long distance users to avoid additional phone charges, but the system is also compatible with regular telephone technology.

VOLUNTEER INTERPRETER SERVICES
At Bellevue Hospital, providers in departments equipped to use TEMIS are encouraged to call TEMIS first. If a TEMIS interpreter is not available, the provider calls the volunteer Interpreter Services. While TEMIS offers a promise of a high-tech solution to language access, far more of Bellevue Hospital's Limited English Proficient (LEP) patients are served through this more traditional interpretation program.

Medical interpreters such as those available at Bellevue Hospital are a vital component of an effective language access program. Without specialized training, an average person is not prepared to translate specialized medical terminology. Moreover, asking a patient to relinquish their privacy by having a family member, friend, or other person translate can pose additional communication barriers and confidentiality issues. Conversations about health often include subjects people are ashamed to discuss, even with a professional; having a child or other family member interpret can prevent the patient from discussing these subjects at all. At Bellevue, anyone can request an interpreter through the Interpreter Services office. Either a provider or a patient can schedule an appointment ahead of time; most often, though, a provider calls when the patient arrives for care. The dispatcher records the time, language, the patient's chart number, the location where needed, the name of the requester, and a telephone number or pager number. When an interpreter is available—the goal is to dispatch an interpreter within 20 minutes of the call—the dispatcher notes the time the interpreter leaves and the name of the interpreter.

THE DEVELOPMENT OF THE INTERPRETER PROGRAM
Bellevue has transformed institutional practices to meet the needs of its LEP patients. In 1999, Bellevue opened its Interpreter Services office as a part of the Ambulatory Care department. Irene Quinones, the Director of Quality Assurance for

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National Standards for Culturally and Linguistically Appropriate Services

The "National Standards for Culturally and Linguistically Appropriate Services in Health Care" offer a useful framework for health care institutions to follow. The CLAS standards state that organizations should:

✔ Ensure that patients/consumers receive effective, understandable, and respectful care that is compatible with their cultural health beliefs and practices; implement strategies to recruit, retain, and promote a diverse staff and leadership; and ensure that staff receive ongoing education and training in culturally and linguistically appropriate service delivery.

✔ Provide language assistance services, including bilingual staff and interpreter services, at no cost and at all points of contact; assure the competence of language assistance, and ensure that family and friends are not used to provide interpretation services (except on request by the patient/consumer); and provide patient-related print materials and signage in multiple languages.

✔ Develop a strategic plan that outlines clear goals, policies, and operational plans for providing culturally and linguistically appropriate services; conduct initial and ongoing assessments of CLAS-related activities; and integrate cultural and linguistic competence-related measures into internal audits, assessments, and evaluations.

✔ Ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected, and maintain a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

✔ Develop collaborative partnerships with communities to facilitate community involvement in designing and implementing CLAS-related activities; ensure that conflict and grievance resolution processes are culturally and linguistically sensitive; and make information available to the public about progress in implementing the CLAS standards.

Source: Office of Minority Health 2000 (adapted)

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ambulatory care at the time, was assigned the task of re-organizing and building the existing programs into the Interpreter Services program. By then, it was very clear that demand for the service was mostly unmet and that it was increasing.

With her quality assurance background, Quinones approached the reorganization task as a quality assurance investigation. She implemented a data collection system that allowed her to see which departments in the hospital were using the services. She soon realized that they were getting requests from many areas of the hospital, such as the financial departments, and not just the clinical departments. More importantly, data collection allowed her to determine which languages were in greatest demand. During the first year of data collection, the most requested languages were Spanish, Chinese, and Bengali. During the second year, Polish replaced Bengali as the third-most-requested language. Tracking the requests allowed Quinones and her staff to address these changing needs by recruiting more Polish-speaking interpreters.

The data collection also showed how quickly health care providers responded to increased availability of services by increasing their demand. During the first month, interpreters took 120 calls and satisfied 30 percent of them. The next month, the calls increased exponentially. Quinones began recruiting volunteers through outreach to schools and community groups to fill the gaps. By the end of 2000, they had taken 15,000 calls, with 70 percent satisfied. Overall, the demand continues to increase by a few thousand requests each year. Ms. Quinones had known that there was a big demand but couldn't assess what the need was until the Interpreter Services department started serving it.

BUILDING A VOLUNTEER INTERPRETATION PROGRAM

Quinones began by assigning a volunteer to answer the phone because the program had no staff. She found that the more consistently they answered the phone, the more people called for their services. She concluded that they needed someone to answer phone full time, and they needed more students with bilingual skills.

The next challenge was recruiting, training, and retaining enough volunteers to keep up with the new demand. Quinones hired a trainer who could train in both simultaneous interpretation and medical interpretation. Together they developed a 40-hour training program. Volunteers, who must first pass an initial language assessment, receive training in ethics, medical terminology, techniques, and the role of interpreters. Role playing follows each component of the training.

Most volunteers are students or retired people, and the free training has proven to be a good recruiting tool. Other incentives for students to volunteer include mentoring and the opportunity to spend time in the hospital and learn about careers in health care. Quinones tries to get the hospital staff involved, encouraging them to make the volunteers feel like part of the team. Interpreter Services is also assessing the language capac-

DR. ARTHUR CHEN

Chief Medical Officer for the Alameda Alliance for Health, Vice-Chair of the Board of Directors of The California Endowment, and chair of the Board of Directors of the Asian and Pacific Islander American Health Forum.

A few weeks ago I was called by a nurse who asked me to interpret for a Chinese patient. They were trying to insert a Foley catheter into her urethra. Can you imagine having someone do that if you didn't know what was happening? If the nurse hadn't seen me, she thought she would have called the Language Line, but if interpretation wasn't available I think they would have done the procedure by pantomiming and trying their best to be sensitive.

We're a majority minority county, with immigrants from all over the world, so you would think that our hospitals would be up to speed on language services. But the Board of Supervisors in Alameda found that of the 12 or 13 hospitals here, only four had an organized system of interpretation. Health plans should be paying for interpretation, mainly to assist solo practitioners and small group practices. Larger institutions (e.g., hospitals) should cover their own interpreter costs. That means convincing large corporations to set aside money for interpretation. Once you've found the money, you have to find the interpreters, ensure that they're skilled, trained medical interpreters, and set up a system to make sure they're where you need them.

ity of hospital staff members who are bilingual. Staff who pass the assessment are trained as qualified medical interpreters, which has increased the available pool of interpreters.

Quinones works with local schools to facilitate recruiting and work/study arrangements. There are also a few student intern positions that come with a small stipend funded through the hospital auxiliary and the hospital. Still, most of the interpreters are unpaid. The program has only two paid, full-time employees: a clerical associate who takes calls and coordinates and dispatches interpreters, and the Coordinating Manager. When all the Spanish interpreters are busy and more requests come in, they close up their offices and fill in as interpreters.

Quinones also must educate the hospital staff about the availability of interpretation services. Bellevue is a teaching hospital and thus has a high turnover among health care providers. As a result, Quinones must regularly attend orientation sessions to explain the protocol for accessing and utilizing volunteer interpretation services.

A MANDATE FOR LANGUAGE ACCESS

With its use of volunteer interpreters, TEMIS, and the Language Line, Bellevue hospital is one of the few health care facilities that meet federal standards for language access. Title VI of the Civil Rights Act of 1964 requires health care facilities that receive federal funding through Medicaid, SCHIP, Medicare, or any other source to take reasonable steps to provide people with limited English proficiency with meaningful access to their services. This means that virtually all hospitals, clinics, and other providers must provide competent interpreters and other language services necessary to ensure that the patient receives quality health care, at no cost to the patient.

This requirement was clarified in 2000 by President Clinton's Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." The National Standards for Culturally and Linguistically Appropriate Services in Health Care, commonly known as the CLAS standards, were created by the United States Department of Health and Human Services' Office of Minority Health as a guide for agencies that receive federal funding.

While these federal standards exist, they are rarely followed. Many health care facilities have not made the initial commitment of resources that is required to meet them. Dr. Bateman noted that some hospitals try to provide interpretation in ways that they consider no-cost, but these methods invariably bring hidden costs. For example, asking patients to bring a family member or friend to interpret can lead to misdiagnoses, overdone tests, or repeat visits by patients who misunderstand their providers' instructions. Having staff members interpret can also have negative ramifications; staff may not be adequately trained as interpreters, and interpretation work pulls staff away from other tasks.

Advocates point out that language services should be a budgeting priority for anyone running a health care facility. Cost analyses support their position. A 2002 Office of Management and Budget report estimated the overall costs of interpreter services for the U.S. health care system at only $4.04 more per encounter, or a .5% increase in premiums. (OMB, 2002) Moreover, a recent study published in the American Journal of Public Health measured the cost of trained interpreters in a model HMO at only $.20 per member per month. (Jacobs et al, 2004) In addition, good communication between provider and patient ensures that the patient receives quality care, which reduces costs in the long run. Communication prevents misdiagnoses, unnecessary but costly tests and treatments, and potential malpractice suits. Even without a legal mandate, providing language services is critical and cost-effective.

CONCLUSION

Everyone interviewed at Bellevue agreed that the greatest barriers they confronted in bringing high-quality language services to patients were perceived cost and institutional resistance. To bring good language services to a health care facility "you need to have a strong sense of purpose and understand the need of the community to have these services," says Ximena Granada, TEMIS Coordinating Manager. "Unless you know what your goal is, and you have that very clear in your mind, it's very easy to get sidetracked and discouraged. And you always have to be thinking that it's for the benefit of the people that you're doing it, people who don't speak [English]."

Yet even with legal, pragmatic, and ethical reasons for improving language access, few places in the country have met CLAS standards. In a national survey, only 48 percent of respondents who needed an interpreter said they always or usually get one, and only one percent reported that they had a trained interpreter. (Commonwealth Fund, 2002) The federal government will match state spending on interpretation and translation services for SCHIP or Medicaid recipients, but only five states have chosen to take advantage of this funding so far: Washington, Minnesota, Utah, Maine, and Hawaii. (Health Care Financing Administration, 2000)

Of the obstacles to providing language services, cost is the one cited most often by health care providers, including those at Bellevue. Yet the costs are minor when compared to the potentially life-or-death consequences of not caring for someone simply because they speak a different language. This is a consequence that Bellevue Hospital is determined to avoid. Several lessons can be learned from Bellevue's language services programs.

Every LEP patient must have access to a trained medical interpreter for every encounter.

Multiple systems may be necessary to cover high demand. None of the three systems—TEMIS, volunteer interpreters, or the

Language Line—is a satisfactory solution to all of Bellevue's needs. TEMIS has not yet reached a scale to allow it to cover all of the hospital needs. Because volunteers choose their own hours, it is difficult to cover all of the times and languages needed. While the Language Line is a critical resource, it is both expensive and inadequate for medical interpretation. But together the three methods served over 35,000 people last year. By using all three services, Bellevue is managing to provide interpretation in every needed language, at all times, while continually improving the quality and reduce the cost of those services.

A comprehensive interpretation program requires an institutional commitment from both administrators and providers.

Interpreters and administrators continually work to ensure that providers and patients know that interpretation is available and that services are easily accessed. Irene Quinones works with administrators behind the scenes and facilitates departmental and hospital-wide meetings to educate and remind staff about interpreter services. Interpreter Services also gives patients cards that say "I speak…" with the language the patient speaks. When the patient arrives at the hospital, they can hand the card to hospital staff and access the service immediately and easily.

Patients need access to interpretation and translation at every contact point. Patients and their families need language services when working with staff other than health care providers; it is important that all staff, including receptionists, billing staff, and patient advocates, can access interpreters. Bellevue has provided multilingual signage in the hospital, so LEP patients can find their way around the hospital's expansive facility. Data collection to track usage and availability of services helps target resources and ensure efficient use of interpreters and services.

Language access standards must be supported by public funding and government regulations that strongly enforce these standards for private providers and insurers.

Federal CLAS standards provide a comprehensive framework for a language access program. Public health programs must provide funding for these language services, and private insurers should be required to pay for this critical element of quality care. If states are committed to language access, Medicaid matching funds from the federal government can ease state expenditures. Community groups can play a role in urging their state governments to cover language services through Medicaid and SCHIP. Another lesson from the Bellevue experience is that it is possible to find resources in unexpected places. For example, the developers of TEMIS found a partner in the New York State Department for the Blind and Visually Handicapped. That partnership provided funding for training in the crucial beginning stages of the project. Language access may cost money to implement initially but may also achieve improvements in care and cost savings in the future. ■

GABRIELLE LESSARD

Staff Attorney with the National Immigration Law Center

There's always a gap between the law on the books and what happens in reality. Title VI of the Civil Rights Act of 1964 has made it illegal for anyone who receives federal funds to discriminate on the basis of race or national origin. Case law interprets national origin discrimination to include failing to provide access to people of Limited English Proficiency, but there's no adequate enforcement mechanism.

It's difficult for communities to enforce the law on their own behalf because there is legal precedent that bars individuals from bringing cases based on a pattern and practice of discriminatory behavior. So people whose rights are violated have to file a complaint with the Department of Health and Human Services Office of Civil Rights (OCR), which isn't adequately funded to investigate and prosecute these complaints.

ACCESS TO QUALITY HEALTH CARE
Washington, D.C. and Santa Clara County, CA

By June 2002, Gilberto and Margarita Portillo* had managed to pay off more than $5,000 in medical bills accumulated over several years of treating their diabetes. But a few months earlier, Margarita had gone to the hospital again, and the couple found themselves back in debt. Now they owed money to the hospital, to the ambulance service, and to the community clinic. The bills continued to arrive, and Gilberto and Margarita made payments whenever they could, but they never had enough to pay the debt off entirely.

The Portillos' debilitating medical debt was due to their inability to find and retain health insurance coverage. Margarita was enrolled in Basic Health, a state-run managed care program, but the insurance didn't go far enough. (Basic Health is unique to Washington. Had Margarita been living in another state, this kind of coverage—which still covers less and costs more than Medicaid—probably would not have been available to her.) Hospital visits still cost $50, and Margarita had had to wait nine months for the program to cover treatment for her diabetes, since it was considered a pre-existing condition. Gilberto had no health insurance—none was provided by his employer, and the state had closed enrollment in Basic Health, placing new applicants on a waiting list.

Medicaid, which would have provided them the health care they needed without the premiums and other charges, was not available to them because of immigration-related barriers and other eligibility obstacles. Even if they had been eligible, though, they did not want to enroll. They were afraid enrolling might jeopardize Margarita's immigration "sponsor," who had signed an affidavit pledging to become responsible for her support in the event she needed assistance. But Gilberto and Margarita were not receiving any financial help from their sponsor and would not ask for any. The stress of medical debt was having its effect on their health. "Sometimes I feel sick," Margarita said, "but I don't go to the hospital, because of what they charge."

Diabetes is a serious disease, made much worse without regular access to health care. It often leads to kidney failure, necessitating ongoing dialysis and shortening a person's lifespan. Other complications include heart disease, nerve damage, vulnerability to infection, and retinopathy (abnormalities of blood vessels in the eye) that, if untreated, can result in blindness. Amputation of lower extremities is also common among people with diabetes. Those lacking comprehensive insurance and access to adequate care run a much greater risk of such complications and often have little choice but to let the disease ravage their bodies.

It is hard to exaggerate the importance of health insurance. Uninsured adults receive fewer preventive services and screening, get less care for chronic illnesses, live sicker, and die younger. Continuity of coverage—not just continuity of care—also makes a difference. Quality of insurance also matters. To be most effective in providing access to care, it should include coverage of preventive and screening services, prescription drugs, and mental health services. (Institute of Medicine, 2002)

Yet the number of people of color who lack health insurance is alarmingly high. Over one-third of Latinos under the age of 65 are uninsured, as are 27 percent of Native Americans/Alaska

Rates of Uninsurance by Race/Ethnicity
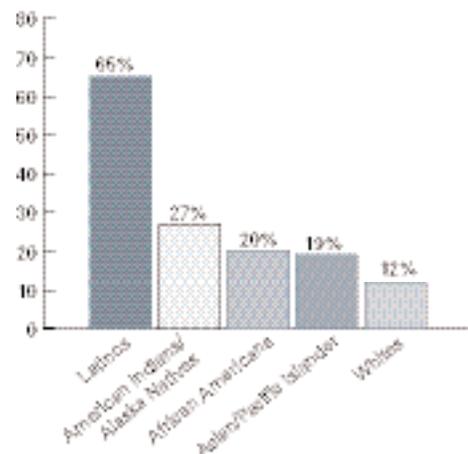
Source: Kaiser Family Foundation, 2003

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* Names have been changed.

Natives, 20 percent of African Americans, and 19 percent of Asian/Pacific Islander Americans. By comparison, only 12 percent of whites under age 65 are uninsured. (Kaiser Family Foundation, 2003) The situation is especially dire for immigrants like the Portillos. Over half of recent immigrants are uninsured. (Fremstad and Cox, 2004)

A universal health insurance program would address many of these disparities, providing comprehensive coverage regardless of race, income, occupation, and citizenship. Universal coverage alone would not reverse racial disparities in health, but it is widely recognized as a necessary step toward resolving the fragmentation among health insurance plans and addressing racial inequity in health care access. Despite the success of such programs in numerous other countries, the adoption of such a policy in the United States has been hindered by political obstacles. (Davis, 2001)

Uninsured adults receive fewer preventive services and screening, get less care for chronic illnesses, live sicker, and die younger.

Nonetheless, public health coverage programs remain a critical support in the U.S., particularly for people of color. African Americans, Native Americans, and Latinos under age 65 are all at least twice as likely as whites of the same age group to be enrolled in public health coverage programs. Without insurance through Medicaid, Medicare, and the State Children's Health Insurance Program (SCHIP), even greater numbers of people of color would be uninsured and the disparities would be even more alarming. Why is public health insurance necessary? Key to answering this question is the structure of the U.S. health insurance system. The United States relies principally on the private market to provide health coverage and access to health care. For working-age people and their children, employment continues to be the major source of coverage, despite recent declines in employment-based insurance and the growth among businesses that do not provide health benefits. (Fronstin, 2004; Gould, 2004) Racial disparities in health coverage are linked to inequities in labor markets and the immigration system, and the refusal of state and federal governments to replace this private, market-based insurance system with a public one.

The Portillos understand how inequities related to employment and immigration can undermine the ability to access health insurance. Immigrants from Mexico, both Margarita and Gilberto found work in fruit packing sheds in Washington's Yakima Valley, where Mexicans and Mexican Americans work hard for low wages with few, if any, benefits. The couple, who were also help-

ing raise three grandchildren, managed to survive on the $17,000 or so that Gilberto earned each year, although it didn't provide enough for the diet that had been recommended for management of their disease. Like the Portillos, many people of color can't count on getting health insurance through employment. African Americans and Latinos are about as likely as whites to work full-time and year-round, but they are much more likely to be uninsured. Native Americans are in a similar situation. Thirty percent of Native Americans with permanent, full-time employment are uninsured, compared to only eight percent of whites working the same amount. (Crow et al, 2002) This disconnect between work and insurance also more often holds true for immigrants. (Fremstad and Cox, 2004)

These disparities may be explained, in part, by the segregation of people of color into low-wage occupations and job sectors where fewer employers insure their workers. For example, half of all people who work in others' homes as domestic employees are uninsured, compared to ten percent of professionals. And working in agriculture, fishing, construction, and mining puts a person at high risk of being uninsured. (Institute of Medicine, 2001) Job segregation and employment discrimination, therefore, take their toll not only on the wages and financial security of people of color, but also on their access to health care and on their health.

In the absence of a viable universal coverage proposal, expansion of currently existing public health coverage programs holds the most promise for reducing the racial and ethnic gaps in insurance coverage. Medicaid, a joint state/federal program, covers more people than does any other public or private health insurer in the United States. Since states determine many of the features of their respective Medicaid plans, the program is a good candidate for coverage expansions. While no current efforts provide the scope or scale of coverage that would eliminate racial disparities in health care access, Washington, D.C. has been able to cover a higher proportion of its residents who would not otherwise have health coverage than any state.

EXPANDING PUBLIC HEALTH INSURANCE IN WASHINGTON, D.C.

If you go into a grocery store in Washington, D.C., you may come across pamphlets describing "D.C. Healthy Families," the city's Medicaid program for low-income families. Grocery stores are one of the many places—like bus lines and even the Miss Black D.C. competition—where D.C. Action for Children distributes information as part of its effort to reach out to city residents and sign them up for health coverage.

Getting people insured is a matter of urgency in D.C. The mortality rate in the District is 30 percent higher than the national rate. D.C. residents run a much greater risk of dying from HIV/AIDS, diabetes, and high blood pressure. (Wurth and Lasker, 2004) The options for uninsured D.C. residents are limited and costly. "People use the emergency room," says Kim

Racial disparities in health coverage are linked to inequities in labor markets and the immigration system, and the refusal of state and federal governments to replace this private, market-based insurance system with a public one.

Bell, Director of Strategic Initiatives for D.C. Action for Children. "They wait until it gets really bad, which leaves them with huge emergency room bills. They wind up having creditors chasing them down for a hospital bill they can't pay."

Insurance alone won't bring D.C. in line with the rest of the nation, since health is largely determined by factors operating outside the health care setting, but it is the most viable possibility for getting care to people when they need it. The District of Columbia has taken some important steps toward getting more of its residents insured. When Congress created SCHIP in 1997, states had the opportunity to get federal funding for children's coverage. The District decided to use this money to raise children's eligibility for Medicaid and to expand coverage for parents, too. "D.C. was unique," says Bell, "because we automatically included parents also. It was just a matter of smart thinking." Now both children and parents qualify for Medicaid coverage at the same income level (200 percent of poverty). (D.C. Action for Children, 2005) Research has shown that Medicaid expansions for parents can increase enrollment of children who are already eligible for coverage but not yet signed up. (Ku and Broaddus, 2000)

Bell relates the story of one new mother, a Latina working as a hair stylist at a local chain salon, who had just found out that her child would not be covered under the health plan she had through work. On top of that, she was going to be working fewer hours now that she had a baby and making less money to cover the out-of-pocket costs her insurance required. Fortunately, the Medicaid program was there to cover the baby and mother as a "secondary payer," filling in the gaps left behind by the private plan.

The benefits of the program are also evident by looking at the numbers. As of November 2004, over 9,300 adults were covered by the D.C. expansion to parents. That is a significant figure for a city the size of D.C. "That's a very big deal," says Sarah Lichtman Spector, an attorney with the Legal Aid Society of D.C. "In the District, not only do we have a lot of poverty, we have a lot of illness, too, so having this health care coverage is very important for the city overall."

J. CARLOS VELAZQUEZ

Training and Research Director at
The Praxis Project

Providing culturally appropriate health care is a real problem for HIV/AIDS health programs, both for prevention efforts and treatment and care services. The Centers for Disease Control (CDC) will not give any federal money to an intervention program unless it has approved the program as an effective intervention.

There is excellent research showing that traditional interventions, based on individualistic decision-making practices that consider what is good for the person, can lead to behavioral change that prevents HIV infections. But the research shows that Latino men don't always make decisions based on the individual, but rather on the larger community and family context. So, most intervention programs approved by the CDC are not culturally effective in Latino communities. If we use organic models developed from our community, we have to use our own money, not federal money.

The Santa Clara County
CHILDREN'S HEALTH INITIATIVE

Thousands of people are living in the shadow of affluence in California's Santa Clara County, the heart of Silicon Valley. To make the tech economy hum, the industry relies on people of color—mainly immigrants from Asia and Latin America—to fill low-paid and often temporary jobs ranging from computer chip assembly to cleaning homes. The tech industry is extremely hazardous to a person's health. Numerous contaminants are used in production, and workers and neighborhoods are exposed to these on a routine and ongoing basis. The region hosts the highest density of Superfund sites in the country. So, people living in the Valley are likely to have high health care needs. But, because health insurance is so hard to come by, when it comes time to treat health conditions low-income workers and their families often have no place to turn. (Fisher, 2001; Iles, 2004)

In 2000, almost 70,000 children living in Santa Clara County were uninsured. (Gaura, 2004) Then, in January 2001, spurred by years of community organizing by labor, religious groups, immigrant organizations, and other community advocates, the county launched the "Children's Health Initiative" using funds from the tobacco settlement, foundations, tobacco tax, and other sources. The Initiative includes two components: a new insurance plan and outreach to get children enrolled. To qualify for Healthy Kids (the insurance component), children must be uninsured and ineligible for Medicaid and SCHIP, live in the county, and have family income below 300 percent of the federal poverty level. (Santa Clara County Family Health Plan, 2005) This allows the program to reach children shut out of federal programs because of immigration-related restrictions or family income. The program charges premiums and a five dollar co-payment for some services, so it is not as affordable as Medicaid, but the premiums range from four to six dollars a month, with a family maximum. (Santa Clara County Family Health Plan, 2005)

By 2002, the Initiative reduced the number of uninsured children in the county by 62 percent (California Endowment, 2004) through the insurance plan and outreach, which resulted in almost an equal number of children signing up for Medicaid and SCHIP as for Healthy Kids. (Trenholm, 2004) The new simplicity of the program had a lot to do with these gains. According to analysts of the program, "CHI fundamentally changed the outreach message to Santa Clara families with uninsured children. The idea is now simple and direct—your children will receive health insurance if you apply." (Trenholm, 2004) Much of the confusion about eligibility that prevented families from enrolling their children in government-funded health coverage programs was thus eliminated.

The insurance program was covering 13,000 children (most of whom are Latino or Asian) as of December 2003. (Santa Clara County Family Health Plan, 2005) But that was its limit. Due to funding shortages, a waiting list was established in March 2003. In February 2004, the program received a $1.1 million donation from the California Healthcare Foundation and the Lucile Packard Children's Hospital. The Santa Clara County Health Plan, which runs the program, launched a holiday fundraising campaign. (Children's Health Initiative, 2004; Rombeck, 2004) Still, maintaining stable funding has been a challenge.

Despite the funding difficulties, numerous other California counties have seen the health benefits of covering more children and have followed Santa Clara's lead by starting their own children's health care initiatives. (Ostrov, 2004) ∎

CHALLENGES TO THE D.C. MEDICAID PROGRAM

Enrollment: There are still plenty of kinks in D.C.'s Medicaid program to work on. The application forms for initial enrollment have been improved and shortened, and are relatively easy to manage. However, the recertification forms haven't been revised in the same way, and they can be very daunting. Spector describes the recertification forms as "these double-sided, rectangle-shaped things with carbony ink and teeny, teeny boxes that are very hard to read." For parents enrolled in Medicaid, recertification forms must be submitted every 12 months.

Many people can't make it through this process and lose coverage. Spector tells of one client who enrolled in Medicaid, thanks to the parent expansion, but wound up losing coverage due to agency mix-ups during recertification. The client was a young African American woman who worked part-time as a security guard in a downtown gallery. Her job provided no health benefits. Although she didn't have major health conditions, she had bills from a few doctor's visits that threatened her ability to maintain good credit. Eventually, Medicaid covered those payments.

"Medicaid was important for her health care needs, and it also helped with her credit issues," Spector explains. And, without the parent expansion, she wouldn't have been eligible for Medicaid at all. She would have been another of the many uninsured.

Provider participation: Medicaid faces other challenges beyond administrative hurdles. Finding a doctor can often be difficult for people enrolled in the program. Doctors are not required to participate in the program, and many do not, often stating that Medicaid pays less for primary and specialty care than the doctors would typically charge. As a result, Medicaid enrollees often have access to only the same safety-net providers they would see if they were uninsured. Since these providers are already overburdened, Medicaid enrollees face long delays, difficulty getting referrals, and less continuity of care. Compounding this problem is the fact that eligibility for Medicaid is limited, and the requirements are complex, so people may fall in and out of coverage when their circumstances change. (Institute of Medicine, 2002)

Nevertheless, on a number of measures, Medicaid and other public programs outperform private insurance. For example, as of 1999, the average overhead in private insurance (11.7 percent) greatly exceeded the average overhead in Medicare (3.6 percent) and Medicaid (6.8 percent). (Woolhandler et al, 2003) Abundant research also shows that in order for health insurance to really be effective the services it covers have to be affordable. Insurance that burdens low-income people with out-of-pocket costs, such as co-payments and deductibles, doesn't get people the health care they need. Though coverage varies from state to state, Medicaid generally provides comprehensive benefits without out-of-pocket costs.

DAE YOON

Executive Director of the Korean Resource Center in Los Angeles, California

The UCLA Center for Health Policy Research found in 2001 that 45 percent of Korean Americans were uninsured. Twenty-four percent of Korean Americans in the U.S. are self-employed with mom-and-pop groceries or dry cleaners, which means they have a hard time buying employment-based insurance or insurance on the group market. Nationally, 18 percent of Korean Americans are undocumented, creating other access issues. Too many people make too much to qualify for public programs, or don't qualify because of immigration status, but don't earn enough to buy insurance.

Korean is a threshold language for Los Angeles County, which means translation and interpretation services are required. But every day we see seniors who are receiving letters, documents, and notices in English instead of Korean. When we talk to the County Health Department, they say they're working on it, but nothing is happening. Medicaid recipients have to report their income twice a year or they lose their benefits, but they send the letters in English. Seniors can't read them, think they're junk mail, throw them out, and then get dropped from the program.

Immigrant access to public programs: The benefits of Washington, D.C.'s Medicaid expansion do not reach all residents. For example, many people treated at La Clínica del Pueblo in Columbia Heights, a small clinic that serves D.C.'s Central American immigrant community, are not enrolled in Medicaid. Work in construction, hospitality, housecleaning, and restaurants leaves people without benefits and with stark choices. According to Luis Morales, Director of the Social Services Department at the clinic, the question is often, "Do I buy medication, or do I pay my rent? Do I buy medication or buy food for my family?"

The Columbia Heights neighborhood is rapidly gentrifying, and people are being pushed out of the city into Maryland or Virginia, where they no longer qualify for the parent expansion. "Everything is becoming too expensive," Morales says. "And they don't have time for health care until they get sick."

When Congress created the State Children's Health Insurance Program in 1997, states had the opportunity to get federal funding for children's coverage. The District decided to use this money to raise children's eligibility for Medicaid and to expand coverage for parents, too.

Even if they lived in the city, many of the clinic's patients still wouldn't qualify for Medicaid, due to stringent and complicated federal restrictions on immigrants' eligibility. Before the welfare and immigration reform of 1996, non-citizens with status in the United States generally did not face immigration-related barriers to Medicaid. Now there are requirements so numerous and so complex that even people who are still eligible on paper often either don't apply or are turned down for coverage. This doesn't mean that states can't extend Medicaid "look-alike" coverage to people who don't qualify for the federal program; it just means that they must find other funds to do so.

A number of states and localities have done that. Almost half of states use state money to offer insurance to non-citizens who aren't eligible for Medicaid. But many offer this coverage just to a limited set of immigrants, such as pregnant women. And often this insurance covers much less or is much more expensive than Medicaid. To complicate matters further, in the wake of the recent recession, states have begun to roll back the coverage they extended in the wake of the 1996 welfare and immigration reform. Clearly, states aren't filling in the gap left by the federal government when it comes to coverage for noncitizens. But the existence of these programs is proof that they have tools at their disposal to do so.

CONCLUSION

The story of the Portillos is far from unique. They are immigrants from Mexico who have worked hard in a low-paying industry that doesn't provide the insurance they need to take care of their health care needs. Across the country, millions of people of color are in the same situation. As dire as the health insurance crisis is generally, it's particularly affecting people of color. Yet Medicaid and other public health insurance programs, the best solutions for decreasing the numbers of the uninsured, still have not received the full public commitment needed. But the expansion of health care programs in Washington, D.C. and Santa Clara County are promising practices in a long-term effort by some to reverse the inequities that are leaving people of color without access to health care and treatment.

A comprehensive, public response is needed to resolve racial disparities in health care coverage. The private health insurance market cannot be fixed in a way that addresses this problem, because the disparities reflect both racism in employment and the overall, intractable failure of the private health insurance market. As long as a person's health insurance status depends exclusively on his or her job or the employment of a family member, people of color will find that they are denied access to coverage and care at much greater rates than whites.

The best way to address racial disparities in access to health insurance is through a universal health coverage program.

Most people still depend on their employer to provide for their health insurance coverage through private insurance plans. This is a costly enterprise—hospitals and doctors' offices dedicate a good deal of staff time just to figuring out which patients have which insurance and how to handle billing. As a result, the U.S. spends more money on health care overhead and administrative costs than any other country. (Devereaux, 2004) This model is failing, particularly for people of color, who are disproportionately left out of the health insurance structure altogether.

Many countries have de-linked health coverage and employment, recognizing health care as a basic public service. Universal health coverage programs have potential for a more just distribution of health care resources. Outside the U.S., universal health care has been shown to improve equal access to primary care and hospital services, leading to a narrowing of the socioeconomic gap in mortality. (Veugelers and Yip, 2003) Such programs are also cost-effective. A 2003 study by the Institute of Medicine estimates that the value lost due to poorer health and earlier death among the 41 million uninsured Americans costs the U.S. economy between $65 billion and

Almost half of states use state money to offer insurance to non-citizens who aren't eligible for Medicaid.

$130 billion every year. By comparison, the cost of providing the uninsured with health care is estimated at between $34 billion and $69 billion each year. (Institute of Medicine, 2003)

Yet despite its health benefits and cost-effectiveness, the adoption of a universal health care program continues to be extremely challenging in the United States. In the absence of a viable proposal for universal health coverage, expanding and improving existing public health programs is a necessary step.

States and localities should expand existing public health coverage programs.

There are a number of things that states can do to provide access to quality health coverage to more people. As Washington, D.C. demonstrates, the Medicaid program, which generally includes comprehensive coverage at an affordable price, is a model starting point for getting health care to people of color.

- **States should make use of all available federal dollars to cover all individuals who qualify for Medicaid.** The federal government allows states to receive matching funds when they raise eligibility levels and cover more people. When states expand coverage for children and leave parents behind, they are turning down federal dollars, limiting the success of the children's program and losing an opportunity to improve access to coverage for adults. The experience in the District of Columbia shows that side-by-side expansion for children and parents will increase usage and improve people's health.

- **Dedicate state funds to cover individuals who cannot be covered using federal funding, particularly for people excluded based upon immigration status.** Federal policy explicitly uses immigration status as a means for discriminating against people, especially people of color. States do not have to follow suit. Many states and localities have opted to use their own funding to cover immigrants excluded from the federal program. In addition, there are other groups of people, such as adults without children, whom states can cover using independent funds.

- **Improve access to services under Medicaid.** Coverage is only the first step. States must ensure adequate provider participation in Medicaid and other public health coverage programs. ▪

PING WONG

The first acupuncturist at International Community Health Services in Seattle, WA

Before 1996, no health insurance company in Washington State covered acupuncture. Patients had to pay for acupuncture services out-of-pocket. In 1995, the legislature passed the "Every Category of Provider Law," which has made a big difference for many patients whose insurance companies now pay for acupuncture. But it has not solved all of the access problems. Patients who are uninsured, and patients covered by Medicare, Medicaid, and L&I (Washington's workers compensation insurance) do not have coverage for acupuncture.

Even insurance companies that cover acupuncture still create barriers. With the Basic Health Plan (a state-sponsored program that provides affordable health care coverage to low-income Washington State residents), patients must show that the symptoms have been present for more than three months and that the symptoms don't respond to the "usual" treatment before they can ask for an acupuncture referral. After the patient and the insurer spend money on doctor visits and the "usual" treatments, the patient is limited to eight visits in four months, which might not be enough to relieve the patient's symptoms.

COMMUNITY-BASED APPROACHES
Sells, AZ and Berkeley, CA

The preceding chapters focused on the health care system and highlighted models for eliminating racial disparities in health by improving quality and access to health care, providing language interpretation and translation, and incorporating alternative medicine. While these practices will mitigate some of the root causes of health disparities, most of the causes of poor health within communities of color are due to environmental, social, and economic inequities. Stresses of dealing with racism and discrimination; housing conditions; neighborhood design, safety, and location; workplace issues; racial discrimination; wages; job availability; educational opportunities; and pollution all affect the health of individuals and communities.

This chapter includes practices outside the health care system that may help reduce health disparities. While these examples are by no means comprehensive, they highlight some promising practices that emerged from the research. First, Tohono O'odham Community Action in Sells, Arizona demonstrates how returning to traditional agricultural practice has revitalized a community's cultural heritage while increasing exercise and reducing rates of diabetes. The Edible Schoolyard in Berkeley, California is a unique approach to providing health education while improving nutrition in schools. This chapter also includes snapshots of public health efforts in housing and development, and the importance of union organizing in workplace health and safety.

TOHONO O'ODHAM COMMUNITY ACTION: A COMMUNITY FOOD SYSTEM

Tohono O'odham Community Action (TOCA) is based in Sells, Arizona, on the 4,600-square-mile Tohono O'odham Reservation, in the heart of the Sonora Desert. The tribe now has around 24,000 members.

Until the mid 1900s, the O'odham used traditional agricultural practices they had developed over a thousand years. But a series of government policies seriously undermined their ability to continue these practices. Federal food programs introduced processed foods, displacing traditional nutrition. O'odham were encouraged to take jobs as field laborers for large irrigated cotton farms that surrounded O'odham land, resulting in many families leaving for six to eight months a year and being unable to maintain their own fields. Nearby development lowered the flood table and, as a result of governmental flood control projects, water became scarce, and flood waters were eliminated from important lands. On top of these devastating changes, large numbers of children were forcibly sent to boarding schools, where they were severely punished for speaking their language and participating in their culture. (Lopez et al, 2002) All of these factors resulted in a break in the transfer of knowledge and traditions.

These changes wreaked havoc on O'odham agriculture. In the 1920s, over 20,000 acres of flood plain were cultivated using flash-flood irrigation conducive to the area's pattern of frequent summer monsoons. But by 1949 only 2,500 acres were cultivated, and by 2000 only a few acres were cultivated.

There are other major challenges as well. The reservation is extremely rural and has the lowest per capita income of all U.S. reservations. And the Tohono O'odham Nation has the highest diabetes rate in the world; over 50 percent of adults have adult-onset diabetes. The major changes in diet and community have certainly played a role in the diabetes epidemic.

In response to the crisis facing its people, TOCA has developed an innovative program that is working to improve the health of residents, reduce diabetes, and encourage cultural traditions that community members worried were slipping away. The organization started nine years ago. Terrol Dew Johnson, now co-director of TOCA, was teaching basket weaving classes. "Kids taking my class would go over to the community garden where Tristan Reader [now TOCA co-director] was working with kids to grow traditional plants. Tristan asked Danny Lopez, a community elder who was teaching at the primary school, to bless the ground. Danny brought his class over, and they sang, and they danced, and they planted."

Johnson saw an opportunity to build a program centered on the reservation's cultural history and worked with Reader to apply for funding. They received a grant, and the program

was launched. "Tristan had space, and I had connections with other artists in the community. With the grant we could pay people to teach classes. We would grow traditional basket weaving materials in the garden," says Johnson. "Parents heard something positive was happening and were very encouraging. At the end of the summer, we shared the fruits of the classes: pottery, basket weaving, photography, people harvesting food from the garden. All the components of TOCA fell into place that summer."

TOCA has four program areas: basket weaving, community arts and culture, a youth/elder outreach program, and a community food system program. All four areas are inseparably connected. As Johnson explains, "We cannot have one thing without the other. The elders share culture with the youth. The parents, too, are interested and are relearning, as they went to boarding schools and literally had the Indian beat out of them. Many of them didn't teach the language and traditions to their kids because they thought it wouldn't benefit them."

Danny Lopez, an Elder and Language and Culture Instructor at Tohono O'odham Community College, explains how all of these activities are intricately related to health. "Health is not just one thing. There are different components of being healthy. Your mental attitude is important. Eating healthy food will help in the long run. But it is not just eating the food itself. Being active is important. Harvesting is hard work—dropping seeds in the ground, singing a song, or saying a little prayer to the seeds, and when the plants were coming up, there were harvest songs, certain dances, part of a little ceremony. All these things were involved. If everyone worked in their own garden or field, we'd be a pretty healthy people."

TOCA grew out of a concern about what was being lost. Many ceremonies, such as the rain ceremony, are closely linked to planting and harvesting but were no longer being performed in many communities because few people were still farming. Younger people were not learning basket weaving, traditional ceremonies, or the language. Traditional games—athletic competitions—

hadn't been done as a community in 30 years. It was nearly impossible to buy traditional foods such as tepary beans, squash, and buds from the cholla cactus.

While TOCA developed in reaction to a loss of cultural traditions, it also grew out of a vision for what could be gained. Many of the foods once commonly grown by the O'odham are low on the glycemic index and are thought to help regulate blood sugar and may help reduce the effect of diabetes. In addition to eating healthy foods, exercise is another important component of health. Growing traditional foods and the associated ceremonies, as well as traditional games and runs, all require physical activity. Encouraging sharing between youth and elders helps ensure the continuation of community traditions and knowledge.

Michael Juan, who works on the TOCA farm, talks about his family and diabetes. "My dad, my grandmother, almost everybody in my family has diabetes, my mom's side and my dad's side. They eat well now. Since I started working at TOCA, they eat more traditional foods—the stuff we grow at TOCA. I think it has improved their health. My grandma's diet has changed a lot."

In addition to nutrition, one of the most important means of combating diabetes and other diseases on the reservation is exercise. But common strategies for encouraging diabetics to exercise don't necessarily work very well on the rural reservation. Reader explains, "There is one gym on the reservation. But a third of the people in the area don't have a car, and many of those that do would have to drive 60 miles to get to the gym to run on a treadmill." Gardening and traditional games can easily be done at home.

Lopez also sees how TOCA's emphasis on education can improve the health of the community. "We are trying to avoid diabetes. Elders notice younger people dying ahead of us. There must be something wrong, and part of that is the way we are living," Lopez says. He believes the only way to improve the sit-

uation is through education. "When I look at my own grand-kids, I don't want them to be future diabetics. We must show the youth we care, teach them to plant the corn, the beans, the squash. To grow things, you have to work at it, you have to weed it, you have to water it. It is almost like raising a child. You have to care for it every day, then there are other things you have to do because here come the rabbits, you have to figure out how to keep out the rabbits, the javelinas, the birds that peck away at the corn."

Lopez believes that the health of his community, especially its young people, also depends on intergenerational sharing and maintaining cultural traditions. "We must teach the kids our language and the ceremonies, not just about planting," he says. "Many elders have been buried with their knowledge. I want kids to know the ancient teaching and to become educated. I think kids feel better when they know their language. I encourage other elders to teach, to find someone to mentor. Maybe someday when I can't lead the rain ceremony anymore, that will be ok, because the person I mentored will be right there to take my place."

A RURAL VERSION OF COMMUNITY GARDENS

While both are seen as a way to improve health and nutrition, TOCA's concept of community gardening differs in scale from the model found in most urban areas, where there is little land and lots of people. One of TOCA's first steps was to provide support for home gardens, which can cover up to an acre of land. TOCA provides seeds of traditional crops and donations of fencing and lets community members borrow a heavy-duty Rototiller. TOCA also leads trips to harvest wild foods and basketry materials.

For TOCA, however, this is only a first step in a vision for a larger food system that will support the entire community. There are estimates that over 20,000 acres were under cultivation on the Tohono O'odham Reservation in 1930. That year, reservation lands produced around 1.6 million pounds of tepary beans in the desert with traditional farming methods and depending entirely on monsoon rains in the months of June, July, and August. Yet in 2000, reservation lands produced only 100 pounds of tepary beans, and only two acres were cultivated.

This would soon begin to change. In 2001, TOCA hired Noland Johnson (Terrol Dew Johnson's brother) to begin clearing mesquite trees from the land that their grandfather used to farm. They were fortunate to have seeds available to start growing several traditional crops. But much information on how to best cultivate these plants had been lost. Noland Johnson has been learning as he goes. "At first, my idea was to just do the fencing and clearing, and whoever came on and knew what they were doing, I would help them. So I started clearing my grandfather's field, where TOCA first farmed." At first, Noland Johnson had little experience. "I didn't even know how to run a tractor," he says. Now, Noland Johnson works to share what he has

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Chief of the Cancer Control Branch of California's Department of Health Services

In 1988, an initiative called Proposition 99 that added 25 cents in tax on cigarettes generated enough revenue for our department to take on an extensive anti-tobacco control program. At that time, the tobacco industry did a lot of predatory marketing, targeting lesser-educated people, low-income people, people of lower socio-economic strata, and people of color. We funded counter-advertisement at the local level and statewide level.

Obesity and lack of physical activity together are a near-equivalent risk to tobacco in the United States. Part of the problem is very insidious predatory marketing, all the way through production, wholesaling, and marketing. Fast food is doing the same predatory marketing in ethnic neighborhoods that the tobacco industry did. The result is children with diabetes, children going blind from Type 2 diabetes in high school. We need to change the norms as we did in tobacco and counter the marketing of fast food with our own messages.

learned about farming with the community. "It would be one thing if we just grew this and kept it for ourselves and never brought in people to bless the fields, but we try to let everybody know what is going on. I go to schools and do presentations. It makes me feel good inside that our culture is being revived. So many of our traditions are tied into our food and our culture and the blessings."

In 2003, the farm crew harvested eight acres of tepary beans. Michael Juan, who works on TOCA's farm, explains, "Last year we spent a lot of time cleaning the beans. We had to clean them by hand. We would stomp on the beans, hit them with a pitch fork so they pop out of their pods, flip them over, shake them out with a pitch fork, move them, and then the beans would be underneath." In 2004, TOCA received a major grant to purchase equipment, and they grew 30 acres of beans. The equipment purchase included a combine to more quickly process the beans. "We will get to feed a lot more people now that we have the combine," says Juan.

During the summer of 2004, TOCA was selling 400 pounds of squash per week. The total 2004 harvest will include 10,000 pounds of squash, and they are hoping for 25,000 to 30,000 pounds of tepary beans. "I enjoy seeing all the squash, the beans, the watermelon, getting big, watching them grow," says Juan. "I am most proud of the beans, to see them take off. They are good for people with diabetes and the most popular food we grow. I eat them once a week."

GOALS FOR THE FOOD SYSTEM PROJECT

"We need to create systems that support healthy choices," says Reader. "Right now, even if people want to purchase traditional foods, they can't do it reliably. TOCA can create a system that makes these choices possible."

TOCA's goal is to develop a food system and then encourage people to make healthy choices. TOCA's food system project focuses on three incentives: health, culture, and economy. In addition to their health benefits, traditional foods and crops are closely related to O'odham cultural identity. Many of TOCA's programs work to encourage the continuity of these linked traditions. TOCA is also working to encourage production and supply of traditional foods. For example, Saguaro fruit syrup is an important part of the rain ceremony but is extremely rare. TOCA will buy the syrup for $15 an ounce and can resell it to area chefs. This encourages families to produce the syrup themselves, begins to create an infrastructure, and means families will likely have extra to share with their communities and for the rain ceremony. It also creates a market for traditional foods.

Another example is the Women, Infants and Children (WIC) Farmer's Market Nutrition Program, for which all tribal members are eligible. WIC often provides milk for families, but many O'odham are lactose intolerant. Ounce per ounce, buds from the cholla cactus provide more calcium than milk. TOCA is working to change WIC policy to cover the purchase of cholla buds. In addition to being healthy, as more people eat cholla buds there is more incentive to supply them at local stores.

CHALLENGES AND VISIONS FOR THE FUTURE

All the labor required in harvesting tepary beans made processing large quantities a particular challenge until TOCA was able to purchase the combine. A small office with one small room that serves as a gift shop, office space, and a meeting room can make meetings difficult. Despite the lack of infrastructure, Johnson believes that the staff will stay committed. "One year ago, we all worked for four months without pay," he recalls. "We sat the staff down and told them we had no money to pay them. And they all decided to stay—they all believe in what we are doing."

Despite funding difficulties, TOCA has specific visions, including a research project to track the impact of dietary changes, marketing traditional crops to the profitable gourmet food market, a cookbook, and the possible takeover of a 1,100-acre tribal

farm. If they acquire the farm, they are considering experimenting with planting perennial plants used for food and basketry. Cholla usually grow in more rugged mountainous areas, but they may experiment with growing cholla in the flood plain where the farmland is.

The possibilities spiral out from there. Says Johnson, "We want to get a wellness center out here on the farm, where people can come and learn about the issues and the food, and eat it and cook it and learn how they can incorporate it in their everyday lives. We want to run the farm on solar rather than diesel. We want a bigger meeting space with an art gallery and a restaurant where we can serve traditional food."

Already, TOCA has made major steps. Now people can buy traditional foods in the local supermarket and in trading posts across the reservation. TOCA has surplus crops to distribute to over 100 community members as part of the second annual harvest celebration. As TOCA looks into the future, it hopes to reach out even more broadly to improve the health of members of its community.

THE EDIBLE SCHOOLYARD:
SCHOOL LUNCH PROGRAMS AND GARDENS

TOCA has demonstrated how sharing cultural and agricultural traditions can improve the health and well-being of a community. On a smaller scale, communities in cities and rural areas around the nation have turned to community gardens as a way to improve health. In Berkeley, California, Martin Luther King Jr. Middle School is demonstrating how engaging youth in the production of their own food has positive outcomes for both educational achievement and health.

The Edible Schoolyard (TES) is a nonprofit organization on the campus of Martin Luther King Jr. Middle School. In many ways, King Middle School is typical of most inner-city public schools. Around 40 percent of the school's 930 6th, 7th, and 8th graders qualify for free or reduced-price school lunches. It is racially and ethnically diverse: 30 percent of students are African American, one percent are Filipino, one percent are Native American or Alaska Natives, ten percent are Asian American, 20 percent are Latino, and 38 percent are white. (California Department of Education, 2003) Many students at King are recent immigrants; 22 different languages are spoken at the middle school. What makes their experience unique is the school's focus on health and nutrition, through TES.

The Edible Schoolyard is one approach to a growing national concern about children's health, particularly as related to nutrition and exercise. The percentage of children age six to 19 who are overweight has more than doubled to over 15 percent since 1980. (U.S. General Accounting Office, 2003) Poor children are disproportionately represented among the overweight. (USDA, 1999) Much of this is attributed to diet. Children's diets are often too high in fat, but low in fruits, vegetables, and other nutrient-laden foods. Many children from low-income

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Researchers, health professionals, and foundations have begun to pay close attention to racial and ethnic disparities in health. It must be an issue of national urgency that the life expectancy for African-American men is 7.1 years less than for white men, 7.5 years less than for African-American women and 12.7 years less than for white women.

Private foundations alone will not be able to close the gaps in health care options and life opportunities that cause these disparities. Foundations can play a role in supporting research and bringing people from different sectors and institutions together to discuss solutions, but it will take commitment at the local, state, and federal levels to truly address health disparities.

HOUSING AND HEALTH

COMMUNITY HEALTH WORKERS

Many health problems that disproportionately affect people of color are connected to housing conditions. Due to inequities and discrimination in income and housing, people of color are more likely to live in older homes or rental units that are characterized by deteriorated walls, leaks, poor plumbing, poor ventilation, and high moisture levels. These conditions result in increased exposure to pests, molds, and dust mites, and are linked to health problems including respiratory infections and asthma. Poorly maintained rental units have a higher likelihood of peeling paint and exposure to lead paint. Deteriorated housing and poor lighting are associated with depression. Overcrowded housing increases stress and the transmission of disease. In short, poor housing conditions have a major impact on people's health.

In Washington State, the Seattle-King County public health department has developed a community health worker program that is improving health conditions inside the home. Their "Healthy Homes" program recruits and trains people from low-income neighborhoods to help other people in their communities to address the environmental conditions that trigger asthma. Over the course of a year, outreach workers visit the homes of asthmatic children to educate families about asthma and its causes. They also provide materials—such as bedding covers, vacuums, door mats, and cleaning kits—to reduce exposure to asthma triggers and help connect families with assistance for structural improvements that reduce moisture.

The community health workers provide additional support for families throughout the second year. The results thus far have been positive. "In our randomized trial evaluating this program, homes that received intensive consultations had decreased asthma symptoms, improved quality of life for caretakers, and reduced emergency department visits and hospitalizations," says James Krieger, Chief, Epidemiology Planning and Evaluation Unit, Public Health, Seattle and King County.

HEALTH IMPACT ASSESSMENTS

The World Health Organization defines health impact assessments as "a combination of procedures or methods by which a policy, program or project may be judged as to the effects it may have on the health of a population." Health impact assessments are tools to incorporate health criteria into planning and development processes. These assessments bring stakeholders together to review the health impacts of non-health related policies, such as the building of a major new facility in a community. Modeled after environmental impact assessments, health impact assessments have yet to be widely utilized. When they have been implemented, however, the result has often been greater transparency and accountability in development plans. Currently, health impact assessments are a useful framework for advocates. Legal or contractual requirements requiring their use would increase their efficacy.

San Francisco, California has been a leader in the development and use of health impact assessments in public planning processes. The Department of Public Health in San Francisco has collaborated with community organizations and the San Francisco Department of City Planning to conduct assessments of development projects and neighborhood land use plans. "The analyses predict how development projects might impact key community health resources, including quality housing, economic diversity, social cohesion, and public infrastructure such as parks, schools, and public transit," says Rajiv Bhatia, Director, Occupational and Environmental Health, San Francisco Department of Public Health.

"[Health Impact Assessment] reflects the simple premise that public policy making should take into account direct and indirect impacts on human health," Bhatia says. The HIA of different development projects have resulted in alterations to development plans with benefits to residents that include successful negotiations for additional developer-funded affordable housing, guaranteed lifetime leases for current residents, agreements to maintain rent at present rates, and agreements to delay demolitions until sufficient replacement units have been built. After participating in these collaborations, the staff of the Department of City Planning now routinely request public health analyses for certain types of planning issues. ∎

families get much of their caloric intake from the National School Lunch Program, which provides them with free and reduced-price meals at school. At many schools, however, these meals do not meet basic standards for a healthy diet—more than three-quarters of the schools in the program have not yet met the requirement that school lunches provide no more than 30 percent of calories from fat. (U.S. General Accounting Office, 2003) Many schools also tempt students with foods and beverages with little nutritional value in school stores and in vending machines.

School garden programs are one way to provide children with healthier options and teach them to make healthier choices. There are 3,000 school gardens in California alone, says Emily Ozer, Assistant Professor in the School of Public Health at the University of California at Berkeley. "More common are less integrated gardens—after school programs or gardens in some science classes. Many operate on a shoe string budget," Ozer explains. "Some are just a teacher gardening with students in a few donated pots."

Berkeley's TES is one of the exceptions, Ozer says. "Every school garden program has some growing space, some adult who supports the growing space, and some curriculum. But The Edible Schoolyard has a large garden with a lot of features, a cooking component, integration into the school day, funding, and resources, and all the students go through the program. It is probably the best known and most developed school garden program in the country."

In addition to a one-acre garden, TES also has a pizza oven, a bank of olive trees for possible future olive oil pressing, a chicken coop, compost piles, an extensive tool shed, a plant propagation area, and a kitchen classroom where students learn to cook what they've just learned to grow. Two kitchen staff, two garden staff, two office staff, two Americorps members, numerous community volunteers, and a garden consultant help with all aspects of the program.

New 6th graders start their year with an introduction to TES' garden and its rituals by roasting corn planted by other 6th graders during the previous spring. For many students, the garden is a rare opportunity to be in a natural environment and often an introduction to many new foods. "We want them to have fun—to forage, taste, smell, experience the garden fully," explains Natsumi Iimura, Assistant Program Coordinator at TES. In the garden, classes start and end at a large open structure, where kids can sit on a semi-circle of hay bales. Students select the projects they want to work on that day, then end class with some time to ask questions and reflect.

The philosophy of the garden is that children learn best when they do not know they are learning. When kids are involved in growing food, they are more adventurous about eating it in the kitchen. Propagation is a great activity for students, because they get to see rapid change in a small place. When they work

Many children from low-income families get much of their caloric intake from the National School Lunch Program, which provides them with free and reduced-price meals at school. At many schools, however, these meals do not meet basic standards for a healthy diet.

with compost, they realize that resources can be scarce. Raspberries disappear quickly when students are here—students do not let ripe fruit linger on the vine. The staff also teach students to respect and care for tools, while teaching them how to interact with things and people. "We teach the kids that if you treat things with care they will last a long time, that things are not disposable," Iimura explains.

The garden classes are connected to the school curricula. Math and science classes are connected to the garden classes, while humanities classes are connected to the kitchen classes. Many lessons integrate well with the middle school curriculum. For example, classes on the carbon cycle and pollination, as well as lessons on graphing and ratios, are easily adapted to garden classes. The students also learn how to prepare food from the garden and share meals together. In the kitchen, students cook seasonal meals, and almost all of the ingredients come from the garden. Afterward, they sit down and eat. "For a lot of students, it is a rare occurrence to sit around a table and eat a meal. So we like to make the best of the time we have," says Iimura.

"The garden and kitchen provide a different way of looking at food, where everything has an effect on everything else," says Iimura. Many of the health components of the program are implicit threads that run through the garden and kitchen classes. Students get exercise in the garden. They learn how to grow and cook healthy food, and that eating healthy food can be both tasty and fun.

TES has already demonstrated positive results for children. In 2003, J. Michael Murphy, who is an Associate Professor of Psychology at the Harvard Medical School and works with the Center for Ecoliteracy in Berkeley, completed a study of the impacts of The Edible Schoolyard. The study found students at TES showed greater gains in overall GPA, math, and science, and greater understanding of the garden cycle than students at a similar school that did not include the TES program. The study also found that students who made improvements in understanding ecological principles also showed significant

improvement in what they ate. In short, the study suggests that teaching students where food comes from and how it is prepared may be an important contributor to overall diet change. (Murphy, 2003)

Research on the positive impacts of school gardens will continue. Ozer, too, is interested in researching the impacts of school gardens. "Research hasn't been done on which pieces of school gardens are effective for certain outcomes. It is an open question on which resources are the most important. But there are many testimonials from many different instructors that kids get lots out of school gardens regardless of the budget," Ozer says. She will be collaborating with schools in California to study the impact of school gardens. The research project is beginning with case studies of school gardens in the San Francisco Bay area. "I am particularly interested in the impact of school gardens on individual nutrition, as well as their capacity-building opportunities for the whole school community," Ozer reports.

The nutrition and health benefits of eating fresh produce at school will soon be something that the entire school can experience every day. In 2005, the district will begin implementation of its School Lunch Curriculum Initiative. The program will be first introduced at King Middle School in a new cafeteria facility called the Dining Commons. The Dining Commons will be a place where all the students can sit and eat a lunch of fresh, seasonal, organic food together. The school district has plans to implement a district-wide program in the near future.

CONCLUSION

Many of the causes of health disparities have their roots in environmental, social, and economic conditions. For example, nutrition, schools and education, housing segregation, neighborhood design, workplace issues, and wages and job availability all play a role in the long-term health of an individual or community. Improving health and mitigating racial disparities will require broad, community-based solutions to health problems.

The most effective solutions to health disparities often form within communities. Because community health-related issues are complex, interconnected, and community-specific, the most effective models will often adapt to fit the local context. Innovative programs across the country are addressing health disparities at the local level, offering lessons for communities nationwide.

Access to healthy food and the ability to maintain regular physical activity are critical for health.

Many rural areas, racially segregated neighborhoods, and low-income neighborhoods have less access to stores that sell healthy food, are less conducive to walking, and have lower concentrations of parks and green spaces that promote physical activ-

ity. Dietary factors are associated with numerous health problems such as diabetes, coronary hearth disease, stroke, and certain cancers.

Tohono O'odham Community Action demonstrates how cultural and agricultural traditions are linked to nutrition and physical fitness and can play an integral role in reducing the causes of disease and improving the health of a community. The Edible Schoolyard and Berkeley Public Schools demonstrate a way to integrate health, nutrition, and exercise within a public education setting and curriculum. Strategies to improve access to nutritious food and exercise could also include: community and home garden programs, programs that address the nutritional content of food available in schools, diet and nutrition education programs, and designing new communities or altering existing communities to be walkable and include easy access to farmer's markets and supermarkets.

Housing conditions, quality, safety, and location dramatically influence health.

Older or poor-condition housing often contributes to poor health. Examples include inadequate ventilation and water leaks that foster mold growth and increase asthma problems. Low-income housing stock tends to be older and more poorly maintained, decreasing air quality and increasing lead paint exposure. Communities of color and low-income areas tend to have higher numbers of polluting sites than other areas. Neighborhoods with more toxic areas are also likely to have other detrimental social or environmental conditions.

In Washington's King County, programs that educate residents on how they can improve their housing conditions have reduced incidences of asthma. Health Impact Assessments are integrating health issues into community development and planning projects. Health outcomes can be improved by: improving and enforcing building codes that promote safe, healthy housing; designing new housing to be breathe-easy homes that reduce asthma symptoms; monitoring the locations of new highways and high-traffic zones, and the locations and impacts of toxic sites, polluting industries, and other stressors such as high-noise zones; and increasing the availability of healthy, affordable housing.

Unions give workers collective leverage in addressing issues of worker health and safety.

Many low-income jobs have extremely dangerous work environments, such as farm labor and meatpacking. Farm labor, for example, is associated with numerous occupational hazards, including injuries from exposure to pesticides and other farming-related chemicals—for example, eye irritation, rashes, and headaches—and disabling injuries. Moreover, many low-wage workers cannot afford to pay for health care. And undocumented farmworkers face further challenges claiming worker's compensation for illness or injuries. ■

AN ANTI-RACIST APPROACH
St. Thomas Health Services

The range of socioeconomic and environmental factors that influence health for people of color is broad. The effect of historical and present-day racism on communities of color in the U.S. has led to inequities in housing, education, jobs and wages, and neighborhood segregation, all of which influence health. Yet when policymakers, businesses, or government institutions make decisions about community design, economic development, housing construction, education programs, or other similar issues, the consequences are rarely discussed from a health perspective. In New Orleans, Louisiana, St. Thomas Health Services is demonstrating how a health care organization can not only meet individual health needs, but also play a role in improving the health of a community.

In the mid-1980s, a council representing the residents of a New Orleans housing development called the St. Thomas petitioned the city's mayor to fund a primary care clinic for patients with Medicaid or no insurance. The residents had recognized that their community faced a health crisis that is compounded within most of the nation's inner cities. Due to an interaction of socioeconomic and environmental factors, low-income people and particularly people of color in inner cities face higher rates of chronic and acute illnesses such as tuberculosis, asthma, diabetes, kidney disease, cardiovascular disease, hypertension, mental illness, cancer, HIV infection and AIDS, and infant mortality, among others. Many of these illnesses are associated with conditions of poverty such as poor nutrition and inadequate or unsafe housing. The most prevalent diseases—such as diabetes, hypertension, and congestive heart failure—are also associated with a lack of access to primary care.

In many urban and rural areas, community health clinics are the primary source of care for the uninsured and underinsured. Such clinics serve more than ten million people, including seven million people of color. (National Association of Community Health Centers, 2005) The clinic launched by the St. Thomas Resident Council, St. Thomas Health Services, is now the community's primary vehicle for addressing the range of issues that affect the mostly low-income African American community that it serves. Since the clinic's birth, changes in the neighborhood—including gentrification and the destruction of most of the development's housing units—have presented many challenges for both St. Thomas Health Services and the overall community.

Rather than limit its activities just to the delivery of health care services, the clinic has taken leadership for grappling with broader health issues, including the loss of affordable housing. As a result, over the past 17 years, St. Thomas Health Services has been a model for integrating: 1) a broader vision of community health, one that includes explicitly addressing the consequences of racism and discrimination, and 2) accessible, high-quality primary care. This integrated approach provides valuable lessons about addressing disparities in health.

THE HISTORY OF ST. THOMAS HEALTH SERVICES

When hurricanes point toward New Orleans, residents either leave town or head to the most solid structures they can find. For decades, the residents of the St. Thomas Irish Channel community needed go no further than the brick structures of the St. Thomas housing development. Tucked in the curl of the Mississippi River as it bends north toward downtown and the French Quarter, the housing development—known locally as "the St. Thomas"—had long been the community's defining characteristic. For many years, over 1,500 units in rows of brick buildings housed a tight-knit community of mostly low-income African American residents.

But the city refused to maintain the St. Thomas, and residents began to organize. "They deliberately let the St. Thomas run down, and the money stopped coming in to fix it," says Barbara Jackson, a community activist who is the chair of the St. Thomas Health Services board. "There were nice, clean apartments in the development. People worked hard, some people were paying $500 to $600 a month for their units. They could have afforded to go elsewhere, but they wanted to stay. But there was a movement underfoot to try to frustrate people." Angered by the degradation and neglect of the development, the residents responded by mounting the nation's largest rent strike in the early 1980s.

Unhealthy conditions in the St. Thomas housing development, including the existence of lead paint in many people's homes, were one of the residents' chief concerns. But they understood that lead poisoning was not the only health risk that their community faced and decided they would also fight for a health clinic. Like many low-income communities, there was no primary care center in the neighborhood. They petitioned the mayor's office, which connected them with two members of the Sisters of Mercy, who were looking for a location in New Orleans to open a primary care center.

For people from the St. Thomas, like most low-income people who are underinsured or uninsured, experiences with the health care system ranged from frustration at long lines and paperwork to a lack of primary care altogether. Even in the surrounding areas, few clinics would accept patients without health insurance, and it was difficult even for those who were covered by Medicaid to access primary care. For many, the emergency room was the only time they would see a doctor.

People who do not have regular access to primary care are subject to an array of avoidable health risks. A lack of prenatal care is partly responsible for infant mortality rates for African Americans that are more than twice the rate of whites (13.3 deaths for every 1,000 live births for African Americans, versus 5.7 deaths for whites). Adult cancer screenings, pap smears, mammograms, and cholesterol and blood pressure screenings are necessary to improve chances of avoiding or odds of recovering from strokes, cardiac arrest, and cancer. In addition to the health risks of not seeing a primary care physician, the costs of emergency care are typically four times greater than similar care from a primary care physician.

St. Thomas Health Services, the only primary medical facility in the St. Thomas Irish Channel community, was established to address these critical health needs by providing accessible primary care. The clinic is now a cornerstone of the neighborhood, a place where people can receive quality medical care in a comfortable setting regardless of their ability to pay.

Most mornings, the clinic's 30 waiting room chairs are filled with people of all ages. In one corner, a television airs health-related programs as children play together on the floor. Mothers and fathers watch casually or converse with other neighbors on the stairs outside. In one corner an elderly couple converses quietly in Spanish. The waiting room posts notices of resume workshops and community events. One announces HIV screenings and counseling, free and anonymous, at the clinic each Wednesday.

The clinic has approximately 10,000 patients, over 90 percent of whom are African American. A small number of white and Latinos patients also utilize the clinic's services. Seventy to 75 percent of the clinic's patients are uninsured, and Medicare/Medicaid only cover 25 to 30 percent of patients. The clinic is able to serve their clients through an array of support mechanisms,

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People understand that building healthy communities means more than medical care. We need to talk about healthy public policies. Public health departments can serve as facilitators and conveners. We need to be at the table with other sectors—urban planning, education, housing, etc. Too often, though, those other sectors don't think that we need to be at those tables.

Within the public health department, we need more community organizers and more policy analysts who can do things like health impact assessments in a way that makes sense to the community. We need to get to the point where communities can advocate for themselves. We need to be able to address broader social and environmental factors, and to do that we must engage communities in the process.

including government funding, foundation grants, and sliding-scale payments from uninsured patients.

At the clinic, patients are offered a full range of primary care services. St. Thomas' family services include prenatal care and adolescent medicine, pediatrics, hypertension, and a diabetes clinic. The clinic offers adult screenings for cervical, breast, prostrate, and colon cancers, as well as cholesterol. Ear, nose, and throat care includes dealing with tooth abscesses, ear infections, and headaches. Dr. Wood, the clinic's full-time family medicine practitioner, also conducts minor surgical procedures such as IUD placement, drainage of abscesses, lacerations, and staple removal. The clinic also offers musculoskeletal care in cases of arthritis, back or joint pain, and muscle strains or spasms.

The second floor houses pediatrics, optometry, counseling, and administrative offices. When the elevator door opens, children are ushered to rooms in bright primary colors painted with animal figures. "Not all clinics will do Medicaid, or will do KidMed," says Carol Craig, St. Thomas' family nurse practitioner who provides primary pediatric care. "A lot will either contract those out or just won't take those cases."

Down the hall from the pediatrics unit, an eye clinic offers free eye care and eyeglasses for the uninsured, as well as referrals for ophthalmology specialists and eye surgery. Around the corner, Dawn Roussell is an on-site social worker who offers counseling services to adults and adolescents. Another social worker helps with financial issues and refers patients to a range of social services available outside of the clinic.

The clinic augments its care through an array of specialized services offered by partner organizations and medical schools. These networks also link patients to secondary and tertiary medical services only available at larger medical institutions and rarely available to uninsured and underinsured patients. While these partnerships improve treatment for St. Thomas patients, they also provide an opportunity for St. Thomas Health Services to spread its organizational philosophy. As Barbara Major, the clinic's Executive Director, states, "We want to work with other service providers and say look, maybe there's a different way of being, of behaving, of developing and creating institutions." The "different way of being" refers to the clinic's commitment to an anti-racist approach to health care.

ACCESSIBLE HEALTH CARE WITH AN ANTI-RACIST APPROACH

St. Thomas Health Services' mission statement says that the clinic is committed to "an anti-racist process of self-determination." This explicit focus involves both community accountability and maintaining an anti-racist organizational culture.

The fact that a clinic is located in a low-income neighborhood and describes itself as a community clinic does not guarantee that patients will feel welcome and respected. Creating that environment requires institutional vision and commitment.

For St. Thomas Health Services, anti-racism means being in partnership with and taking leadership from the community they serve, while drawing on the indigenous knowledge and survival skills of the community. The clinic hires staff from the St. Thomas community. It is also accountable to an oversight board that is comprised mostly of community members. Angela Winfrey-Bowman, core trainer of the People's Institute for Survival and Beyond, an organization that specializes in anti-racist trainings and institutional transformation, says this accountability is a critical component of its anti-racist philosophy.

"The residents have veto power over anything brought there so there's built-in accountability," says Winfrey-Bowman. "If you have an organization that doesn't have a community other than the clients, you have to ask who is on your advisory board. Do you have board members there who are not there as tokens, but they really are in decision-making positions? You start from there, and then you begin to develop anti-racist policies," she says.

All clinic staff must participate in the People's Institute's two-and-a-half day Undoing Racism workshops. Barbara Jackson, a community activist who is the chair of the St. Thomas Health Services board, recognizes the impact of this training and commitment on the quality of services. Receptionists greet patients by name as they enter the building. Several employees of the clinic are a part of the community and know the patients well.

"The majority of people in St. Thomas have a problem going to the outpatient clinics at the hospitals because there is a long waiting period, and some of them are so insensitive to the needs of the people," says Jackson, who is also a patient at the clinic. "In the beginning, we were talking about this as a way to relieve some of the tension of people who were already stressed out. We don't close the door on anyone, no matter where you're from. I have seen an overwhelming number of people who are not from St. Thomas who come here."

One Thursday afternoon, a young man came to the clinic to look for prenatal care materials. That's something that Sydney Lewis, the clinic's Adolescent Wellness Coordinator, says she wouldn't see at other clinics. "We really defy the numbers, as far as getting men in," she says. While the majority (65 percent) of patients are women, a large number of men also feel comfortable entering the clinic because of the environment that the staff has created. "That came out of the organizing at St. Thomas," says Winfrey-Bowman of the People's Institute. "It's one of the few family clinics that you see men coming into."

Maintaining a staff that upholds its anti-racist principles and values, and developing an institution that supports those values, is a process that requires constant vigilance. Winfrey-Bowman warns that there is no "cookie-cutter answer" to developing or maintaining culturally competent institutions. "You start

looking to make sure your values are represented in your actions," she says. "It's a long-term process. For those organizations that have been around for a while, you have to address a culture that may be resistant to change. And another thing that makes it hard is that there are few models out there." The clinic, Winfrey-Bowman asserts, is one such model.

ADDRESSING COMMUNITY HEALTH

Providing quality health care is not all that St. Thomas Health Services does. The clinic also works to resolve the conditions that contribute to poor health. Barbara Major points out that the organization's mission to improve the health of the St. Thomas Irish Channel community stems from its origins—a community that saw neglect and environmental degradation affecting their health and began organizing for change.

Almost as soon as the clinic started seeing patients, St. Thomas Health Services began to encounter the health effects of gentrification that was threatening long-term residents. With its proximity to downtown and the riverfront, the neighborhood has become a hot spot for investment and a target of an aggressive "economic development" effort. In the past two decades, rising rents in the French Quarter pushed mostly white hipsters, artists, and young professionals to seek haven along Magazine Street, which runs through the heart of the neighborhood. Antique shops, vintage clothing stores, and boutiques far outnumber the corner markets that were once the street's commercial life.

This gentrification process is threatening affordable housing in the neighborhood. Beginning in 2002, using federal funding from the Hope VI housing redevelopment program, the city turned loose its wrecking crews upon the St. Thomas housing development. A handful of the brick structures remain as historical markers, cast-iron balconies and staircases still adorning the hollow shells. With a promise to return a significant portion of the units back to the original tenants, the city has replaced the rest of the historical buildings with a Wal-Mart and wooden Hope VI units designed not just for low-income former residents, but for mixed-income use.

CONSEQUENCES FOR COMMUNITY HEALTH

The redevelopment of the St. Thomas had dramatic health consequences for St. Thomas Health Services patients, as well as all residents of the St. Thomas Irish Channel community. "I have seen a lot of new kids in the past two years, with a lot more pathology than I previously saw," says Carol Craig, family nurse practitioner in pediatrics. "The new kids have mental health issues. There were a lot of issues when they tore down the projects over here." As families dealt with the trauma of having their homes destroyed, youth violence increased. "During the relocation, 27 boys were shot," recalls Barbara Jackson.

Residents were displaced to other locations throughout the city, often substandard housing that was far from the health services at St. Thomas. "There's an increasing lead problem based on a

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When thinking about race and health, one question is about health services and another question is about how life conditions drive the onset of disease. Thinking about this in a civil rights framework brings up the issue of data collection. Some groups are thinking about moving toward making data collection at the point of service a requirement—this is important for ascertaining whether discrimination occurred. Some people are wary about confidentiality issues and potential discrimination, so you have to be clear about why you're collecting the data.

We also need to improve public health surveillance systems. We need to look at the outcomes that are routinely recorded by the state at the population level and make sure that they are collecting socioeconomic data. We need this to understand the extent of socioeconomic disparities in health and see how they contribute to racial/ethnic disparities.

St. Thomas Health Services is engaged in the community's struggles for quality education and against homelessness, mental health problems, HIV/AIDS, and a range of other issues.

lot of the chewing up of the streets and the housing," says Craig. But without access to health care and support services, many children have suffered. "These kids don't get the attention that kids in other schools or homes that are more affluent get," Craig reports.

In addition to meeting the acute health needs of neighborhood residents, St. Thomas Health Services is working to ensure that the original St. Thomas residents will have space in the new Hope VI units. The original agreement was that 750 of the original St. Thomas residents would be able to return and that 500 would get houses. Now the residents are concerned that income requirements will make it difficult for them to get back in. "They're trying to get rid of all of the African Americans," Jackson says. "People are trying to buy houses and run us out. They're trying to get people to sell."

As she walks down Magazine Street, Executive Director Barbara Major comments on the lack of African American children and adults from the neighborhood. "These sidewalks used to be filled with local kids," she says. "Now, they know this isn't where they are supposed to be." Major sees it as symptomatic of a larger problem of isolation and marginalization of the African American community. "We want to improve the wellness of the St. Thomas community and participate in a community-driven process of self-determination," says Major.

St. Thomas Health Services is at the front lines of the fight to maintain subsidized units for displaced residents. The clinic is also engaged in the community's struggles for quality education and against homelessness, mental health problems, HIV/AIDS, and a range of other issues. The clinic was an active member of the St. Thomas Health Consortium, which was developed by the St. Thomas Resident Council to create a system of community accountability and empowerment. Organizations within the Consortium became accountable to community residents and were pushed to address many of the social and economic determinants of health that the residents saw as most vital.

Another way the clinic promotes community health is through youth education and organizing programs. Its youth program covers traditional health topics but incorporates them within a focus on cultural pride and heritage and the structural

causes of their health problems. "There are so many more critical things in urban environments," says Sydney Lewis. "We don't want someone saying, 'The problem with your kids is that they're obese, and you have to tell them not to eat so many Doritos.' The problem is not that they're obese. It may be that they're depressed because of the conditions under which they are expected to survive, and thus they eat. So if we can talk to them about the conditions and about working together to change the situation, they're likely to feel less depressed by it," Lewis explains.

Lewis, a 31-year-old woman whose father is African American and whose mother was born in the Dominican Republic, coordinates youth education programs out of the clinic. The clinic runs education programs in four local public schools throughout the year. Curricula include health issues such as sex education, peer pressure, reproductive health, media literacy, and nutrition, topics that are no longer covered in New Orleans public schools. The clinic's programs also acknowledge that internalized racism is a factor in health disparities. The first topics that Lewis addresses with a new group of young people are often African history and culture. "If you think your roots are diseased, you're going to be sick too," says Lewis.

CONCLUSION

While access to health care is a major barrier to health equity, the causes of health disparities cannot be addressed through health care alone. St. Thomas Health Services demonstrates how community clinics can integrate primary care for uninsured or underinsured people into a broader mission of addressing root causes of health inequities. "We believe that just prescribing medicine does not deal with the issues that confront people that come into this clinic," says Barbara Major. "There are things that people deal with everyday in their lives, and if we want to help them be healthy, we have to understand that and be able to address it." Some important lessons from St. Thomas Health Services include:

Community health centers that are accountable to the community can provide more than individual health care.

Health care organizations are uniquely positioned to speak out about issues that affect the health of low-income communities. If clinics are engaged in the health of a particular community, they can bring credibility to residents' claims on issues ranging from pollution or lead paint to campaigns for parks, grocery stores, or higher-quality public school facilities. They can also serve as a hub for addressing the underlying environmental causes of health disparities. Through its youth organizing components and political engagement on issues of housing, pollution, and education, St. Thomas Health Services recognizes that health is related to an array of social and economic factors and takes action to improve the well-being of the community. This is a role that more health care institutions can and should play.

Access to community-based, high-quality, culturally appropriate primary care, regardless of ability to pay, can mitigate a major cause of health disparities.

People of color in the U.S., particularly African Americans, suffer disproportionately from a range of illnesses that are best treated with prevention and primary care. Yet people of color are less likely to have adequate health insurance and often live in communities where no primary care facilities are located. Through partnerships with local hospitals and medical schools, and access to a well-trained clinical staff, patients at St. Thomas receive high-quality care even if they are uninsured or underinsured. This includes primary care and pediatrics at the clinic and referrals to a range of specialists at partner institutions. Doctors and nurses who are not expected to meet quotas spend time getting to know patients and building trust. Yet this quality of care is a result of creative partnerships and foundation fundraising, rather than stable funding streams. Improving the quality of health care that is available to low-income communities of color will require a renewed understanding of the importance of publicly financed health care as a means of reducing health disparities and the rates of the uninsured.

An explicit focus on the effects of racism on health will help address racial disparities.

As discussed in Chapter One, health care institutions often contribute to the persistence of racial disparities in health. Yet it is possible for health care organizations to proactively address the causes of racial disparities both internally and within the community they serve. As a policy, everyone who works at St. Thomas Health Services, from the director to administrative staff, must participate in intensive anti-racist trainings. In addition, the organization first seeks people from the community, including patients, when hiring new staff. This helps ensure that the clinic is welcoming to and respectful of the people of color that it serves. The clinic's explicit anti-racist focus is reflected in its mission and governing values, and evident in its education programs and efforts to address racial inequities in the community. The clinic demonstrates how mitigating racial disparities may require a commitment to internal institutional change as well as proactive community engagement. ■

IGNATIUS BAU

Program Officer for Cultural Competence in Health at the California Endowment

Cultural competency is often misunderstood. It really is a process and a continuum of change. It's not just training or a magic curriculum, nor is it merely an issue of staffing. It is becoming a responsive, learning organization. It requires being critical about mapping assets and deficits within organizations and designing interventions that bring you closer to serving clients. The continuous evaluation and monitoring of those efforts is critical.

In my view, there has been and still is a divide between the community organizing side and the funding side. There are a handful of foundations working broadly on issues of disparities, fewer working on cultural competency, and fewer working on language access. But there still isn't enough engagement by community organizing groups and historically identified advocacy organizations based in D.C. It is clear, from my health policy perspective, that you need both to move policy and systems change.

RICHARD HOFRICHTER, PH.D.

Writer and social critic whose work focuses on health equity and environmental justice

You can name dozens of factors and conditions that lead to health inequities, but you are always left with the question: Why do those differences exist, e.g., why is there poverty, why do certain communities experience those factors rather than others? To grasp root causes, it is essential to understand the fundamental power differential that enables social injustice.

Really addressing that injustice requires systemic change like a living wage, equality of education, and ending the exclusions that place stresses on the immune system that lead to these health inequities. Racism is also an originating injustice along with class; the stress of living with it and being treated differently at institutional and personal levels negatively affects health.

IMPROVING HEALTH
Key Findings & Recommendations

Health disparities constitute an injustice and a moral and economic crisis. Racism within social and economic structures leads to negative health outcomes for people of color across the U.S. These inequities are compounded within the health care system, which as a whole provides vastly unequal access and treatment based on race, language, and ethnicity. Ultimately, racial and ethnic disparities in health cost hundreds of thousands of lives every year and prevent millions of people from enjoying a healthy life.

Reducing the gap in health between people of color and whites will require proactive solutions that address the root causes of health disparities, including inequities within the health care system and within larger social, environmental, and economic structures. This report has profiled several promising efforts to mitigate health disparities by addressing their root causes. Progress toward racial equity in health will require building on these policies and practices toward comprehensive, national solutions.

Part 1: The Health Care System

In the health care arena, there are four key areas in which shifts in policy and practice are needed to reduce racial disparities: access to health care, quality of care, doctor/patient communication, and alternative and culturally appropriate care. There are examples in each of these areas that show promise for creating an equitable health care system.

ACCESS TO HEALTH CARE

People of color face enormous barriers in accessing primary and specialty care. Some of these barriers are geographic—primary care is not available in many urban neighborhoods and rural regions. Other barriers are financial—people of color are more likely to lack health insurance or have governmental coverage like Medicaid, which some providers do not accept. Even where health care providers exist and are affordable, however, people of color are likely to report being treated with disrespect when they try to access health care. Inadequate financing systems give incentives for providers to deny people care or limit the kinds of care they receive. All of these contribute to health disparities.

Recommendations

1 **Work toward a system of universal health care.** The United States spends more on health care per capita than any other industrialized nation, but that spending is unevenly distributed. Millions of Americans, including a disproportionate number of people of color, still lack health care coverage. Universal health care has been proven to reduce the inefficiencies of patchwork funding systems, equalize access to primary care and hospital services, and lead to a narrowing of racial and socioeconomic gaps in health outcomes.

2 **Expand public health programs.** As Washington, D.C.'s Medicaid program demonstrates, expanding access to public health programs like SCHIP, Medicaid, and Medicare will have a direct impact on health disparities. Because of the failures of employer-based health care, it is essential to provide coverage for people who are working but cannot afford health care. States should expand Medicaid coverage to all recipients allowed under federal law and use state funds to cover people, such as many immigrants, who are currently excluded.

3 **Improve health care in medically underserved areas, which are often in communities of color.** Nonprofit, community-owned health centers, like St. Thomas Health Services in New Orleans, are much more likely to provide care for people of color, migrant workers, and people who are limited English proficient than other health facilities. Yet most community clinics, while excellent sources of primary care, are not designed to provide access to specialty care. Supporting community health centers that can provide comprehensive, high-quality health care, and providing funding for dentistry, ophthalmology, radiology, and other specialties, can improve health outcomes for people of color.

QUALITY HEALTH CARE

The quality of care that people receive depends on multiple factors, including institutional priorities, financing, and accountability. Health care institutions need to create a culture that welcomes and respects all patients and provides the highest-quality care possible. Yet people of color often report very low levels of trust in the health care system, and this distrust is legitimated by documented differences in treatment. Moreover, the facilities and resources available in clinics in communities of color are often inadequate.

Recommendations

1 **Prioritize the creation of an institutional culture that is welcoming and respectful to people of color.** Two health care organizations profiled in this report, the Southcentral Foundation and St. Thomas Health Services, have prioritized developing a culture that treats patients with respect. These priorities are evident in their written mission and values, training programs, recruitment, staff expectations, and physical structures, as well as in the services they provide. For people of color who often feel disrespected in health care settings, creating a welcoming environment increases the usage of primary and preventive care and improves the quality of care that people receive.

2 **Recruit, train, and develop a knowledgeable and diverse staff.** While improving diversity in health care staff does not in itself solve the problem of differential treatment, medical professionals who are people of color are more likely to work in communities of color, which would improve access to quality care. Health care providers should hire multilingual staff to meet the language needs of the community. Institutions should create a workplace climate that welcomes and supports a diverse staff.

3 **Track racial disparities in health care provision.** With proper data collection, health care institutions can be held to a high quality of care standard for all patients. At Bellevue Hospital in New York, tracking data on requests and usage of language services, by both providers and patients, allowed the hospital to meet the needs of a much larger propor-

tion of its LEP patients. In Alaska, the Southcentral Foundation's system of tracking provider performance has led to a dramatic increase in preventive care and screenings. Using data to ensure high standards for care for all patients can eliminate inequities in treatment.

DOCTOR/PATIENT COMMUNICATION

The greatest impediment to accessing high-quality health care for millions in the United States is a language barrier. People who do not speak English, a large portion of the nation's people of color, are less likely to receive health care that meets their needs. Those who do not receive interpretation are less likely to understand their provider's instructions and more likely to be misdiagnosed. Every patient who needs interpretation should receive assistance from a trained, bilingual medical interpreter. Yet too few people receive any interpretation at all, and the majority of those people receive inadequate help—interpretation by a relative, friend, or staff member without any training in medical interpretation.

Recommendations

1 **Hospitals and clinics should provide access to trained medical interpreters for all clinical encounters.** Health care institutions need to provide language services at every point of contact with the health care system, including not only patient/doctor interactions, but also billing departments and signage throughout the facility. Remote medical interpretation such as TEMIS can improve communication during clinical encounters and increase patients' comfort level by removing a third party from the treatment room. Institutions can also address the need for language access by training, recruiting, and hiring bilingual staff.

2 **Language services should be supported by public funding.** The CLAS standards promulgated by the U.S. Department of Health and Human Services are an excellent framework for improving health care
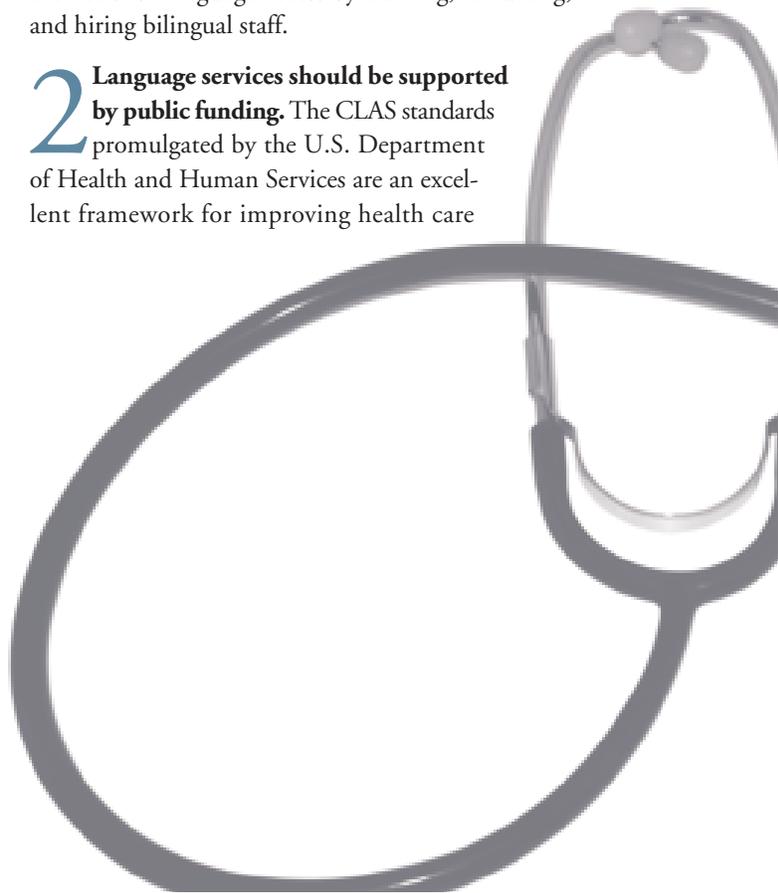
services for people of color and LEP patients, but they fall short of achieving their purpose for two reasons: funding and enforcement. Federal, state, and local governments, as well as health insurance providers and health care providers, should recognize language services as a medical necessity and support them with funding. Advocacy groups should encourage states to take advantage of federal Medicaid matching funds for language services, and the federal government should impose regulations to enforce language access standards.

ALTERNATIVE MEDICINE AND CULTURALLY APPROPRIATE CARE

Many racial and ethnic groups have rich medical traditions that people continue to practice. Despite the efficacy of many practices for the people who use them, patients still lack access because insurance programs rarely cover alternative or non-Western medicine. Mainstream practitioners often lack basic information about alternative practices and are unable or unwilling to help patients integrate their traditional practices with Western medicine, which poses additional health risks.

Recommendations

1 **Expand training and research about alternative medical practices**. Medical professionals should receive training about alternative medicine, and research funds should be increased and allocated to better understand the efficacy and outcomes of alternative healing practices. With so many residents of the United States using alternative and complementary medical practices, understanding and integrating these practices is a critical component of quality care.

2 **Require insurers to cover alternative and culturally appropriate health care.** Washington State's "Alternative Provider Statute" ensures that consumers who are insured in the state have access to care from licensed providers, such as acupuncturists, from non-Western traditions. Such regulations can improve access to culturally appropriate care.

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"Disparities" is a government word. A true representation would be "social inequity equals health inequity." Access to health care is only one piece of it; education, jobs, employment are very important things. The main step is the realization that you can't reduce disparities with just a health care strategy. The main determinants are outside of the system. It's about social change (big change), not only policy change (small change).

The goal is to create a value-based framework from which new ideas can flow. Reframing issues is a social change strategy, and framing is more than a quick message. Media advocacy has been a useful approach to thinking about the importance of framing. It's about working through the news media to reframe what are commonly seen as individual, personal, behavioral problems to be seen as social, political, policy issues.

Part 2: Creating Healthy Communities

There are many contributors to health inequity that are unrelated to the health care system. Unequal access to education and economic opportunity is a prime cause of disparate health outcomes. People of color are less likely to have health insurance and are more likely to live in neighborhoods characterized by dilapidated housing, pollution, fewer parks, more fast food restaurants, fewer grocery stores, and other conditions that contribute to poor health. Raising wages and equalizing educational opportunities would contribute to reducing health disparities. In addition to education and economic opportunity, improvements within the arenas of workplace safety, the environment, community design, and segregation can all play an important role.

WORKPLACE HEALTH AND SAFETY

People of color are more likely to suffer workplace injuries, less likely to have health and disability insurance, and less likely to have the economic stability to weather health crises. Immigrant workers, and undocumented workers in particular, are particularly at risk. Addressing workplace causes of health disparities requires empowering workers to bargain on their own behalf, as well as government intervention to protect vulnerable workers.

Recommendation

1 **Support and enforce policies that promote safety and health.** People of color are much more likely than whites to work under dangerous or unhealthy conditions. In addition to decent wages and health benefits, industry should be required to provide for safe working conditions and healthy environments. Government regulations such as the Occupational Safety and Health Act can provide workers with critical protections that businesses would not voluntarily adopt. The Occupational Safety and Health Act of 1970 has helped to reduce workplace fatalities by more than 60 percent and occupational injury and illness rates by 40 percent since it was enacted. (OSHA 2001) Unions have historically played a major role in advocating for safer working conditions and should not be limited in their efforts to organize.

COMMUNITY DESIGN AND SEGREGATION

Environmental factors have a major impact on the health of people of color. For example, asthma rates are higher in neighborhoods near highways. Housing and neighborhood design affect health in many ways: concentration of low-income people in neighborhoods without parks, grocery stores, and access to public transportation exacerbates obesity rates; deteriorating housing is linked to lead poisoning, respiratory illnesses, and other environmentally influenced illnesses; badly designed housing developments isolate communities and prevent economic development. These and other environmental factors can be controlled with thoughtful community design and development.

Recommendation

1 **State and local governments must play a role in ensuring that community design and development includes an assessment of the racial impact of all development efforts.** Community organizations, community-based health centers, public health departments, and health experts can all play a role in identifying and addressing the health risks in a community.

NUTRITION AND EXERCISE

People of color are disproportionately likely to be low-income and to live in places where fast food restaurants and mini-marts outnumber grocery stores and parks. Local governments and community groups have a role to play in ensuring that

all neighborhoods have access to services that encourage healthy choices, such as grocery stores, parks, recreation programs, community gardens, and health education.

Recommendations

1 **Improve access to nutritious food and exercise options.** Local planning boards and community groups should work together to encourage the construction of grocery stores and healthy restaurants, and discourage fast food restaurant expansions. Tohono O'odham Community Action sells freshly grown, traditional agricultural products in local stores; in other areas, farmers' markets participate in WIC coupon, food stamps, and local or state nutrition programs. Public officials should be responsible for providing healthy options, as well as promoting healthy alternatives through media and advertising.

2 **Public schools must take an active role in promoting nutrition and exercise.** School garden programs teach children about healthy foods, bring those foods to their communities, and teach children how to take an active role in improving their own health. Yet too often schools are forced to operate under testing mandates and divert scarce resources away from health education and physical education, even as health problems related to lack of exercise and poor nutrition persist. Physical health and academic performance are directly correlated. States and cities must maintain funding for health education and physical education for all public school students.

CULTURAL TRADITIONS

Culture is an asset and can facilitate health and well-being. Some of the most promising solutions to health disparities come from communities of color and incorporate cultural pride and heritage in their approach to improving the health of their communities.

Recommendation

1 **Support programs that incorporate cultural traditions.** Education programs through Tohono O'odham Community Action, St. Thomas Health Services, and the South-central Foundation all recognize that improving health outcomes depends on addressing the connection between cultural pride and overall mental, spiritual, and physical health. These programs are successful because they use cultural traditions as a base from which health can be addressed. ∎

10 Key Recommendations for Addressing Racial and Ethnic Disparities in Health

✔ **Eliminate disparities in access to health insurance.** Expand public health programs such as Medicaid and work toward a universal health care system guaranteeing basic access.

✔ **Improve health care in medically underserved areas, which are often communities of color.** Support community health clinics that provide high-quality care to underinsured and uninsured patients.

✔ **Develop health care institutions that are welcoming and respectful to people of different races and ethnicities.** Improve access to quality care for people of color by minimizing financial barriers to patient/doctor communication, training staff in culturally appropriate care, and building a diverse workforce.

✔ **Track racial disparities in health care provision.** With proper data collection, health care institutions can be held accountable for eliminating these disparities and meeting high quality of care standards for all patients.

✔ **Provide medical interpretation services for all clinical encounters.** Federal, state, and local governments, as well as insurers and health care providers, should fund language services as a medical necessity.

✔ **Improve access to traditional and non-Western treatments.** Insurers should be required to cover alternative and culturally appropriate health care. Health care providers should be provided training and access to research about alternative and non-Western medical practices.

✔ **Adopt and enforce policies that promote safety and health.** The adoption of worker protections and environmental standards are necessary to address root causes of health inequality.

✔ **Include public health experts and community organizations in community development and planning processes.** Health concerns must be at the forefront in discussions about housing, transportation, and economic development.

✔ **Provide funding and support for improved nutrition, physical education, and health education in schools.** School environments that emphasize health can lead to improved health outcomes and higher academic achievement.

✔ **Support programs that incorporate cultural traditions.** Connecting people to their cultural heritage can be an effective way to improve individual and community health.

APPENDIX

**INTRODUCTION AND CHAPTER 1:
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(http://www.osha.gov/as/opa/osha-at-30.html)

Websites with Information on Racial Disparities in Health

Kaiser Family Foundation
www.kff.org

Health Care for All (MA)
www.hcfama.org

Professor Vernellia Randall, Race, HealthCare, and the Law:
http://academic.udayton.edu/health

The California Endowment
www.calendow.org

W.K. Kellogg Foundation
www.wkkf.org

The Commonwealth Fund
www.cmwf.org

Institute of Medicine
www.iom.edu

The Access Project
www.accessproject.org

Center for the Advancement of Health
www.cfah.org
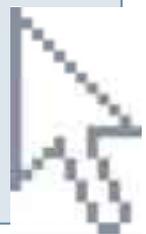
NORTHWEST FEDERATION OF COMMUNITY ORGANIZATIONS

The Northwest Federation of Community Organizations (NWFCO) is a regional network of four grassroots organizations: Idaho Community Action Network (ICAN), Montana People´s Action (MPA), Oregon Action (OA), Washington Citizen Action (WCA).

NWFCO's mission is to achieve systemic change by building strong state affiliate organizations and by executing national and regional campaigns that advance economic, racial, and social justice. In the ten years since its founding, NWFCO has trained hundreds of community leaders who are taking action and making change for their communities.

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APPLIED RESEARCH CENTER

The Applied Research Center (ARC) is a public policy, educational and research institute whose work emphasizes issues of race and social change. The Applied Research Center publishes the award-winning magazine Color-Lines.

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Brian Smedley	The Opportunity Agenda	Washington, D.C.
Nancy Krieger	Harvard School of Public Health	Boston, MA
Douglas Chung	Asian Health Center	Grand Rapids, MI
Joe Gone	University of Michigan	Ann Arbor, MI
Ping Wong	International Community Health Services	Seattle, WA
Art Chen	Alameda Alliance for Health	Alameda, CA
Gabrielle Lessard	National Immigration Law Center	Washington, D.C.
Ira SenGupta	Cross Cultural Health Program	Seattle, WA
J. Carlos Velasquez	The Praxis Project	Washington, D.C.
Dae Yoon	Korean Resource Center	Los Angeles, CA
Tom Pérez	University of Maryland School of Law	Baltimore, MD
	Tenants' and Workers' Support Committee	Alexandria, VA
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Ignatius Bau	California Endowment	San Francisco, CA
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Marilyn Aguirre-Molina	Mailman School of Public Health, Columbia University	New York, NY
Ralph Forquera	University of Washington School of Public Health and Seattle Indian Health Board	Seattle, WA
Maxine Golub	Institute for Urban Family Health and Bronx Health REACH Coalition	New York, NY
Dong Suh	Asian Health Services	Oakland, CA
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www.tocaonline.org

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www.stthomasclinic.org

Tenant and Workers Support Committee
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www.twsc.org

The Cross Cultural Health Care Program
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www.xculture.org

Seattle-King County Public Health Dept.
Healthy Homes program
www.metrokc.gov/health/asthma/healthy-homes/