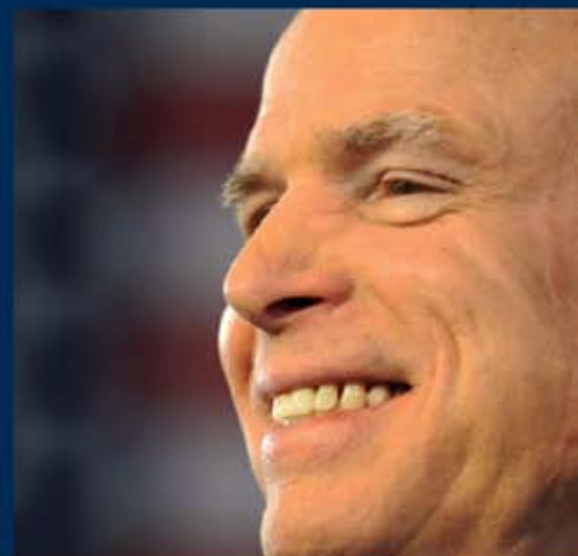


HEALTH CARE PROPOSALS OF THE 2008 DEMOCRATIC AND REPUBLICAN PRESIDENTIAL NOMINEES



*Implications for Improving Access, Affordability and
Quality for America's Minorities*



**HEALTH CARE PROPOSALS OF THE 2008
DEMOCRATIC AND REPUBLICAN PRESIDENTIAL NOMINEES:
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QUALITY FOR AMERICA'S MINORITIES**

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Preface

Health Care Proposals of The Democratic and Republican Presidential Nominees: Implications for Improving Access, Affordability and Quality for America's Minorities

In 2008, we know that there are over 47 million Americans without health insurance—half of whom are minorities. As the population of the United States becomes more racially and ethnically diverse, so, too, does the significance of health care and the resultant disparities in access. Racial/ethnic health disparities are well-documented in the United States. These disparities include higher rates of mortality as well as higher rates of many cancers and other diseases. In addition, HIV rates among African Americans in some parts of the U.S. exceed the rates of some countries in Africa. Minority populations have higher rates of conditions such as asthma, diabetes, heart failure, high blood pressure and stroke.

Racial/ethnic disparities in access to health care are staggering. Nearly two-thirds of Hispanic adults and one-third of African American adults were uninsured at some point in 2005, and immigrant children have the highest uninsured rate among people under the age of 18.

The election of a new President of the United States brings new policies and positions to the forefront, especially regarding the topic of health care reform. This report examines Senator Barack Obama's and Senator John McCain's health care proposals in the context of eliminating the nation's longstanding racial/ethnic disparities in health and health care. The following publication examines the candidates' proposals, keeping five priorities in mind:

- Expanding health insurance coverage;
- Expanding access to health and medical care;
- Cost containment;
- Quality improvement; and
- Infrastructure support for reducing racial and ethnic disparities.

This report also features side-by-side tables that present the primary health positions of Senator Obama and Senator McCain and the implications for minorities. By synthesizing both candidates' positions on health care and health care access, this report will educate voters and academics in the similarities and differences between the candidates and how such distinctions will affect the American public.

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Ralph B. Everett
President and CEO
Joint Center for Political and Economic Studies

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Executive Summary

In this election year, affordable health care is among the top issues for voters. Recognizing the need for action, the Republican and Democratic nominees have made health care reform a centerpiece of their respective presidential platforms. Each believes his approach will work best to expand health insurance coverage, reduce costs and improve quality for the world's most costly health care system. Of greatest concern are the 47 million Americans without health insurance—half of whom are minorities. As the U.S. grows more racially and ethnically diverse, so, too, does the significance of disparities in chronic disease rates, shorter life spans and access to affordable, high quality health care. High uninsured rates and racial/ethnic disparities are the primary reasons why the United States lags behind the world's most developed countries on most indicators of health status.

Part I. Setting the Context of Health Disparities: Challenges to Achieving an Equitable, High Quality Health Care System

This report examines Senator Barack Obama's and Senator John McCain's health care proposals in the context of eliminating the nation's longstanding racial/ethnic disparities in health and health care. The challenges are great, and inextricably linked to problems with the U.S. health system generally. While employer-based coverage is the bedrock of insurance in the U.S., it is eroding with increased globalization and soaring health care costs. Public programs reduce gaps in coverage, particularly for children, but most working-poor adults do not qualify for these programs.

The U.S. also lags behind developed nations in the use of health information technologies, such as electronic

medical records, that help to lower rates of medical errors and reduce the use of unnecessary tests and procedures. The quality of care Americans receive often varies by insurance status, income, region of the country—and race/ethnicity. The consequences of a health care system that fails to ensure all residents access to affordable, high quality care makes health care more expensive, less safe and less effective for everyone, even those with insurance. These burdens, however, fall disproportionately upon racial/ethnic minorities and their communities.

Part II. Health Disparities in The United States

Racial/ethnic health disparities in the U.S. are well-documented. They include higher rates of mortality and higher rates of many cancers and other diseases. HIV rates among African Americans in some parts of the U.S. exceed the rates of some countries in Africa. Minority populations have higher rates of chronic conditions such as asthma, diabetes, heart failure, high blood pressure and strokes.

Racial/ethnic disparities in health care affordability and insurance coverage are extensive. Almost two-thirds of Hispanic adults and one third of African-American adults was uninsured at some point during 2005; immigrant children have the highest uninsured rates among those under 18.

Health disparities are not only a result of inequities in insurance coverage and access to care. Unsafe neighborhoods, pollution, poor housing and an absence of access to healthy food sources in communities of color contribute to disproportionate rates of disease, disability and premature death for the nation's minorities. Reducing racial/ethnic health disparities requires reforming the health care system, and much more.



Part III. Comparing Health Care Proposals of Senator Barack Obama and Senator John McCain

We examined the health care proposals of the Democratic and Republican Presidential nominees on five priorities: expanding health insurance coverage; expanding access to health and medical care; cost containment; quality improvement; and infrastructure support for reducing racial and ethnic disparities. In a set of side-by-side tables, we present the primary positions of each candidate on these priorities and draw implications in the context of how the proposed actions have the potential to improve health care for minorities; may be limited in their potential to reduce disparities without addressing specific challenges facing minorities; or leave potential outcomes uncertain because of a lack of specificity.

Both candidates acknowledge the need to make high quality health care affordable for all; however, their approaches are very different. Each plan has implications for racial/ethnic minorities. For example, Senator Obama favors building on the employer-based insurance system, to which minorities have relatively less access. He also favors a strong federal role in expanding access to care, which may help reduce disparities in regions of the country with large populations of poor minorities if subsidy amounts are adequate. Senator McCain proposes eliminating the preferential tax treatment of employer health benefits and giving tax credits to individuals and families to purchase coverage in the individual insurance market. Many low income minorities, who disproportionately suffer from chronic conditions, may find that coverage

is still unaffordable, especially if the state high-risk pools Senator McCain favors for those denied coverage are not adequately subsidized.

Senators McCain and Obama share a number of similarities in their proposals to improve the quality of care. Each emphasizes both the importance of improving care management for those with chronic illness and the importance of a medical home. Each stresses the need to improve accountability in health care through better data collection, measurement and public reporting, and widespread adoption of electronic medical records. Senator Obama's proposal explicitly acknowledges the significance of racial and ethnic disparities in health and the need to hold health care providers responsible for disparities in quality. His plan proposes collecting data and reporting on differences in outcomes by race/ethnicity, increasing workforce diversity in the health professions, and expanding cultural competence training to reduce disparities. Senator McCain's platform does not specifically address racial and ethnic health disparities.

Part IV. Health Care Equality within Our Reach

A beginning of a new presidential era always offers hope that the nation will cross a threshold, leading the way to redress these inequalities and to take great strides in improving health and well-being for those historically left behind. The question before the next president is whether his proposals, if enacted, will set us on a path to achieve quality and equality in health care for all.

Introduction

Health care reform is again a major election issue for voters. Their anxiety is broad and deep, with worries, especially in a severe economic downturn, about losing coverage, paying more for medical bills and getting the best quality care for themselves and their families. Presidential nominees of the two major political parties, Republican John McCain and Democrat Barack Obama have each presented their platforms on health care. Both platforms present approaches that they believe will improve access to health care, rein in health care costs and improve health care quality.

All Americans and their families encounter a need for health and medical care many times throughout their lives. Both candidates speak of a health care system that works for everyone, but they offer very different reforms to achieve this goal. For America's minorities, making high quality health care truly available and affordable for all also means eliminating long-standing racial and ethnic disparities and discrimination in access to health care and health status. African Americans face significant disparities in a wide range of diseases and conditions compared to whites. Hispanic children and adults have the highest uninsured rates of any racial/ethnic group. Both are less likely to have a regular provider, a "medical home," compared to whites. Other minority groups face similar barriers to affordable, high quality health care.

While many groups have reviewed how the candidates' health care proposals compare generally, this report examines how their plans directly and indirectly address racial and ethnic disparities in access to health insurance and needed services, affordability of care and the quality of health care. The failure to eliminate racial/ethnic disparities in health status and health

care is not a problem for just a minority of Americans. According to Census Bureau estimates, the "majority" population of the United States, non-Hispanic whites, will decline to about 50 percent of the U.S. population by 2050; many areas of the nation have reached this threshold or will cross it sooner. Our ability to reduce, and ultimately eliminate, racial and ethnic disparities in health and health care is critical to our nation's workforce, the vitality of its communities, and its future prosperity and economic competitiveness in the world.

This report is organized into four parts. Part I presents a brief primer on the major factors that limit access to care, make health care expensive and perpetuate internationally low performance—all of which contribute to racial/ethnic disparities. Part II describes the disparities that result from our current health system, in the context of access, cost and quality. Part III compares how the Obama and McCain health care platforms seek to address access, affordability and quality concerns, and discusses their implications for reducing racial/ethnic disparities in health and health care. Part IV highlights examples of past U.S. Presidents who used their leadership to bring about national reforms that helped to reduce racial/ethnic health disparities, and highlights health care reforms that the next president has an opportunity to pursue that will put the country on the path to making high quality health care affordable and available to all Americans, regardless of race or ethnicity.

Reference:

U.S. Census Bureau. (2004). U.S. Interim Projections by Age, Sex, Race and Hispanic Origin.

Part I.

Setting the Context of Health Disparities: Challenges to Achieving an Equitable, High Quality Health Care System

The Commonwealth Fund, a well-respected, non-partisan health care foundation, has defined a high performance health system as one that helps everyone (to the extent possible) lead longer, healthier and more productive lives. Achieving such a system requires access to care for all; efficient, high-value care that can alter the trajectory of health care costs; and safe, high-quality care that incorporates continuous innovation and improvement.

Briefly, we describe the greatest challenges that will face the next president and Congress in making health care more equitable and higher quality. The systemic barriers to high quality, affordable health care also play a major role in affecting, and in many ways, perpetuating racial and ethnic disparities in health status and access to care. As such, they set the context for and represent the key “points of entry” for addressing inequities in health care.

A. A Patchwork Health Care System

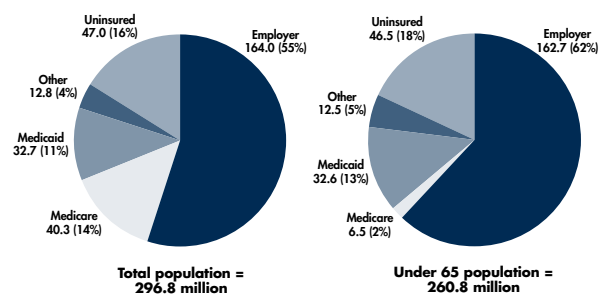
Although the inception of health insurance dates back to the late 18th century, the current employer-based system in the U.S. emerged 70 years ago in the wake of war and depression. Two major historic events—President Franklin D. Roosevelt’s decision not to pursue universal health care coverage in 1932 and a series of federal laws enacted in the 1940s and 1950s, including wage and price controls, employee health benefit tax exemptions and employer corporate tax deductions for providing coverage—precipitated and expanded this system, delegating the job to cover individuals and families to private employers and insurance companies (Blumenthal, 2006).

Limitations of employer-based coverage. Over the years, this default system of coverage has had profound implications for Americans and their ability to afford and obtain quality health care. First, health insurance benefits are regarded by private employers as a cost

of business. As health care costs have continued to rapidly grow, employers have shifted rising costs to their employees in forms of lower wages, reduced generosity of benefits and increased out-of-pocket payments. Furthermore, the availability and generosity of health care coverage has depended largely on the economic viability of private companies, particularly in the global market.

Since 2000, the primary reason for the increase in the uninsured—which stands at nearly 47 million—is due to a sharp decline in employer-sponsored insurance (ESI), as a result of rising premiums and worsening economic conditions (Holahan and Cook, 2008). (See Figure 1.) While 66 percent of non-elderly Americans had ESI coverage in 2000, only 61 percent had ESI coverage in 2004 and rates continue to decline.. Much of the debate about expanding health insurance turns on how to shore up employer-based coverage or shift from it toward individually purchased coverage or a single payer.

Figure 1. Health Insurance Coverage in the U.S., Total and Under 65 Population, 2006



Source: The Commonwealth Fund; Data from the Current Population Survey, March 2007.

Government-sponsored insurance does not close the gap. While the federal government has filled large voids in coverage, major gaps persist. In 1965, Congress passed the amendments to the Social Security Act that created Medicare and Medicaid. Medicare was created primarily for the elderly and Medicaid was available for the extremely poor and disabled. The

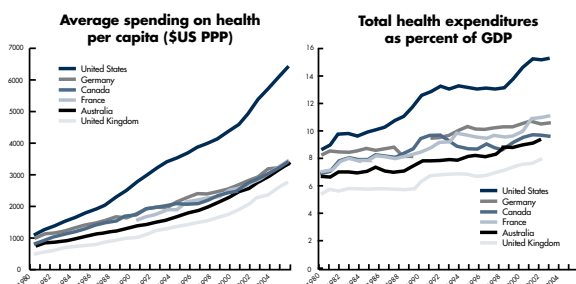
State Children's Health Insurance Program (SCHIP), a federal-state program enacted in 1997 has helped expand coverage to low income children, whose family income exceeds eligibility for Medicaid but has done little for low income, uninsured adults. Over the years and in response to the persistent gaps in coverage and a limited federal response, two dozen states have explored and introduced "reform" plans and strategies for expanding coverage and reducing health care inequality, as have many localities.

This patchwork of private/public and national/state/local coverage efforts has yielded some positive and piecemeal results but it has failed to provide access to affordable and high-quality health care for **all** Americans.

B. The Most Expensive (and Inefficient) Health Care in the World

The U.S. spends more money per person on health care (\$6,401 per capita in 2005) than any other nation in the world (OECD, 2007). While we remain the only industrialized nation that lacks universal health insurance coverage for all of its citizens, the U.S. spends the greatest percentage of gross domestic product (15.3 percent in 2005) on health services. (See Figure 2.)

Figure 2. International Comparisons of Health Spending, 1980-2005



Source: OECD Health Data 2007.

Generally, the higher amount of money countries spend per capita on health care translates into better health and life expectancy. However, the United States is an outlier, spending more and getting much less in return.

In a recent ranking of the health systems of six countries (Australia, Canada, Germany, New Zealand, the United Kingdom and the United States), the U.S. was at the bottom on almost all measures of performance (Davis et al., 2007). A combination of higher rates of infant mortality, homicides and deaths from accidents also contributed to this poor showing.

What contributes to the high costs and inefficiencies of the health care system in the United States?

High administrative costs. We spend a substantially larger share of our health care dollars, not on providing health care services, but on managing them. Annual insurance administration costs amount to \$465 per person, seven times the median of other developed nations reporting this information, and higher than any other nation except Luxembourg (Angrisano et al., 2007).

Unhealthy behaviors and chronic diseases. Poor diet, lack of exercise and chronic diseases contribute to greater spending on health care. Over the past 25 years, the prevalence of obesity and the prevalence of diabetes have doubled. Between 1987 and 2002, obesity and related conditions, such as diabetes, high cholesterol and heart disease accounted for a 27 percent increase in health care spending (Thorpe, 2005).

Overuse of services and unwarranted variations in medical practice. Various studies estimate that 20 to 30 percent of all health care spending is for unneeded care (NCHS, 2007). Health care providers respond to financial incentives and tend to prescribe more marginally appropriate but profitable procedures, especially for those with generous insurance coverage. In addition, health care consumers are often not aware of the full costs associated with health care—largely because services are paid for by a third party—and thus tend to demand more services (Thorpe, 2005). Additionally, the rates in many types of procedures and tests across the country have proven to be a function of the availability of services. The greater the number of physicians, hospital beds and diagnostic imaging equipment in a community, the higher the rates are of hospitalization, physician visits and testing (Wennberg

et al., 2008). One study found that the unnecessary use of three low-cost tests—urinalysis, electrocardiograms and X-rays—cost the health care system \$50 million to \$200 million annually (Merenstein, 2006). Higher expenditures do not equate with better outcomes, however. Regions that tend to spend the most have some of the worst health outcomes. A contributing factor in the variation and overuse of services is a lack of adherence to evidence-based guidelines about what types of care are most effective in particular circumstances.

New medical technology, innovations and drugs.

The rapid growth and adoption of new diagnostic technologies, medical and surgical procedures, drugs, medical devices and support systems have contributed to rising health care spending, often without proven effectiveness over existing and less expensive treatments (KFF, 2007).

C. Barriers to High Quality

Quality is defined by the Institute of Medicine (IOM) as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (IOM, 1999). In its 2001 watershed report, *Crossing the Quality Chasm*, which led to a national partnership effort at improving health care quality, the IOM identified six key attributes of high quality care:

- *Safe*: care avoids causing injury to patients from the provided care.
- *Timely*: wait times and delays are minimized for those who receive and provide care.
- *Effective*: services are provided based on scientific knowledge to all who could benefit and are not provided to those who would not benefit.
- *Efficient*: care avoids wasting equipment, supplies, ideas and energy.
- *Patient-centered*: care is delivered with “compassion, empathy and responsiveness to the needs, values, and expressed preferences of the individual patient” and ensures that patients

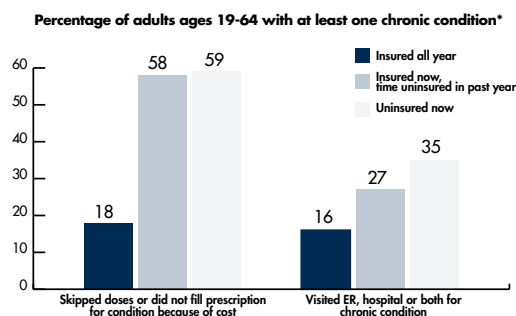
“have the education and support they need to make decisions and participate in their own care.”

- *Equitable*: care does not vary in quality because of personal characteristics, including gender, race, ethnicity, geographic location, or socioeconomic status.

The report highlighted the significant gap that exists between the quality of health care people should receive and the quality of care they actually receive. Primary barriers undermining quality can include:

Lack of continuous health coverage. With over one-third of the population chronically uninsured, unstably insured or underinsured, a large number of people continue to lack ready access to health care services (Hoffman et al., 2005). Gaps in coverage lead to high out-of-pocket spending, which is associated with skipping medical tests, treatments, and follow-up appointments, and forgoing prescribed medications (Gauthier and Serber, 2005). Chronically ill individuals with either no insurance or breaks in coverage are less likely to have a regular physician and to receive preventive care, and are more likely to use an emergency room for their condition (See Figure 3).

Figure 3. Uninsured Adults are Less Likely to Be Able to Manage Chronic Conditions



* Hypertension, high blood pressure or stroke; heart attack or heart disease; diabetes; asthma; emphysema or lung disease. Source: S.R. Collins, K. Davis, M. M. Doty, J.L. Kris and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem: Findings from the Commonwealth Biennial Health Insurance Survey* (New York: The Commonwealth Fund, April 2006).

Fragmented care. Health care is decentralized among many insurers and payers, and uncoordinated among physicians who may not have an efficient way to communicate medical information among specialists.

This fragmentation has kept the U.S. behind many other countries in adopting electronic medical records, which further contributes to a lack of coordination and continuity of care. Uncoordinated care is not high quality care. Compared to individuals in other countries with a centralized health care system, Americans are more likely to experience one of the following: unavailability of test results or records at the time of an appointment; duplication of testing; or provision of conflicting information by patient's various providers (Gauthier and Serber, 2005). Medication errors and medical mistakes (such as incorrect results or delays in receiving notification about abnormal results) are also more common occurrences for Americans.

Lack of health information technology. While U.S. physicians are swift to adopt new medical procedures and techniques, often of questionable effectiveness, our health system lags behind that of European countries in the use of health information technologies (HIT) for the reasons described above. Only 28 percent of physicians in the U.S. have electronic medical record capabilities. In the Netherlands, New Zealand and the U.K., each with a universal health care system, the HIT rates are above 90 percent. Compared to physicians in many other countries, U.S. physicians have low rates of electronic prescribing (20 percent) and electronic access to patient test results (48 percent) (CMWF, 2006). Wider adoption of HIT in U.S. physician practices has the potential to improve health care quality and efficiency (Anderson et al., 2006).

Lack of adherence to evidence-based guidelines. Many of the variations in treatment patterns for similar patients stem from a lack of adherence to evidence-based guidelines, and a payment system that rewards the quantity of care over the use of best practices. This results in both the overuse and underuse of care. One study found that patients only receive 55 percent of clinically recommended preventive care services and care for chronic conditions such as hypertension, high cholesterol and diabetes (McGlynn et al., 2003).

Inadequate use of preventive and primary care not only leads to more expensive and preventable sick care treatment, but is also associated with lower quality of care and preventable deaths.

Lack of patient-centered care. Effective communication between caregivers and patients increases the likelihood that patients will accept advice, adhere to treatment and be satisfied with their care (Stewart et al., 2000; Stewart et al., 1995). It is more likely to reduce malpractice risks as well. Too often, however, physicians miss the opportunity to communicate effectively, involve patients in treatment decisions and recognize patients' preferences, beliefs and concerns (Schoen et al., 2004). These are all aspects of patient-centered care. Almost half of all Americans feel that their doctor does not spend enough time with them and 40 percent feel that their doctor does not always listen carefully or explain things clearly (Gauthier and Serber, 2005). Racial/ethnic minorities face greater difficulty communicating with physicians and thus are less likely to adhere to physician advice and treatment plans.

The consequences of a health care system that fails to ensure that all residents have access to affordable, high quality care affect all individuals and communities through higher prices and excess morbidity and mortality. As the information in the next section demonstrates, while these burdens affect everyone, they fall disproportionately upon racial/ethnic minorities and their communities.

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Part II. Health Disparities in the United States

The national consensus document, *Healthy People 2010*, embraced by both the Clinton and Bush administrations, set as a preeminent goal the elimination of racial and ethnic disparities in health and health care by 2010. Congress has required the annual reporting of progress in the elimination of disparities in treatment for the last five years. While there has been some progress, racial and ethnic disparities in health status and health care treatment and outcomes are far from eliminated, and are well-documented, as the following sections illustrate.

A. Disparities in Health Status

Overall, blacks in the United States have higher rates of disease and premature mortality than whites. Hispanics have higher rates of particular types of cancers and higher mortality rates from those cancers. Income and educational differences do not fully account for all of the racial and ethnic health disparities that are routinely reported every year. These include:

Overall Mortality

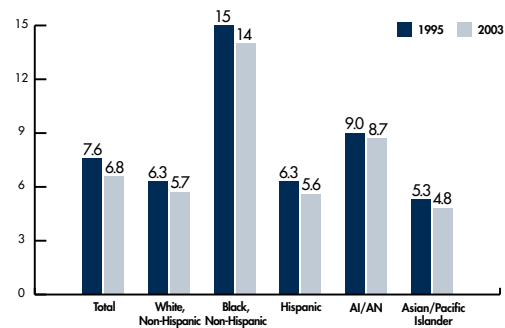
- Life expectancy of blacks is five years shorter than whites at birth and two years shorter at age 65 (NCHS, 2007).
- The infant mortality rate for blacks is more than twice that of whites (Mathews and MacDorman, 2008). (See Figure 4.)

Cancer

- Black women have a lower incidence of breast cancer than whites but are more likely to die from the disease (NCHS, 2007).
- Blacks have a higher incidence of and mortality from colorectal cancer (NCHS, 2007).
- Black men are 50 percent more likely to have prostate cancer and twice as likely to die from it (NCHS, 2007).

- Both black and Hispanic women are more likely to have cervical cancer and black women are twice as likely to die from this disease (National Cancer Institute, 2003).

Figure 4. Infant Deaths per 1,000 Live Births by Maternal Race/Ethnicity, 1995 and 2003



AI/AN = American Indian/Alaska Native.
Note: Infant is defined as a child under one year of age.
Source: T. J. Mathews and M.E. MacDorman, "Infant Mortality Statistics from the 2003 Period Linked Birth/Infant Death Data Set," *National Vital Statistics Reports*, May 3, 2006 54(16):1-29.

Chronic Diseases

- Black men and women are more likely to have heart failure, high blood pressure and strokes than whites, and are more likely to die from heart disease than other racial and ethnic groups (NCHS, 2007; Thom et al., 2006).
- Blacks and American Indians/Alaska Natives have higher rates of asthma, and blacks are three times as likely to die from asthma as whites (Akinbami, 2003-2005).
- The prevalence of diabetes among blacks is 65 percent higher than whites. Obesity rates are also 50 percent higher for blacks compared to whites (CDC, 2006).
- Blacks are ten times as likely, and Hispanics almost three times as likely, as whites to have AIDS (CDC, 2006), and a recent study shows that more infected black Americans are living with the virus than infected populations of

Botswana, Ethiopia, Guyana, Haiti, Namibia, Rwanda or Vietnam (Altman, 2008; UNAIDS, 2008).

B. Disparities in Access to Health Care

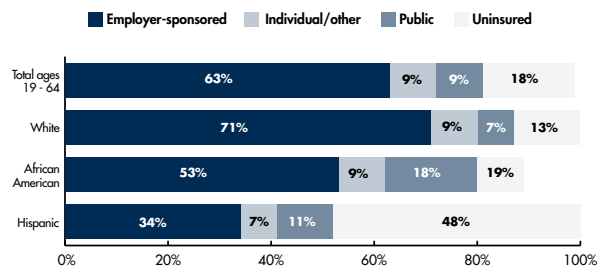
Health insurance as a barrier to needed care.

Socioeconomic status and health insurance are significant predictors of access to health care. While minorities currently comprise approximately 30 percent of the nation's population, they make up over half of the nation's 47 million uninsured (Smedley, 2008). Specifically:

- Nearly two-thirds of Hispanic adults (about 15 million) and one-third of African American adults (about 6 million) were uninsured at some point during 2005, compared with 20 percent of white adults. (Doty and Holmgren, 2006).
- Only one-third of working-age (18 to 64) Hispanic adults and half of working-age African American adults had employer-sponsored health insurance in 2005, as compared to 71 percent of working-age whites (Doty and Holmgren, 2006). (See Figure 5.)
- Low-income Hispanic adults are less likely to be covered by public insurance than low-income African Americans and whites (Doty and Holmgren, 2006).
- Immigrant children are more likely to be uninsured than other children; the disparity between immigrant and citizen children has grown over the past decade (Kiu et al., 2007).

A large body of literature documents how a lack of health insurance disproportionately presents a barrier to disadvantaged minorities seeking health care. For example, uninsured minority adults are significantly less likely to receive recommended preventive care. Having continuous insurance coverage significantly reduces this disparity between white and Hispanic adults (Doty and Holmgren, 2006).

Figure 5. Employer-Sponsored Insurance Coverage Rates Are Particularly Low for Hispanics and African Americans



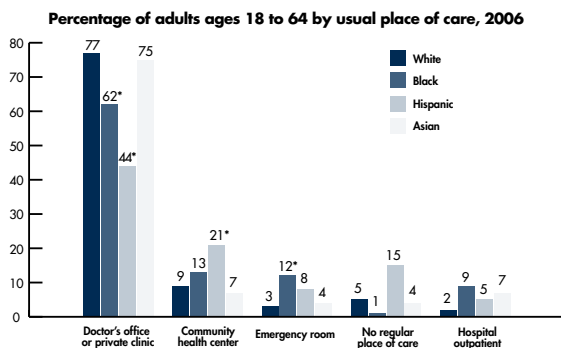
Note: Percentages may not sum to 100% because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Other barriers to health care. Socioeconomic status and health insurance, however, do not explain all the disparities encountered by racial/ethnic minorities in obtaining health care. A myriad of other factors (e.g., unequal geographic distribution of health care resources, cultural/language barriers, and availability of support services such as child care and transportation) can also affect access to care. Recent studies show:

- Minorities are less likely than whites to have a usual source of care, even after adjusting for age, insurance and income (Mead et al., 2008).
- More than half of Hispanic adults report not having a regular doctor, even after adjusting for insurance status and income—a rate that is almost 2.5 times greater than the proportion of whites (Mead et al., 2008).
- Compared to whites (77 percent), Hispanics and blacks are less likely to receive care in a private doctor's office (44 percent and 62 percent, respectively) and are more likely to seek care in community health centers (CHCs) and emergency departments (Mead et al., 2008). The higher reliance on CHCs may be explained by the support services they often provide, such as interpreter/language assistance, as well as their convenient locations and willingness to serve patients for discounted fees based on income (See Figure 6).

- Patients who face language barriers are less likely than others to have a usual source of medical care and to receive preventive services (Flores, 2006).
- Almost half of patients with limited English proficiency who seek care at emergency departments are not provided with interpreter services (Flores, 2006).

Figure 6. Hispanics and Blacks are Less Likely to Receive Care in a Doctor's Office



* Compared with whites, differences remain statistically significant after adjusting for insurance or income.
Source: The Commonwealth Fund, Health Care Quality Survey, 2006.

C. Disparities in Affordability of Health Care

Many health care services are unaffordable for people who are uninsured or under-insured—especially when they get sick. With lower rates of coverage and higher rates of chronic illness, low-income minorities face a greater financial burden in obtaining needed care. High out-of-pocket expenditures force many low-income minorities to forgo needed medical care (Banthin et al., 2008; Smedley, 2008).

Less access to needed prescriptions. Because of these disparities in health coverage, working-age African Americans and Hispanics are less likely to be able to afford needed prescription medications. In 2001, about one in five black adults and one in six Hispanic adults did not purchase needed prescription drugs due to cost, as compared to about one in ten white adults (Reed and Hargreaves, 2003). This trend is even more pronounced for minorities with chronic

conditions. Almost one-third of African Americans and one-quarter of Hispanics with one or more chronic conditions did not purchase all of their needed medications due to cost, as compared to 17 percent of chronically ill whites.

Greater financial burden for medical expenses.

African Americans are more likely than whites (44 percent v. 33 percent) to be unable to pay their medical bills, be contacted by a collection agency for unpaid medical bills, have outstanding medical debt, or need to “change their way of life significantly” in order to pay their bills (Doty and Holmgren, 2006).

Financial burden on safety-net providers.

Affordability of health care is a problem not just for the individuals who are underinsured or lack health coverage altogether, but for the hospitals and communities that serve them. Financial health is correlated with quality of care. The financial ability of hospitals and other providers to afford the staffing levels, expertise and national quality standards is severely strained when they are located in poor communities, where low-income minorities often live. For example:

- Primary care physicians who care mainly for black patients were more likely to report that they were unable to provide high quality care to all their patients than physicians who care primarily for white patients (Bach et al., 2004).
- Mortality after heart attack is higher at hospitals with more black patients than those with no admissions of blacks (Skinner et al., 2005).
- States with the largest percentage of white residents have the highest Medicare quality rankings (Jencks et al., 2003)

D. Disparities in Quality of Health Care

The care that racial and ethnic minorities receive often falls short on the dimensions of high quality of care as identified by the IOM and outlined in Part I (IOM, 2007). The quality of health care provided to minorities often is not equitable. It is often:

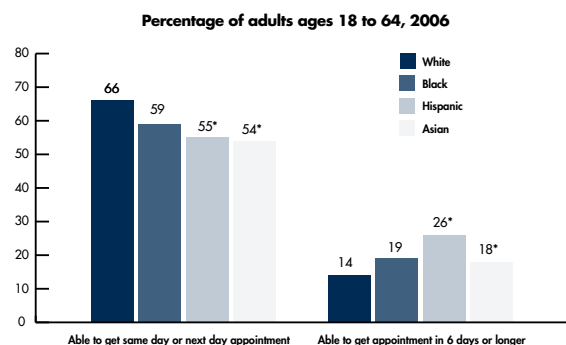
Not safe:

- Asian/Pacific Islanders and Hispanics are more likely to die from complications of hospital care than blacks or whites (AHRQ, 2007).
- Blacks are more likely to suffer from post-operative complications than other racial/ethnic groups (AHRQ, 2007).
- Controlling for diagnosis, black youth are twice as likely, and Hispanic youth 1.7 times as likely, as white youth to be restrained upon admission to a psychiatric hospital (Donovan et al., 2003).

Not timely:

- Hispanics and Asians are less likely to get a same day appointment and more likely to wait six days or longer to see a doctor than whites (Mead et al., 2008). (See Figure 7.)
- Blacks are more likely than whites to suffer from a perforated appendix, a condition brought on by delayed treatment, regardless of the income of the neighborhood in which they live (AHRQ, 2008).
- Blacks are more likely than whites to leave an emergency room without being seen (Mead et al., 2008).
- Blacks who experience a heart attack wait longer, on average, to receive recommended care than other racial/ethnic groups (Bradley et al., 2004).

Figure 7. Hispanics and Asians are Less Likely to Get a Same Day or Next Day Appointment



* Compared with whites, differences remain statistically significant after adjusting for insurance or income.
Source: The Commonwealth Fund, Health Care Quality Survey, 2006.

Not effective:

- Minorities are often less likely to receive important preventive and early diagnostic services such as blood cholesterol tests, colorectal and cervical cancer screening, mammograms and recommended vaccinations (Donovan et al., 2003).
- Minority children, especially Hispanic children, are less likely to have visited a dentist in the last year (AHRQ, 2007).
- Minority women are less likely than white, non-Hispanic women to receive prenatal care in the first trimester of pregnancy (Mead et al., 2008).

Not efficient:

- Blacks are two to four times more likely than whites to be hospitalized for potentially preventable admissions such as congestive heart failure, diabetes and pediatric asthma (CMWF, 2006).
- Blacks are 1.75 times more likely than whites to visit an emergency room for conditions that could have been treated by a primary care provider (Doty and Holmgren, 2005).
- Blacks with Medicare are 1.8 times more likely than whites to be admitted to an intensive care unit in the last six months of life (Baicker et al., 2004).

Not patient centered:

- Asians and Hispanics are less likely to understand their doctor and less likely to feel that their doctor has listened to them (Mead et al., 2008).
- Hispanics are twice as likely to leave the doctor's office with unasked questions (Mead et al., 2008).
- Adults whose preferred language is not English are more likely to report dissatisfaction with their health care provider (AHRQ, 2008).
- Blacks and Hispanics are less likely to report confidence and trust in their specialty physician than whites (Keating et al., 2004).

E. Social Determinants and Racial/Ethnic Health Disparities

According to the World Health Organization (WHO), social determinants are the economic and social conditions that affect people's health. A myriad of factors outside the health care system and within the broader social, political and economic arrangements of communities perpetuate unequal health and unequal treatment.

Poverty and Inequalities of Opportunity. Since the 1970s, income inequalities have continued to widen in the U.S. High rates of crime, unemployment and social exclusion are generally corollaries of poverty. A large body of evidence suggests that these manifestations of poverty adversely affect individual health and well-being. (Kawachi and Kennedy, 1999).

In communities with high poverty rates, local resources, including schools, health care, public health, social services and protection services are often inadequate and under-financed for the level of need (Andrulis, Reid and Duchon, 2004). These communities are also more likely to experience racial and economic segregation, often lacking employment opportunities, high quality affordable food, and safe places for outdoor activities (Andrulis, 2008). Children in disenfranchised neighborhoods are at greater risk for developmental delays, teen parenthood, and academic failure (Brooks-Gunn and Duncan, 1997), which can have long-term implications for communities of color and society at large, such as lower rates of employment and greater demand for health and social services. Furthermore, individuals living in poverty are more likely to suffer from a range of negative health outcomes, including low birth weight, infant mortality, asthma, tuberculosis, depression, and poor self-rated health, all of which are common health concerns among minorities (Do et al., 2008).

Environment and Housing. A large body of evidence consistently shows that high poverty and minority communities are more likely to be subject to substandard housing conditions and environmental degradation. For example, the percentages of African

Americans, Hispanic/Latinos and Asian/Pacific Islanders in neighborhoods hosting commercial hazardous waste facilities are each about twice the percentages living in non-host neighborhoods. These disparities have remained unchanged since they were first documented more than twenty years ago (Bulliard et al., 2007; Ash and Fetter, 2004).

Urban sprawl adversely affects the health of everyone, but it has the most serious effects on racial/ethnic minorities by concentrating automobile pollution of suburban commuters in the urban core, and thus increasing respiratory illnesses (Frumkin et al., 2004). In fact, research indicates that black and Latino children are three to five times more likely to die from asthma than white children, and there is some evidence that such disparities are correlated with air toxicity (Pastor, 2006). Furthermore, childhood lead poisoning, a preventable disease, continues to be the most significant environmental health threat to black children in the United States (Pastor, 2006; Kraft and Scheberle, 1995).

Education. Research indicates a significant correlation between education and life expectancy. In 2000, life expectancy for a 25-year old with a high school education or less was 50 years, whereas for an individual with at least some college education, it was almost 57 years (Meara et al., 2008). By some estimates, if all Americans benefited from the same health statistics as college graduates, the economic benefits would exceed one trillion dollars (Braverman and Egerter, 2008). Those potential health benefits have been disproportionately unavailable to racial/ethnic minorities; among those over the age of 25, blacks are only sixty percent as likely and Hispanics only half as likely as whites to have graduated from college.

Nutrition and Physical Activity. Adherence to healthy behaviors could reduce the prevalence of poor health and premature death among minorities. Where people live, however, shapes the opportunities to engage in healthy behaviors. The availability of grocery stores with fresh fruits and vegetables, parks and recreation facilities are far more limited in high poverty

neighborhoods of color (National REACH Coalition, 2008). Blacks are five times less likely than whites to live in a census tract with a supermarket (Kimberly et al., 2002); nearly half of black neighborhoods lack access to a full-service grocery store or supermarket (Flournoy, 2002).

Geographic Accessibility and Transportation.

Low-income, minority families often face barriers related to geographic accessibility of health services. Many poor neighborhoods of color experience disproportionate shortages of medical facilities and health care providers, which increases out-of-pocket costs and time of travel for residents. Low-income minorities often lack private transportation and may have limited public transportation options, especially if they live in rural or suburban communities. One study found that nearly one in five Latino parents reported transportation as a problem in accessing health care for their children (Flores, 1998). The closure of community hospitals in inner-city regions, often populated by low-income minorities, can further exacerbate barriers to needed care.

This is but a small sample of the evidence of the impact of the surrounding environment and local economic conditions on health status.¹ The conclusions are largely the same: racial/ethnic disparities in health status, access to care and the quality of care in the United States are substantial, and extend far beyond the medical care system. These disparities increase the overall cost of health care, undermining access to care and the quality of care for *everyone*.

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¹ For a more comprehensive and systematic review, see for example, IOM's *Unequal Treatment* (2003), AHRQ's series of *National Healthcare Disparities Reports*, and the Commonwealth Fund's 2008 *Racial and Ethnic Disparities in Health-care: A Chartbook*.

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Part III.

Comparing Health Care Proposals of Barack Obama and John McCain

In this section, we compare the health care proposals of Senators Barack Obama² and John McCain³ on four fundamental issues—access, cost, quality and infrastructure support—and discuss their implications for reducing racial and ethnic disparities in health and health care. Recognizing that these disparities are embedded in social, economic and environmental determinants of health, we also examine how each candidate’s proposals address these broader contextual issues.

A. Access

A.1. Expanding Health Insurance Coverage. A lack of continuous health coverage prevents millions of Americans from getting the health care they need. Significantly reducing the number of uninsured is the centerpiece of major national health care reform initiatives. Expanding access to health insurance coverage will eliminate racial/ethnic disparities in coverage rates because minorities represent such a large proportion of the uninsured.

The health plans for Senators Obama and McCain both acknowledge the need to increase the number of residents with access to affordable insurance (Table 1). Each considers the role of government, reforming the insurance market, the value of subsidies and the continuation of employer-based support for employees’

health insurance. While they share common ground on the importance of these dimensions, they differ significantly on their approaches to expanding coverage.

Obama’s National Health Insurance Exchange (NIE) would offer direct support for small businesses and individuals and use sliding fee scales to increase affordability for individuals. McCain’s Guaranteed Access Plan (GAP) aims to increase opportunities for individuals with higher rates of chronic and other preexisting conditions to obtain coverage, stressing the role that states will play in designing strategies such as multi-state risk pools. However, only Obama’s plan specifically states that reducing disparities in insurance coverage is a national priority.

Other differences that also have significant potential to affect minorities are: mandatory coverage for children (Obama) versus voluntary coverage for all (McCain); an assertive role for government to expand Medicaid and children’s health programs and create an NIE (Obama) versus emphasis on private sector and state initiatives to improve access (McCain); and continued involvement and support for employers in providing insurance (Obama) versus shifting from an employer-based system toward individual insurance coverage (McCain).

Despite these differences, the candidates’ plans share common ground on issues of importance to minorities. Both emphasize increasing access for those with pre-existing conditions, including support for health insurance to be portable so that job changes will not disrupt coverage. Both emphasize the role of individuals and families in making decisions, but with little detail on the role of language, literacy or cultural issues in making those decisions.

2 Unless noted otherwise, Senator Barack Obama’s positions are directly drawn from the following campaign documents found on his website (www.barackobama.com): Barack Obama’s Plan for a Healthy America; Barack Obama: Working for the Asian American and Pacific Islander Community; and Latino Blueprint for Change: Barack Obama’s Plan for America.

3 Unless noted otherwise, Senator John McCain’s positions are directly drawn from his campaign document, Straight Talk on Health System Reform, found on his website (www.johnmccain.com) and his remarks made in Arlington, VA, on Day Two of the “Call to Action Tour,” on April 29, 2008.

Table 1: Democratic and Republican Presidential Nominees on Expanding Access to Affordable Health Coverage

Expanding Access to Affordable Health Coverage		Implications for Racial/Ethnic Minorities
Barack Obama ¹		John McCain ²
Democrat		Republican
Party Affiliation		
Insurance Market Reforms	<ul style="list-style-type: none"> Establish a new public plan for individuals not covered through their employer or a current public program; self-employed; and small businesses. Options would be similar to those available to federal employees. National Health Insurance Exchange (NIE) will be made available to help individuals enroll in the new public plan or purchase an approved private plan. Income-based subsidies will be made available for individuals and families based on definition of need. Medicare to remain intact for older and disabled Americans. Guaranteed eligibility; no American will be turned away from any insurance plan because of illness or pre-existing conditions. 	<p>Obama:</p> <ul style="list-style-type: none"> New public plan could help expand coverage for low income, minorities. Effectiveness by race/ethnicity requires monitoring to ensure that disparities in affordability and access to quality health care are reduced.⁴ Extensive outreach or enrollment assistance may be required for some populations (e.g., uninsured immigrant children). NIE standards for private sector plans may help to ensure low income minorities have access to affordable and comprehensive care; sustainability likely to be challenging without cost-containment. <p>McCain:</p> <ul style="list-style-type: none"> State high-risk pools have had limited success to date making coverage affordable to people with pre-existing conditions.⁵ People with health problems may seek out states with community rating, and healthier individuals may seek coverage in less regulated states, thereby increasing premiums, and making coverage less affordable for seriously ill, low income minority populations.⁶ HSAs have not proven effective to date in expanding coverage to uninsured, low income populations; benefits may be limited to healthy, higher-income minorities.⁷ Minority veterans could have better access to needed health care.

Expanding Access to Affordable Health Coverage

Barack Obama¹

- Mandatory vs. Voluntary Insurance Coverage**
- Mandatory coverage for children through public or private plans.
 - Expansion of coverage to young adults up to age 25 to maintain insurance through parents' plan.
 - Voluntary coverage for adults.

John McCain²

- Voluntary coverage for both children and adults.

Implications for Racial/Ethnic Minorities

Obama:

- Mandate for children would build on the State Children's Health Insurance Program (SCHIP) to expand coverage to minority children currently uninsured; young minority adults with insured parents could gain coverage.
- Voluntary emphasis for adults does not guarantee expansion of coverage for low-income minority adults.

McCain:

- Voluntary emphasis does not guarantee expansion of coverage for low income, minority children or adults.

Both:

- Ability to expand coverage voluntarily may be limited without significant subsidies to motivate healthy, uninsured individuals to get coverage.

Employer Role

- Employers that do not offer "meaningful" coverage or make a "meaningful" contribution to employee coverage will be required to contribute a percentage of payroll toward the costs of the new public plan.
- Reduce or end most state insurance regulation especially affecting workplace coverage.
- Reduce tax preference for employers.
- Option of employer based coverage; reduce support for employer role in subsidizing insurance for employees.

Obama:

- Uncertainty about amount of penalty on employers that do not participate. A large penalty could unintentionally decrease wages for employees, to the detriment of low income minorities.³

McCain:

- Move away from employer coverage may shift healthier workers to individual market, causing adverse selection and rising premiums in job-based coverage; some employers may choose to drop coverage.

Federal Government Role

- Strong role for federal government in expanding access through existing programs (e.g., Medicaid and SCHIP), a proposed new public program and NIE.
- Limited role for federal government, primarily to expand access to private coverage in individual insurance market.

Obama:

- Central role of federal government and proposed NIE in expanding coverage could reduce number of low income minorities lacking continuous insurance, but is highly subject to public financing for subsidies and implementation; national strategy could reduce racial/ethnic disparities in state uninsured rates.

McCain:

- Private market and voluntary initiatives, without adequate federal funding or market reforms, may have limited impact on expanding coverage for low income and chronically ill minorities.

Expanding Access to Affordable Health Coverage

Barack Obama¹

Federal Tax Credits and Subsidies

- Make federal income-related subsidies available to help low- and middle-income individuals and families buy the new public plan or other qualified insurance.³
- Federal subsidies would partially reimburse employers for their catastrophic health care costs if the employers guaranteed that premium savings would be used to reduce employee premiums.³
- Federal subsidies for small employers offering health insurance.⁸

John McCain²

- Refundable tax credit of up to \$2,500 (individuals) and \$5,000 (families) to all individuals and families for the purchase of insurance.³
- Federal income-related premium subsidies to individuals enrolled in the GAP. These are intended to target those who are in high-risk health insurance pools.³

Implications for Racial/Ethnic Minorities

Obama:

- Lack of details on the size and scale of subsidies for employers and individuals makes uncertain the impact subsidies would have on making coverage more affordable and motivating more healthy individuals to take up coverage.⁸

McCain:

- Tax credit amount is fixed, regardless of income. Low income minorities may find it difficult to make up the difference between the credit and premium (about \$12,000 for family coverage through employer-based insurance.)⁶
- GAP subsidies may be insufficient for low income minorities with existing illnesses to obtain affordable, comprehensive coverage.⁸
- Small and medium firms that do offer coverage may choose to drop it if they know employees could obtain tax credits for non-group coverage.⁸

Individual Role

- Health insurance is a personal and a social responsibility.
- Support for patient "empowerment."

- Health insurance is a personal responsibility.

- "Empower" families to be in charge of health care spending decisions.

Obama:

- Promotes shared responsibility among employers, government and individuals in making coverage affordable. Could increase administrative costs and thus, overall costs of coverage.

McCain:

- Promotes individual responsibility for obtaining health insurance, with limited government role and optional employer role. Families may face higher premiums in non-group insurance market.

Both:

- Uncertainty as to how implementation of proposals would educate and empower people to make best decisions for their needs.

Expanding Access to Affordable Health Coverage

Barack Obama¹John McCain²

Implications for Racial/Ethnic Minorities

State Flexibility

- Support states continuing to experiment with health care reform, but must meet minimum new public plan standards.

- Allow states flexibility to alternate forms of access, coordinate Medicaid payments, use of private insurance for Medicaid and alternate insurance policies.

Obama:

- Minimum requirements would set a “floor” for as yet undefined benefit levels that may help reduce state disparities in access to care for minorities, or could limit ability of poorer states to expand coverage without significant federal support.

McCain:

- Low income minorities in states pursuing strategies to expand coverage could benefit. Has potential to perpetuate state disparities in coverage and access. State efforts to expand coverage may not be successful without significant federal support.

Portability

- Those in the new public plan or NIE keep coverage with job change.
- Individuals can carry their insurance and providers from job to job.
- Insurance coverage is available across state lines.

Both:

- Portability of coverage could reduce “job lock,” increasing job mobility, and continuity of coverage for low income, minority workers.

Financing

- \$50-65 billion per year when phased in; financing comes from savings in health care system efficiencies and eliminating excessive subsidies, including those for Medicare Advantage plans.
- Tax cut discontinuation for those earning over \$250,000.³
- Not specified but indicates cost containment would be a focus.³

Obama:

- Full funding from proposed sources may not materialize, which would limit amount of subsidies available to help low income minorities obtain coverage.

McCain:

- Uncertain implications for minorities due to lack of specificity.

1. www.barackobama.com
2. www.johnmccain.com and Senator McCain's remarks, April 29, 2008. Arlington, VA.
3. Kaiser Family Foundation, 2008.
4. National REACH Coalition, 2008.
5. Chollet, 2002.
6. Collins and Kriss, 2008.
7. Glied and Remler, 2005.
8. Burman et al., 2008.

A.2. Expanding Access to Health and Medical

Care. Access to timely and needed health and medical care is a major challenge for minorities and their communities. A substantial body of evidence demonstrates the depth and breadth of these disparities throughout all aspects of care including preventive, primary, specialty, inpatient and long term care. Geographic disparities in access to services and many other community amenities contribute to poor health care status and outcomes for minority populations.

Both candidates propose general and some specific solutions to improving medical and health care access that would benefit minorities (Table 2). Prevention initiatives are a large part of these efforts with both positions supporting increased attention to health promotion or wellness programs, especially in schools but also, to varying degrees, in the workplace; and enhancing smoking cessation assistance. Each also recognizes the need to build public health infrastructure.

While there is general agreement on the general areas of focus, detailed aspects differ significantly. Senator Obama proposes a more expansive role for schools,

with these settings providing not only screening, dietary and physical activity improvement but also clinical services. He also makes specific mention of the need to provide safety net support—a resource often critical for underserved minority communities. Senator McCain stresses easing access to primary care by supporting clinics in areas potentially accessible to minority and underserved communities such as through retail outlets and malls, and working with providers through telemedicine in community clinics.

Beyond general support for prevention and smoking cessation, Senator McCain's platform does not offer more specific information. Senator Obama's proposal explicitly states the importance of reducing disparities through prevention. His plan stresses the need for individuals, government, schools and others to work together, and promotes the role of worksite and community-based prevention efforts. Finally, while both Senators' positions acknowledge the importance of public health in improving dietary and other lifestyle choices to prevent chronic disease, Senator Obama's platform explicitly acknowledges that public health plays a central role in reducing racial/ethnic disparities.

Table 2: Democratic and Republican Presidential Nominees on Expanding Access to Health and Medical Care

Expanding Access to Health and Medical Care	
Barack Obama ¹	John McCain ²
Democrat	Republican
<p>Expanding Availability of Care</p> <ul style="list-style-type: none"> • Work with schools to create more healthful environments, including grant support for health screenings and clinical services. • Develop greater choices in long term care; improve quality of "elder care," increase geriatric training for health care professionals; and reform the financing of long term care.³ 	
<p>Obama:</p> <ul style="list-style-type: none"> • Cites importance of schools for prevention, screening, early intervention and care for low income and minority children. • Geriatric training support offers opportunity to address race/culture specific concerns for seniors. <p>McCain:</p> <ul style="list-style-type: none"> • Walk-in clinics and retail outlets may provide expanded opportunities for low income minorities to access basic prevention services. • Telemedicine may expand care to underserved minority communities. <p>Both:</p> <ul style="list-style-type: none"> • Offer potentially important home and community-based care support to assist low-income minority seniors and others needing long term care services. 	
<p>Prevention</p> <ul style="list-style-type: none"> • Tackle root causes of health disparities by promoting prevention. • Emphasize collaboration across health and non-health agencies for prevention, health promotion and early intervention. • Require coverage of preventive services, such as cancer screenings and smoking cessation, in federally-funded health plans. • Promote employee health by expanding and rewarding worksite prevention services. <p>Obama:</p> <ul style="list-style-type: none"> • Acknowledges a need for broad prevention strategies and collaboration that extends beyond health care to address racial/ethnic disparities. <p>McCain:</p> <ul style="list-style-type: none"> • Could increase access to preventive care services through private insurance; no specificity about reducing disparities through prevention. <p>Both:</p> <ul style="list-style-type: none"> • Covered benefits for prevention in both public and private insurance could make these services more widely available to minorities. 	

Expanding Access to Health and Medical Care

Barack Obama¹

John McCain²

Implications for Racial/Ethnic Minorities

Public Health

- Address root causes of health disparities by promoting public health.
- Work with schools to provide healthy dietary choices and expand physical education.
- Develop national and regional strategy for public health and align funding for support.
- Encourage development of healthy environments for healthy food choices and physical fitness; restrict tobacco and alcohol advertising aimed at children.

Support greater development of public health infrastructure.

- Support the expansion of healthy dietary choices in schools.⁴
- Support the use of public health initiatives to encourage individuals to prevent chronic disease, receive appropriate tests for early detection and follow treatment guidelines.⁴

Obama:

- Explicitly states intention to reduce disparities through public health initiatives; school-based initiatives could benefit minority children.
- Regional, national coordination could help target resources to low income, underserved communities. Better access to fresh produce and recreation would promote healthy choices in minority communities.

McCain:

- Stronger public health infrastructure and initiatives to promote early detection and treatment could benefit low income, underserved minorities; school-based initiatives could benefit minority children.

Protection/Expansion of Health Care Safety Net

- Support adequate funding of safety net and technical resources to improve capacity of safety net providers to care for underserved populations.

Expand availability of walk-in and community clinics; not specific to safety net providers.

Obama:

- Because low-income minorities disproportionately rely on safety-net institutions³, greater financial support for them could improve access to care for minorities in underserved/low income communities.

McCain:

- No specific mention of “safety net” in underserved communities.

1. www.barackobama.com

2. www.johnmccain.com and Senator McCain's remarks, April 29, 2008, Arlington, VA.

3. AARP, 2008.

4. Collins and Kriss, 2008.

4. Mead et al., 2008.

B. Cost Containment

Identifying strategies to reduce or limit increases in health care costs is critical to assuring access to needed care for all. Low-income minorities and other vulnerable populations often forego insurance or needed care because they cannot afford premiums, deductibles or copayments. At the same time, monitoring the health care system to minimize unnecessary expenses and promote efficiencies can help reduce the rate of increase in health care spending.

Both candidates propose initiatives to contain health care costs for individuals and for the nation as a whole (Table 3). Areas of focus are wide-ranging and have potentially positive implications for minorities. Both candidates promote programs to expand drug competition, including easing drug reimportation and promoting generic drugs. They also support using malpractice reform to promote patient safety and reduce medical errors—critical goals for minorities, whose rates of illness and disease are higher than whites for many conditions.

Candidates also see their proposals as promoting health plan competition and choice through better public reporting. Both see information technology, including the widespread adoption of electronic medical records, as playing an important role in improving availability of information for providers. Left unaddressed, however, is the need for these technologies to integrate essential language and cultural information critical to effective and efficient patient care; however, Senator Obama supports the collection of disparities data linked to quality.

In sum, the candidates' proposals to contain costs focus on similar areas, and, for certain initiatives such as reducing prescription drug costs, generally parallel each other. While drawing on competition and technology, both McCain and Obama link reigning in costs to the improvement of patient safety. Implicitly, these proposals would help to make health care more affordable for minorities.

Table 3: Democratic and Republican Presidential Nominees on Health Care Cost Containment

Health Care Cost Containment		Implications for Racial/Ethnic Minorities	
Barack Obama ¹		John McCain ²	
Democrat		Republican	
Party Affiliation			
Containing Drug Costs	<ul style="list-style-type: none"> Initiate policies to promote generic drugs, allow drug re-importation, and repeal the ban on direct price negotiation between Medicare and drug companies.³ Reform medical malpractice while preserving patient rights by strengthening antitrust laws and promoting new models for addressing physician errors.³ 	<ul style="list-style-type: none"> Bring greater competition to drug markets through safe re-importation of drugs and faster introduction of generic drugs. 	<p>Both:</p> <ul style="list-style-type: none"> Initiatives to reduce prescription drug costs may assist low income minority families and seniors in obtaining needed medicines, and may reduce disparities in access to prescription medications.⁴
Malpractice Reform	<ul style="list-style-type: none"> Adopt malpractice reforms that limit frivolous lawsuits and excessive damages, and protect providers that follow clinical guidelines and safety protocols.³ 	<p>Obama:</p> <ul style="list-style-type: none"> New models for reducing medical errors and improving patient safety could include improving doctor-patient relationship—often a source of errors in care for minorities due to low trust levels—low health literacy, language and cultural barriers. Has potential to reduce inappropriate care, improve quality of care. <p>McCain:</p> <ul style="list-style-type: none"> Providing an emphasis on safety in treatment may encourage providers to focus on actions that assure safe practices for minorities (e.g. overcoming barriers such as culture, language and low health literacy). 	
Promoting Competition	<ul style="list-style-type: none"> Promote insurer competition through NIE and by regulating the portion of health plan premiums that must be paid out in benefits.³ 	<ul style="list-style-type: none"> Promote competition among providers by paying them only for quality and promote use of alternative providers and treatment settings.³ Cooperation among states in the purchase of insurance to rid the market of costly regulations and promote competition. 	<p>Both:</p> <ul style="list-style-type: none"> Low-income minorities are disproportionately enrolled in “lower-tier” health insurance plans which often limit coverage, services and choice of providers.⁵ Promoting competition among health plans may expand choices for minorities and enhance access to more affordable and higher quality services.
Health Information Technology	<ul style="list-style-type: none"> Invest \$50 billion over five years to adopt electronic medical records and other health information technology.³ 	<ul style="list-style-type: none"> Promote the rapid deployment of information systems and technology that allows doctors to practice across state lines. 	<p>Both:</p> <ul style="list-style-type: none"> Potential to decrease unnecessary spending from duplication of care, preventable errors, inefficient paper billing and other administrative efficiencies.

1. www.barackobama.com
 2. www.johnmccain.com and Senator McCain’s remarks, April 29, 2008, Arlington, VA.
 3. Kaiser Family Foundation, 2008.
 4. Reed and Hargraves, 2003.
 5. National REACH Coalition, 2008.

C. Quality Improvement

Health policies that improve the quality of care will need to consider a range of actions that support doctors, nurses, and health care organizations in providing evidence-based medicine, and improve patients' ability to act effectively in managing their own care and health. Initiatives will be most effective in addressing racial/ethnic disparities by also integrating the needs, values and culture of individuals through all major aspects of health care: primary, specialty, inpatient and long term.

Both candidates' positions reflect a recognition that multiple approaches are needed to improve health care quality (Table 4). Senators McCain and Obama each offer incentives and disincentives for practitioners and health care settings, acknowledge the importance of measurement, promote research on evidence-based practices, propose actions to encourage care coordination, and set treatment and prevention priorities for specific diseases.

Their proposals are similar on promoting public reporting of quality and cost data, supporting measurement and increasing assistance for developing and disseminating best practices. The candidates' support for expanding chronic disease prevention and management offers opportunities to reduce racial/ethnic disparities in health. However, neither candidate directly addresses the role that language, literacy and culture play in effective disease management and prevention. Senator Obama encourages application of medical home models for coordination of care, which is associated with reducing racial/ethnic disparities. Senator McCain also recognizes care coordination and

mentions "medical homes" in the context of providing individuals and families the opportunity to continue with their preferred source of care, even in the event of a job change.

Both candidates have overlapping priorities for research on specific diseases, including cancer, obesity, smoking, autism and other chronic conditions (e.g., diabetes and heart disease). Senator McCain's plan highlights his desire to combat autism, specifically stating that he will support federal research: to understand the broad range of health and environmental factors that contribute to its incidence; and to identify appropriate prevention and treatment options. Senator Obama focuses explicitly on combating HIV/AIDS globally, nationally as well as among the nation's growing racially and ethnically diverse communities. He asserts his support for innovative community-based initiatives for testing HIV/AIDS among minorities. Other health priorities for Senator Obama are disability, mental health and childhood lead poisoning.

The most significant difference in the candidates' proposals relates to the inclusion of language that acknowledges racial/ethnic disparities. Senator Obama's plan explicitly acknowledges the importance of holding health care providers responsible for disparities in quality and would require detailed reporting on racial/ethnic disparities in hospital-acquired infections, medical errors, and other quality and safety indicators. Senator McCain's plan does not mention disparities in health care quality.

Neither candidate specifies ways to use civil rights law or other legal avenues to address discrimination or disparities.

Table 4: Democratic and Republican Presidential Nominees on Health Care Quality Improvement

Health Care Quality Improvement		Implications for Racial/Ethnic Minorities	
Barack Obama ¹		John McCain ²	
Democrat		Republican	
Party Affiliation			
Incentives/ Penalties	<ul style="list-style-type: none"> Reward providers for reaching performance thresholds on valid outcome measures, and hold hospitals and plans accountable for disparities in quality. 	<ul style="list-style-type: none"> Reform Medicare and Medicaid to allow for compensation for diagnosis, prevention and care coordination. No payment for preventable errors or mismanagement. 	<p>Obama:</p> <ul style="list-style-type: none"> Explicitly states the intent to use funding and quality requirements to increase responsibility for addressing disparities in outcomes. <p>McCain:</p> <ul style="list-style-type: none"> Encourages but does not specify adjustments (and financial disincentives) for key health care priorities affecting minorities. <p>Both:</p> <ul style="list-style-type: none"> Pay-for-performance initiatives need to consider the potential for creating disincentives for providers to care for minorities, whose illness prevalence rates are higher and who often face greater barriers complying with treatment recommendations.⁴
Data Collection and Public Reporting	<ul style="list-style-type: none"> Require hospitals/providers to collect and publicly report measures of health care cost and quality, including data on preventable medical errors, nurse staffing ratios, hospital-acquired infections, and disparities in care; align reimbursement with quality care. NIE would evaluate performance of participating health plans on costs, quality and other measures. 	<ul style="list-style-type: none"> Collect information on practice patterns, costs and effectiveness of providers. Develop national standards for measuring and "recording" treatments and outcomes.⁵ Require transparency for medical outcomes, care quality, costs and prices and pay only for care that is the "right care".⁵ Improve public's access to information about treatment options, performance, provider safety records and quality measures.³ 	<p>Obama:</p> <ul style="list-style-type: none"> Requiring providers to monitor and report progress on reducing disparities could lead to national benchmarks and public reporting. <p>McCain:</p> <ul style="list-style-type: none"> No specificity about collection, reporting of data related to racial/ethnic health disparities. <p>Both:</p> <ul style="list-style-type: none"> Greater public accountability for effective treatments and improved outcomes could help minority patients make more informed medical decisions. Public reporting of data on disparities in quality would offer opportunities to raise visibility of racial/ethnic inequalities and support actions to reduce disparities.

Health Care Quality Improvement
John McCain²
Implications for Racial/Ethnic Minorities

Barack Obama¹

Care Coordination and Disease Management

- Improve prevention and management of chronic conditions.³
- Plans participating in new public plan, Medicare or FEHBP must use “proven” disease management programs.⁵
- Support care management programs; encourage medical home-type models to improve coordination and integration especially for chronic conditions
- Encourage cost reduction through disease management and individual case management as well as health and wellness programs.
- Making providers more accountable for care and ensuring that patients pay a “single bill” for high quality care.
- Provide “medical homes” to ensure patients have continuity of care with doctors who know their medical history

Both:

- Focus on chronic disease holds promise for the disproportionately higher number of minorities suffering from these illnesses, especially if language and cultural needs and circumstances contributing to their disease are central to these efforts.
- Strong support for disease management may assist minority patients in treatment adherence and self-management if language, health literacy and cultural competence are integrated into related protocols.
- Support for medical homes could positively impact minorities who are much less likely to have a regular source of care.

Promoting Evidence-Based Medicine

- Support development and dissemination of best practices.
- Establish an institute to guide reviews and research on comparative effectiveness for providers to make best decisions.
- Implement evidence-based guidelines across all spheres of medicine.
- Support documenting and disseminating information on best practices to eliminate excess costs.
- Increase federally funded research on chronic illness and treatment of patients with multiple chronic conditions.⁵

Both:

- Strong support for dissemination of best-practices could lead to greater racial/ethnic equality in application of evidence-based medicine.

Civil Rights Enforcement and Legal Action

- Not Specified
- Not Specified

Both:

- No specificity regarding the use of anti-discrimination statutes or other legal recourse to enforce equal access and protection, and prosecute civil rights violations in federal courts. No specificity about making states comply with federal requirements to provide preventive, diagnostic and treatment services to children in Medicaid.⁶

Health Care Quality Improvement

Implications for Racial/Ethnic Minorities

Barack Obama¹

John McCain²

Disease-Specific Priorities

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Smoking: Require smoking cessation in federally funded plans. • Obesity: Provide healthy dietary choices and expand physical education in schools. Expand availability of fresh vegetable and fruit choices in communities. • Cancer: Eliminating cancer is a top priority. Increase funding for NIH, NCI and other medical research programs.⁷ • Autism: Encourage government and community collaboration to expand support available to autistic individuals. • HIV/AIDS: Be a global leader in fighting HIV/AIDS. Commit resources to promote innovative HIV/AIDS testing initiatives in minority communities, partnering with community leaders, churches and community-based organizations. • Disability: Strengthen and enforce Americans with Disabilities Act (ADA) and ensure disabled Americans receive Medicaid and Medicare benefits in a low-cost, effective and timely manner. • Mental health: Support mental health benefits that parallel coverage for physical illness and disease: mental health “parity.” • Child lead poisoning: Require child health facilities to be lead-safe within five years. | <ul style="list-style-type: none"> • Smoking: Promote the availability of smoking cessation programs. • Obesity: Support the expansion of healthy dietary choices in schools. • Cancer: Promote quality cancer care and early screening and testing for breast, colon and other types of cancer. • Autism: Support federal research on the causes and prevention of autism. | <p>Obama:</p> <ul style="list-style-type: none"> • Support of community-based efforts to address HIV/AIDS explicitly targets minorities. • Requiring child facilities to be lead-safe in five years could benefit minority children who bear a disproportionate burden of childhood lead poisoning.⁸ • Parity for mental health coverage could improve access to care for minorities with mental illnesses. • Better access to Medicaid and Medicare for low income, disabled minorities could improve quality of life and health outcomes for this vulnerable group. <p>McCain:</p> <ul style="list-style-type: none"> • No specificity on reducing disparities in the prevalence of specific diseases or chronic conditions, but proposed efforts could lead to better health outcomes for minority populations. <p>Both:</p> <ul style="list-style-type: none"> • Support for efforts to reduce smoking, obesity, cancer and autism and improve access to testing and treatment for these conditions could reduce racial/ethnic disparities in the prevalence and availability of treatment for these conditions. |
|--|---|--|

1. www.barackobama.com
2. www.johnmccain.com and Senator McCain's remarks, April 29, 2008. Arlington, VA.
3. Kaiser Family Foundation, 2008.
4. National REACH Coalition, 2008.
5. Collins and Kriss, 2008.
6. Teitelbaum, 2008.
7. Intercultural Cancer Council Caucus, 2008.
8. Pastor et al., 2006.

D. Infrastructure Support for Reducing Racial/Ethnic Disparities

With decades of experience working with diverse communities, practitioners, health care professionals and advocates, as well as patients, have come to similar conclusions on the importance of specific actions needed to reduce racial/ethnic disparities in health care. Recommendations include programs to: increase the racial/ethnic diversity of the health care workforce; to support health care providers and staff in providing culturally competent care; and to increase health literacy.

The candidates' health plans demonstrate their greatest differences on infrastructure support for

reducing racial/ethnic disparities (Table 5). Senator Obama's proposal identifies at least five areas for assisting minorities and reducing disparities: requiring collection, analysis and reporting of health care information on diverse patient populations; encouraging cultural competence education and training for health care providers; supporting greater racial/ethnic diversity in the health care workforce; increasing availability of language assistance; and assisting patients in obtaining appropriate health services. Senator McCain's plan encourages collection of information documenting effectiveness, costs and practice patterns, but does not mention racial/ethnic disparities.

Table 5: Democratic and Republican Presidential Nominees on Infrastructure Support for Reducing Disparities

Infrastructure Support for Reducing Racial/Ethnic Disparities Implications for Racial/Ethnic Minorities	
Barack Obama ¹	John McCain ²
Democrat	Republican
<p>Party Affiliation</p> <p>Collecting Data on Disparities in Quality of Care</p> <ul style="list-style-type: none"> Evaluation or health impact assessments to determine effectiveness in reducing disparities. 	<p>Obama:</p> <ul style="list-style-type: none"> Monitoring status and progress in reducing disparities could identify areas needing improvement. <p>McCain:</p> <ul style="list-style-type: none"> Without specific consideration of disparities, the ability to monitor effectiveness of programs to address the needs of minority patients may be limited.
<p>Cultural Competence and Language Assistance</p> <ul style="list-style-type: none"> Expand outreach and educational efforts to improve the cultural competence and language skills of hospital providers. Expand efforts to provide more tools such as bilingual hotlines to help rural hospitals treat patients who do not speak English. Invest in public health workforce recruitment efforts such as loan repayment or forgiveness programs to make health care workforce more diverse. 	<p>Obama:</p> <ul style="list-style-type: none"> Explicit support of cultural competence and language assistance training and education for hospitals and providers could improve the quality of care for ethnic minorities. Does not specifically address financial support or other assistance to increase availability of qualified interpreters. <p>McCain:</p> <p>No specificity on cultural competence training/education or language assistance programs.</p>
<p>Health Workforce Diversity</p>	<p>Obama:</p> <ul style="list-style-type: none"> Explicitly acknowledges the critical importance of supporting programs that will result in greater racial/ethnic diversity among physicians, nurses and other health care workers. Increasing incentives to health professionals to work in minority and underserved communities through tuition credits, loan forgiveness and other means could help make the workforce more diverse and potentially improve access to quality health care for minorities.³ <p>McCain:</p> <ul style="list-style-type: none"> No specificity on expanding health care workforce diversity.
<p>Patient Navigation</p> <ul style="list-style-type: none"> Implement patient "navigation" programs to address disparities. 	<p>Obama:</p> <ul style="list-style-type: none"> Attention to disparities in efforts to improve patients' ability to understand their medical information, test results, treatment regimens and other aspects of their care could help to ensure that language, literacy and cultural needs are met across all aspects of care. <p>McCain:</p> <ul style="list-style-type: none"> No specificity about patient navigation.

1. www.barackobama.com

2. www.johnmccain.com and Senator McCain's remarks, April 29, 2008, Arlington, VA.

3. National REACH Coalition, 2008.



E. Disparities in the Community Context: Addressing the Social Dynamics that Influence and Determine Health

The health care platforms of Senator Obama and Senator McCain largely focus on improving access to affordable, quality health care by aligning incentives among providers, patients and payers to reward quality, efficiency and better health outcomes. Health care incentives that promote quality and efficiency, and innovations that advance measurement and reporting are essential to reducing racial and ethnic disparities. However, efforts that focus solely on improving access to health care are not sufficient for reducing racial and ethnic health disparities. As one study indicates, "... having health insurance does not guarantee access to care—and certainly does not guarantee access to high quality of care" (Lurie and Dubowitz, 2008).

Eliminating disparities requires comprehensive strategies that reach far into the daily lives of individuals and communities. As recently stated, "...racial and ethnic disparities in health status are primarily a reflection of inequality in U.S. society and it is this inequality—in housing, education, employment and in broader social, political and economic arrangements—that marginalizes and disenfranchises people of color" (Smedley, 2006). Therefore, addressing the social and economic dynamics that influence and determine health must be a core aim in eliminating health inequalities.

Both candidates' plans recognize the importance of public health collaboration with schools and workplaces to promote healthy lifestyles and expand access to prevention services that otherwise may not be available within certain neighborhoods and communities. For example, they both propose working with schools to provide healthy dietary choices for children and working with employers to encourage the offering of wellness and smoking cessation programs. Both candidates' plans also acknowledge the important role that personal decisions play in health

by encouraging lifestyle changes to prevent or delay chronic disease and illness. In reference to developing healthy habits to ward off diabetes, obesity and other "common conditions," Senator McCain concludes, "Watch your diet, walk thirty minutes per day and take a few other simple precautions and you won't have to worry about these afflictions" (April 29, 2008).

Senator Obama's plan acknowledges the importance of community-level determinants to health outcomes and broadly recommends actions to improve opportunities for healthy living in poor neighborhoods, such as providing more sidewalks, bike paths and walking trails; making fresh produce more available; restricting tobacco and alcohol advertising aimed at children; and expanding community-based prevention programs. He also proposes public health collaborations with other public agencies and the private sector, and a more assertive government examination of related agricultural, education and environmental policies as they influence public health.

Beyond these proposals, however, both candidates will need to assess the broader implications of their proposed health care reforms on the social and economic factors that shape the health and health care opportunities for minorities. For example, Senator Obama's acknowledgement of the importance of coordinating public health with other public and private sectors is a good start but needs to go further. His plan offers little in the way of specific actions that these collaborations would take to improve the social-environmental factors that affect health, such as better housing, reduced crime, more educational opportunities and expanded public transportation. It is critical to acknowledge the effects of residential segregation on poorer health outcomes and reduced access to care so that proposals address these aspects of inequality that contribute to racial/ethnic disparities in health.

Senator McCain's proposal, which currently offers very limited acknowledgement of such interrelationships, leaves open to question how far-reaching his

initiatives will be if they neither recognize nor address underlying community and individual circumstances that influence health and health care decisions. For example his statement about walking and watching one's diet does not mention that many areas do not have safe areas to walk, fast food franchises dominate many disadvantaged communities, and access to fresh produce is often severely limited.

Health care proposals of both candidates must address the complex interplay of medical, health care, public health, social and economic factors necessary to guaranteeing equality in health and health care. Finally, both candidates need to advance policies in other areas—the economy, education, immigration, and the environment—that directly acknowledge their association with and impact on the health and health care of Americans, particularly those in low income, underserved and minority communities.

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Part IV. Health Care Equality within our Reach

The presidential candidates' health care platforms each present a "road map" to improving health care for the nation. Senator McCain and Senator Obama each believe that his proposals offer the right mix of health system reforms and incentives to individuals, providers and health care purchasers that will make health care more affordable and more efficient, and thus improve access to needed care and the quality of health care for all. Only Senator Obama's plan, however, directly acknowledges the need for and proposes specific actions to reduce racial/ethnic disparities. However, there are still looming questions over how far either candidate would use his presidential power and influence to take the nation beyond incremental actions to guarantee health care coverage and eliminate inequalities in health care access, quality and health outcomes.

A. Historical Presidential Reforms that Helped Reduce Racial/Ethnic Disparities

The new president will have a singular opportunity to achieve goals all Americans can support: to make health care more affordable, higher quality and available when and where it is needed—regardless of race, ethnicity or cultural background. Although this report cites well-documented and longstanding racial and ethnic disparities in health care and health status, there is nothing inevitable about this divide. In fact, history offers lessons on how presidential initiatives contributed to significant progress in improving health care and reducing or eliminating disparities in access, quality and outcomes. Several examples illustrate the power of presidential leadership to confront and reduce racial and income disparities in health.

President Truman and the armed forces. Disparities in health treatment and outcomes among military personnel began to be eliminated following the racial integration of the armed services through the executive

order of President Truman sixty years ago. Active duty and military personnel and their families (8.3 million beneficiaries) have access to a universal system of government-sponsored health and dental care (KFF, 2008). As a result:

- The large racial/ethnic disparities in dental health that exist in the civilian population are now virtually eliminated among the armed forces, as measured by the incidence of untreated dental carries and recent dental visit rates (Hyman et al., 2006).
- Substantial racial/ethnic disparities in survival rates from lung cancer among the civilian population are non-existent in the armed services (Mulligan et al., 2006).
- Black-white disparities in infant mortality rates that plague the civilian population have nearly disappeared in the armed services (Rawlings and Weir, 1992).

President Johnson and Medicare and Medicaid. The implementation of the Medicare and Medicaid programs, led and shaped by President Johnson, produced profound shifts in access to care and health care outcomes for poor and minority Americans.

- Following the implementation of Medicare, racial and income disparities in rates of hospital admissions and physicians visits were eliminated in a decade (Smith, 1999).
- PSA screening rates for prostate cancer in the Medicare program are now essentially the same by race (Mariotto et al., 2007).
- The overall difference in black and white age-specific death rates declines after age 65; after age 80, there is a "crossover" where black age-specific death rates are actually lower than white rates (Corti et al., 1999).
- The black infant mortality rate fell 30 percent between 1965 and 1971, after the introduction

of Medicaid, narrowing the gap between blacks and whites (Chay and Greenstone, 2000).

President Johnson and Neighborhood Health Centers. President Lyndon B. Johnson supported the passage of legislation that led to the creation of federally-funded health care centers in high-poverty communities. Bipartisan presidential support since then has resulted in more than 3,000 community health care centers (CHCs) that provide care to over 10 million low-income residents across the country including: preventive care to one of every six low-income children (4.5 million); prenatal care to pregnant women in one of every five low-income births (400,000); and care to one of every 10 uninsured persons (4.4 million). Two-thirds of CHC patients are minorities (HRSA, 2008).

Presidential and congressional influence on health care quality and safety. Presidents have also been influential in the passage of federal legislation designed to provide new opportunities for minorities to obtain better quality care.

- Major teaching centers have received substantial federal funding for training and research with the support of all presidents beginning with Eisenhower. By nature of their mission and location, academic medical centers, often acknowledged as centers of excellence in medical care provide a disproportionate share of health care to minorities.
- Federal legislation has enabled the Veterans Administration (VA) health program, which serves as a safety net provider to veterans, to adopt an integrated system of electronic medical records, which is now considered a national model. This has improved the quality of care for minority and white patients served in VA hospitals.

B. Recent Developments to Reduce Disparities

Part of presidential leadership has always involved responding to a changed or changing social and political environment. Recent trends suggest a growing

national willingness to address health disparities. These present new leadership opportunities for the next president to support policies that will promote equality in health outcomes.

Recent federal actions to reduce disparities. National efforts over the past several years have begun to shed light on the institutional and structural barriers to making progress in reducing health disparities. Federal agencies have been critical to this progress.

Documentation of the nature and extent to which health disparities occur and affect minorities is essential to reducing disparities. Recommendations from the Civil Rights Commission, the Institute of Medicine and many advocacy groups over the decades to improve the measurement of disparities have finally borne results:

- For the first time, the national consensus effort, *Healthy People 2010* set as one of its overarching measurable goals the elimination of racial and ethnic disparities in health.
- Since 2003, the Federal Agency for Health Research and Quality (AHRQ), as directed by Congress, has produced an annual report on disparities in treatment, distilling the evidence from all major national data sources and tracking progress in correcting these problems (AHRQ, 2008).
- Under the current Bush Administration, the Centers for Medicare and Medicaid Services (CMS) launched a hospital quality improvement program in collaboration with all of the relevant health related organizations in 2005. The Hospital Compare program supplies information on selected quality measures for heart attack, pneumonia, heart failure and surgical infection prevention, tracking hospitals' degree of compliance with national quality standards. Hospitals face reimbursement penalties if they fail to provide this information, making the rate of participation nearly universal. While no racial information is currently supplied, patient surveys that include racial identifiers will begin to be

publicly reported for all participating hospitals in 2009.

- CMS is also seeking to use health disparities data to improve quality and outcomes. Quality Improvement Organizations that support quality improvement efforts of Medicare providers and managed care plans will be required to develop interventions to address identified disparities.

Private efforts to redress and reduce racial/ethnic health disparities. The Joint Commission for Accreditation of Health Care Organizations (JCAHO), the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA) are all national, private organizations that, along with private health care foundations and many advocacy organizations work with CMS, AHRQ as well as state Medicaid programs and health departments to improve health care for minorities and improve measurement of racial/ethnic health disparities. A public-private health care system requires public-private collaboration in confronting and reducing racial/ethnic disparities.

Shift in the perspective of organized medicine. The American Medical Association (AMA) recently acknowledged and apologized for its legacy of racial discrimination toward African American physicians. The AMA's admissions illustrate the historical role of organized medicine in perpetuating racial discrimination; its call for health care equity and the end of racism in the medical professions is an example of the progress that can be made and must continue toward racial/ethnic equality in health care.

A commentary by the immediate past President of the American Medical Association concludes:

The medical profession must have diversity in the physician workforce equivalent to that in the general population, and equity in health care delivery for all persons. A unity of purpose must be achieved among all physicians, and the association that represents them, to make this envisioned future a reality. To some, whether looking back or looking forward, attaining equality of

opportunity in medicine may seem an audacious goal, but it is not an option for the medical profession. It is within reach, and the nation will celebrate the day when racial harmony is achieved in health care for the benefit of patients, communities and the medical profession (Davis, 2008).

C. How Will the Next President Use His Leadership to Support Policies that Help Eliminate Racial/Ethnic Disparities in Health Care?

The next President of the United States will have enormous opportunities to harness the energy and commitment of leaders and providers across the public and private health care sectors to build upon the progress made to eliminate racial/ethnic disparities in health.

Guaranteed access to needed health care remains the centerpiece of any health care reform that is to be effective in eliminating racial/ethnic disparities (Andrulis, 1998). The lack of adequate or any insurance represents the most formidable barrier to reducing health disparities (AHRQ, 2008). The next President can use his executive leadership to advance policies that help ensure that all Americans, regardless of race/ethnicity, have continuous health insurance coverage.

Presidential leadership can also play a vital role in promoting policies that address the many other factors beyond insurance coverage that contribute to and perpetuate disparities in access, treatment and health outcomes, as described in this report. The proposals of the two major presidential candidates offer guidance, to varying degrees, about their approaches to improving quality, affordability and access to care. There is, however, a significant opportunity for both to build on their current proposals by explicitly supporting national policies and strategies that are critical to reducing racial/ethnic disparities in health and health care. These include:

- **Expanding access to medical and health care for underserved communities** through the

development of coordinated care and medical homes, particularly in publicly-funded health care settings serving large minority and low-income populations, such as community health centers and safety-net institutions.

- ***Promoting quality and equality in health care programs and practices*** by assuring that evidence-based guidelines are applied without discrimination; by developing quality improvement programs that include incentives to providers and health plans for reducing disparities and improving patient outcomes; and by tailoring prevention and wellness programs to meet the distinct health and community needs of underserved and minority populations.
- ***Developing targeted strategies and tools for reducing racial/ethnic disparities*** such as health information technology to standardize collection and monitoring of health care disparities in access, utilization and quality; cultural competence education for health care professionals; incentives to promote diversity in the health professions workforce; and culturally and linguistically-tailored patient education programs.
- ***Promoting broader social and economic development in underserved communities*** by expanding support for federal, state and local efforts to expand or improve community infrastructure. These include: affordable housing; access to public transportation, safe parks and recreational facilities, and grocery stores with affordable, fresh produce; and education and job opportunities. Promoting collaboration across governmental agencies for health, education, housing, employment, environmental protection, transportation, commerce and criminal justice is critical to these efforts. Enforcement of civil rights within each of these government spheres is necessary to eliminate all aspects of racial discrimination, including discrimination in health care.

D. Conclusion

Since the mid-1990s, when major health care reform was last on the national legislative agenda, health care has changed significantly. Demands for greater accountability in health care have stimulated advances in information technologies and measurement that are helping to improve the performance of our nation's health care system. Yet health care costs continue to skyrocket and millions of Americans—up to 47 million—have no health insurance. Concerns around chronic disease, obesity and the influence of the local environment and socioeconomic conditions on health have only intensified. And while there is much greater recognition today about the extent of racial and ethnic disparities in health status and access to affordable and high quality care, there has been only limited progress toward eliminating such disparities.

The beginning of a new presidential era always offers hope that the nation will cross a threshold, leading the way to redress these inequalities and taking great strides in improving health and well-being for those historically left behind. The question before the next president is whether his proposals, if enacted, will set us on a path to achieve quality and equality in health care for all.

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The mission of the Joint Center Health Policy Institute (HPI) is to ignite a "Fair Health" movement that gives people of color the inalienable right to equal opportunity for healthy lives. HPI's goal is to help communities of color identify short- and long-term policy objectives and related activities in key areas.

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